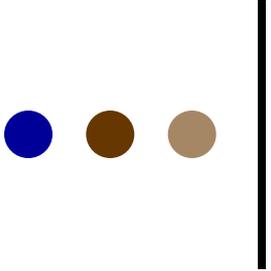


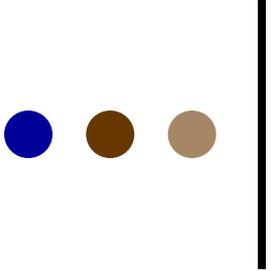
Medicaid Eligibility: Notice of Proposed Rulemaking

Pam Silberman, JD, DrPH



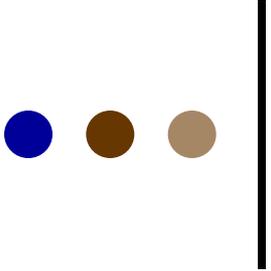
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- Overview
- NPRM: Comment Period
- Key Definitions and Overview of ACA Provisions
- Eligibility Determination and Redeterminations
- Distinguishing between Newly Eligibles and Existing Eligibles
- Coordination between Medicaid, CHIP, and Health Benefit Exchange
- State Options and Flexibility
- Discussion Questions



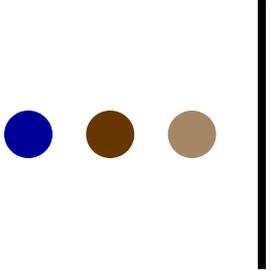
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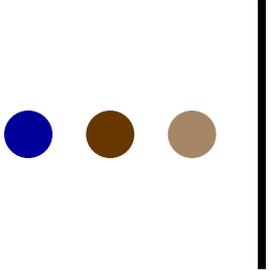
Overview

- The three sets of proposed regulations outline the procedures for:
 - Enrollment in unsubsidized coverage in the HBE.
 - Eligibility verification for any of the insurance affordability programs, including:
 - Advance payment of the premium tax credit, and cost sharing subsidies.
 - Medicaid, CHIP or the Basic Health Program (if applicable).
- The Notices of Proposed Rulemaking (NPRM) attempt to balance administrative simplicity and ease of enrollment with the need to ensure program integrity.



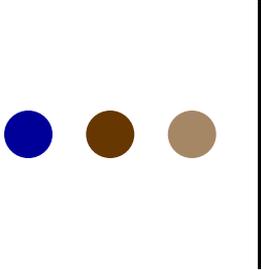
Overview (cont'd)

- Eligibility for all insurance affordability programs based on MAGI-income standards.
 - There are some differences in how income is calculated among different insurance affordability programs.
- Eligibility for Medicaid based on MAGI-income standards determined first.
 - Next, determine eligibility for other insurance affordability programs that are based on being ineligible for Medicaid (ie, Children's Health Insurance Program (CHIP) or Basic Health Plan (BHP)).
 - Then determine if person eligible for affordable employer based coverage.
 - Finally, determine eligibility for the advance premium tax credit and cost sharing subsidies.



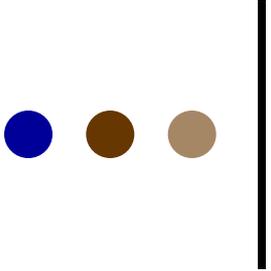
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Medicaid Eligibility and Enrollment NPRM

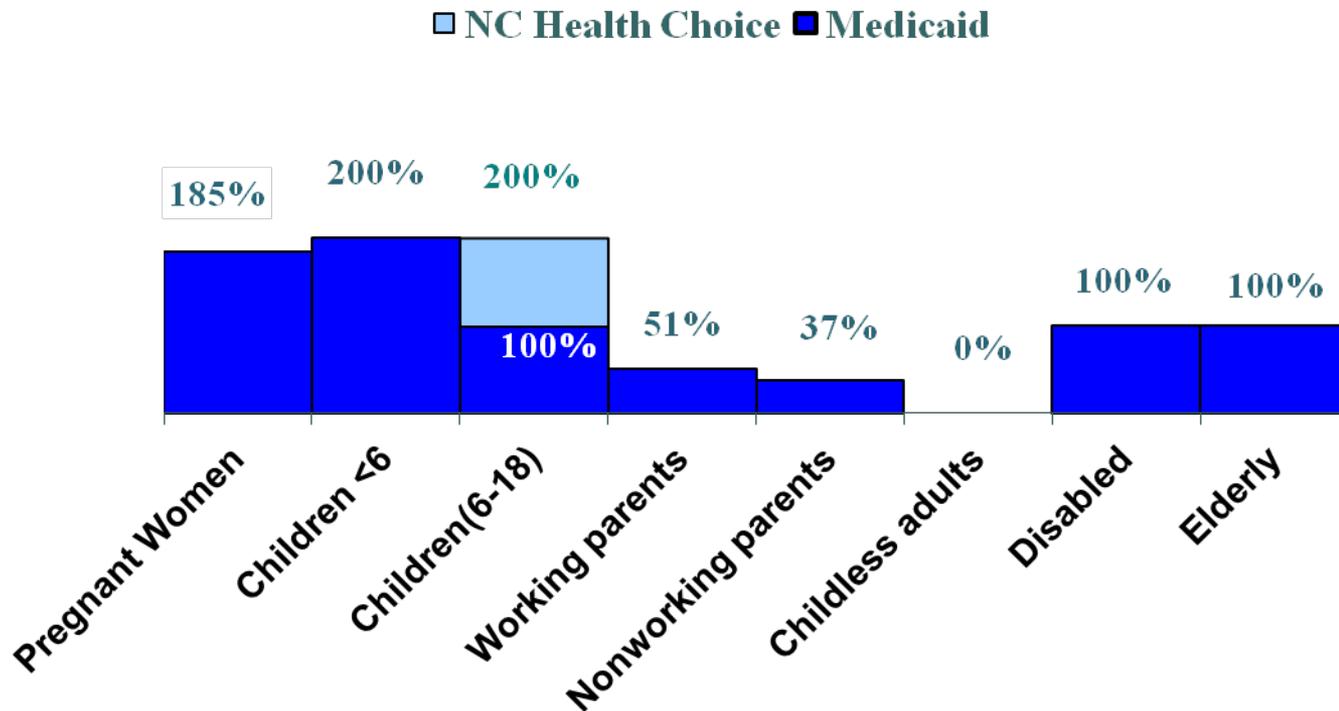
- NPRM released August 17, 2011.
 - 76 Federal Register 51148-51199.
- Public comment due no later than October 31, 2011.



