Medicaid and CHIP All State Call
April 2, 2024

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Agenda

- Verbal Update on Rural Emergency Hospital Designations and FQHC Provider Changes
- Streamlining Enrollment and Renewal Processes in Medicaid and CHIP Final Rule (CMS-2421-F2)
- Open Mic Q and A

Verbal Update on Rural Emergency Hospital Designations and FQHC Provider Changes

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Streamlining Enrollment and Renewal Processes in Medicaid and CHIP (CMS-2421-F2)

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Streamlining Eligibility for 85 Million Americans

On March 27, 2024, we finalized the 2nd half of our regulation on streamlining enrollment in Medicaid, the Children's Health Insurance Program (CHIP), and the Basic Health Program (BHP)

Part 2:	Part 1:
Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes (CMS-2421-F2) Publication Date: March 27, 2024 Effective Date: June 3, 2024 https://www.federalregister.gov/d/2024-06566	Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment (CMS-2421-F) Publication Date: September 21, 2023 Effective Date: November 17, 2023 https://www.federalregister.gov/d/2023-20382

Backdrop: Strengthening Medicaid & CHIP Access

- Presidential Directives
  - Executive Order on Strengthening Medicaid and the Affordable Care Act (January 2021)
  - Executive Order on Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage (April 2022)
- Affordable Care Act (ACA) Accomplishments
  - Streamlined application and renewal processes (e.g., increased reliance on electronic data sources and use of pre-populated forms)
  - Focus on MAGI-based populations

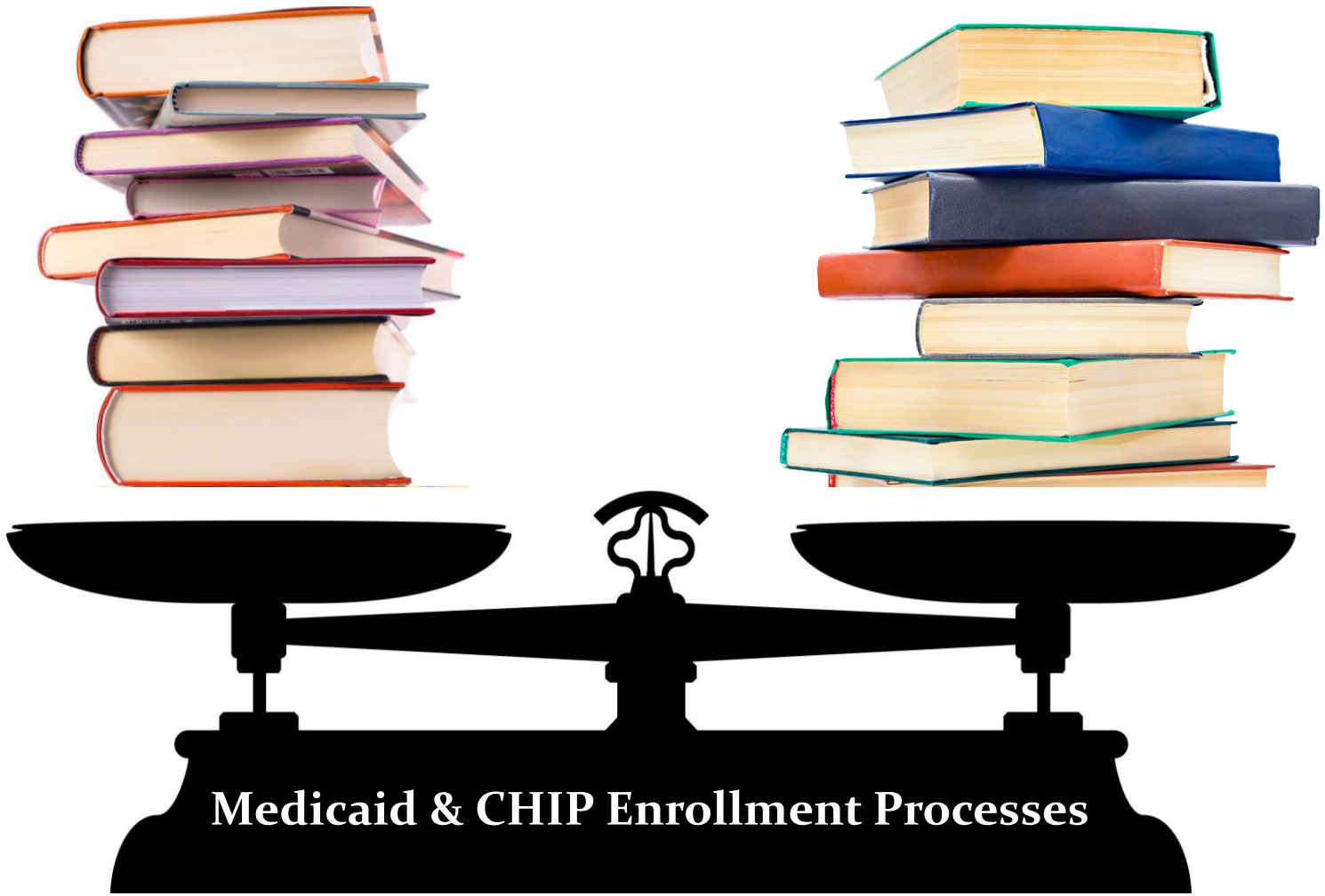
Many important ACA simplifications were not available for eligibility determinations for older adults and individuals with blindness or a disability

