

Event Title: CMCS Webinar Series: Application, Verification, and Renewals
Date: April 19, 2012
Time: 3:00 PM EDT

>>Jennifer Ryan: Thank you very much and thanks everyone for joining us today. This is our fourth in our series of webinars related to the Medicaid and CHIP eligibility and enrollment final rule. I am very pleased to have so many of you with us today. And today's session is focusing in on really the seamless path to affordable coverage, so we're going to be talking today about application, the application process, verification policies and rules, and also the renewal process to promote continuity of coverage.

I want to mention that today's slides, just in case you're having trouble accessing the webinar, are actually available already on Medicaid.gov, as well as all the other webinar materials. And if you go to Medicaid.gov, and then you click on the top navigation bar and click on "State Resource Center" you'll find a link to those webinar slides. So I encourage you follow up with those after the event as well.

As Jennifer mentioned, please do submit your questions throughout the course of the webinar. We're monitoring them on a kind of flow basis here and we'll also be breaking at various points during the presentation to allow an opportunity for questions on specific topics. So if we can go to the first -
- I'm sorry. I should mention our speakers today. Let me introduce our two speakers today. Rebecca Bruno is the Health Insurance Specialist here in the Division of Eligibility Enrollment and Outreach in the Children and Adults Health Programs Group. And we're actually going to be opening with Dena Greenblum who is also a Health Insurance specialist here in the Division of Eligibility Enrollment and Outreach. And they have been the two leading policy experts on these issues and the final rule, so we're looking forward to hearing from them.

So if I can turn to the slides. I think we will go to the first slide. It doesn't look like I can advance it. Um --

>>(Jennifer Jaques): Let's click "anymore" On the slide. There we go.

>>Jennifer Ryan: Here you go. Okay. So I will just touch off on this first slide, which hopefully people have seen before in other presentations, but this is really sort of the "eye on the prize" that we're working toward here. And this is a picture representation of this streamlined enrollment process. So the idea here is that individuals can come to any door to submit their application for Medicaid, CHIP or Exchange coverage. They can apply online, by phone, by mail, and also, of course, in-person for those individuals in particular that would like some assistance with the enrollment

process. Then the next step is for eligibility to be determined and verified. And so that will, of course, be involve filling out the application, and then looking at people's income and other eligibility criteria. And then we move toward a very simplified verification process that Rebecca is going to tell us about a little bit later. And then finally, we move to enrollment and affordable insurance coverage.

On the Exchange side that will mean that individuals will have an opportunity to look at health plans and compare them before they make their selection. The advance payment of the premium tax credit for the Exchange will be transferred to that health plan, and individuals on the Medicaid and CHIP side will be enrolled in a health plan as well. So with that I will turn over the presentation to Dena Greenblum who is going to talk to us about the application process. Dena.

>>Dena Greenblum: Great. Thank you. So for the single streamlined application the requirements for it are discussed in 435.907 on the Medicaid side and 457.330 on the CHIP side, and there are some options that states have in order for people to apply. For the determination of eligibility on the basis of modified adjusted gross income, states have two basic options. The first is that the Secretary will be releasing a model application, and we're working on that now. There'll be an opportunity for public comment on the data elements in that application, and that'll include both a paper form that will be usable for states as well as a dynamic online form. And both of these paper and online forms are being designed to be used by the federally facilitated Exchange. So they'll definitely be up to par in terms of something that states will be able to just write in their correct names and addresses, and go forward with - for applicants to use right away.

The other option that states have is to submit their own alternative application or even more than one to be approved by the Secretary, and this application could -- it would need to meet guidelines that would be similar to that which is the model application that would have to be in order to be approved. And something we got a lot of comments on in the proposed rule is whether an alternative application could be used to apply for multiple benefits. Right now a lot of states combine their Medicaid and CHIP applications with applications for TANF and SNAP, and we do want to make sure that that continues to be an option for applicants who want multiple benefits. But at the same time also it's important that applicants have the opportunity to apply on a health coverage-only application. So what our final rule preamble lays out is that states can have an application approved by the Secretary as an alternative application that does include

questions to determine eligibility for multiple benefits in addition to health benefits. But for a state to use that application they also have to make available a health coverage-only application that would just have the questions that are necessary for determinations for Medicaid, CHIP, the Exchange and BHP.

