Application, Verification and Renewal Federal Provisions and State Options

Sacramento, CA
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manatt

Focus for Today

APPLICATION

- Federal Requirements
- Options for Consideration

VERIFICATION

- Federal Requirements
- Options for Consideration

RENEWAL AND CHANGE REPORTING

- Federal Requirements
- Options for Consideration

Focus for Today

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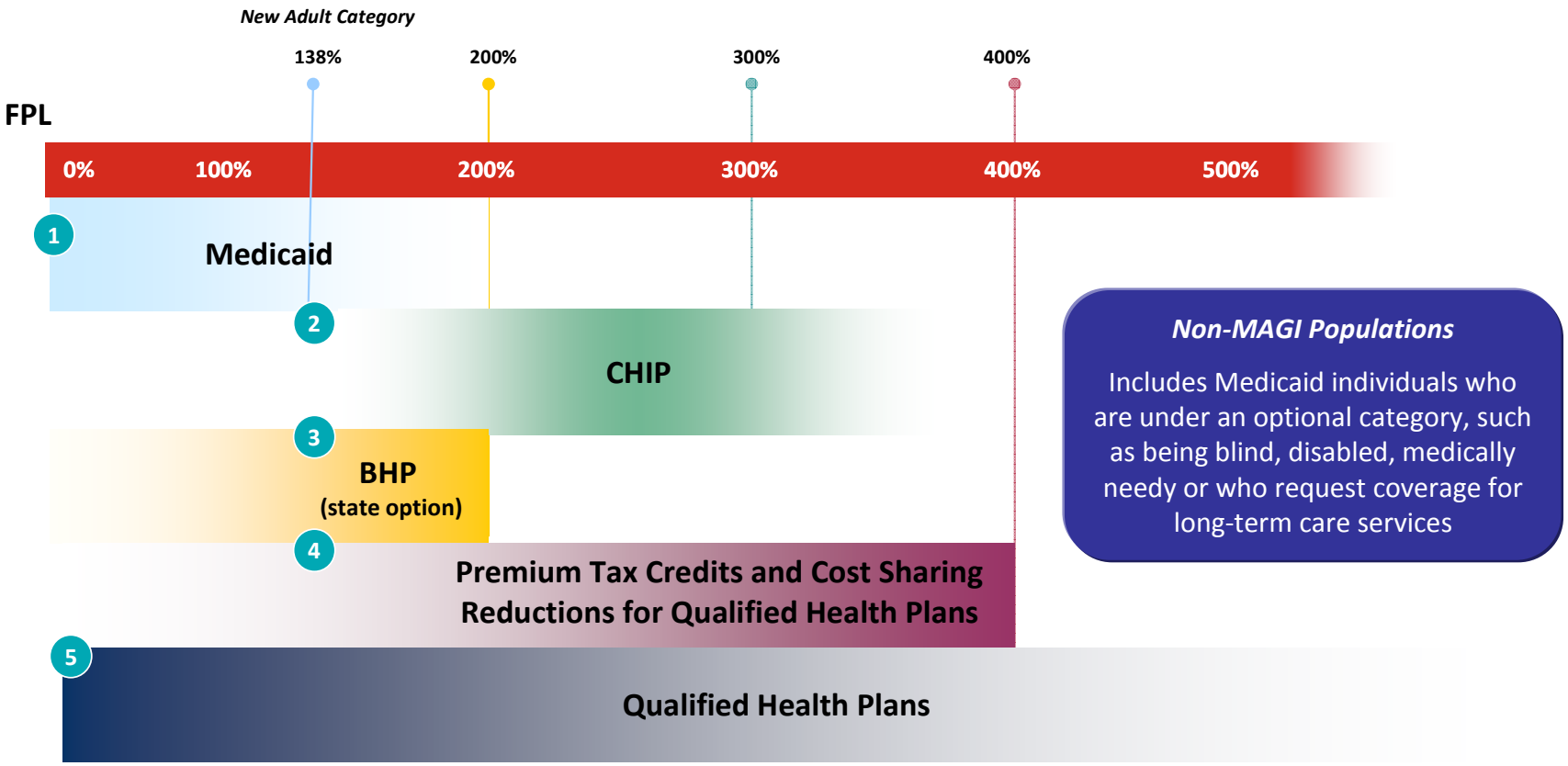
Coverage Continuum in 2014



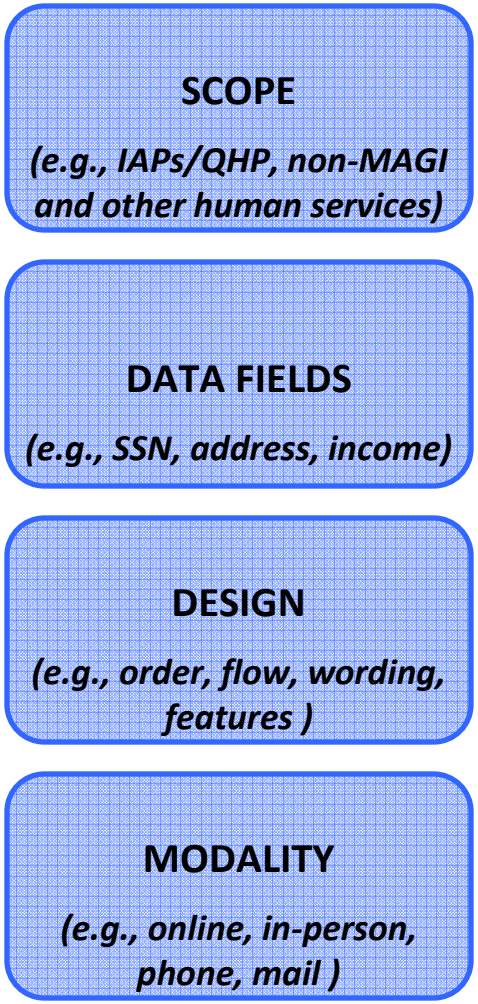
Seamless Eligibility and Enrollment Process

