

## Medicaid/CHIP Affordable Care Act Implementation

### *Answers to Frequently Asked Questions*

#### **Availability of Enhanced Funding for IT Systems (90/10)**

**Q1: CMS has advised states that the 90/10 matching funds for modernization of Medicaid eligibility and enrollment systems is not related to a state’s decision about whether to proceed with the Medicaid expansion for the new adult group. Is 90/10 funding contingent on a state complying with other aspects of the Affordable Care Act related to eligibility? Must a state that uses 90/10 funding build into its design and development support for the new “adult group”, even if it does not plan now to proceed with the expansion?**

A: The 90/10 funding is not contingent on a state’s decision to proceed with its Medicaid expansion. As the preamble to the final regulation makes clear, the enhanced funding was not solely for eligibility determination systems that support the Medicaid expansion. (76 Fed Reg 21950-21975 (April 19, 2011) and 42 CFR Part 433.

CMS was clear in the final rule that enhanced funding could be available for eligibility determination systems that determine eligibility for traditional eligibility groups. However, such systems must meet all requirements, standards and conditions included in the final rule, including the seven “conditions and standards” that ensure modernized and efficient eligibility systems that produce accurate and timely eligibility determinations and that can interface seamlessly with the Exchange operating in that state. In all states, including those that do not proceed with the expansion, state eligibility systems must be able to electronically pass accounts between the Exchange (whether state-based or federally-facilitated) in order to facilitate seamless coordination. In addition, the systems must be able to support a single streamlined application for coverage among insurance affordability programs, support Modified Adjusted Gross Income (MAGI)-based eligibility determinations; and must support new renewal processes and connections for data-driven, electronic verifications as described in the Medicaid eligibility final rule issued March 23, 2012 (available at <http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6560.pdf>).

States are not required to “build in” programming for the new adult group. However, a state that conforms to the seven standards and conditions (particularly modular design and separation of business rules from core programming) will be able to quickly and efficiently support enrollment for the expansion population regardless of whether a state proceeds in 2014 or at some later point. In addition, enhanced funding is available for states that wish to explicitly “build in” placeholder programming for the new adult group now to provide for future flexibility.

We remind states that the 90/10 funding for systems development is only available for costs incurred for goods and services furnished on or before December 31, 2015; subsequently, development expenditures are matched at 50 percent. There is no time limit on the enhanced operations and maintenance funding for the systems that received the enhanced developmental funding. This funding is set at 75 percent—as long as the system continues to meet all standards and conditions of the final rule.

**Q2: What technical guidance and deliverables can CMS offer to states that are getting a late start on their modernized eligibility system builds?**

A: Risk assessment and contingency planning are necessary and required components of any significant IT project or state systems build. We are encouraging every state to formulate contingency plans, which by necessity must take into account current state operational and technical realities. We have and will continue to make available a series of policy and technical “accelerators” that can help states achieve readiness for the October 1, 2013 open enrollment period. These include multi-state partnership models to jumpstart states’ design and development timelines and recommendations about how to reflect these strategies and an expectation of reuse in states’ request for proposals and contract language. CMS is providing states with targeted technical assistance, as well as multiple examples, templates and sample documents to support these strategies.

To support reuse as a means to accelerate system builds, as states develop their own artifacts in support of operational and technical progress, they are posting that information in a shared environment accessible to all Exchange, Medicaid and CHIP programs for reuse by others. Detailed information about CMS System Accelerators can be found in the CMS Application LifeCycle Tool (CALT) Medicaid Community in the Accelerators Folder:  
[https://calt.cms.gov/sf/docman/do/listDocuments/projects.medicaid\\_state\\_collaborative\\_com/docman.root.system\\_accelerators.multi\\_state\\_model?message=1342007963543](https://calt.cms.gov/sf/docman/do/listDocuments/projects.medicaid_state_collaborative_com/docman.root.system_accelerators.multi_state_model?message=1342007963543).