So that's for MAGI-based eligibility. For non MAGI-based eligibility the options start out the same because states can use that same single streamlined application to start everyone out, which could be either that model application or an approved alternative application. But because there will be criteria necessary for non-MAGI based eligibility that won't be able to be gathered on that single streamlined MAGI form, states would then require applicants to submit supplemental forms that would get the additional information that's needed for that eligibility determination. The other option that states have is to create an application that takes people from start to finish in the non-MAGI process; and so that would be a MAGI exempt application that states would submit to us. So both the supplemental forms and the MAGI-exempt forms need to be submitted to the Secretary, and should also follow guidelines, but don't need to be approved prior to use. And we know that states are using these types of applications currently and we don't want to hold that up. But we do want to make sure that everyone knows what they are, and that they meet the standards.

So for all of these types of applications that we've just discussed they need to -- the state needs to receive these through all the mechanisms that are laid out in the rule and that's online, through the computer, telephone, in-person, mail, and other electronic means, which is a change in our rule which takes out what we had previously, which was submission via fax, and instead allows for the rule to really fit with the times because as certain technologies are superseded by something that's more efficient, the idea of other electronic means are commonly available make sure that applicants are able to submit their applications as best fits the technology that is available. So part of this concept of people being able to apply through any of these modes is that people shouldn't have to do in-person interviews if their eligibility is based on modified adjusted gross income, and so we've laid that out in the rule as well that there can't be a requirement for that type of in-person interview for MAGI-based determinations.

So then we come to the question of who is it that is turning in these applications? And the way that it works is that it could be an applicant themselves who can sign and submit it. It can be a non-applicant in the applicant's family or household; so that would be someone who doesn't

want coverage for themselves, but does want coverage for someone else who is in their family or household that specific entity that we have defined on previous calls. And it could also be someone who isn't in the household if they are acting responsibly on behalf of a minor or someone who is incapacitated and can't submit their own application on their own behalf.

And then the final opportunity is for an applicant to designate an authorized representative who would be able to act on their behalf by signing and submitting that application for them which is something that happens in states today. So in order for this application to be the optimal application we really do want to minimize the burden. So that means that we're only going to require applicants to provide information that's necessary to make an eligibility determination, or directly connected to the administration of the state plan. And in order to make that eligibility determination, states can also request information related to other insurance affordability programs or benefit programs. So that really means that you wouldn't be asking anything that isn't part of what you're going to be using to make the eligibility determination or fulfill the requirements of your state plan. And when it comes to some specific criteria, we've laid out specifically for Social Security numbers what happens when someone is not applying for coverage for themselves. And you can only request a Social Security number of a non-applicant if these three criteria are met which is that that request for the Social Security number has to be voluntary. And the use of that Social Security number, if someone does provide it, has to be only to determine eligibility or for a purpose directly connected to the state plan as we've mentioned, and the individual, that non-applicant, has to be clearly notified when -- in that space that you're providing to put the Social Security number, they have to know at that point that it is voluntary and what it would be used for.

So in order to really bring ourselves to the full capacity of what an application can look like in 2014, we've been thinking about some principles that will be helpful for online applications. We know that there will still be a lot of people who do need to apply through paper applications, and it's important to make those as user friendly as possible, but I think we want to get into a little more detail of what the requirements will be for an effective online application.

So to start with, an effective online application needs to be dynamic, and that means that it only asks the questions that pertain to that person who's filling out the application. Not every online application is going to ask the same questions, and that might be as simple as not asking someone who's -- indicates that they're male, whether they're pregnant, but it can also go

further because there are certain questions in terms of it being a single streamlined application that's used to make eligibility determinations, not just for Medicaid and CHIP, but also for advance payments of the premium tax credits. That means that for some people you do need to ask questions about something like access to employer sponsored insurance, which is not a requirement for Medicaid and CHIP. But if you have a dynamic application which asks questions about income right up front, and lets you figure out who it is that would be Medicaid eligible, then based on that income determination you wouldn't have to ask those people, who you can tell already are going to be Medicaid and CHIP eligible, about that access to employer sponsored insurance.