Backdrop:
Building on Lessons Learned

- Program Integrity Concerns
  - Medicaid and CHIP recordkeeping regulations are both outdated and lacking in specificity
  - Insufficient documentation is a leading cause of eligibility-related improper payments
- Unwinding the Continuous Enrollment Condition
  - Unprecedented number of eligibility renewals as states unwind from the continuous enrollment condition and return to normal operations
  - Active collaboration to ensure that application and renewal protections are available to all individuals during the unwinding period

Finding the Right Balance

Ensuring Enrollment of Eligible Individuals



Preventing Enrollment of Ineligible Individuals

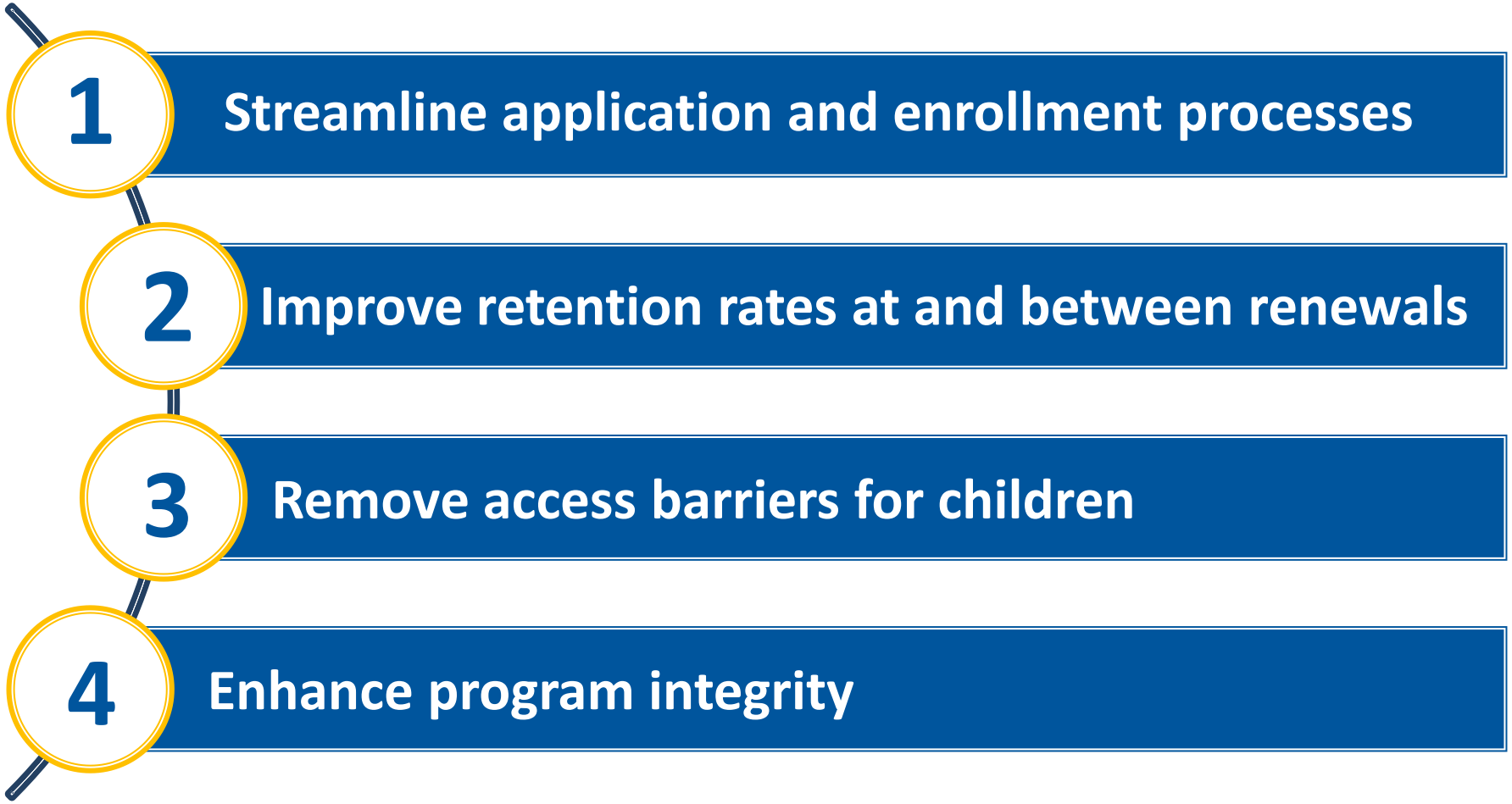
Public Comments = Substantial Support for Proposed Changes

