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Implementing Eligibility Changes under the Affordable Care Act: Issues Facing State Medicaid and CHIP Programs

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INTRODUCTION

The Affordable Care Act (ACA) includes many provisions designed to expand and streamline Medicaid eligibility. The ACA extends coverage to non-disabled, non-elderly citizens with income under 133 percent of the Federal Poverty Level (FPL); adopts new methodologies for determining and renewing eligibility; and requires establishment of a streamlined process to allow state Medicaid programs to coordinate seamlessly with other insurance affordability programs and affordable health insurance exchanges.

These provisions are intended to change the Medicaid eligibility determination and renewal processes for most Medicaid applicants and beneficiaries from one based on a static, 20th century welfare program model to one that utilizes information technology (IT) to provide the insurance coverage option that fits each individual's current circumstances and needs.

The effectiveness of this new model will depend upon states' ability to implement it successfully. Implementation will require substantial changes to state policy; extensive enhancements, if not replacements, of state IT systems; the production of new application and enrollment materials; the establishment of new outreach methods; the potential reorganization of state eligibility personnel; and unprecedented coordination between state organizations. Drawing on preliminary federal guidance, most states initiated a planning process in 2010 and 2011. While final federal guidance is now being released, states still face many implementation issues.

HISTORICAL ELIGIBILITY PRACTICES

When the Medicaid program was created in 1965, eligibility was limited to low-income families with dependent children receiving cash assistance under the Aid to Families with Dependent Children (AFDC) welfare program. Generally, state offices used their AFDC application materials, policies, and procedures, including the methodologies for counting income and resources, to determine Medicaid eligibility. For instance, if state AFDC policy excluded 18-year-old full-time students from being eligible, Medicaid policy also did.

Congress gradually expanded the Medicaid program to cover additional categories of individuals, including disabled individuals receiving Supplemental Security Income (SSI) cash assistance and individuals not receiving AFDC or SSI, but states still have been required to follow the AFDC program's rules for determining eligibility for parents/caretaker relatives, pregnant women, and children (even after the Temporary Assistance for Needy Families program replaced AFDC in 1996). Because AFDC income limits were very low, most states provide Medicaid only to parents/caretakers with income well below 100 percent of the FPL. All states, by law, cover pregnant women and children under age 6 with family income through 133 percent of the FPL and children ages 6 through 18 with income through 100 percent of the FPL; most cover individuals in these categories with much higher levels of income (up to 300 percent of the FPL).

Medicaid applications for parents/caretaker relatives, pregnant women, and children take two general forms: (1) joint applications for Medicaid, cash

assistance, the Supplemental Nutrition Assistance Program (SNAP, formerly known as the Food Stamp program), child care subsidies, energy assistance, and other state-administered social service programs; and (2) applications only for Medicaid and the Children's Health Insurance Program (CHIP). All application forms contain questions about applicants and family/household members, their demographics, relationships, and sources of earned and unearned income; some also ask about assets. Joint program applications typically request more information than Medicaid/CHIP-only forms.

Most states accept applications in-person, by mail, or electronically, although some still require them to be submitted in conjunction with face-to-face interviews. While application assistants and staff working for qualified entities (such as participating providers) may assist with completing and filing applications, merit system employees in state or local Medicaid or welfare agency offices currently must make final eligibility determinations. Eligibility caseworkers data enter or import application data into a computer system and, either manually or by prompting an automated system: (1) establish household composition and size, (2) determine which individual(s) on the application belong to eligibility categories (e.g., caretaker relative or child), (3) verify income and resources and other non-financial factors of eligibility, such as residency and citizenship, (4) calculate gross income (and assets, if relevant), (5) determine net income by subtracting deductions and disregards, and (6) compare monthly net income and total countable assets to the state's income and resource limits for eligibility groups within the applicable eligibility categories. Caseworkers verify financial and non-financial information by reviewing paper documentation or by querying state databases such as unemployment compensation systems, or federal systems like the U.S. Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) program. They first test whether the applicant(s) qualifies for the most beneficial eligibility groups and then "cascade" through all possible eligibility groups before making a final determination. By regulation, the entire determination process may take up to 45 days. Once an individual is enrolled in Medicaid, his/her case is reviewed if there is a change of circumstances that might affect eligibility, or after a set period of time not to exceed 12 months. If the individual was simultaneously enrolled in other programs like SNAP, the state will typically coordinate reviews for all