Real-time processing

- Integrated and simplified eligibility processes for ***Insurance Affordability Programs,*** with website for enrollment/renewal
- State Medicaid Agency must determine potential eligibility for other IAPs if not eligible for Medicaid/CHIP
- Exchange *must* assess for MAGI and non-MAGI eligibility for Medi-Cal/Healthy Families and then:
  - determine eligibility for Medi-Cal/Healthy Families or
  - promptly transfer information to the Medicaid agency for determination
- Exchange *must* determine eligibility for APTCs/CSRs
- Eligibility determinations must be conducted "promptly and without undue delay"
  - At most, Medicaid determinations must be completed within 45 days for a MAGI application and 90 days for a non-MAGI application

42 CFR 435.435.912, 435. 1200, 457.350, 45 CFR 155.302, 155.305, 155.310

Application Components



- **Federal Requirements:** ACA, Exchange and Medicaid Implementing Regulations, Federal Model Application, Federal Portal, Section 1561 standards, IT Guidance
- **State Policies:** W&IC, AB 1296, SB 87
- **State Design Choices:** Enroll UX 2014

Comparison of Application Data Fields

Application Elements	2014 Application (preliminary)	Application for Medi-Cal MC 210	Healthy Families Application/ Medi-Cal Screening Tool MC 321	CHDP Pre-Enrollment DHCS 4073	PE for Pregnancy MC 263	PE for Pregnancy-Medi-Cal MC 263	BCCTP	Non-MAGI (MC 223)	Cal Works (SAWS 2/ DFA 285)	Cal Fresh (SAWS 2/ DFA 285
Name/Address/Phone	X	X	X	X	X	X	X	X	X	X
SSN	Required	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional
DOB	X	X	X	X	X	X	X	X	X	X
Language	X	X	X	X	X	X	X	X		
Existing Benefits #		X	X	X			X	X		
Income Level and Sources	X	X	X	Level only	X			X	X	X
Assets		X						X	X	X
HH/Family Composition	X	X	X		X			X	X	X
Deductions/Expenses		X	X					X	X	X
Cit/Imm Status	X	X	X				X	X	X	X
Absent Parent/Spouse	X	X	X					X	X	X
Other Medical Expenses	X	X	X				X	X		
Other Coverage	X	X	X				X	X	X	
Plan Selection			X							
Tax Filing Information	X									
SSI Disability Status								X		
Medical History								X		
Social and Educational History								X		
Work History/Participation								X	X	X
Convictions									X	X

Ethnicity is also an optional question on the preliminary 2014 application and MC 210/321

Application: Scope

ACA Law and Regulations

- **Single application for all Insurance Affordability Programs (Medicaid/CHIP, BHP, APTC/CSRs) and QHPs** *ACA §1413(b)(1)(A)*
  - HHS will develop a single, streamlined form but States may also design their own alternatives *ACA §1413(b)(1)(A), 42 CFR 435.907, 45 CFR 155.045*
  - State-alternative form must be approved by HHS and be no more burdensome than HHS form *42 CFR 435.907(b)(2), 45 CFR 155.405*
  - "Individual must have an option to apply for Medicaid using the Secretary-developed or a Secretary-approved single streamlined application which asks questions relevant only to the eligibility and administration of IAPs." *77 FR 17163*

- **State option to use supplemental or alternative forms for non-MAGI programs** *ACA §1413(b)(1)(C)*
  - These forms must also be approved by HHS *42 CFR 435.907(c)*
  - "Use of supplemental forms in conjunction with the streamlined application would be one acceptable approach to assure access to a range of benefits, but States also are permitted to develop alternative multi-benefit applications which do not use supplemental forms." *77 FR 17163*

Application: Scope

State Law and Regulations

- Simplified application for Medi-Cal adults, pregnant women and children and "no wrong door" *W&IC 14011.1, 14011.15, 15926(b) and (c)(1)*
- Single, accessible, standardized application to be used by all entities authorized to make an eligibility determination for any state health subsidy program and by their agents *AB 1296*
- Application may be used for, but shall not be limited to, screening *AB 1296*
- Nothing precludes the use of a provider-based application form or enrollment procedures for state health subsidy programs or other health programs that differs from the application single streamlined form *AB 1296*

- ***Average Monthly Volume of Applications (approximate)***

Medi-Cal*:* 150,000 CalFresh: 175,000 CalWorks: 50,000 Health-e-App: 4,000

Sources: CWDA, DSS, CHCF

Application: Scope

State Policy and Design Considerations

- Should California use the federal model application or design its own application form for MAGI populations?
- Should California develop an alternative form, or supplement the single application form, for non-MAGI populations?
  - Is this a 2014 priority or a 2015 and beyond priority?
- Should California develop an alternative form, or supplement the single application form, for CalWorks, CalFresh and other human services programs?
  - Is this a 2014 priority or a 2015 and beyond priority?
- To what extent should alternative Medi-Cal and CHIP applications be maintained?
- Will the single, streamlined application be used for presumptive eligibility? How does that impact the design of the application?