- 7,055 timely comments submitted by state Medicaid and CHIP agencies, advocacy groups, health care providers and associations, health insurers and plans, and individual members of the public
- Most commenters, both individuals and organizations, supported the proposed changes in whole or in part
- A number of individual commenters generally opposed the rule and urged CMS to withdraw it
- 21 state agencies submitted comments, which included significant support, recommendations to increase state flexibility, and some concerns about operational burden related to implementation

Phase-in Compliance over 36 Months

- In response to comments, compliance with new requirements is phased in over 36 months
- Timeframes for compliance vary by provision
- Compliance required upon effective date for some provisions
- For other provisions, compliance date varies from 12 – 36 months
- States encouraged to implement as quickly as possible

Key Objectives



Objective 1: Streamline Application and Enrollment

1 Streamline Application and Enrollment Processes

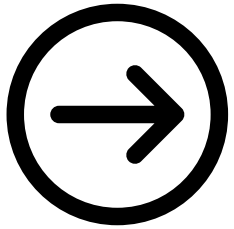
- Align Non-MAGI with MAGI application requirements (§ 435.907)
- Establish standards when individuals need to provide additional information at application (§§ 435.907 and 457.330)
- Facilitate medically needy enrollment by permitting deduction of prospective medical expenses (§§ 435.831 and 436.831)
- Confirm primacy of electronic verification and applicability of reasonable compatibility standard for resource information (§§ 435.952 and 435.940)
- Streamline verification of citizenship (§§ 435.407 and 457.380)
- Remove requirement to apply for other benefits (§§ 435.608 and 436.608)
- Remove optional limitation on the number of reasonable opportunity periods (§§ 435.956 and 457.380)

Align Non-MAGI with MAGI Application Requirements (§§ 435.907(c)(4) and 435.916(b)(2)(iv))

Make the same streamlined application procedures available to all applicants – both MAGI and non-MAGI applications

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
• In-person interviews may not be required for ***MAGI-based applicants*** • States must accept MAGI-based applications online, by phone, through the mail, and in person	• Prohibits in-person interviews for ***all applicants*** • Requires MAGI-excepted applications and supplemental forms to be accepted through all modalities currently provided for MAGI-based applications	None	36 months after effective date

Establish Standards when Individuals Need to Provide Additional Information at Application (§§ 435.907 and 457.330*)

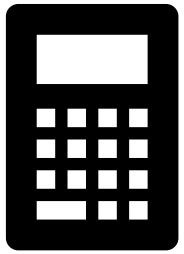


When eligibility cannot be determined based on available information, ensure that applicants have adequate time to provide needed information

