CMS Answers to Frequently Asked Questions:
Telephonic Applications, Medicaid and CHIP Eligibility Policy and 75/25 Federal Matching Rate
August 9, 2013

TELEPHONE APPLICATIONS IN 2014

Q1: What are the expectations for states in implementing telephonic applications as required by the statute at section 1413(b)(1)(A) and regulations at 42 CFR 435.907?

A1: The statute and regulations require that states provide individuals several channels through which they can apply for Medicaid and CHIP coverage – by mail, in person, on line and over the telephone. Following are some guiding principles for administering telephonic applications based on successful strategies many states have in place today.

1. Accepting a Telephonic Application: States may develop their own processes for accepting and adjudicating telephonic applications. The process for accepting applications by phone must be designed to gather data into a sufficient format that will be accessible for account transfer to the appropriate insurance affordability program. For example, a customer service representative could verbally communicate application questions to the applicant, while electronically filling out the online version of the single streamlined application.
2. Voice Signatures: All applications must be signed (under penalty of perjury) in order to complete an eligibility determination. In the case of telephonic applications, states must have a process in place to assist individuals in applying by phone and be able to accept telephonically recorded signatures at the time of application submission. If applicable, states can maintain their current practices of audio recording and accepting voice signatures as required for identity proofing.
3. Records and Storage: Upon request, states must be able to provide individuals with a record of their completed application, including all information used to make the eligibility determination. As such, CMS recommends that states record all telephonic applications. This may be accomplished by taping the complete application transaction as an audio file, or by producing a written transcript of the application transaction, among other options. The length of storage of these records should comply with current regulations on application storage.
4. Confirmations and Receipts: States should provide a confirmation receipt documenting the telephonic application to the applicant. Such confirmation should be provided upon submission of the application or at any time the applicant wishes to end the customer representative interaction. Confirmation receipts can be delivered via electronic or paper mail (based on the applicant's preference). Confirmation receipts must include key information for applicants, including but not limited to the application summary, the eligibility determination summary page, a copy of the attestations/rights and responsibilities and the submission date of the signed application.

MAGI-BASED ELIGIBILITY

Q2: How will a state determine a child's household composition when the child leaves the home of his/her parent(s) to live with a caretaker relative, but is still expected to be claimed as a tax dependent by one or both parents.

A2: CMS regulations at 42 CFR 435.603(f)(2) provide that the parents would be included in the child's household in this situation. However, if the parents do not intend to continue to claim the child as a tax dependent for the following tax year, states may alternatively use the option provided at 435.603(h)(3) to consider the child's move to the live with another caretaker relative as a "reasonably predictable change in income" and apply the non-filer rules to the child at 435.603(f)(3). Under the non-filer rules, neither the parents nor the caretaker with whom the child is living would be included in the child's household for purposes of Medicaid and CHIP eligibility.

Note that to be claimed as a "qualifying child," children generally must live with their parents for at least half of the year (certain exceptions apply), but parents may also be able to continue to claim a child as a "qualifying relative." States are not expected to determine whether or not a parent is permitted to claim their child as a tax dependent or not, but states may wish to consult IRS Publication 501 to better understand the general requirements which must be met for a tax filer to claim another individual either as a "qualifying child" or "qualifying relative." IRS Publication 501 can be accessed at the following link: http://www.irs.gov/pub/irs-pdf/p501.pdf.

Q3: **Is there a difference between the definition of Indian/Native American for Medicaid and the Exchange. Can you clarify what the difference is?**

A3: For purposes of eligibility for coverage through the Marketplace, the Affordable Care Act defines Indians as individuals who are members of a federally recognized Indian Tribe. The definition of Indian currently in use for Medicaid beneficiaries follows a broader definition that includes descendants of Indians and all American Indians and Alaska Natives. As a result, American Indians and Alaska Natives who are not members of an Indian tribe would not be eligible for exemptions available through an Exchange, including from individual responsibility payments, qualification for special monthly enrollment periods and cost-sharing reductions.