Another important principle is real time verification, and this is something that Rebecca is going to elucidate for us a little bit more shortly. But in terms of the way that it plays into the application, what we're envisioning is that someone doesn't have to go through the whole online application before the -- it reaches out to the data sources and the Hub to get information back to verify what they have put. You can actually do that interspersed with the application questions, and that might mean that when someone puts in a Social Security number that you can tell right away by going out to the Social Security Administration whether there might be one number that's a mistake that someone put; it's just one digit misplaced. And then you could provide a message to that person real time so that, while they're still sitting there at the screen, they're able to make the correction they need and move on.

The third criteria that we have here is about pre-population and that means that when the system knows something where it's practical and helpful you can put it right in. The state can program it so the information will appear and a person can respond to what's given to them rather than coming up with that piece of information themselves. So for example if someone is receiving unemployment insurance, and the state is able to get through their data sources the amount that they're receiving -- they already know it. Instead of requiring the person to type in the amount -- instead a smart online application could show that amount that they're receiving each month and have the person confirm it, or make an edit if needed rather than typing in the amount and then just verifying afterwards on the back end.

So in order to play out a little bit what it looks like to really collect the minimum amount of information to determine eligibility, specifically as related to a non-applicant for whom you don't really need very much to be able to determine eligibility of the people who do want coverage. We're

gonna go through one scenario of a simple situation in which a parent who is not applying for coverage for him or herself does want coverage for his or her child. And so what you do need to ask on the application from the non-applicant parent is just this. You need to ask the contact information, so you can follow up with the family. You need to be able to calculate the household composition for the child who is applying. You would need the parent's tax filing information. You would need to know the relationship between that parent and child, so you in fact do know that they are parent and child; and then a state option because pregnancy can relate to household size if the state chooses for someone other than the pregnant woman herself. You would want to ask whether that parent was pregnant. And then to calculate the household income for the child you would need the parent's income, so that's something else that involves them though they're a non-applicant, and in order to check income data bases -- this is somewhere where a reason why the state might want to follow those criteria and do request the Social Security number from that non-applicant parent, but that would need to -- in order to do so it would need to be clear, those criteria we discussed on the previous slide.

So what you aren't seeing here and what needs to be asked of the non-applicant is citizenship and immigration information, for example because that is not relevant to the child's eligibility, the parents' citizenship and immigration status may not be requested. And that's something that we lay out for all non-applicants in the preamble of our final rule. So in order for people to submit these applications something that we know that a lot of new applicants are going to need, and people who are conducting their renewals and continuing as beneficiaries, is assistance. And one of the requirements that we have in 435.908 and for CHIP in 457.340 is that the agency itself must provide assistance through all the modes of application submission. So that's including the paper, online, phone and in-person.

So in addition to the assistance that's offered by the agency itself, an individual may also choose to utilize other forms of assistance; so one example that are authorized representatives. So as used today those authorized representatives can be very important for vulnerable populations to make sure that people who aren't able to submit the application themselves or aren't able to follow up themselves can choose to have someone to help them with that and do it for them as well as the assisters who are separate from authorized representatives. The assisters are the staff and volunteers of organizations that are authorized by Medicaid and CHIP agencies to provide assistance to individuals with the application and renewal process at the request of applicants and beneficiaries. So on both

these two types of people who can provide assistance at the beneficiary or applicant's request, we're going to provide some future guidance that will really lay out how we can continue to make sure that these options are available because they're so critically important to making the application process a success.

And as we mentioned these types of assistance do need to be provided both at application and renewal.

>>Jennifer Ryan: Okay. Thank you very much Dena. I will go back to that. So a number of questions have come in, so I think we will pause and just ask you a few of those before we move on to verification. Here's kind of a straightforward one Dena. Will faxed applications be accepted even though we are no longer listing them in the means of required options?

>>Dena Greenblum: Yes. So as it is commonly available, and part of the state's practice to accept faxed applications. They should be accepted now until they are superseded and no longer relevant as states should be accepting them currently.