programs. States with separate CHIP programs coordinate Medicaid and CHIP eligibility determinations to different degrees. In some separate CHIP program states, the Medicaid and CHIP programs share offices, caseworkers, and computer systems; in others, they operate completely separately.

ACA ELIGIBILITY PROVISIONS

To provide coordinated guidance on the eligibility determination process for insurance affordability programs and health plan coverage through an exchange, the Centers for Medicare & Medicaid Services (CMS) published the proposed rule "Medicaid Program: Eligibility Changes Under the Affordable Care Act of 2010" on August 17, 2011, in conjunction with the Department of Health and Human Services' (HHS) proposed rule on exchange eligibility determinations and the Internal Revenue Services' "Health insurance premium tax credit" proposed rule. After reviewing over 800 formal comments, as well as feedback obtained from states, tribes, and other parties, CMS issued a final/interim final rule incorporating significant changes on March 23, 2012. While the March 23 rule reflects final policies, CMS has stated it will issue additional regulatory and subregulatory guidance on related policy and operational issues.

The March rule's intent is to align Medicaid and CHIP eligibility determinations for parents/caretaker relatives, other adults, pregnant women, and children with determinations for health plan coverage by the exchanges and determinations for advance payments of premium tax credits and cost-sharing subsidies by the IRS. The rule modifies the Code of Federal Regulations to enable an entity to determine eligibility for all insurance affordability programs using a single streamlined application, IRS income rules, and a shared electronic verification service. The most significant actions of the March rule as of January 1, 2014, are listed in Figure 1.

STATE IMPLEMENTATION ISSUES

While federal guidance was being developed, a workshop of state Medicaid and CHIP eligibility directors and national health care reform and tax policy experts convened in May 2011 to identify the

Figure 1. The Most Significant Actions of the March 2012 Rule on Medicaid Eligibility Changes

Creates eligibility groups for adults ages 19 through 64 who are not otherwise eligible for Medicaid as a parent/caretaker relative of a dependent child, pregnant woman, disabled individual, or Medicare beneficiary

Establishes a minimum eligibility level of 133 percent of the FPL (effectively 138 percent of the FPL when a 5 percent disregard is taking into account) for individuals in these categories

Prohibits states from considering assets in determining eligibility for individuals in these categories

Requires that states use the IRS' methodology for determining Modified Adjusted Gross Income (MAGI), with certain exceptions, to determine household composition, family size, and income eligibility, thereby eliminating most income deductions and disregards

Provides increased federal financial participation for "newly eligible" adults who would not have been covered under the state's policies and procedures in effect as of December 2009

Mandates that all states use a standard, streamlined application form developed by HHS for all insurance affordability programs, or an approved alternative that is no more burdensome, and accept it via an internet Web site and other electronic means, telephone, mail, and in person. (States may use a multi-benefit program application in addition to the standard application form.)

Mandates that states make available Web sites in accessible, plain language with information regarding application for and receipt of Medicaid and other insurance affordability program benefits

Requires states to rely to the extent possible upon electronic data, including a shared electronic service (or federal data hub) established by HHS, to verify financial and non-financial information

Establishes that Medicaid agencies must accept and transfer via secure electronic interface eligibility information, including eligibility determinations, from other insurance affordability programs

Permits entities other than the Medicaid or welfare agency, including nongovernmental exchange entities, to determine eligibility¹

¹In its May 16, 2012, "General Guidance on Federally-facilitated Exchanges," CMS states that it will seek further comment regarding ways states can engage non-profits and private contractors while having government agencies still make final eligibility determinations.

issues states face in implementing these provisions, particularly the switch to MAGI methodologies. State participants were clear about their main needs and challenges.