Q4: What are some examples of income that is not considered taxable, and therefore excluded from MAGI?

A4: Supplemental Security Income (SSI), Temporary Assistance to Needy Families (TANF), Veterans' disability, Workers' Compensation, child support, federal tax credits, and cash assistance are common types of income that are not taxable. Please see Question 5 below for additional details on veterans' benefits.

Q5: Will Veterans Administration (VA) benefits be counted as taxable income effective January 1, 2014?

A5: The IRS has provided guidance on how VA benefits should be considered when calculating income. As noted in IRS Publication 17, states should not count any veterans benefits paid under any law, regulation or administrative practice administered by the Department of Veterans Affairs in their income calculations. CMS agrees that VA benefits are not part of the Modified Adjusted Gross Income (MAGI) calculation.

Following are some examples of payments issued to veterans' or their families that are not taxable:

- Education, training and subsistence allowances
- Disability compensation and pensions payments for disabilities paid either to veterans or their families
- Grants for homes designed for wheelchair living
- Grants for motor vehicles for veterans who lost their sight or the use of their limbs
- Veterans' insurance proceeds and dividend paid either to veterans or their beneficiaries, including the proceeds of a veteran's endowment policy paid before death
- Interest on insurance dividends left on deposit with the VA
- Benefits under a dependent care assistance program
- The death gratuity paid to a survivor of a member of the Armed Forces who died after September 10, 2001
- Payments made under the compensated work therapy program
- Any bonus payment by a state or political subdivision because of service in a combat zone

Additional information on how the IRS views veteran's income can be found at http://www.irs.gov/pub/irs-pdf/p17.pdf.

Q6: With respect to MAGI conversion, how will the 5% disregard be applied?

A6: The Affordable Care Act established an income disregard equal to five percentage points of the FPL disregard "for the purposes of determining income eligibility" for individuals whose eligibility is based on MAGI. In our final rule issued July 15, 2013, we provide that the disregard is applied to the income calculation of individuals only to the extent that the disregard matters for the purposes of determining eligibility for Medicaid or CHIP under MAGI-based rules—that is, those for whom the application of the disregard means the difference between being eligible for Medicaid or CHIP and being ineligible.

The disregard matters for purposes of determining Medicaid or CHIP eligibility only in cases where individuals have MAGI-based income that is above the highest applicable income standard under the program (Medicaid or CHIP), but would be within that income standard if the disregard were applied. This is the case only when the MAGI-based income is no higher than five percent of the FPL higher than that income standard. The disregard would not be applied for a determination of the particular eligibility group in which the individual qualifies, but only for

overall eligibility for Medicaid or CHIP. We understand that this policy changes how disregards have been applied in the past, but believe this policy should be administratively simple to apply, for example, by applying the disregard at the point before a decision of ineligibility based on income would otherwise be made. This also ensures that the disregard does not reduce the "newly eligible" population for whom the increased federal matching rate is available.

For example, in a state that extends coverage to the new adult group, if a parent applied and has MAGI-based income within five percentage points of the FPL above the net income standard for the mandatory parent/caretaker relative group, the disregard would not apply because the disregard would not be needed for eligibility. The parent could be made eligible in the adult group instead. In that same state, if a parent applied with MAGI income within five percentage points of the FPL above the net income standard for the adult group (133% FPL), the five percent disregard would be applied to ensure that the parent could obtain eligibility in Medicaid and the parent would be made eligible in the adult group.

RENEWALS IN 2014

Q7: How should states handle eligibility renewals between January 1, 2014 and March 31, 2014 in order to comply with the ACA provisions that prohibit states from terminating an individual's existing Medicaid eligibility prior to April 1, 2014.

A7: According to section 1902(e)(14)(D)(v) of the Act, implemented at 42 CFR 435.603(a)(3), a person enrolled in Medicaid on or before December 31, 2013, shall not be found ineligible solely because of the application of MAGI and new household composition rules before March 31, 2014, or the individual's next regular renewal date, whichever is later.