Agenda

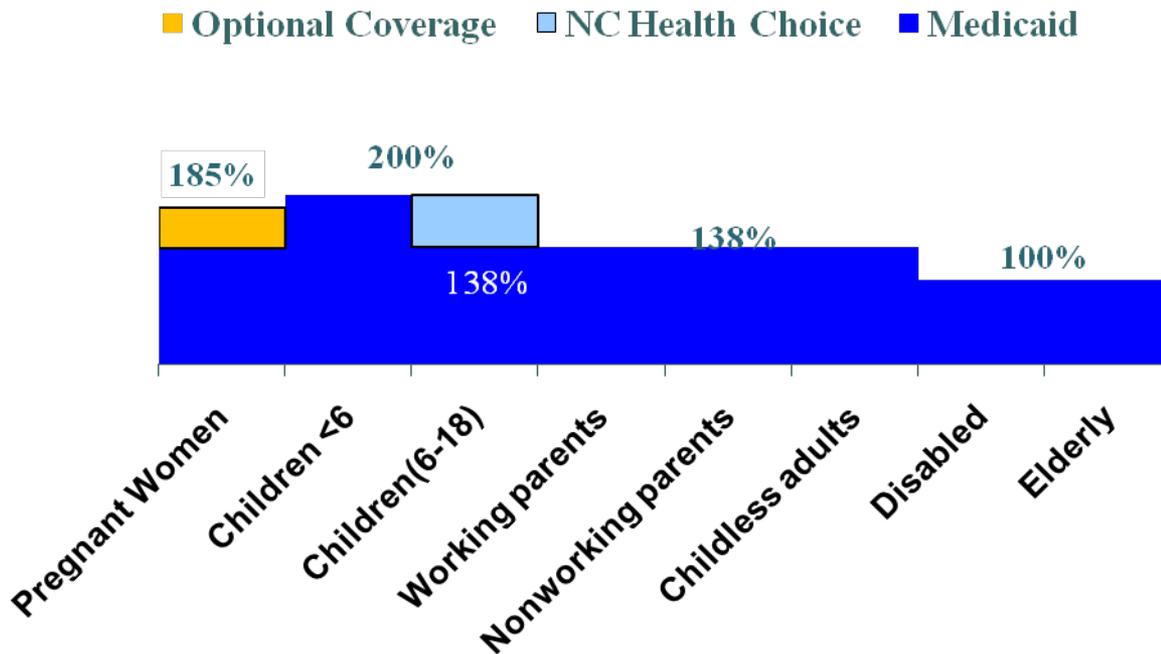
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Existing NC Medicaid Income Eligibility (2010)



Currently, childless, non-disabled, non-elderly adults can not qualify for Medicaid

Existing NC Medicaid Income Eligibility (2014)

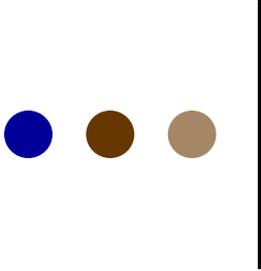


- *Beginning in 2014, adults can qualify for Medicaid if their income is no greater than 138% FPL, or \$30,843 for a family of four (2011)*
- *ACA requires greater outreach and enrollment simplification*

Source: Affordable Care Act (Sec. 2001, 2002). The ACA expands Medicaid for adults up to 133% FPL, but also includes a 5% income disregard. Effectively, this raised the income limits to 138% FPL.

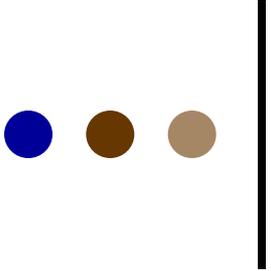
● ● ● | Medicaid Eligibility Rules

- Generally requires states to maintain current enrollment and eligibility standards until the state Exchange is established (Sec. 2001)
- No asset tests or use of income disregards to determine eligibility for children and most adults (Sec. 2002)
 - Asset rules still used for long-term care, home and community based services, medically needy program
- Undocumented immigrants not eligible for Medicaid
 - Most lawfully present immigrants are not eligible for coverage for the first five years (except state option for pregnant women and children)



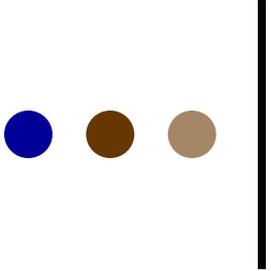
Key Definitions

- *Insurance affordability program*: Includes Medicaid, CHIP, basic health plan (if applicable), coverage in a qualified health plan with advance payments of the premium tax credit or cost sharing reductions. (42 CFR 435.4)
- *MAGI*: Modified adjusted gross income as defined in section 36B(d)(2) of the IRS Code of 1986. (42 CFR 435.603(e)).
- *Newly eligible individuals*: Adults who would not have been eligible for Medicaid under the state's eligibility rules in effect on Dec. 1, 2009. (42 CFR 433.204)
 - *Existing eligibles* are those children and adults who would have qualified for Medicaid under the state's eligibility rules in effect on Dec. 1, 2009 (regardless of whether they were, in fact, enrolled).