>>Jennifer Ryan: Okay. And we mentioned that one of the options that the states must make available to applicants is to apply by phone. What's our expectation in terms of how submission will be provided for a phone application?

>>Dena Greenblum: Right. So we have a couple options that we laid out in the preamble that something that we're envisioning the way that a telephone -- telephonic application would work would be not just sort of an automated process where someone punches buttons into the phone to be able to continue through a long application, but instead a call center where it might be someone who's sitting on the other end the line who has the online dynamic application in front of them, and able to really walk the person, that applicant, through that online application, and we do have states who have used telephonic signatures with success so far, and have been able to record them and found that they're able to do it in a way that's efficient and low cost.

>>Jennifer Ryan: And just to confirm, electronic and telephonic signatures are permitted today. That's not new under the final rule, correct?

>>Dena Greenblum: Yes. So in our 435.907 we do lay out that signatures will be accepted electronically and by phone.

>> Anne Marie Costello: I believe CHIP will also authorize these for electronic signatures.

>>Jennifer Ryan: Good point. That is Anne Marie Costello, our other friend here who I'm going to refer another question to right now. So Anne Marie can you say a little bit - I'm going to ask to you give an overview of both our

timing and process for releasing the model application, and then I will ask you a couple follow up questions in terms of what we're planning.

Anne Marie Costello: Sure. So we've done a tremendous amount of work around the development of the data elements for the application, and we're in the midst of drafting both a model paper application and the development of wire frames and functionality for an online application. I don't have the timeline for when we will publish it, but we will publish drafts as part of the Paperwork Reduction Act. And there will be a notice in the Federal Register so that we can receive a wide breadth of comments on the draft, on draft models for the paper, and definitely paper to start, and we'll hopefully be able to publish wire frames for the online application. We're also working with a group of states on the development of the application. They've been incredibly helpful on identifying the data elements, the best practices they have now in relation to paper applications; how they ask particular questions. Their experience has really been invaluable in helping us to move our work forward. We've also begun to meet with a group of consumer stakeholders. So that we have very much both input into the development. And then after we have revised versions of the models which will also go out for consumer testing. We think that'll be critically important, but we want input into those models before we proceed with the testing.

>>Jennifer Ryan: And Anne Marie, of course though, you just said there'll be a paper application as well as online application model. Will there be a model phone application process, and what about in person?

>>Anne Marie Costello: I think as Dena mentioned, we envision that the telephone will not be an AVR system, but rather it would be to call in a call center, and a customer service rep or an assistant would be at the other end and able to enter that information, and have the discussion with the individual over the phone, and in addition if someone comes in for in-person assistance we envision it would be entered into an online application. That's why we think that most people will come in through an online application, not just because they will have the ability to do it themselves, but because there are other avenues where they will be able to ask for help with an online application.

>>Jennifer Ryan: Great. A couple of questions have come in about the in-person interview. Can you just kind of restate that policy, and let us know if it's still an option for states to do an in-person interview for MAGI populations, and then what about for non MAGI populations?

>>Dena Greenblum: Sure. So for determinations that are being made on the basis of MAGI, states cannot require an in-person interview. For determinations that are being made on a non-MAGI basis states do retain

that option.

>>Jennifer Ryan: Good. Okay. And Sarah Spector is also here with us. She's another one of our policy leads, and Sarah I want to ask you if you could just kind of clarify for us again -- Dena went over them in her slides, but the rules for information requested -- Social Security number information requested from applicants and also what's the policy on non-applicants?

>>Sarah Spector: Sure. We haven't actually gotten to the applicant policies, so I think I want to defer that one until Rebecca gets into her slides on verification because she sets out those rules, and we can take a question on that I think after those are gone over a little bit more. But on the non-applicant let me get to it now because Dena covered it nicely.