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
Regulations are ***silent on the timeframes*** for applicants to respond to requests for additional information needed to determine eligibility	• Must provide all applicants with a reasonable period ***(at least 15 calendar days)*** to respond to requests for additional information (RAI) • Establish minimum ***90 calendar day reconsideration period*** for applicants determined ineligible for failure to respond to RAI request • Effective date of coverage for individuals found eligible during reconsideration period the date needed information is received	• Single timeframe ***for all applicants*** to respond to requests for information • Extended reconsideration period at application from ***30 to 90 days*** • Changed effective date of coverage following reconsideration period	36 months after effective date

*This provision applies to CHIP through a cross reference at § 457.330

Facilitate Medically Needy Enrollment: Option to Deduct Prospective Medical Expenses (§§ 435.831(g)(2) and 436.831 (g)(2))



Reduce institutional bias by permitting deduction of constant and predictable non-institutional expenses, along with institutional expenses, when determining medically needy eligibility

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
States are permitted to allow medically needy individuals to deduct from income their prospective institutional expenses, but ***not*** non-institutional expenses, to establish medically needy eligibility	States also may allow medically needy individuals to deduct predictable ***non-institutional*** medical or remedial expenses, such as: • Cost of HCBS included in a section 1915(c), (i), (j), or (k) plan of care • Prescription drug expenses included in a patient's pharmacy profile	None	Upon effective date

Option to Deduct Prospective Medical Expenses: Example

Example Scenario:

Individual countable monthly income	$1,200
State's medically needy income level (MNIL)	$700
Difference between countable monthly income and MNIL	$500 ($1,200 - $700 = $500)
State budget period	3 months
Individual's spenddown for budget period	$1,500 ($500 x 3 = $1,500)
Individual's reasonably constant and predictable expenses (*e.g.* drugs prescribed to treat a chronic condition, or services in the individual's 1915(c) plan of care).	$600 per month

Prior Requirements:

- Individual is not eligible at start of budget period
- Medicaid eligibility starts only after $1,500 in expenses is incurred (partway into 3rd month of budget period)
- Individual experiences gap in coverage and cycles on and off Medicaid each budget period

Final Rule Option:

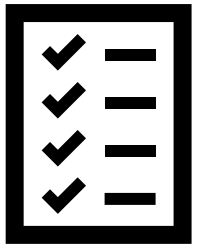
- Individual would be eligible at start of budget period using projected expenses at Medicaid rate ($600 x 3 = $1,800; $1,800 > $1,500)
- Individual does not experience gap in coverage caused by cycling on and off Medicaid each budget period
- The projected expenses used to meet spenddown will be the individual's liability; state will reconcile projected amounts with incurred amounts when budget period ends

Confirm Primacy of Electronic Verification and Applicability of Reasonable Compatibility Standards for Resource Information (§§ 435.952(b) and (c) and 435.940)

Simplifies enrollment by reducing need for applicants and beneficiaries to provide documentation of resources when electronic data is available

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
• States are required to verify financial assets (for individuals subject to a resource test) using an Asset Verification System (AVS) • Regulations ***do not explicitly address*** relationship of AVS to other documentation in verifying assets	• Resource information obtained from an electronic data source, such as an AVS, is reasonably compatible with attested information if both are above, at or below applicable resource standard • Individuals cannot be required to provide documentation of resources when asset eligibility can be verified using available electronic data	None	Upon effective date

Streamline Verification of Citizenship (§§ 435.407, 457.380(b)(1)(i), and 435.956(a)(1)(ii)(B)*)



Remove requirement for applicants to provide separate proof of identity when US citizenship is verified with a state's vital statistics records or DHS SAVE, since both sources already provide reliable documentation of identity

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
Individuals whose US citizenship is verified with a State's vital statistics agency or DHS' Systematic Alien Verification for Entitlements (SAVE) Program **must also provide separate proof of identity**	Treats verification of US citizenship with a State vital statistics agency or SAVE as stand-alone evidence of U.S. citizenship, ***not*** **requiring separate proof of identity**	None	24 months after effective date

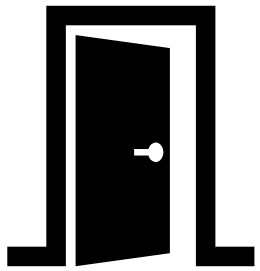
*This provision applies to CHIP through cross references at §§ 457.380(b)(1)(i) and 435.956(a)(1)(ii)(B).