Application: Data Fields

ACA Law and Regulations

- Federal conditions of eligibility for IAPs and QHPs dictate the information required to determine eligibility. *ACA §1411, SSA §1902, 45 CFR 155.405*
- Federal model application will provide a template for information collection.
- Open policy question about what information the applicant must affirmatively provide

State Law and Regulations

- Require only information necessary to support eligibility and enrollment for state health subsidy programs *AB 1296*, *W&IC 14011.1, 14011.15*
- Do not request non-applicant information that is not necessary to determine eligibility *AB 1296*
- Include voluntary questions regarding race, ethnicity, primary language, disability status *AB 1296*

Application: Data Fields

State Policy and Design Considerations

- What are the core data elements? To what extent should California attempt to depart from the Federal data elements?
- What is the appropriate balance between minimizing initial information requested of the consumer at application versus avoiding the need to ask for additional information post-application?
- What data elements might be available through third party data sources rather than being collected from every applicant?

Application: Design

ACA Law and Regulations

- Federal model application and portal will provide a template for order and flow of questions, wording of questions, format of application.
- State-alternative form must be approved by HHS and be no more burdensome than HHS form *42 CFR 435.907(b)(2), 45 CFR 155.405*
- Any application or supplemental form must be accessible to persons who are limited English proficient and persons who have disabilities *42 CFR 435.907(g)*

State Law and Regulations

- Pre-populate application and renewal forms, with opportunity for applicant to review and correct, to the extent practicable by CalHEERS *AB 1296*
- Forms and notices developed pursuant to this section shall be developed using plain language and shall be provided in a manner that affords meaningful access to limited-English-proficient individuals, in accordance with applicable state and federal law, and at a minimum, provided in the same threshold languages as Medi-Cal managed care *AB 1296*

Application: Design

State Policy and Design Considerations

- To what extent will Federal model application and Enroll UX 2014 be leveraged in California?
- How should California approach information gathering around complex concepts like household and income?
- Should California add supplemental questions that may explain discrepancies between information attested to by the applicant and obtained from databases?

Application: Modality

ACA Law and Regulations

- Make available an application that may be filed:
  online, in-person, by mail, by phone, or other electronic means

ACA §1413(b)(1)(A)(ii); 45 CFR 155.405, 42 CFR 435.907(a)

State Law and Regulations

- Provide option to apply for state health subsidy programs in person, by mail, online, by fax, or by phone *AB 1296*

State Policy and Design Considerations

- To what extent will application vary depending on modality? Are there unique needs for each modality?
- How will California facilitate continuity in the application process for individuals who may traverse modalities?

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Verification

ACA Law and Regulations

Self-Attestation: With certain exceptions, Exchange or the Medicaid/CHIP Agency may accept attestation of information and conduct database verification needed to determine eligibility without further documentation. *42 CFR 435.945, 45 CFR 155.315, 155.320*

Data-matching: States must develop secure, electronic interfaces to allow for data matching and eligibility determination for IAPs. States must use data matching to the maximum extent practicable. *ACA §1411, §1413(c)*

- Federal government is developing a data hub for verifying consumer-provided information against required federal data sources (i.e., SSA, DHS, IRS)

Reasonable Compatibility: Standard for assessing whether verification can be considered complete, or if additional information is necessary. When data obtained is "reasonably compatible" with an applicant's attestation, State agencies are prohibited from requiring additional documentation. *42 CFR 435.952, 45 CFR 155.300*

Verification

ACA Law and Regulations

Reasonable Compatibility

Exchange:

- **General:** "...the difference or discrepancy does not impact the eligibility of the applicant, including the amount of advance payments of the premium tax credit or category of cost sharing reductions." *45 CFR 155.300*