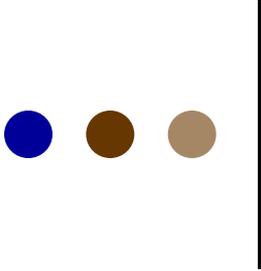
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- **Eligibility Determination and Redeterminations**
 - **Application**
 - **Existing eligibles**
 - **Eligibility verification**
 - **Redetermination**
 - **Assistance with enrollment and redeterminations**
- Distinguishing between Newly Eligibles and Existing Eligibles
- Coordination between Medicaid, CHIP, and Health Benefit Exchange
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Application

- States must use a single, streamlined application for all insurance affordability programs. The application will be developed by the Secretary. (42 CFR 435.907)
 - States can use alternative applications if approved by the Secretary.
 - States can use supplemental forms to obtain other information for people who are not eligible on the basis of MAGI.
- Individuals must be able to apply by internet, telephone, mail, in person, or fax.



Existing Medicaid Eligibles

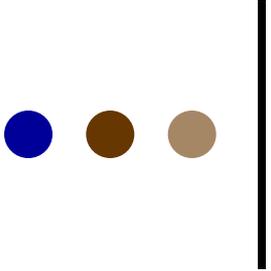
- Streamline existing mandatory and optional eligibility groups into three categories (in 2014):
 - Parents and caretaker relatives (42 CFR 435.110)
 - Parents can only be covered if their children are also enrolled in Medicaid, CHIP or some other health insurance coverage that meets minimum essential coverage. (42 CFR 435.119(c)).
 - Pregnant women (42 CFR 435.116)
 - Children (42 CFR 435.118)

Mandatory Medicaid Elig: Preg. Women, Children, Parents

- States must provide Medicaid to parents and other caretaker relatives if their household income is below the income standard established by the state.
 - States must establish applicable income standards, converted to a MAGI-equivalent standard.
 - Federal government sets minimum and maximum levels, states can set income threshold between these amounts. (42 CFR 435.110-435.118)
 - Individuals who are determined to be eligible for Medicaid based on the state established income standards are eligible for full (not benchmark) coverage.

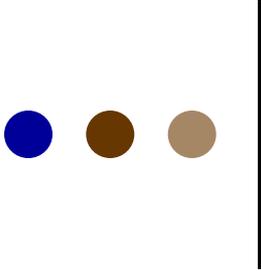
Differences in Benefit Package

	Essential Benefits	Minimum M'aid Benchmark	Standard Medicaid
Physician Services	√	√	√
Lab and x-ray	√	√	√
Inpatient hospital services	√	√	√
Prescription drugs	√	√	√
Pediatric services (inc. oral/vision)	√	√	√
Mental health/substance abuse	√	√	√
Outpatient hospital services	√	√	√
Rehabilitative/habilitative services	√	√	√
EPSDT		√	√
Family planning		√	√
Non-emergency medical transportation		√	√
FQHC/Rural Health Clinic services		√	√
Nursing facility services			√
Home health care services			√



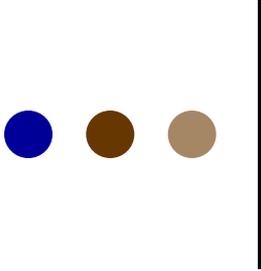
Optional Eligibility Groups

- States can set higher income limits for nonelderly adults (42 CFR 435.218).
 - States can limit coverage for pregnant women with higher income limits to pregnancy only services. (42 CFR 435.116(d))
 - If state establishes new eligibility groups with higher income limits (higher than 138% FPL), then they are currently eligible for full Medicaid coverage.
 - This could lead to strange circumstance when mandatory groups receive full Medicaid, new expansion group (up to 138% FPL) receive benchmark coverage, and optional eligibility group receives full Medicaid.
 - CMS will seek technical amendment to clarify that optional eligibles can also be limited to benchmark coverage.



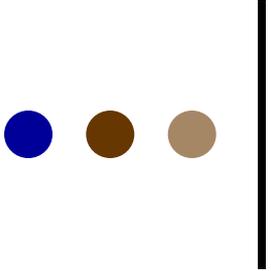
Special Rules for Parent/ Caretaker Coverage

- Special rules for parents/caretaker relatives if living with dependent child.
 - Can not receive coverage unless the child is enrolled in minimum essential coverage (public or private) (42 CFR 435.119)



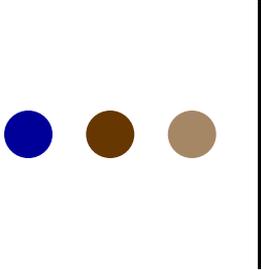
Eligibility Determination: Overview

- All Medicaid applicants will be required to demonstrate proof of:
 - Citizenship or lawful permanent status
 - Residency
 - Income
 - Financial eligibility determinations for most people based on Modified Adjusted Gross Income (MAGI).
 - 5% income disregard (which effectively raised income limits from 133-138% FPL). No other income disregards allowed. (42 CFR 435.603(d)(1))
- Some Medicaid applicants will also need to meet other requirements, including proof of disability or blindness, and resources.



Eligibility Verification

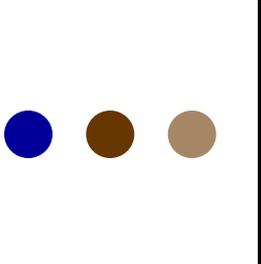
- Self-attestation allowed for most eligibility requirements (42 CFR 435.956; 42 CFR 457.380):
 - Residency (allowed), pregnancy (required), household composition (required), and age and date of birth (allowed), unless the state has other information that is not “*reasonably compatible*” with such attestation.
 - States may not use self-attestation for citizenship and immigration status.