In addition, every state has an eligibility and enrollment systems lead (as well as a policy lead) through the State Operations and Technical Assistance (SOTA) teams. The “E & E” leads are available to assist states in pursuing the most appropriate options for their particular situation.

**Q3: How can state staff gain access to the CALT?**

A: The CALT is indeed an important learning environment for both systems and policy staff in the states. State staff can email [calt\\_support@cms.hhs.gov](mailto:calt_support@cms.hhs.gov) to request the electronic application packet and then will need to secure approval from their designated CALT access contact in their state. CALT access is open to an unlimited number of state staff.

## FFE Interactions with Medicaid and CHIP

**Q1: When does CMS need to know states' intention to proceed with the Medicaid expansion for purposes of the FFE build? What if a State adopts the expansion too late to have the change accommodated by the FFE (at least for some period of time); how would the coordination provisions of the law be accommodated?**

A: There is no deadline by which states need to decide on the Medicaid expansion. We understand that there are many considerations involved in this decision, and CMS stands ready to work with states on their individual timetables. Regardless of the expansion, every state that uses the Federally Facilitated Exchange will need to support coordination between the Medicaid and CHIP programs and the FFE and otherwise comply with the new MAGI rules as well as the application, renewal and verification procedures described in the Medicaid eligibility final rule issued March 23, 2012 (available at <http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6560.pdf>). We will be working with each state to ensure that the appropriate business rules are accommodated and tested, and the necessary electronic account handoffs are in place, before the FFE is operational and the new Medicaid rules are in effect. We are continuing to provide more guidance and information on these issues as part of the FFE manual and MOU process as well as through our SOTA calls. We are also establishing a state- to- FFE change process to help manage changes in policies that a state may make over time; a state that decides later to proceed with expansion will be accommodated within that process.

**Q2: How will the Supreme Court Decision affect CMS's ability to ensure other aspects of the law such as those affecting interactions with the Federally-facilitated Exchange? For example, if a state does not want to exchange electronic accounts with the FFE, what will be required and what, if any, penalties could be imposed?**

A: As previously stated in a letter from the Secretary to the nation's governors, the Supreme Court held that a state may not lose federal funding for its existing Medicaid program if the state chooses not to participate in the expansion of Medicaid eligibility for low-income adults. The Court's decision did not affect other provisions of the law. State Medicaid and CHIP programs will need to coordinate with the Federally-facilitated Exchange, regardless of a state's decision to proceed with expansion. States will need to be part of the seamless system for people to apply for all coverage programs; and will need to coordinate eligibility with the new insurance affordability programs. These provisions have relevance regardless of whether a state chooses to participate in the expansion for low-income adults.

**Q3: What will be the role of the FFE in reviewing applications from individuals with incomes below 133% of the FPL in states that do not implement the Medicaid expansion?**

A: The FFE's role is the same whether or not a state implements the Medicaid expansion for low-income adults. The FFE will still make MAGI-based determinations or assessments of eligibility for Medicaid and CHIP and will assess eligibility for premium tax credits and cost sharing. The FFE will apply the state's eligibility levels for Medicaid/CHIP when it makes the Medicaid determination or assessment. In addition, as established in the Exchange and Medicaid/CHIP eligibility final rules, the FFE will electronically transfer accounts for

individuals who are either determined or assessed as eligible for Medicaid and CHIP (it is a state option whether to have the FFE determine or assess eligibility) for further evaluation/action.

**Q4: How would a state’s decision not to expand their Medicaid program’s eligibility affect their ability to get information from the federal HUB under a state-based exchange model?**

A: The federal hub will provide data verification services to any state-based exchange and to the Medicaid and CHIP program without regard to whether a state has adopted the low-income adult expansion. Consistent with the regulations issued on March 23, 2012, state Medicaid and CHIP programs must rely on the HUB for certain information; this provision applies without regard to whether a state has adopted the Medicaid expansion for low-income adults.