States have two options regarding implementation. They can apply both pre-MAGI rules and MAGI rules to anyone whose renewal date falls between January 1 and March 31, 2014 as described below. Alternately, states may request the waiver authority to delay renewals outlined in our May 17, 2013 guidance titled, "Facilitating Medicaid and CHIP Enrollment and Renewal in 2014" (available at http://medicaid.gov/Federal-Policy-Guidance/Downloads/SHO-13-003.pdf).

The steps described below will ensure that Medicaid enrollees who come up for renewal between January and March 2014 are addressed appropriately. For example, for an individual who comes up for renewal on February 1, 2014, states need to:

1. Conduct an eligibility redetermination by applying MAGI-based methods (at the converted income standard). If eligible, renew coverage for a 12-month period ending in February 2015.

2. If the individual is found to be ineligible under step 1, determine whether s/he remains eligible based on 2013 (current) methods and income standard. If so, a finding of eligibility until April 1, 2014 is necessary under the 2013 methods. Go to step 4.

3. If the individual is *not* eligible per either step 1 or 2, consider whether the individual might be eligible on other bases of eligibility, and pursue any possibilities. If no other pathways apply, provide the individual with notice of termination and appeal rights and transfer their account to the Exchange (or CHIP) for eligibility determination and enrollment in a QHP (or CHIP).

4. On April 1, 2014, for those who remain eligible per step 2 (using 2013 methods and income standards), consider whether the individual qualifies on other bases of eligibility. If the individual does, renew eligibility until April 1, 2015. If not, provide notice and appeal rights for termination effective April 1, 2014.

PREGNANT WOMEN

Q8: Is there a strategy for states to retain coverage of pregnant teens without being required to count parents' income in 2014?

A8: States wishing to continue the practice of disregarding parental income may do so by adopting coverage of a reasonable classification of individuals under age 21 under section 42 CFR 435.222. In this case, the "reasonable classification" would be pregnant individuals under age 21 (or under age 18, 19, or 20). The statutory income standard for this group would be based on the state's AFDC payment standard in effect in the state in July 1996. But if a state uses section 1902(r)(2) of the Act to disregard all income for this group, as has been done for other reasonable classifications of children (such as those in state foster care), there will be no determination of income required for eligibility, and MAGI-based income requirements will not apply.

To effectuate this option, states should submit a state plan amendment (SPA) to amend Attachment 2.2-A of the Medicaid state plan to cover a reasonable classification of pregnant individuals under age 21 under 42 CFR 435.222. The state should also amend Supplement 8a to Attachment 2.6-A to disregard all income for this new group.

CHIP

Q10: How does section 2001(a)(5)(B) of the Affordable Care Act impact states currently covering children 6-18 up to 133 percent of the FPL under a separate CHIP?

A10: Section 2001(a)(5)(B) of the Affordable Care Act (implemented through regulations for the Medicaid program at §435.118) increased the minimum income limit applicable to Medicaid eligibility for the mandatory group for poverty-level related children aged 6-18 from 100 to 133 percent of the FPL under section 1902(a)(10)(A)(i)(VII) of the Act. Therefore, if a state is currently covering uninsured children up to 133 percent of the FPL under a separate CHIP, these children must be transitioned to the Medicaid state plan under this children's group effective January 1, 2014. CMS is available to work with states individually on their transition plans for this population.

Q11: Are these children who are being transferred from CHIP to the Medicaid state plan considered optional targeted low-income children under section 1902(a)(10)(A)(ii)(XIV) of the Act?

A11: No. For the purposes of eligibility, these children are considered a mandatory Medicaid group for poverty-level related children under section 1902(a)(10)(A)(i)(VII) of the Act. As described below, states will continue to receive the CHIP matching rate for this population.

Q12: Will new applicants/children ages 6-18 with incomes between 100 and 133 percent of the FPL *with other health insurance* qualify for coverage under the Medicaid state plan?