Remove Requirement to Apply for Other Benefits (§§ 435.608 and 436.608)

Remove barrier that required individuals to apply for certain other benefits, as a condition of Medicaid eligibility

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
All Medicaid applicants and beneficiaries ***must apply*** for certain benefits to which they are entitled (e.g., annuities, pensions, retirement, disability, and unemployment benefits) as a condition of eligibility, even in circumstances in which the benefits would not impact eligibility (e.g., the eligibility for which an individual may be eligible does not impose an income test)	• ***Eliminates requirement*** to apply for other benefits as a condition of Medicaid eligibility • States are encouraged to continue educating applicants about other available benefits	None	12 months after effective date

Remove Optional Limitation on Reasonable Opportunity Periods (§§ 435.956(b)(4) and 457.380(b)(1)(ii)*)



Protect access for eligible individuals who may need more than one reasonable opportunity period (ROP), so they can access the benefits to which they are entitled while the state completes verification of citizenship or satisfactory immigration status

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
States ***permitted*** to establish limits on the number of ROPs, if needed to ensure program integrity and approved by CMS • No State currently elects this option	***Eliminates*** state option	None	Upon effective date

*This provision applies to CHIP through a cross reference at § 457.380(b)(1)(ii).

Objective 2: Improve Retention Rates

2 Improve Retention Rates at and Between Renewals

- Align MAGI and non-MAGI renewal requirements (§ 435.916)
- Clarify requirements for acting on changes in circumstances (§§ 435.919, 457.344)
- Establish required actions when beneficiaries address changes (§§ 435.919 and 457.344)
- Facilitate transitions between Medicaid and CHIP (§§ 431.10, 435.1200, 457.348, 457.350)

Aligning MAGI and Non-MAGI Renewal Requirements (§§ 435.916(a)(1), 435.916(b)(2)(i) and (iii))

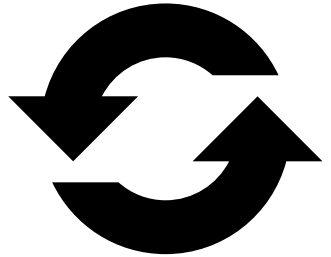
Reduce churning by making the same streamlined renewal procedures available to all beneficiaries – both MAGI and non-MAGI

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
• Eligibility must be renewed once every 12 months ***and no more frequently for MAGI-based beneficiaries only*** • At renewal, states must provide ***MAGI-based beneficiaries*** with: ❖ Prepopulated renewal form ❖ Minimum of 30 calendar days to return form ❖ Minimum 90 calendar day reconsideration period	Requires same streamlined renewal processes, formerly required only for MAGI beneficiaries, ***for all Medicaid beneficiaries***, except as specifically allowed under statute*	None	36 months after effective date

*Section 1902(e)(8) of the Social Security Act allows States to renew eligibility for QMBs no more frequently than once every 6 months

Acting on Changes in Circumstances (§§ 435.919, 457.344)

Reduce churn between regular renewals by requiring clear action steps and sufficient time for beneficiaries to provide information needed to demonstrate continued eligibility



Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
Regulations are silent on expectations for processing redeterminations based on changes in circumstances	1. Establishes required steps for states when redetermining Medicaid and CHIP eligibility based on changes in circumstances 2. Requires minimum 30 calendar days to respond to requests for information 3. Provides 90 calendar day reconsideration period 4. Prohibits procedural terminations when verifying eligibility for additional benefits	Streamline requirements for different types of changes into a single set of required actions.	36 months after effective date

Updating Beneficiary Addresses (§§ 435.919(f) and (g) and 457.344 (f) and (g))

Take proactive steps to ensure that eligible individuals don't lose coverage when their address changes

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
Regulations do not prescribe proactive steps for obtaining information when a beneficiary's address may have changed, although the Consolidated Appropriations Act, 2023 (CAA, 2023) included new requirements.	***Requires states to take proactive steps*** to update address information • Leverage data from reliable sources for automatic updates • Make a good-faith effort to confirm updated information from other sources • Obtain new information for mail returned without a forwarding address	• Simplify requirements to align with the protections established by the CAA, 2023 • Require states to obtain address changes from USPS and managed care plans and to update in-state contact information	18 months after effective date