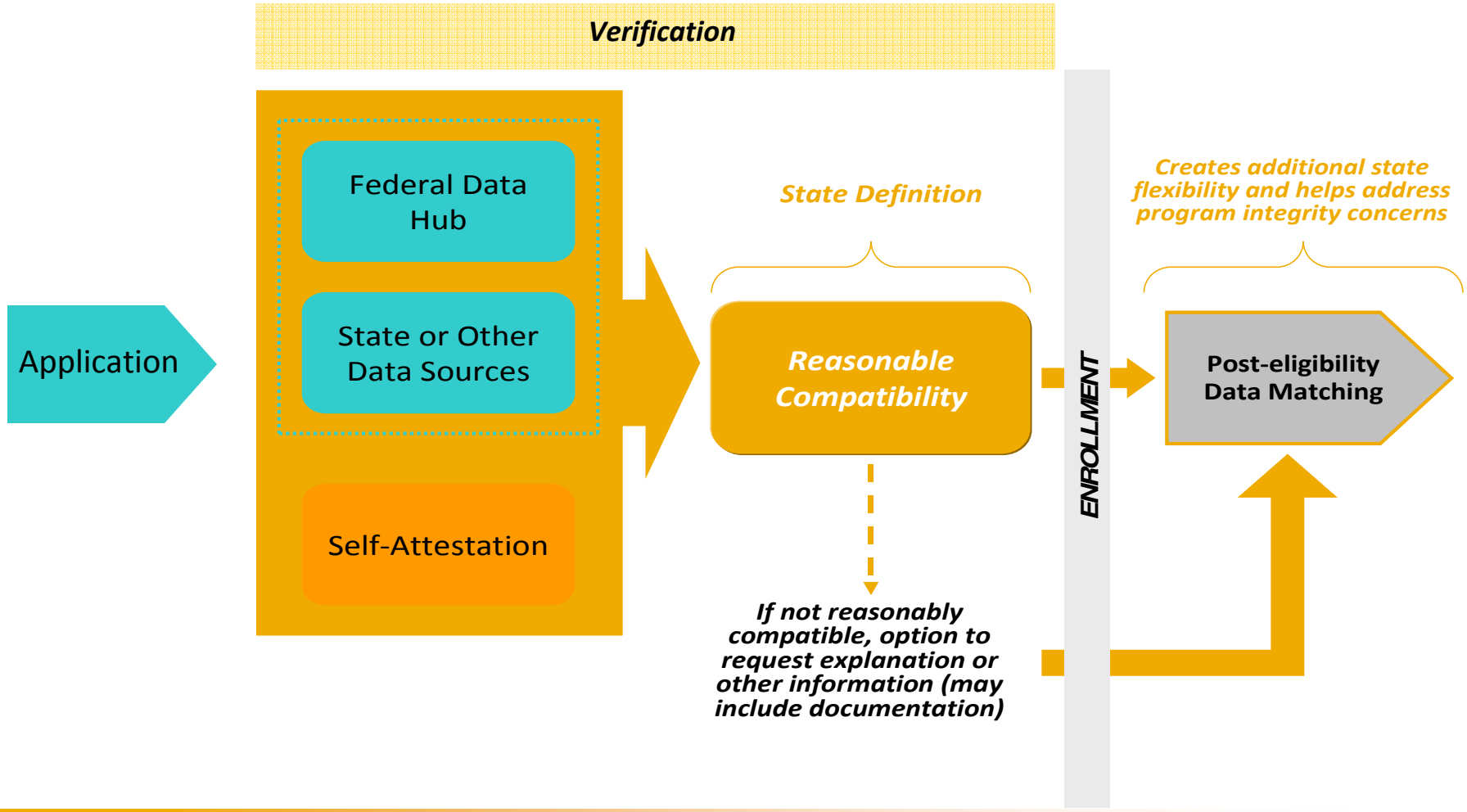
- **Income:** "If an applicant's attestation to projected annual household income is no more than ten percent below his or her prior tax data, the Exchange must rely on the attestation without further verification as part of the alternate verification." *45 CFR 155.320*

Medicaid/CHIP Agencies:

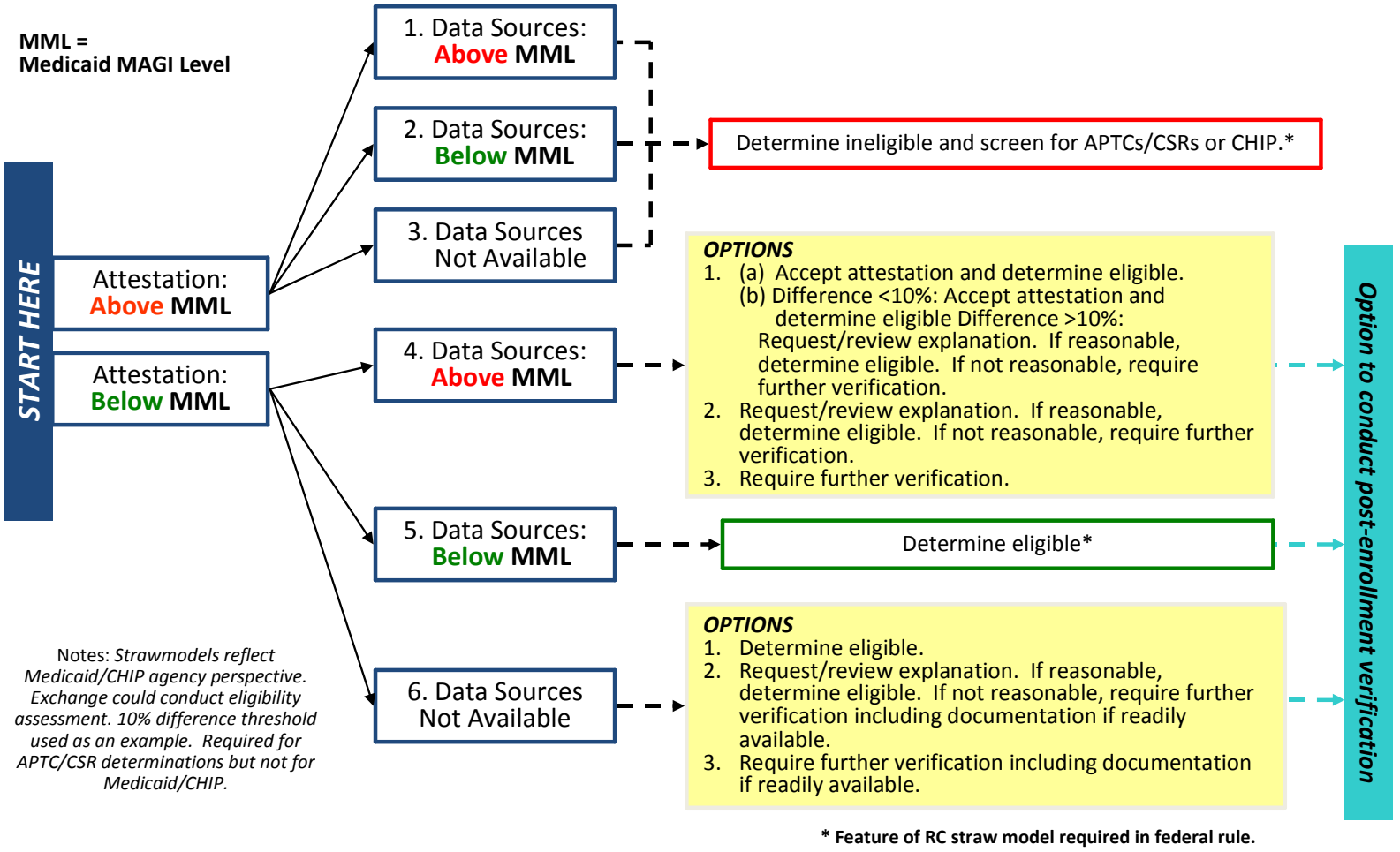
- **General:** With certain exceptions, State flexibility in defining reasonable compatibility. Applies to MAGI and non-MAGI populations. *42 CFR 435.952*