A12: Yes. Under the Medicaid mandatory group for poverty-level related children under section 1902(a)(10)(A)(i)(VII) of the Act, insured children must be covered in addition to uninsured children (please also see applicable match rate questions below). This is different from the rules governing a separate CHIP program, which preclude coverage for insured children.

Q13: Does 2001(a)(5)(B) of the Affordable Care Act impact children eligible in a separate or Medicaid expansion that are currently covered at income levels above 133 percent of the FPL?

A13: No. States continue to have the option to cover children above 133 percent of the FPL either under a Medicaid expansion or separate program. States must maintain CHIP "eligibility standards, methodologies, and procedures" for children that are no more restrictive than those in effect on March 23, 2010 as specified under the "maintenance of effort" provision at 2105(d)(3) of the Act. A parallel requirement in Medicaid can be found at sections 1902(a)(74) and 1902(gg) of the Act. These provisions are effective through September 30, 2019.

Q14: Will states continue to receive the CHIP enhanced FMAP for children currently enrolled in a separate CHIP up to 133 percent of the FPL after the transition to coverage of these children under the Medicaid mandatory group for poverty-level related children? ?

A14: Yes. The CHIP enhanced FMAP will continue to be available for children whose income is greater than the Medicaid applicable income level (defined in § 457.301 and based on the 1997 Medicaid income standard for children) after these children transition to Medicaid. This includes children who previously qualified for CHIP in a separate program and uninsured children whose family incomes are up to 133 percent of the Federal poverty level, and therefore will be eligible for Medicaid in 2014. Regular Medicaid matching rates will apply for all other children covered under the mandatory group for children aged 6-18—children with income no more than 100 percent FPL and insured children with income above 100 percent to 133 percent FPL.

Q15: Will a Medicaid and/or CHIP SPA be necessary for this transition?

A15: Yes. States that are transitioning children from a separate CHIP to the Medicaid state plan under the mandatory group for poverty-level related children under section 1902(a)(10)(A)(i)(VII) of the Act (which will be part of the newly consolidated mandatory group for children at 42 CFR 435.118), will need to submit both a Medicaid and CHIP SPA. The Medicaid SPA will need to be approved prior to, or simultaneously with, the CHIP SPA.

In addition, states that currently cover uninsured children aged 6-18 with income above 100 percent to 133 percent FPL under the Medicaid eligibility group for optional targeted low-income children at section 1902(a)(10)(A)(ii)(XIV) of the Act (42 CFR 435.229) will need a Medicaid SPA to transition these children to the mandatory group for poverty-level related children under section 1902(a)(10)(A)(i)(VII) of the Act under the mandatory children's consolidated group at 42 CFR 435.118 and must expand their coverage to include insured children.

The SPA templates are available at http://www.medicaid.gov/State-Resource-Center/Medicaid-and-CHIP-Program-Portal/Medicaid-and-CHIP-Program-Portal.html and CMS is available to provide technical assistance to states as they work through this transition.

Q16: What are the key considerations for states preparing for this transition from CHIP to Medicaid?

A16: In order to ensure a smooth transition of children from a separate CHIP to Medicaid state plan coverage, we encourage states to consider the following points as they prepare for this transition. CMS will work with states on these issues as part of the CHIP SPA review process:

- Proper and timely notification to families, including detailed information on changes related to managed care plans, providers, benefits and cost sharing and what families can expect and need to do in preparation for the transition.
- Education and notification to key stakeholders, including providers, managed care plans, and carve outs, such as mental health or dental services.
- Establishment of a help line to address questions from families during the transition.
- Continuity of care for children in treatment, such as the transfer of prior authorization requests from CHIP to Medicaid providers.

Q17: Are states permitted to continue to cover children protected by section 2101(f) of the Affordable Care Act (ACA) in Medicaid?