First and foremost, the state directors wanted immediate and detailed guidance on several provisions of the law. Using scenarios, they demonstrated the need for specific instructions from CMS on how to compose household and family units when the AFDC/Medicaid and IRS statutes conflict. The scenarios raised questions such as "Should states include in the Medicaid household a 19-year-old living at home who is not a dependent of the parents for tax purposes but who would traditionally be included in

the household under Medicaid?" or "Can unmarried parents still apply for Medicaid as one family if they do not file a joint tax return?"

The state representatives also identified the need for explicit direction regarding what budget period to use to determine and renew eligibility after 2013, since MAGI is based on annual income and AFDC/Medicaid financial eligibility is calculated using monthly income. They asked, for example, "In the event that the latest tax return does not reflect a very recent change in employment, should states still use the annual income from that return, or calculate income based on the applicant's monthly earnings from a new job?"

Workshop participants highlighted the need for a formula to convert current Medicaid net income standards into equivalent MAGI-based standards. Specifically, they requested a formula to determine how much income an individual applicant or families of different sizes could have and still be eligible for Medicaid when MAGI methodologies replace current procedures for counting net income, which typically include disregarding certain types and amounts of earned and unearned income.

States emphasized that they cannot amend their Medicaid state plans (essentially their contracts with CMS) to reflect compliance with the ACA until they receive guidance on these provisions. They added that, after receiving approval of their state plan amendments, they would still need to enact conforming legislation, develop new regulations, and draft other policy documents, a process which could take more than a year to complete.

In addition to policy guidance, state directors wanted the final standard, streamlined application or details regarding acceptable alternatives. Without either, states cannot finalize and disseminate their own applications (Medicaid and CHIP programs commonly include state-specific information, like logos and phone numbers, on their forms), train caseworkers to use them, and modify their computer systems to receive them. In many states, caseworkers enter data into eligibility systems in the order it is provided on the application. These states will have to reorder their data entry screens if the standard application includes different questions, or if its questions flow differently. States that do not currently use electronic applications will have to add functionality to their systems to accept and import electronic application data by 2014.

States will have to make additional changes to their eligibility systems. States will have to reprogram them to add the new adult eligibility groups (if applicable) and to reflect the MAGI income methodologies and standards. This will require coding business rules for determining the Medicaid eligibility of parents/caretakers, non-disabled adults (if applicable), pregnant women, and children without modifying the rules for other eligibility groups or programs (like SNAP). To meet the requirement to rely upon electronic data to the fullest extent possible to verify eligibility, they will have to connect their systems to

the federal data services hub to get data from the IRS and other federal agencies. States might also have to develop interfaces with systems used by health insurance exchanges so that application data can be transferred for the purposes of making the appropriate eligibility determination. Finally, states will have to program their systems to identify the newly eligible so they will be able to claim them on expenditure reports to CMS. To do this, they will need answers from CMS regarding whom to consider newly eligible. The state representatives asked questions such as, “Is an adult who is determined eligible only for the new adult group after January 1, 2014, still newly eligible if he later qualifies for one of the disability-related eligibility groups that the state covered in 2009?”

According to workshop participants, their systems changes will require considerable resources (including time, funds, personnel, and contracting vehicles). In many states, particularly those with legacy systems, it could take over a year to complete programming activities, including testing. Most states already had long programming queues before the ACA’s enactment because they can only revise computer code for one initiative at a time, or because they employ few skilled programmers. To further complicate matters, many state Medicaid and CHIP agencies do not own their eligibility systems and must prevail upon the system owners (typically the welfare agency) to prioritize and make Medicaid-related changes.