**Federal Data Services Hub**

**Q1. What verification services will be available from the Federal data services hub on October 1, 2013 (“Day 1”)?**

A: The Federal data services hub will provide the following services on Day 1. CMS is also pursuing data sources for additional verifications through the Federal data services hub and will keep states updated as they are confirmed:

- Social Security Number (SSN) verification via the Social Security Administration (SSA)
- Citizenship verification via SSA or the Department of Homeland Security (DHS) when relevant
- Incarceration verification via SSA
- Title II benefit income information via SSA (monthly and annual amounts)
- Quarters of coverage information via SSA
- MAGI income information from the Internal Revenue Service (IRS)
- Max APTC from IRS
- Immigration status verification via DHS, as well as a translation to indicators for lawful presence, qualified non-citizen, and five year bar status.
- Public minimum essential coverage (MEC) verification from Federal agencies

**Q2. Will CMS charge state-based exchanges (SBEs) or Medicaid/CHIP agencies for any of the Federal data hub services or underlying data? If so, which ones and how much?**

A: No. We will not charge state-based exchanges (SBEs) or Medicaid/CHIP agencies for the Federal data hub services or underlying data.

**Q3. Are all of the Federal data hub services separate (“atomic”), such as SSN validation, and citizenship, or will they be wrapped into a single, “composite” service?**

A: Some services will be composite, and others atomic. For instance, it will be possible to invoke individual SSA services in a single composite service, although not all services in the composite will always need to be invoked. If the Exchange is seeking Title II income information for a member

of a household who is not the applicant, then the citizenship and incarceration services would not be invoked. In contract, public MEC verification services will be separate, atomic services.

**Q4. What will a State need to do to invoke the Federal data hub services?**

A: All transactional requests to the Federal data services hub shall be performed via web services. These services shall be invoked by State IT systems via application programming interfaces (API) or Web APIs that are accessed via secure Hypertext Transfer Protocol (HTTP) and shall be executed on the system hosting the requested services. The CMS web services shall accept requests from trusted sources, perform the function based on the request, and return a response to the State system. CMS shall publish these web services in the CMS Service Catalog, which shall contain all services available to the states and the definitions of the standards that must be met to request the service and standard data format for the data provided when making the request and the data that shall be returned.

CMS is still determining the best mechanism for how batch and bulk data transactions will be designed and implemented. At this stage, CMS believes that there shall be a need to establish both web services and possibly alternate interfaces to meet batch and bulk data transaction requirements.

**Q5. How do I learn which data elements and definitions will be available for each Federal data hub service?**

A: Information about the known data elements, definitions for the Federal data hub services are contained in Business Services Description (BSD) documents. The best way to access the BSDs and to avoid version control problems, is to request access to the CMS Service Catalog. States may do so by contacting [dsh.support@qssinc.com](mailto:dsh.support@qssinc.com) and requesting the CMS Services Catalog User Intake Form. Please note that as the information published on the repository is quite technical in nature, state users should ideally have a technical background.

**Q6. Will each Federal agency conduct its own audits of safeguards?**

A: The Federal agencies involved in data verifications are currently involved in discussions of the overall approach to oversight and audits of safeguards. Certain agencies are expected to conduct their own independent audits.

**Q7. Will the DHS data available through the Federal data services hub include the same data elements as is currently provided directly to states?**

A: The Federal data services hub is utilizing the same Department of Homeland Security (DHS) SAVE verification service currently available to states. States will receive both the verification data received from SAVE as well as the Federal data services hub-derived indicators of lawful presence, qualified non-citizen status, and whether the five year bar has been met where applicable.

**Q8. Can states use the data verified through the Federal data services hub for other programs, aside from Medicaid/CHIP eligibility?**

A: Each federal agency has the authority to define use of its data. Therefore CMS defers to IRS, DHS and SSA who are partnering with us to provide data via the Federal data services hub. Please refer to the CMS Services Catalog to review the Business Service Description (BSD) for the verification of income service to identify the Federal tax information data elements and definitions that will be made available to states through the Federal data services hub.