Facilitating Transitions Between Medicaid and CHIP (§§ 431.10, 435.1200(b),(e) and (h), 457.340(f), 457.348, 457.350(b) and (e), and 600.330*)

Prevent termination of eligible individuals by seamlessly transitioning them between Medicaid and CHIP when their eligibility changes

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
• Transfer between Medicaid and separate CHIP based on potential eligibility for the other program • May terminate coverage when data indicates eligibility for separate CHIP (or vice versa) and individual does not respond • Provide combined eligibility notice to the maximum extent feasible	• Seamlessly transition eligibility between Medicaid and separate CHIP when one program determines that the individual is eligible for the other program • Requires combined eligibility notice when eligibility is transferred from one program to the other	None	Upon effective date

* Technical changes only to § 600.330 to maintain current policy for BHP

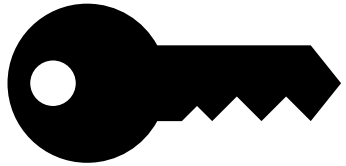
Objective 3: Remove Access Barriers for Children

3 Remove Access Barriers for Children

- Eliminate premium lock-out periods in CHIP (§ 457.570)
- Prohibit CHIP waiting periods (§§ 457.65, 457.340, 457.350, 457.805, 457.810)
- Remove annual and lifetime benefit limits in CHIP (§ 457.480)
- Establish new optional Medicaid eligibility group for reasonable classifications of individuals under age 21 (§ 435.223)

Eliminate Premium Lock-Out Periods in CHIP and BHP (§§ 457.570 and 600.525(b)(2)*)

Align separate CHIPs with Medicaid and plans available through the Marketplace where lock-out periods are not permitted



Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
States are permitted to apply a premium lock-out period for up to 90 days to prevent children in a separate CHIP from enrolling in coverage if they have unpaid premiums or enrollment fees	***Eliminates premium lock-out periods*** and encourages separate CHIPs and BHPs to consider other mechanisms for addressing timely payment of premiums including: • Frequent reminders • Multiple payment options • Pursuit of past due premiums	None	Upon effective date for new lock-out periods; for States sunsetting existing lock-out periods, 12 months after effective date

* This requirement applies to BHPs through a cross-reference at § 600.525(b)(2)

Prohibit CHIP Waiting Periods (§§ 457.65(d), 457.340(d)(3), 457.350(i), 457.805(b), 457.810(a))

Align separate CHIPs with Medicaid and plans available through the Marketplace where waiting periods are not permitted

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
States may impose up to a ***90-day waiting period*** prior to enrollment in separate CHIP, as a strategy to prevent substitution of group health plan coverage • Most states have eliminated their waiting period and use monitoring strategies to prevent substitution of coverage	***Prohibits waiting periods*** in separate CHIPs • Maintains requirement for states to have reasonable procedures to prevent substitution of coverage • States using a waiting period as the only strategy to prevent substitution of coverage must replace with monitoring strategies	None	Upon effective date for new waiting periods; for States sunsetting existing waiting periods periods, 12 months after effective date

Prohibit Annual and Lifetime Benefit Limits in CHIP (§ 457.480(a))

Remove limits that prevent children from receiving needed health care services and exacerbate unmet treatment needs in separate CHIPs

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
Annual and lifetime limits are ***prohibited only for behavioral health benefits*** provided through a separate CHIP due to the Mental Health Parity Act of 1996 • Most States have already taken steps to remove limits on CHIP benefits	Prohibits annual and lifetime limits ***on any CHIP benefits***	None	12 months after effective date

New Optional Medicaid Eligibility Group for Reasonable Classifications of Individuals Under Age 21 (§ 435.223 and § 435.601(f))

Clearly permit states to expand eligibility to reasonable classifications of children who meet eligibility criteria for disability-based or other non-MAGI eligibility groups, and apply disregards to increase effective income and/or resource standard

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
Regulation permitting states to provide optional coverage to reasonable classifications of children (§ 435.222) ***limited to MAGI-based populations***, even though statutory authority is broader	Confirms states' authority to adopt optional eligibility groups serving ***non-MAGI-based*** reasonable classifications of children • States may apply disregards to such groups under the authority of section 1902(r)(2) of the Social Security Act	None	Upon effective date