So if a state would like to request a non-applicant individual's household -- Social Security number, and to reiterate what Dena said, that would be an individual who lives in a household with the applicant, so the best example is a parent who is not applying for coverage for themselves, but applying for the applicant child, that a state may request an assessment of that individual if one: if it's voluntary to do so, so the individual could indeed proceed with the application without providing it. Two, that it is used -- that the state uses it only to determine eligibility for an insurance affordability program, or for another purpose directly connected to the administration of the state plan; and three, that it provides notice at that time it's requesting the information of the individual who is submitting the application, both that it is voluntary and the limitations about how that Social Security number is going to be used.

>>Jennifer Ryan: Great. Thanks Sarah. Can we just offer a clarification? So there's a question that came in about, asking about access to other health insurance coverage, access to ESI for Medicaid and for CHIP, and I believe that -- I think Dena mentioned today that for CHIP that you still need to know whether someone does have someone else's -- someone is enrolled in employer sponsored coverage. So just to be clear there'll still be a question related to access to employer sponsored coverage.

>>Dena Greenblum: So they're actually, yeah, two different issues. Medicaid programs also want to know if someone is enrolled in other coverage, and CHIP wants to know that too, not just for third party liability, but for actual eligibility, but the differences for eligibility for the advanced payments of the premium tax credits and cost sharing reductions it goes beyond what you're enrolled in, or even for CHIP what you previously have been enrolled in to actually ask about whether you're offered insurance by an employer, and more details about that offer, about how much it costs,

and those questions are its criteria for Medicaid and CHIP eligibility.

>>Jennifer Ryan: Thanks Dena. Lots of questions here. Here's one. Will individuals who are seeking renewal have access to all the same modes to submit an application that's new applicant?

>>Dena Greenblum: Yes. So we will get more into the whole process for renewals after our piece on verifications, but definitely that's when someone has to submit a renewal form then they have the capacity to do that through online paper, phone, mail, or in-person.

>>Jennifer Ryan: Great. And then just to kind of close out for now our application discussion, so the features Dena that you went over on slide number six, the dynamic application, the real time verification process, and the pre-populated form.

>>Dena Greenblum: Uh huh.

>>Jennifer Ryan: Are we expecting to see those in more detail on the proposed model application?

>>Dena Greenblum: Yes. So as I mentioned we're designing an online application that's going to be useable, and really be created to have the best results possible so that states can use it to make eligibility determinations right away. So they will incorporate these three principles.

>>Jennifer Ryan: Great. And sorry one more question. Anne Marie, I'm going to let you close this out. So just - we didn't say a whole lot about what we mean by assistance at this point. The final rule doesn't really address -- it doesn't define what authorized representatives are. It doesn't define what an assister is. Can you just say a little bit more about kind of our thinking, and then when we anticipate coming out with more guidance on that?

>>Anne Marie Costello: Sure. I think -- our thinking -- we recognize that both application assistance and the use of authorized representatives is an incredibly important mechanism to ensure that people can get health insurance coverage with a move to a more online electronic environment. That in many ways shifts the role of your assisters. We also -- there also will be navigators available to the Exchanges because of the application process that Dena talked about which includes a dynamic part which integrates the verification procedure; the verification information into the application verification process. We want to make sure that we set up some safeguards around who can see this personal information. So we will be issuing guidance on the accessibility to information for both authorized representatives and application assisters, the requirements around application assistance, particularly those -- we know many people receive assistance in an informal manner; from a volunteer, from a neighbor, from a

friend, from someone who has experience applying for the program before. But we also know that Medicaid and CHIP programs had some very formal relationships with organizations that provide application assistance. States make investments in funding organizations to do application assistance. Health care providers play an incredibly important role with application assistance, and have formal MOUs with many Medicaid agencies to be able to submit applications and facilitate the submission of applications for individuals. So we will be looking at those models and putting out additional guidance in future rulemaking. I think we will also be looking as we develop further develop the online application about what it means to provide assistance in an online environment. You know, is it a call center? Is it online chat? Is it help text in a drop down box and other information embedded? So I think we will be addressing in the issue of assistance very broadly in the near future.

>>Jennifer Ryan: Okay. Great. There are a few more questions on this topic, but I think we're going to keep moving through the presentation, and then we will come back to some of them. So next up we have Rebecca Bruno, so Rebecca is going to talk about verification.