**Q9. Will there be any automatic updates coming through the Federal data services hub? Or will we always need to make a call to the Federal data services hub in order to get any information back? If a change is likely will the state need to send ongoing, frequent requests through the Federal data services hub?**

A: Generally, information from the Federal data services hub will only be sent in direct response to a call from the requesting entity. However, in the case of verifications conducted by DHS, there can be up to three steps to a verification, the second and third of which will not be in real time. If the step 1 query fails, the Federal data services hub will automatically invoke step 2, and the response may take up to several days. If step 2 fails, the Federal data services hub will notify the requesting entity which will need to submit additional documentation from the applicant for step 3. The step 3 response can take weeks. During this time, the Federal data services hub will regularly poll DHS to see if the response has come back.

### **Eligibility and Enrollment Systems**

**Q1: How can States access information about leveraging business processes and borrowing/sharing information from other States' systems? What is the CALT?**

A: The Collaborative Application Lifecycle Tool (CALT) is available for all states to collaborate among State Medicaid Communities to leverage existing business processes, turn-key solutions, document artifacts in the planning and designing an Exchange and Medicaid Eligibility & Enrollment solutions. As States upload Medicaid IT Gate Review artifacts to the CALT, states can view other States' artifacts with respect to Medicaid and Exchange development.

The CALT has the ability to notify users of new information that is posted to the collaboration platform. For more information about the CALT, including how to access it, benefits of the CALT environment, and training opportunities please refer to:

[http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/CALT\\_factsheet.pdf](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/CALT_factsheet.pdf)

There is also a similar portal environment where information about health insurance Exchange development is being shared among states. That information is available at <https://calt.cms.gov>.

**Q2: What is the effective date for enhanced Medicaid funding and for how long is it available?**

A: Enhanced Medicaid funding for Eligibility & Enrollment activities is available prospectively from the approval of an Advanced Planning Document (APD). An ongoing Medicaid administrative match at the 50% rate is available for activities that take place prior to an approved Eligibility & Enrollment APD, as long as the activities fall within the purview of administering the Medicaid program (42 CFR 433.15).

Enhanced funding at the 90% rate is available for costs of goods and services incurred by December 31, 2015 for design, development and implementation (DDI) that comply with certain defined standards and conditions. Enhanced funding at the 75% rate is available for maintenance and operations (M&O) of systems that were built using enhanced funding during the DDI phase. The December 2015 time limit on the availability of 90/10% matching funds does not apply to activities that qualify for the 75/25% matching rate. More information on this issue is available in our final rule, issued in April 2011 (available at <http://www.gpo.gov/fdsys/pkg/FR-2011-04-19/html/2011-9340.htm>).

**Q3: What are the seven conditions and standards that are required for purposes of receiving the enhanced funding?**

A: In accordance with the regulations issued in April 2011, Eligibility & Enrollment projects funded with enhanced funding will have to be: (1) modular; (2) advance the Medicaid Information Technology Architecture (MITA) principle; (3) meet specified industry standards; (4) promote sharing, leverage and reuse of Medicaid technologies of systems within and among States; (5) support business results; (6) meet program reporting; and (7) ensure seamless coordination and integration with the Health Insurance Exchange and allow interoperability with health information exchanges, public health agencies, human services programs, and community organizations providing outreach and enrollment assistance services. Please refer to CMS Guidance on Seven Conditions and Standards available in the CALT (see information in Question 1 about how to access the CALT) and also on [www.medicaid.gov](http://www.medicaid.gov) at <http://www.medicaid.gov/AffordableCareAct/Provisions/Information-Technology-Systems-and-Data.html>.

**Q4: What cost allocation requirements apply to E&E projects and how can States use the temporary exception to OMB-A-87?**

A: The requirements of Circular OMB-A-87 apply to the allocation of costs for design, development and implementation (DDI) and maintenance and operations (M&O) of eligibility and enrollment systems including the respective benefiting health insurance affordability programs: Medicaid, CHIP (for States that have separate Title XXI programs or for portions of separate CHIP programs in States that operate a combination CHIP/Medicaid program) and to CCIIO Grant Funding if the project will include functionality for Health Insurance Exchanges.