Eligibility Verification (45 CFR

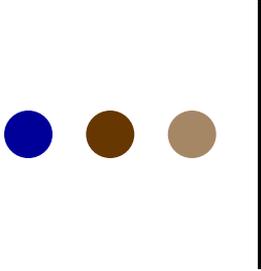
155.315, 155.320, 42 CFR 435.945, 435.948, 435.952)

- Medicaid, CHIP, and Exchange will use electronic data and applicant's attestation to verify eligibility.
 - Data sources include Social Security Administration (SSA), Dept. of Homeland Security (DHS), Internal Revenue Services (IRS), and state data sources (to verify income) or incarceration.
 - May not ask applicant for documentation of information that can be obtained electronically.
 - Should rely on the individual's attestation if the information the applicant provides is reasonably compatible with electronic data or information from other sources.
 - Reasonably compatible means generally consistent. It does not mean identical, but the federal government leaves it to the states to operationalize. (42 CFR 435.952(c); 45 CFR 155.315, 320).



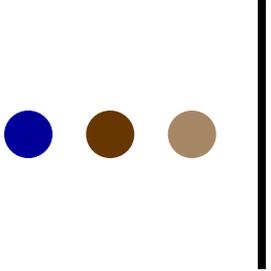
Electronic Data Matches (45 CFR 155.315, 42 CFR 435.948, 435.949)

- Federal hub: The US DHHS will serve as the federal hub for electronic verification of eligibility criteria needed for insurance affordability programs.
 - Will include access to SSA (for citizenship and wages), Department of Homeland Security (immigration status), and Department of Treasury (tax returns).
- State data sources. States must establish electronic interchanges with other state databases to verify current income and other non-financial eligibility criteria.
 - May include: data matches with State Wage Information Collection Agency (SWICA) or Employment Security Commission, and information related to eligibility or enrollment in public assistance, SNAP, and other insurance affordability program, Department of Corrections for incarceration.



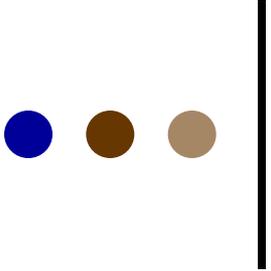
Electronic Data Match

- Agency must rely on the information person supplies, if the information is “*reasonably compatible*” with information obtained through data matches or other agency. (42 CFR 435.952)
 - Agency may not request additional information from applicant unless the information cannot be obtained electronically, or if the information which the agency received electronically is “*not reasonably compatible*”. (42 CFR 435.952; 42 CFR 457.380)
 - *Reasonably compatible* is not the same as identical, but left to state to define.
 - If additional information is needed, the agency must give the applicant a reasonable period to furnish the information.



Social Security Number

- The state may require SSN from applicants, but not from individuals who are not applying for themselves. (42 CFR 435.907(e))

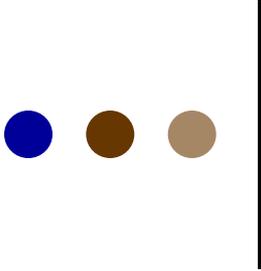


Residency

- Generally, state of residence is where the individual intends to reside even if no permanent address. Special rules:
 - If incapable of showing intent, residency is where the person is living.
 - If under age 21 and not emancipated or living in an institution, residency is where the youth resides (including with a custodial parent/caretaker relative). (42 CFR 435.603; 435.403; 42 CFR 457.320)

Income: Modified Adjusted Gross Income (MAGI)

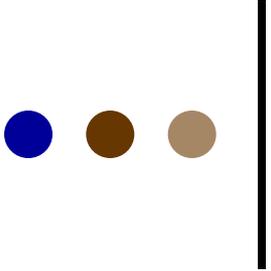
- Individuals will first be determined to be eligible for Medicaid/CHIP using MAGI income determination (42 CFR 435.911; 435.1200; 457.315).
 - Can be either newly eligible or an existing eligible.
 - If determined to be income eligible (eg, below 138% FPL), then enrolled automatically.
 - If not determined to be eligible for coverage under 138% (or higher income limits, for example, for pregnant women), then the state must determine if the person is eligible for Medicaid on any other basis.
 - If not eligible for Medicaid, or eligibility pending determination of disability or blindness status, eligibility for other insurance affordability programs must be determined.



Income Eligibility

(45 CFR 155.305(c)(f), 42 CFR 435.603, IRS 1.36B-2(b)(1))

- Insurance affordability programs use IRS Modified Adjusted Gross Income (MAGI) rules to determine income eligibility:
 - Three Medicaid exceptions to IRS (MAGI) income rules: Lump sum payments counted in month received; educational scholarships or fellowships excluded from income; certain types of income for American Indians or Alaskan Natives excluded; Income of child in the household who is not required to file taxes excluded.
- MAGI income determinations based on:
 - Current income for Medicaid (or at state option, can take into account future changes that can be reasonably anticipated).
 - Annualized income for premium tax credits.
 - *Note: HBE must first look at current income to determine Medicaid eligibility, and if not eligible, base determination for premium tax credit on estimated annual income.*

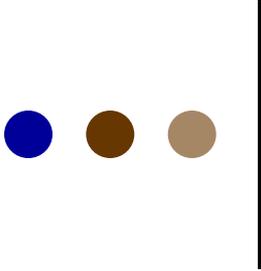


Income: MAGI

- MAGI does not apply to: (42 CFR 435.603(i)):
 - Individuals who are eligible by reason of SSI determination or Express Lane eligibility
 - Individuals who are age 65 or older
 - Individuals who are eligible because they are blind or disabled
 - Individuals whose eligibility determine because of the need for long-term care or home and community based services
 - Individuals eligible for Medicare cost sharing (QMB)
 - Medically needy individuals

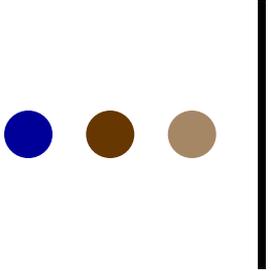
Income Eligibility

- Financial eligibility for *new* applicants must be based on the households income and family size at time of application (42 CFR 435.602(h)).
- However, *ongoing* financial eligibility for current Medicaid eligibles can be based on either current monthly household income and family size or projected annual household income for the current calendar year.
 - Basing ongoing eligibility on an annual basis would prevent individuals who experience small changes in income from bouncing between programs.