- **Income:** "Income information obtained through an electronic data match shall be considered reasonably compatible with income information provided by or on behalf of an individual if both are either above or at or below the applicable income standard or other relevant income threshold." *42 CFR 435.949*

Reasonable Compatibility



Reasonable Compatibility: Medicaid Income Straw Model



Verification

ACA Law and Regulations

If Not Reasonably Compatible...

Exchange:

- **Additional Information from Applicant:** Seek additional information from individual to identify and address cause of the inconsistency (e.g., typographical or other clerical errors).
- **Documentation:** Provide applicant 90 days to submit "satisfactory documentation" to reconcile. May extend the 90 day period if the applicant demonstrates a good faith effort. If still unable to verify, eligibility must be determined based on data sources, unless special circumstances.
- **Case-by-Case**: Exchange may accept an *explanation of circumstances as to why the applicant does not have documentation*.

45 CFR §155.315(f)-(g)

Medicaid/CHIP Agencies:

- **Additional Information from Applicant:** Seek additional information from the individual, *including statement which reasonably explains the discrepancy*.
- **Documentation:** Only to the extent electronic data are not available and establishing a data match would not be effective, considering:
  - Administrative costs associated with establishing and using the data match vs. administrative costs associated with relying on paper documentation
  - Program integrity impact (i.e., potential for ineligible individuals to be approved as well as for eligible individuals to be denied coverage)

42 CFR §435.952(c)

Verification

Criteria	Medicaid/CHIP	Exchange
Financial Eligibility	Must verify using State and Federal data sources (e.g., IRS, State Wage Information Collection, SSA, unemployment compensation agencies, etc.) May: • Determine useful data sources • Determine hierarchy of data sources • Establish state-specific documentation balancing considerations Must at least define "reasonably compatible" as attestation and verification are both below or both above Medicaid levels	Must verify using IRS data to the extent available May: • Determine useful current data sources when alternative verification processes apply • Determine when to use current monthly income data sources Must at least define "reasonably compatible" as difference less than 10%.
Citizenship/ Immigration	Must verify through SSA or DHS. If not reasonably compatible, must request documentation.	Must verify through SSA or DHS.
Social Security Number	Must verify with SSA	Must verify with SSA

* Unless specified, State has flexibility to define reasonable compatibility standard and must use the inconsistency reconciliation process described previously.

Verification

Criteria	Medicaid/CHIP	Exchange
Residency	May: • Accept attestation; or • Conduct additional data match verification	May: • Accept attestation; or • Conduct additional data match verification
Pregnancy	Must accept attestation, unless not reasonably compatible with additional information available to the State Medicaid agency (e.g., claims data).	N/A
Incarceration	N/A	Must verify through electronic data sources
Age/Date of Birth	May: • Accept attestation; or • Conduct additional data match verification	Regulations are silent
Household Size	May: • Accept attestation; or • Conduct additional data match verification	Must accept attestation

* Unless specified, State has flexibility to define reasonable compatibility standard and must use the inconsistency reconciliation process described previously

Verification

Criteria	Medicaid/CHIP	Exchange
MEC: Employer Sponsored Plan	N/A	Must verify through data sources
MEC: Other Than Employer Sponsored Plan	N/A	Must verify through HHS and State Medicaid / Exchange agency

Verification Plan

ACA Law and Regulations

- The State Medicaid/CHIP agency must develop a Verification Plan describing the Agency's:
  - verification policies and procedures;
  - standards for determining the usefulness of data (e.g., when the State will use IRS data and/or current data sources); and
  - circumstances under which it will consider information provided by an applicant to be reasonably compatible with information obtained through an electronic data match, i.e., State's RC Standard.
- The policies described in the State's Verification Plan will serve as the basis for payment error rate measurement (PERM) audits.
- Upon request, Verification Plans must be available to Secretary of HHS.

42 CFR 435.945

Verification

State Law and Regulations

- All state health subsidy programs may accept self-attestation, instead of requiring an individual to produce a documentation to the extent permitted under state and federal law *AB 1296*

State Policy and Design Considerations

- To what extent will attestation be relied on versus documentation? How will documentation be submitted?
- How will the State define "reasonable compatibility" standard(s)?
  - To what extent will reasonable compatibility standards align across IAPs?
- Which data sources will be used?
- How will the use of presumptive eligibility impact this policy?