States can request the temporary exception to Circular OMB-A-87 requirements to use Medicaid enhanced funding for design, development and implementation (DDI) costs of shared eligibility services that will benefit other human service programs (SNAP, TANF, childcare and child

welfare). The exception does not apply to maintenance and operations (M&O) costs and therefore States must cost allocate to benefiting programs for these costs. For more information, please see two Tri-Agency Letters, available at <http://www.medicaid.gov/AffordableCareAct/Provisions/Information-Technology-Systems-and-Data.html>.

**Q5: What information is available for States to reuse and where can it be accessed?**

A: In the CALT, States can find business process models, templates for concepts of operations and other planning and development artifacts, business and technical requirements, Requests for Proposals (RFPs), Statements of Work (SOWs), system design documents, etc. CMS Eligibility & Enrollment State leads are available to discuss and assist States in finding the right artifacts in the CALT collaboration spaces. Your SOTA team and your E & E State lead are available to answer specific questions about what might be available soon that is not already in the CALT.

**Q6: Do Eligibility & Enrollment projects need to have Independent Validation and Verification (IV&V)?**

A: An assessment for IV&V analysis of a State's system development effort will be required for APD projects that meet any of the criteria contained in federal regulations at 45 CFR 95.626(a). If CMS determines that the IV&V analysis is required for a State's system development effort, the provisions contained in federal regulations at 45 CFR 95.626(b) and (c) apply.

**Q7: How are Medicaid and the Exchanges coordinating their systems work at the Federal level?**

A: The Center for Medicaid and CHIP Services (CMCS) and the Center for Consumer Information and Insurance Oversight (CCIIO) are working closely together to develop business processes supporting the concepts of a "Shared Eligibility Service." This includes collaboration on guidance to States, design of the single, streamlined application, and technical assistance efforts more broadly. Additionally, CMCS and CCIIO are engaged in the review of Grant Applications, Advanced Planning Document submissions, and in assessing Establishment Reviews and the Medicaid IT Gate Reviews involving State artifacts.

**Q8: How should States report expenditures in the CMS-64 for approved enhanced funding for Eligibility & Enrollment Advanced Planning Documents?**

A: Medicaid Budget Expenditure System/Children's Budget Expenditure System (MBES/CBES) has been modified to add new Medicaid Eligibility Determination System lines to the 64.10 Form series beginning with Quarter Ending March 31, 2011:

- 28A – DDI of Medicaid E&E systems/cost of in house activities - 90% FFP
- 28B – DDI of Medicaid E&E systems cost of private sector contractors – 90% FFP
- 28C – Operation of an approved Medicaid E&E system/cost of in-house activities – 75 % FFP
- 28D – Operation of an approved Medicaid E&E system/cost private sector contractors– 75% FFP

**Q9: Will CMS certify new Eligibility & Enrollment systems post-implementation as it does with MMIS?**

A: We are currently using the Enterprise Life Cycle framework to review each of the DDI stages of States' projects. We will be establishing, after notice and comment, a series of data requirements that will help States and CMS assess the functionality and compliance of the E&E systems post-implementation. CMS is committed to providing the individualized assistance that each State needs to accelerate progress toward achieving this goal.

**Q10: What are the requirements for submitting a MITA State Self-Assessment?**

A: MITA 3.0 State Self-Assessments will be due 12 months after CMS finalizes the Eligibility & Enrollment supplement of MITA 3.0. CMS will provide additional information to States regarding how assessments should be submitted.

**Q11: What will happen if a State Medicaid and CHIP Agency cannot successfully interface with the Federal data services hub by January 2014?**

A: CMS is working with States to identify strategies and technical assistance resources that States can use to accelerate their implementation to meet the statutory deadlines. States should reach out to their SOTA team and their E & E State lead for individualized consultation and assistance.