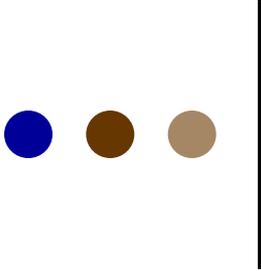
MAGI Modifications: Household Definition

- Eligibility will be based on household—not family income. (42 CFR 435.603)
- In general, CMS is adopting MAGI household definition and size for tax filers. However, some exceptions include, but are not limited to:
 - Child will only be counted in the household of a custodial parent (not a non-custodial parent, even if the non-custodial parent claims the child as a tax deduction).
 - Will count each spouse in the household of the other as long as they are living together, regardless of whether they file joint returns.
 - Different rules apply to non-tax filers (ie, individuals with incomes less than \$9,350, or \$19,800 for a couple in 2010).
 - Household comprised of individual, spouse, and children under age 19/21.



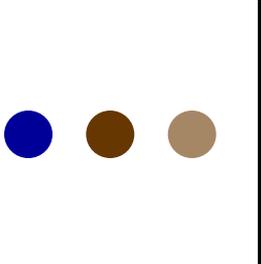
Resource Test

- No resource test or income disregard for people whose eligibility is determined based on MAGI—eg, most children and nonelderly adults. (42 CFR 435.603(g))
- Resource tests still apply to individuals who are receiving Medicare, or who are applying on the need for long-term care services, or under the medically needy program.



Medicaid Recertification

- For MAGI groups, must redetermine eligibility once every 12 months. (42 CFR 435.916; 42 CFR 457.343)
 - The agency must make a redetermination without requiring information from the individual if able to do so, based on information from data matches.
 - If agency does not have all the needed information, it must send out a pre-populated renewal form to the individual, with at least 30 days to provide necessary information.
 - If the person's application is terminated for failing to bring in necessary information, the agency must reconsider eligibility if the person subsequently supplies the needed information in a reasonable period after termination.
 - If individual no longer eligible for Medicaid, the agency must assess the individual for eligibility in other insurance affordability programs (ie, HBE premium tax credit and cost sharing subsidies).

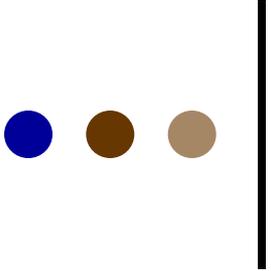


Medicaid Recertification

- For *non-MAGI* groups, must redetermine eligibility at least every 12 months (can be more often). (42 CFR 435.916)
 - The agency may assume that the person's disability or blindness continues, unless it has information to the contrary.
- Individuals have independent responsibility to report changes.
 - Must allow individual to report changes in same way individual can supply information for initial application (eg, Internet, mail, in person, fax).
 - Agency must promptly redetermine eligibility any time the agency has information about changes that may affect eligibility.

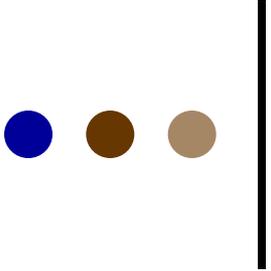
Medicaid Assistance with Application and Redetermination

- Medicaid agency must provide assistance to any individual seeking help with the application or redetermination process. (42 CFR 435.908)



HBE Patient Navigators

- HBE will provide grants to patient navigators. (Sec. 1311(i))
 - Navigators must have relationships with employers and employees, consumers, or self-employed individuals likely to enroll.
 - Navigators can include community and consumer-focused nonprofits; may also include agents/brokers, professional associations, Chambers of Commerce, etc.
 - Navigators must: distribute fair and impartial information concerning enrollment and availability of subsidies; facilitate enrollment into qualified health plans; provide referrals to consumer ombuds programs/other state programs to help with questions or complaints; and provide information in manner that is culturally and linguistically appropriate.
 - Navigators organizations may *not* be paid directly from insurers.



Agenda

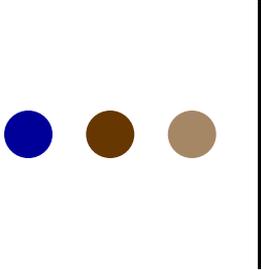
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Federal Medical Assistance Percentage (FMAP) (433.10; 433.204)

- Federal government will pay 100% of costs of *newly eligibles* in first three fiscal years (2014-2016)* (Sec. 2001(3), amended Sec. 1201 Reconciliation)
 - After first three years, federal government will pay 95% (2017), 94% (2018) , 93% (2019) and 90% (2020 and thereafter)
- States receive regular FMAP for people who would have been eligible (“*existing eligibles*”) using eligibility rules in effect in Dec. 2009.
 - Current FMAP rate in North Carolina is 64.71 (FFY 2011)
- States must submit annual report on the number of individuals enrolled and newly enrolled in Medicaid

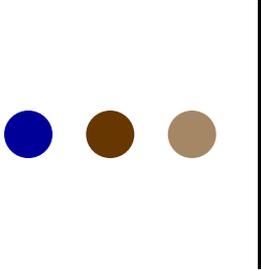


* Different rules apply to states that had already expanded Medicaid eligibility to childless, nonpregnant adults above 100% FPL.