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Renewal and Change Reporting

ACA Law and Regulations

Annual Renewal: Redetermine eligibility for IAPs every 12 months. *42 CFR 435.916 (a), 45 CFR 155.335*

- Non-MAGI redeterminations at least every 12 months. *42 CFR 435.916(b)*

Administrative Renewal: Both the Exchange and State Medicaid/CHIP agencies must use available information to facilitate annual redetermination process. *42 CFR 435.916, 45 CFR 155.335*

Change Reporting: Individuals in IAPs must report changes with respect to eligibility standards through various modalities *42 CFR 435.916(c), 45 CFR 155.330(b)*

Renewal

ACA Law and Regulations

Administrative Renewal

Exchange:

- **Tax Data**: Obtain authorization from enrollees for access to tax data up to 5 years
- **Annual Renewal Form**: Provide enrollee with notice that reflect updated household income information, projected eligibility, APTC/CSR amount
- **Maximum 30-Day Review Period/Non-mandatory Return:** Enrollee has 30 days to correct information, sign and return form.
  - If enrollee makes changes, Exchange applies verification processes previously described.
  - If enrollee fails to return the notice, Exchange will re-determine based on information provided in the notice.

45 CFR 155.335

Medicaid/CHIP Agencies:

Use available information (e.g., databases) and if sufficient:

- Redetermine without requiring information from enrollee
- Notify applicant of renewal and provide applicant with opportunity to correct information
- Must apply to MAGI and non-MAGI populations

If unable to renew:

- **Annual Renewal Form:** Provide enrollee with pre-populated renewal form
- **Minimum 30-Day Review Period/Mandatory Return:** Enrollee must have at least 30 days from date of renewal form to respond and provide necessary information
- **90-Day Grace Period:** Provide at least a 90-day grace period where the beneficiary could be reconsidered and renewed without a new application if enrollee fails to return form.
- May apply to non-MAGI populations *42 CFR 435.916*

Change Reporting

ACA Law and Regulations

Change Reporting

Exchange:

- **Required Reporting:** Enrollee must report any change in circumstance that may affect eligibility within 30 days of such change
- Exchange must periodically examine available data to identify death and eligibility determination for other IAPs

- **State Options:**
  - Exchange may establish reasonable threshold for change in income so that an enrollee is not required to report below that threshold
  - Exchange may also make additional efforts to identify and act on changes relating to QHPs/IAPs

45 CFR 155.330

Medicaid/CHIP Agencies:

- **Required Reporting:** Enrollee must report any change in circumstance that may affect eligibility in a timely manner
- Agency must limit request for additional information to change in circumstance

- **State Options:**
  - If agency has enough information available to renew eligibility with respect to all eligibility criteria, may begin new 12-month renewal period
    - *42 CFR 435.916*
  - May determine the frequency of data matches between regular eligibility renewals

77 FR 17174

Renewal and Change Reporting

State Law and Regulations

- During the processing of an application, renewal or transition due to a change in circumstances, eligibility determination entity should ensure that applicant meets eligibility requirements and moves between programs without any breaks in coverage and without being required to provide/undergo additional, duplicative, or unnecessary information/verification processes. *AB 1296*
- Renewal procedures include all available methods for reporting information, including in-person, by phone, and online. *AB 1296*
- Use SB 87 process – ex parte review, attempted phone call, and sending request for information form – for submitted redeterminations and change in circumstances. *SB 87*
- Currently, adults must renew semi-annually. Children have continuous eligibility.

Renewal and Change Reporting

State Policy and Design Considerations

- Whether to renew eligibility based on information from a public benefits program, if recipient is otherwise eligible?
- Whether to create a process to allow recipients to provide an update to eligibility information in between renewal dates, and have the option to "reset" renewal date?
- For non-MAGI populations:
  - Use 12-month basis for re-determination?
  - Use pre-populated form and grace period process (consistent with MAGI) for non-MAGI individuals who cannot be renewed administratively?