>>Rebecca Bruno: Great. Thanks Jen. She mentioned I'm gonna provide an overview of the verification rules in the final rule, and for Medicaid these are found at 435.940 through 956 and for CHIP it's at 457.380. So in the final rule, there are four major goals when it comes to how verification will be done in 2014 for Medicaid and CHIP. And those goals are to maximize -- excuse me -- automation through the use of data sources, to minimize the needs for documentation and reduce administrative burden, and to provide a simple transparent process for consumers - which Dena touched on a bit when she talked about how the verification process will be integrated into the application process - and to ensure program integrity.

And these goals will be achieved through a primary reliance on electronic sources. The use of a single electronic source for multiple verifications which will be the federal data services Hub, an increased reliance on self-attestation and a decreased reliance on paper documentation. So the intent of these regulations is for states to rely primarily on electronic data to verify information provided by an applicant or recipient. And one of the major ways we achieve this is through the federal data services Hub, or simply the Hub as we like to call it. In the Hub will be a service that enables immediate access to multiple data bases via a single electronic transaction. And, at a minimum, data will be available from the Social Security Administration to validate SSNs and citizenship, from IRS to verify MAGI income and from the Department of Homeland Security to verify

immigration status. And to the extent that information is available through the Hub, Medicaid and CHIP agencies must obtain the information through that service.

And other electronic data sources that states will continue to use include other federal and state agency data bases, commercial entities such as TALK, which some states use today, other data that states obtain through data matching agreements and PARIS. And we note that, if possible, CMS will expand the data sources and the elements that are available through the Hub beyond those three that I previously mentioned. And under the final rule, at 435.945(k), subject to Secretarial approval states can use information from sources other than those listed in 435.948 which codifies section 1137 of the rule which requires match up with certain other federal and state agencies. And they can use a mechanism other than the Hub provided that certain criteria are met that are described in the rule.

So states have the flexibility to decide: the usefulness, the frequency, and the time frame for conducting electronic data matches. And some considerations when deciding whether a data source is useful and the frequency for which it will use the source are accuracy of the data, timeliness of the data, including the ability to access and the age of the data, and comprehensiveness, including the populations covered by the data, and the completeness of the data for verifying an individual's attested information.

So another goal of these regulations is to decrease the reliance on paper documentation. So in the final rule we stipulate that individuals must not be required to provide additional information or documentation unless information cannot be obtained electronically, or is not reasonably compatible with the attested information, and specifically documentation from the individual is permitted only to the extent that establishing a data match would not be effective considering two factors: the administrative costs related to establishing and using the data match versus the administrative costs related to relying on paper documentation and the impact on program integrity. And when we talk about the impact on program integrity we mean not only the potential for ineligible individuals to be enrolled in Medicaid, but also eligible individuals being denied coverage. So that's a factor. So an example of this would be whether it is effective for a state considering these factors to develop and use a match -- for example, with the DMV to verify residency if the state decided not to accept self-attestation.

So one way states can minimize paper documentation is by accepting self-attestation. And Medicaid and CHIP agencies can accept self-attestation of

information to determine eligibility without requiring further information, including documentation from the individual. And self-attestation can be accepted from the applicant, from an adult in the applicant's household or family such as the spouse or a parent or a caretaker, an authorized representative, or someone acting responsible for the individual if they're a minor or incapacitated. These are the same entities that are able to submit and assign an application like Dena described earlier. And self-attestation can be accepted for all factors of eligibility except as required by law, such as for citizenship and immigration status. States must accept self-attestation of pregnancy unless there is information that is not reasonably compatible in the state's files.

So accepting self-attestation does not limit the state's program integrity measures, nor affect the state's obligation to ensure that only eligible individuals receive benefits. It also doesn't affect the state's obligations under Section 1137 of the Act to conduct matches with other agencies and programs such as SSA, IRS and quarterly wage data. So what happens if multiple sources say something different? In this case the state should apply the reasonable compatibility standard to determine whether information is relatively consistent, and does not vary significantly or in a way that is meaningful for eligibility. States have the flexibility to define what is reasonably compatible, but in the final rule, at 435.952, we do stipulate that income information obtained through an electronic data match should be considered reasonably compatible with the income information provided by or on behalf of the individual if both are either above or both are at or below the applicable income standard or other relevant income threshold. And other information sources including self-attestation can provide a reasonable explanation for discrepancies among the verification sources. However, as mentioned for citizenship and immigration status states should continue to follow statute, regulations and guidance for verification and reasonable opportunity requirements.