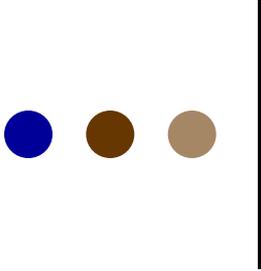
Methodology to Determine New Eligibles (42 CFR 433.206)

- States have a choice of methodology to determine which individuals are newly eligible vs. existing eligibles
 - Apply state specific eligibility thresholds and proxies (42 CFR 433.208)
 - Conducting statistically valid sample (42 CFR 433.210)
 - Using CMS established FMAP proportion rate (42 CFR 433.212)
- States must notify CMS no later than Dec. 31, 2012 (initially), or at least 2 years prior to the year in which the state will implement the method.
 - States must use the methodology for at least 3 consecutive years before changing to another method.



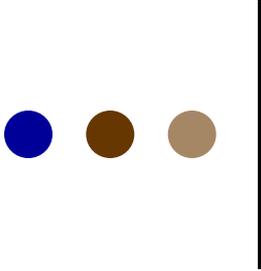
State Specific Eligibility Thresholds (42 CFR 433.208)

- State may use *state specific* methodology approved by CMS that:
 - Incorporates state eligibility standards, disregards and other adjustments in place in Dec. 2009.
 - Is applied to individual applicants determined eligible for adult Medicaid.
- Methodology must show how state will determine eligibility. States may use:
 - Self-declaration, claims history, receipt of Social Security disability income, disability determination by SSA, information from the Asset Verification system, information from tax returns, historical data on proportion of individuals ineligible due to assets or disability status, other disability and asset data sources.



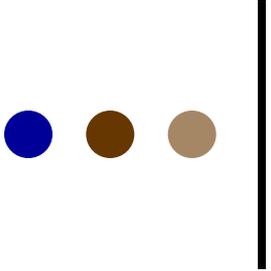
Statistically Valid Sample Methodology (42 CFR 433.210)

- States may implement statistically valid sampling methodology.
 - Methodology must be submitted to CMS on or before Jan. 1 of the CY.
 - The state must evaluate each individual randomly selected adult in the sample to determine if the individual is a newly eligible or existing eligible.
 - The state will extrapolate the expenditure from the sample of newly and existing eligibles to the expenditures of the entire population.
 - Retroactive adjustment of claims once expenditure information for year finalized.



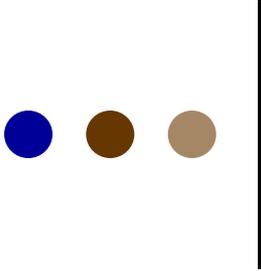
CMS Established FMAP Proportion (42 CFR 433.212)

- CMS will publish *state-specific* estimate of FMAP proportion, using data sources including MEPS and MSIS
 - Rates will be published by October of the preceding year (or by Jan. 1, 2013 for 2014)
 - Validation measures will be incorporated into the estimate on annual basis (CY 2014-2021), on a 3-year basis (CY 2022-2029), and then on a 5-year basis thereafter.



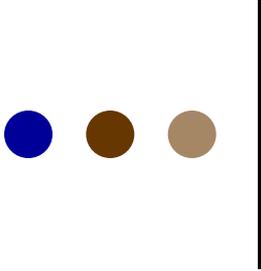
Agenda

- NPRM: Comment Period
- Key Definitions and Overview of ACA Provisions
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- State Options and Flexibility
- Discussion Questions



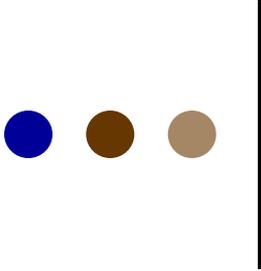
Enrollment Simplification

- States will be required to ***simplify enrollment*** and coordinate between Medicaid, CHIP, and the new Health Insurance Exchange. (Sec. 2201; 1413; 435.907, 435.1200, 457.10, 457.80; 457.330; 457.348; 457.350)
 - State must create an internet website, linked to HBE, through which the individual may apply for Medicaid, CHIP, or subsidized insurance through the HBE. Website must be accessible to people with Limited English Proficiency and disabilities.
 - Secretary will develop a single streamlined enrollment form that will be used to apply for all applicable state health subsidy programs (Medicaid, CHIP, subsidy).
 - Form may be filed online, in person, by mail, or by telephone. Agency must accept electronic signature or telephonically recorded signature.



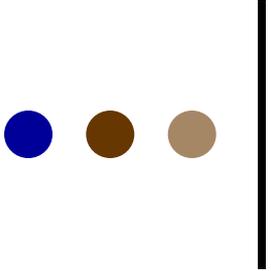
Agreement between Medicaid, CHIP, and HBE

- States must enter into agreements between Medicaid, CHIP, and HBE agencies to ensure seamless eligibility and enrollment (42 CFR 435.1200). Three options:
 - Medicaid, CHIP, and HBE can enter into an agreement to allow one of the agencies to perform all or some of the eligibility/enrollment/redetermination functions.
 - A state could develop a fully integrated system where the responsibilities of all entities are performed by a single integrated entity.
 - Each entity could fulfill its own functions, but seamlessly exchange information and data.



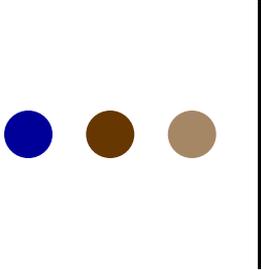
Delegation of Eligibility Determinations (431.10-11)

- State Medicaid agency may enter into agreement with other federal, state or local agencies to make Medicaid eligibility determinations, but:
 - Single state agency has responsibility for quality control and oversight, and to ensure that eligibility determinations are made in the best interest of applicants and beneficiaries
 - Must be written agreement specifying the responsibilities of different agencies
 - State agency must guard against improper incentives and/or outcomes



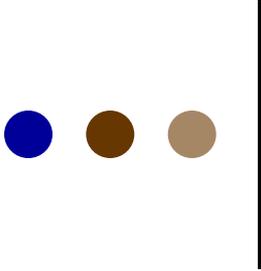
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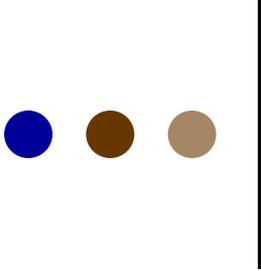
State Options: Eligibility Thresholds and Applications

- Expand eligibility beyond federal minimums. (Sec. 2001(e) of The ACA, 42 CFR 435.218).
 - Eliminate deprivation requirement (for definition of dependent child) (42 CFR 435.4)
 - If pregnant woman in the household, pregnant woman can be counted as family of 1 or 2 for purposes of determining eligibility for other people in the household. Always counted as household of 2 in determining eligibility for pregnant woman coverage. (42 CFR 435.603)
 - Income thresholds for mandatory/optional eligibles.
- States can use their own streamlined application, if approved by the Secretary. (42 CFR 435.907(b)(2)).