Thank You

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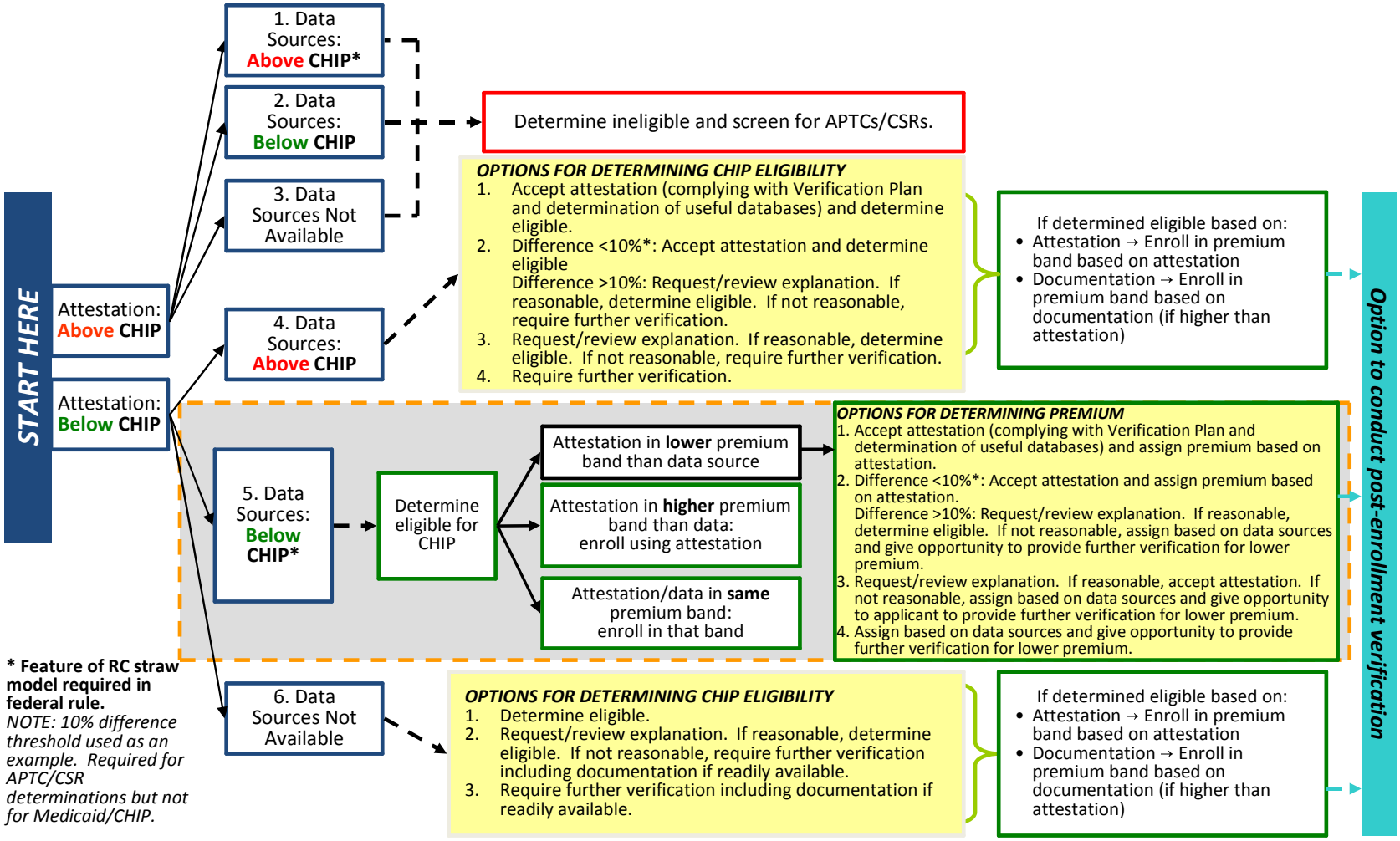
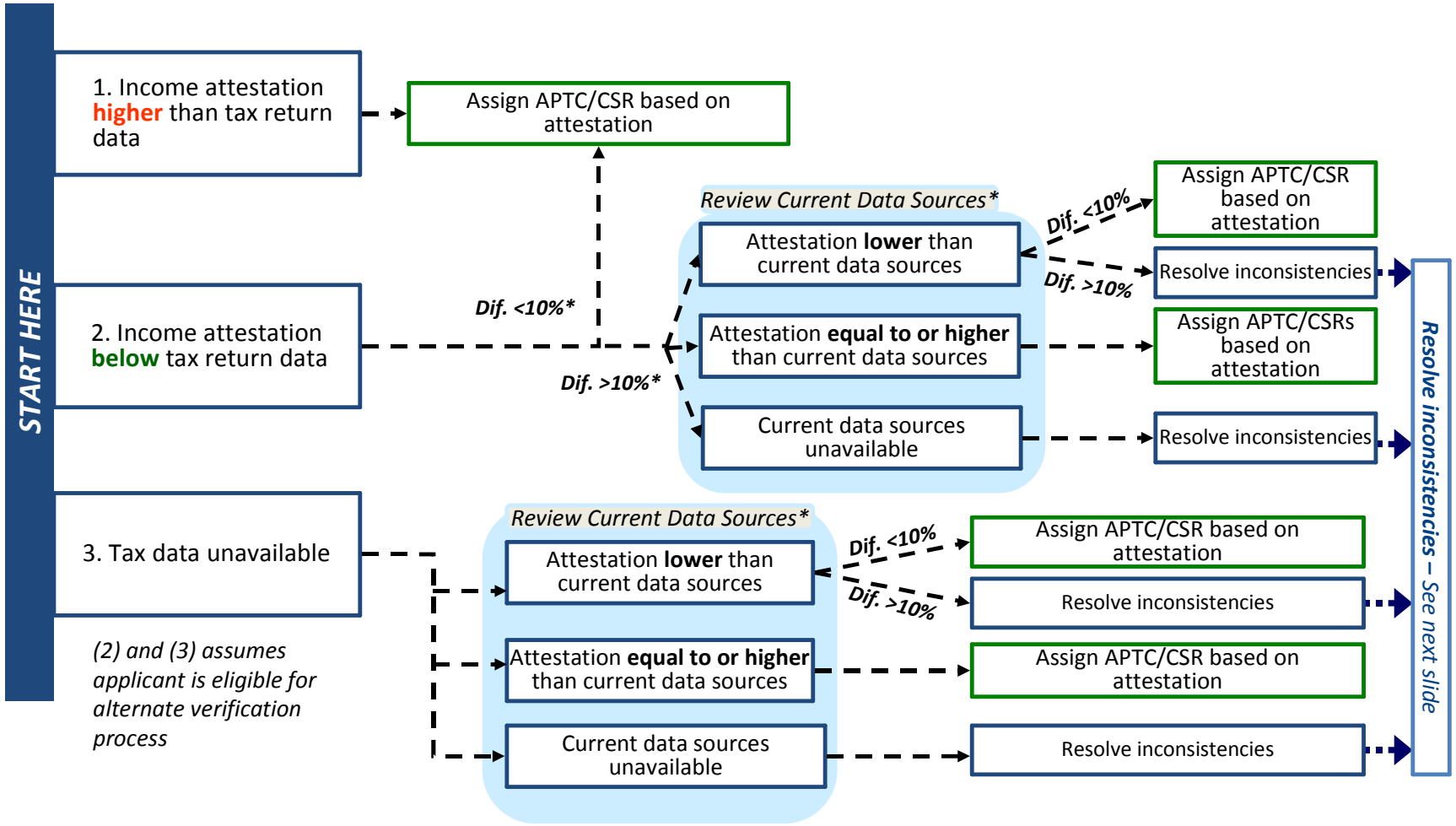
Appendix