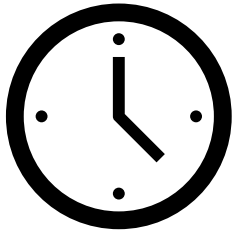
Objective 4: Enhance Program Integrity

4 Enhance Program Integrity

- Establish maximum timeframes for redetermination of eligibility at renewal and based on changes in circumstances (§§ 435.912 and 457.340)

- Strengthen recordkeeping regulations in Medicaid and CHIP (§§ 431.17, 435.914, and 457.965)

Establish Maximum Timeframes for Redetermination of Eligibility (§§ 435.912(b), (c), and (g), and 457.340(d)(1)*)



Provide states with adequate time to redetermine eligibility while also ensuring timely completion of renewals and changes in circumstances

Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
• Silent on timeframes for processing redeterminations at renewal and changes in circumstances • Renewals must be fully processed prior to terminating coverage, even when information is returned at end of eligibility period • States cannot terminate Medicaid coverage before determining eligibility on all bases	Establishes specific timeframes for completing eligibility redeterminations • Different timeframes for specific scenarios at renewal or change in circumstances (table on next slide) • Timeframes extended when additional information needed, information returned late, and determination on another basis	• Streamline standards and increase state flexibility • Revise thresholds for extending timeframes • Align timeframes when eligibility must be determined on another basis	36 months after effective date

*This provision applies to CHIP through a cross reference at § 457.340(d)(1).

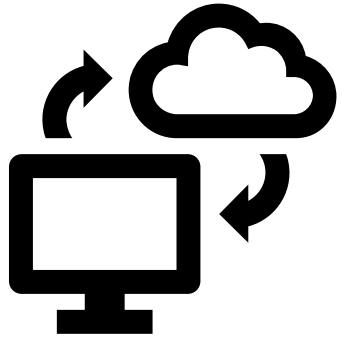
Eligibility Determination-Related Timeframes in the Final Rule

	Application	Change in Circumstances (Reported Change)	Change in Circumstances (Anticipated Change)	Renewal
Maximum Period for State to Complete Timely Determination	• 90 calendar days for applications based on disability • 45 calendar days for all other applications §§ 435.912(c)(3)(i) and (ii); 457.340(d)(1)	• End of month that occurs 30 calendar days following report of change (when no additional information needed), or • End of month that occurs 60 calendar days following report of change, if additional information needed §§ 435.912(c)(5)(i), (ii), and (iii)*; 457.340(d)(1) and (d)(1)(i)	• End of month in which anticipated change occurs, or • End of month following the month in which the anticipated change occurs, if any additional information that may impact the eligibility determination is received less than 30 calendar days before change §§ 435.912(c)(6)(i) and (ii)*; 457.340(d)(1) and (d)(1)(i)	• End of eligibility period, or • End of month following end of eligibility period, if all needed information submitted with less than 30 calendar days in eligibility period §§ 435.912(c)(4)(i) and (ii)*; 457.340(d)(1) and (d)(1)(i)

*If Medicaid eligibility must be newly determined on another basis at renewal or following a change in circumstances, the clock for a timely redetermination of eligibility on another basis begins again on the date the individual is found ineligible on the current basis, and the State must redetermine eligibility within 90 calendar days for determinations based on disability and 45 calendar days for determinations on all other bases

Strengthen Recordkeeping Regulations in Medicaid and CHIP (§§ 431.17(d), 435.914(b), and 457.965)

Modernize outdated recordkeeping requirements to ensure proper documentation of eligibility determinations and electronic verifications



Prior Requirement(s)	Final Rule	Major Changes from NPRM	Compliance Timeframe
Regulations on the maintenance of applicant and beneficiary case records are unclear and outdated • Recent audits and reviews highlighted recordkeeping deficiencies	Modernizes states' recordkeeping systems: • Require records to be stored in an electronic format • Define documentation to be retained as part of case records • Establish a minimum 3-year record retention period	• Exception to minimum retention period when an individual's estate is subject to recoveries • Exception to timeframe for making records available due to administrative or other emergencies	24 months after effective date

Questions