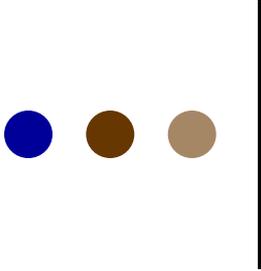
State Options: Determining Eligibility

- In determining initial eligibility, states may taking into account future changes in income that can be reasonably anticipated (eg, seasonal workers who are coming to end of season, or someone with layoff notice). (42 CFR 435.603(h)(1))
- States can determine ongoing eligibility for individuals determined to be eligible using annual income (instead of current income).
 - Minimizes extent to which individuals experience relatively small fluctuations bounce between program (Medicaid and HBE) (42 CFR 435.603(h)(2)).
 - States may adopt reasonable methods to account for future reasonably anticipated changes in future income.



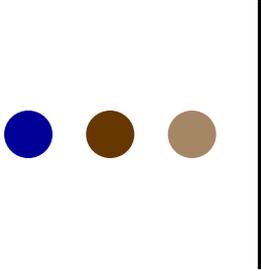
State Options: Eligibility Verification

- Reliance on self-attestation to determine eligibility, consistent with federal regulations, and other ways to verify eligibility. (42 CFR 435.940-956).
 - States must determine what is “reasonably compatible” (42 CFR 435.952(c)).
 - Must continue to ensure program integrity (42 CFR 435.945; 457.380).
- If approved by the Secretary, states can seek income information from a source other than those specifically listed in the regulations if it will reduce administrative burden on individuals and states, and improve accuracy or minimize delay. (42 CFR 435.948(d))



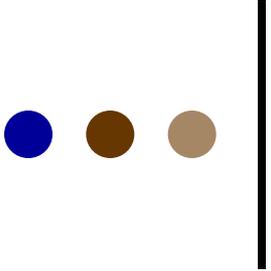
State Options: Eligibility Verification

- States can modify other methods to collect and verify information, subject to approval by the Secretary, if it reduces administrative burden and improves accuracy. (42 CFR 457.380(i)).



State Options: Enrollment and Coordination

- Structure to ensure seamless eligibility and enrollment between HBE, Medicaid, and CHIP. (42 CFR 435.1200(c)(2) 457.348).
- Options for determining new eligibles from existing eligibles. (42 CFR 433.206(a)).



State Options: Assistance

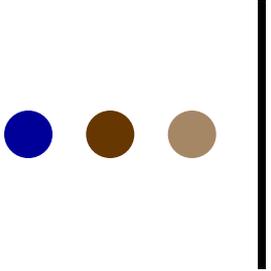
- Providing assistance to individuals who need help with the application or redetermination process. (42 CFR 457.340)
 - States have flexibility in designing assistance, but must meet needs of people with disabilities or who have limited English proficiency.

Feds Seeking Comments

- 1) Certain amounts of Social Security benefits are not counted as income in the MAGI determination.
 - This could make more people eligible for Medicaid.
 - Seeking comments on whether CMS should adopt different income rules for Social Security benefits.
- 2) Whether private agencies, if they operate the HBE, should be able to determine eligibility for Medicaid. (p. 51169).

Continuity of Coverage for People Who Move Between Medicaid/HBE

- Enrollment in Exchange plan begins on the first day of the following month (if determined eligible before 22nd day of month), or the first day of the second month (if determined eligible after 22nd day).
- CMS considering whether to extend Medicaid eligibility to the date when person would be eligible for coverage in the HBE to prevent gaps in coverage.



Agenda

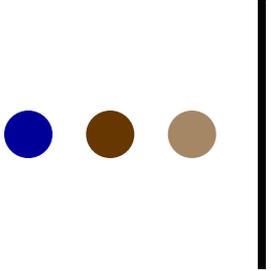
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Questions for Workgroup

- Eligibility requirements: Should the state expand eligibility beyond the federal minimums?
 - 1) Eliminate the deprivation requirement?
 - 2) Continue to count the pregnant woman as two people rather than one?
 - 3) Set income thresholds so that it captures all the existing optional eligibility groups?
 - Examples: Continue to cover pregnant women up to 185% FPL? Continue to cover children <6 up to 200% FPL?

● ● ● | Questions for Workgroup

- Determining eligibility:
 - Should the state consider reasonably anticipated future changes in income in the eligibility determination process?
 - Should the state use annualized income for ongoing eligibility (rather than current income)?

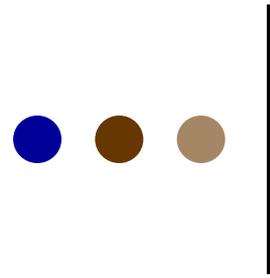


Questions for Workgroup

- Verification requirements:
 - Should the state rely on self-attestation for residency and age and date of birth?
 - How should the state define “reasonably compatible” for verification purposes?
 - Are there other sources of electronic verification which the state can use to verify eligibility?