Reasonable Compatibility: CHIP Straw Model

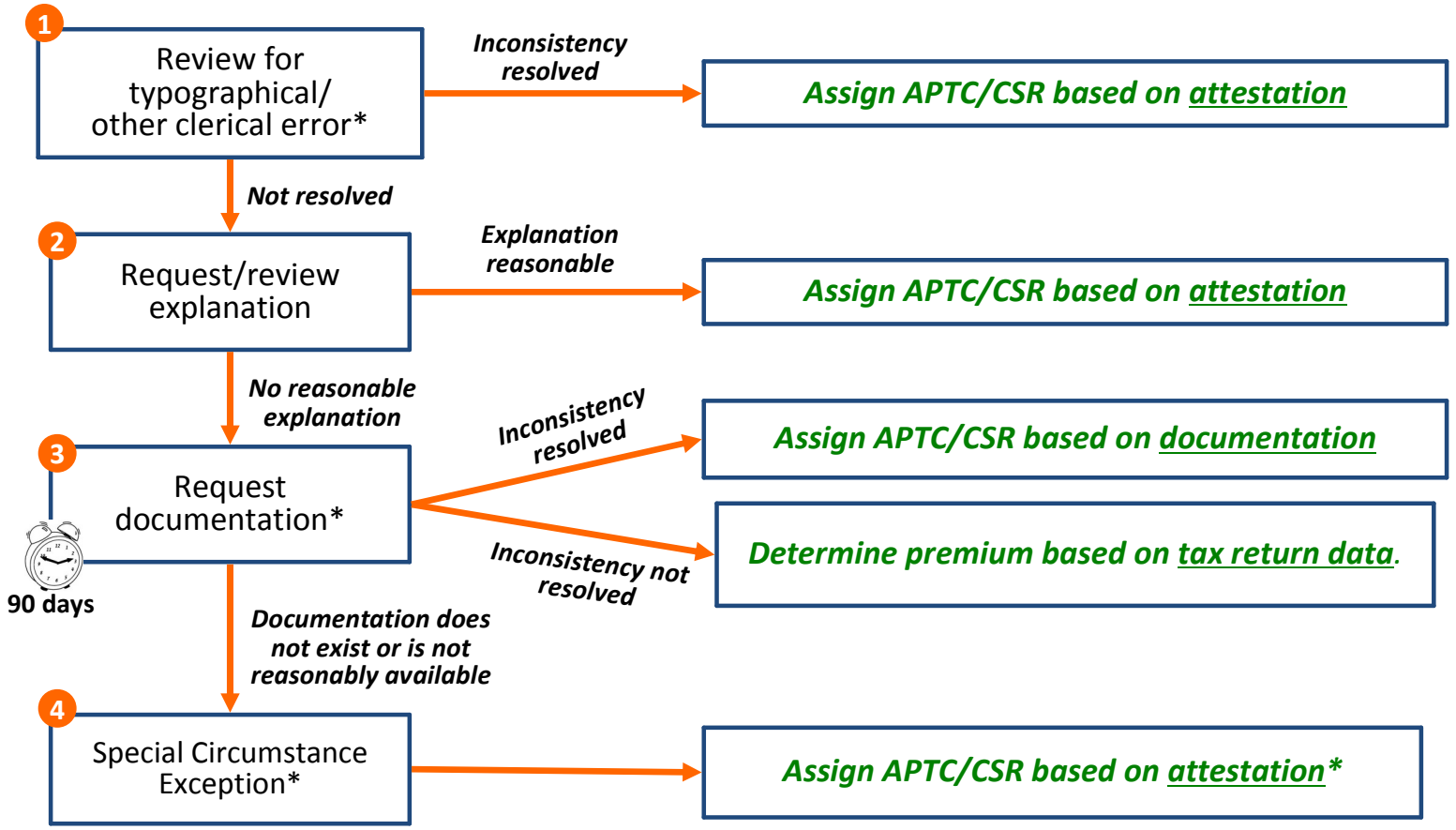


*** Feature of RC straw model required in federal rule.**
NOTE: 10% difference threshold used as an example. Required for APTC/CSR determinations but not for Medicaid/CHIP.

Reasonable Compatibility: APTC/CSR Straw Model



Reasonable Compatibility: APTC/CSR Straw Model
Resolving Inconsistencies



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