A17: Yes. While coverage of children protected by 2101(f) is mandated through a separate CHIP, states may instead continue to provide coverage of these children in the state's Medicaid program, thereby eliminating the need to provide coverage in a separate CHIP in accordance with section 2101(f).

If a state chooses this option, children in the state would not lose Medicaid eligibility due to the elimination of disregards under the new "modified adjusted gross income" (MAGI) based methodologies. A Medicaid SPA could cover such children as an optional reasonable

classification of children under 42 CFR §435.222, with a disregard of all income (so that there would be no required determination of income).

The state will need to accurately identify the population of children who otherwise would lose Medicaid eligibility effective January 1, 2014 due to the elimination of income disregards as the new optional reasonable classification of children covered under this group. Children covered under this classification would remain categorically eligible based on their enrollment in Medicaid on December 31, 2013.

In order to limit the protection afforded under this strategy to the same timeframe as the protection which otherwise would be afforded to each affected child under a separate CHIP, the state may define this group as "children who would lose Medicaid eligibility on the initial redetermination of income using MAGI-based income determination due to the elimination of income disregards." The classification would thus not include individuals whose income is being redetermined after that time. This would be parallel to the treatment of this population in a separate CHIP, as automatically eligible in CHIP only when initially losing Medicaid eligibility.

For SPA page S52 for optional reasonable classifications of children that will be submitted for Medicaid state plan eligibility in 2014, the state should enter information for this new reasonable classification of children, just like it will enter information for any other reasonable classification covered by the state. The state would define this reasonable classification using the approved state plan language and would enter that no income test is used for this classification because there was no income test (i.e., all income was disregarded) in 2013.

In addition, once the Medicaid SPA has been approved, interested states should also submit a CHIP SPA (CS14) and check the first option indicating that: "The state has received approval from CMS to maintain Medicaid eligibility for children who would otherwise be subject to Section 2101(f) such that no child in the state will be subject to this provision."

A state interested in covering children protected by section 2101(f) of the ACA should indicate its interest to CMS on its next State Operations and Technical Assistance (SOTA) call.

75/25 FFP FOR ELIGIBILITY SYSTEMS

Q18: Is a level of care assessment eligible for the 75% match?

A18: No. The 75%/25% matching rate for eligibility systems is limited by the statute to activities directly related to an eligibility determination. A level of care assessment is not *directly* related to the eligibility determination. Although the assessment itself is not eligible for the 75% match, the entry of the level of care result into the eligibility system may be matched at 75%.

Q19: Is a disability determination eligible for the 75% match?

A19: No. A disability determination is not *directly* related to the eligibility determination, even though the outcome of that determination may be used to identify the appropriate eligibility group, financial methodology and the benefits that will be available to the individual. The eligibility group, financial methodology and benefits are based on the state plan, not on the eligibility system. Although the disability determination itself is not eligible for the 75% match, the entry of the disability information into the eligibility system may be matched at 75%. This analysis is based on the SMM Sec. 11276.7 B, which discusses prior authorization and claims processing. The prior authorization itself is not eligible for the 75% match, however the program decision, based on that prior authorization, to pay or not pay a claim that is pending in the system is eligible for the 75% match.

Q20: Are application assisters, navigators and out-stationed eligibility workers eligible for the 75% match?

Q20: Individuals who assist applicants by facilitating their applications, who perform outreach activities, or who enter application data on behalf of the applicant are not eligible for the 75% match. Only individuals who are authorized by the single state agency to enter data other than application elements into the eligibility system, who have responsibility for evaluating data in order to make an eligibility determination, who are authorized to exercise discretion in the evaluation of data, who are authorized to make an eligibility determination and who are accountable to the single state agency for such determinations are eligible the 75% match for those activities. This includes eligibility workers, whether in house or out-stationed, as long as there is a formal, written agreement with the single state agency that authorizes their eligibility activities and specifies direct lines of accountability to the single state agency. Both intake workers and on-going eligibility workers who meet these requirements may be claimed at 75%, based on appropriate cost allocations.