Questions for Workgroup

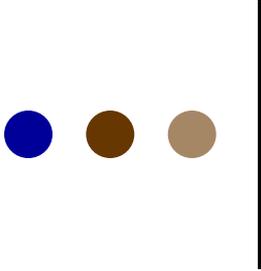
- Outreach and assistance:
 - What is the state's outreach plan?
 - What is the state's plan for providing assistance?
 - What role, if any, should DSS play as patient navigators?
 - Should North Carolina seek federal Medicaid funding for part of the Navigator costs (cost allocation for the time spent screening/enrolling in Medicaid)?



Questions

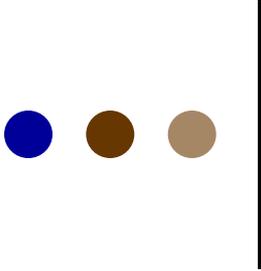
Other Related Proposed Rules

- Proposed regulations governing HBE functions in the individual market, eligibility determinations, and HBE standards for employers.
 - 76 Fed. Register 51202-51237 (August 17, 2011)
 - Comments due no later than October 31, 2011.
- Proposed regulations governing the Health Insurance Premium Tax Credit.
 - 76 Fed. Register 50931-50949 (August 17, 2011)
 - Comments due no later than October 31, 2011. Public hearing scheduled for Nov. 17, 2011.
- Proposed regulations governing HBE and QHPs
 - 76 Fed. Reg. 41866-41926 (July 15, 2011)
 - Comments due to CMS no later than October 31, 2011.



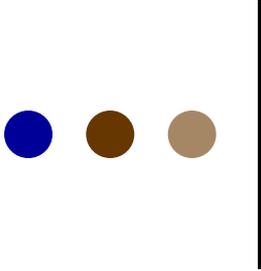
HBE Consumer Assistance Tools (155.205)

- HBE must operate toll free call center.
- HBE must also maintain an Internet website that:
 - Includes standardized comparative information on QHPs, including premium and cost sharing information, summary of benefits and coverage, identification of level of plan, results of enrollee satisfaction survey, quality ratings, medical loss ratio, transparency of coverage measures, and provider directory.
 - Is accessible to people with disabilities, and must provide meaningful access to people with limited English proficiency.



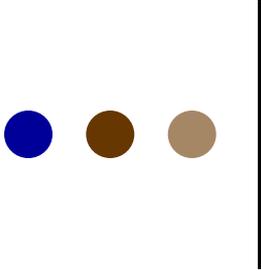
Consumer Assistance Tools (155.205)

- HBE must also maintain an Internet website that (cont'd):
 - Includes financial information on licensure, regulatory and other required payments to HBE, HBE administrative costs, and monies lost to waste, fraud and abuse.
 - Provides information on navigators and consumer assistance services.
 - Allows for eligibility determinations and enrollment in coverage.
 - (Note: DHHS considering requirement to allow applicants/enrollees to store and access personal account information.)
- HBE must also make available an electronic calculator (to facilitate comparison of QHPs after premium tax credits and cost sharing reductions).
- HBE must conduct outreach and education.



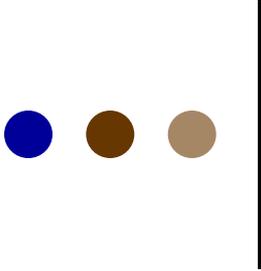
Navigator Requirements (155.210)

- To be a navigator, an entity must:
 - Demonstrate an existing, or that it could readily establish relationships with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be eligible to enroll in a QHP.
 - Meet licensure or certification or other standards.
 - Not have a conflict of interest during the term as Navigator.
 - Navigator cannot be a health insurance issuer.
 - Navigator cannot serve both as a navigator and agent/broker (with financial compensation from insurer) for plans sold inside the HBE; however, agent/broker can serve as a navigator for plans sold inside the HBE, and still receive commission to enroll employers or individuals in non-QHPs (ie, outside the HBE).



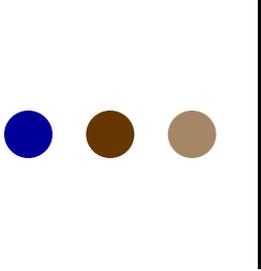
Navigator Requirements (155.210)

- HBE must provide Navigator grants to at least two of the following category of entities:
 - Community and consumer-focused nonprofit groups
 - Trade, industry, and professional associations
 - Commercial fishing industry organizations, ranching and farming organizations
 - Chambers of commerce
 - Unions
 - Resource partners of the Small Business Administration
 - Licensed agents and brokers, and
 - Other public or private entities that meet the requirements of this section (such as Indian tribes, tribal organizations, or state and local human service agencies).



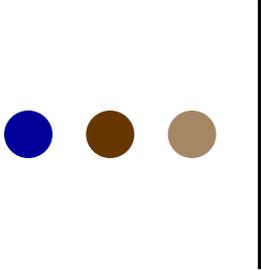
Navigator Requirements (155.210)

- Navigators must be able to:
 - Maintain expertise in eligibility, enrollment and program specifications and conduct public education.
 - Provide information/services in fair, accurate, and impartial manner.
 - Facilitate enrollment in QHPs.
 - Provide referrals to applicable consumer assistance or ombuds program.
 - Provide information in manner that is culturally and linguistically appropriate.



Navigator Funding (155.210)

- Funding may *not* be from federal funds received by the State to establish the HBE.
- However, if the state chooses to permit or require Navigator activities to address Medicaid/CHIP administrative functions (eg, outreach and enrollment), and such functions are performed under a contract or agreement that specifies a method for identifying costs/expenditures related to Medicaid and CHIP activities, the Medicaid/CHIP agency may claim federal funding for the share of expenditures at normal administrative match rate.



Agents and Brokers (155.220)

- States may choose to allow agents and brokers to:
 - Enroll qualified individuals, employers or employees into a QHP offered through the HBE.
 - Assist individuals in applying for advance payments of premium tax credit and cost sharing reductions.
- The HBE may provide information regarding licensed agents and brokers on its website.