Lastly, in addition to revising policy and updating their computer systems, state leaders have to determine how they will organize and staff the Medicaid and CHIP eligibility functions after 2014—for example, will they continue to have caseworkers in welfare offices determine eligibility for social services and health insurance programs, will they co-locate Medicaid and/or CHIP eligibility workers with exchanges, or will they have exchange staff make all Medicaid and/or CHIP eligibility determinations? Reorganizations will take a significant amount of time to implement because they will have significant budgetary, personnel, and even political, ramifications. Before they can finalize staffing plans, states need to learn from CMS exactly who will be able to determine eligibility for the exchanges.

STATUS OF ISSUES

Through its regulations, subregulatory guidance, formal presentations, and direct technical assistance, CMS has addressed many of these implementation issues (as well as other implementation issues raised by states). For example, CMS provided detailed answers to states' specific questions about household composition, income methodologies, and budget periods in the final rule and during a March 29, 2012 "Medicaid Eligibility and Enrollment Final Rule" public webinar on "MAGI Methods and Household Scenarios." CMS has also provided support to states for overhauling or replacing their eligibility systems by making available enhanced federal funding, establishing conditions and standards for receipt of that funding, issuing guidance on cost allocation, and expediting the review and approval of planning and implementation advanced planning documents.

Some issues identified by states at our workshop are unresolved, although progress has been made in bringing them to resolution. CMS is currently working with contractors and selected states to test proposed methodologies for converting income standards into MAGI-based standards and for identifying and claiming the newly eligible -- it expects to issue final regulations on these issues later in 2012. CMS is also working closely with multiple partners to develop paper and electronic versions of the standard application. CMS spelled out its principles for the application during an April 19, 2012, public webinar on "Application, Verification, and Renewals," but is still finalizing the set of questions to be included in each version. Regarding the federal shared services hub, CMS is continuing to consult with its federal partners and states on its development, but questions about data sources, common identifiers, cost allocation, and functionality, among others, remain. Questions also remain about language in the March 23 rule allowing Medicaid agencies to delegate eligibility determinations to an exchange (even when private contractors operate it) - states would like clarification about the meaning of the "merit system personnel protection principles" exchange entities must employ.

CONCLUSION

If implemented successfully, the Affordable Care Act's Medicaid eligibility provisions could modernize and streamline the process by which low-income uninsured and underinsured individuals and families enroll in Medicaid, CHIP, and other affordable insurance coverage options. Implementation requires substantial policy development, information systems updates, and, potentially, organizational changes. It is especially difficult at the state level due to the need to follow federal guidance and resource constraints. Since the ACA's March 2010 enactment, CMS, other federal agencies, state governments, and many other stakeholders have engaged in a flurry of implementation activities, which have resulted in final guidance and financial and technical support for states; however, many of the implementation issues state Medicaid and CHIP eligibility directors have identified remain unresolved. Regular two-way communication between CMS and states, including detailed discussion of outstanding issues like that facilitated in a SHARE workshop, will facilitate timely implementation.

This brief follows a November 2011 presentation at the Association for Public Policy Analysis and Management (APPAM) Fall Conference regarding state perspectives on implementing expanding Medicaid eligibility under the ACA, which is available at http://www.shadac.org/publications/MedicaidEligibilityMAGI_state. It is a companion to the brief titled "Income Eligibility for Assistance under the Affordable Care Act: Estimates for Nonelderly Adults" and to the brief titled "Translating Modified Adjusted Gross Income (MAGI) to Current Monthly Income," which can be found at www.shadac.org/share/grant/Eligibility-MAGI.

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ABOUT SHARE

The State Health Access Reform Evaluation (SHARE) is a Robert Wood Johnson Foundation (RWJF) program that supports rigorous research on health reform issues at a state level, with a focus on state-level implementation of the Affordable Care Act (ACA) and other efforts designed to increase coverage and access. The program operates out of the State Health Access Data Assistance Center (SHADAC), an RWJF-funded research center in the Division of Health Policy and Management, School of Public Health, University of Minnesota. Information is available at www.shadac.org/share.