So the final rule sets out a requirement that Medicaid and CHIP agencies will establish their verification policies and procedures in a verification plan. And this is where states will identify such things as when self-attestation will be accepted, how they will define reasonable compatibility standards, how it will determine which data sources are useful, and the data sources used for verification, and if the state decides to use an alternative data source or a mechanism other than the Hub for verification. And CMS will work with states to develop a template for such plans and they must be made available to the Secretary upon request.

So as stated before one of our goals is to ensure program integrity. And this

final rule in no way modifies current Medicaid program integrity rules but codifies and builds on current states flexibilities. States currently have the option to conduct self-attestation, and many do. And many also employ reasonable compatibility standards when making determinations. And states continue to have the flexibility to accept self-attestation and conduct post eligibility matching, such as with quarterly wage data to verify income. And the verification plans will provide a framework against which states will be measured, standards of states will be measured. And we certainly recognize the importance of aligning program integrity rules and procedures with the new eligibility rules, and taking into account the role of Exchanges who may be making Medicaid determinations.

So there are a few additional policies in the final rule that were different from the NPRM that we wanted to make sure that we pointed out. And the first is that there is a new exception at 435.910(h) to providing and verifying SSN. And this new exception is that if an individual is not eligible for an SSN or may only receive an SSN for a non-work purpose that individual cannot be required to provide an SSN; and, in this case the state will have to issue another identification number for these individuals. Second, for verification of residency we -- based on the number of comments we received we removed the word "alone" from 435.956(c)(2) and clarify that evidence of immigration status cannot be used to determine that an individual is not a state resident. However, it doesn't prevent an individual from presenting evidence of immigration status to prove state residency.

And finally, states have the option to accept self-attestation of household composition. This was a requirement in the NPRM, but in the final rule we made this an option, and this was due to the uncertainty that may exist in the tax filing and tax dependent status for the tax year in which Medicaid is sought. So we wanted to give states more flexibility. So we thought it will be helpful to provide some very basic scenarios of how reasonable compatibility might be operationalized in the states. So we have a couple scenarios. And in scenario one, we have a Medicaid eligibility level of 133% of federal poverty, and the individual has attested income of 115% of federal poverty level and has only reported earnings from work. So the state goes and checks the data sources and looking at the IRS data from the previous year the individual has income of 130% of poverty and the quarterly wage data from the past three months indicates income of 125% of the federal poverty level. So though these three are all slightly different they're all below the applicable income standard for Medicaid. So there is no effect on eligibility, and the state in that case should be consider them to be reasonably compatible, and determine the individual eligible for

Medicaid based on MAGI.

So in the second scenario, again, we have an eligibility level of 133% of poverty, and the attested income is 160% of poverty, and the data sources show 180% of poverty when looking at the IRS data and 155 percent of the federal poverty level when looking at quarter wage data. So again though all are slightly different, they're all above the Medicaid income standard, and so do not effect eligibility and are therefore reasonably compatible based on our rules. However, in this case they're all above the Medicaid limit, so the person should be determined ineligible based on MAGI, and screened for CHIP if applicable or tax credits and cost sharing reductions through the Exchange.

So in the third scenario -- again same eligibility level. In this case, the attested income is 125% of the federal poverty level, and the two data sources, the IRS and the quarterly wage show 160 and 140 effectively. So because the attested income is below the Medicaid standard, but the data sources are above the standard, the state must apply its reasonable compatibility standards. And again, states have the option to determine what the standard will be; but some things they could use are a percentage or a number threshold. For example, they could say the differences are within 10%. That could be reasonably compatible. But that's up for the state to determine. And in this case, if the state were to decide that the data sources were not compatible, they have a couple of options.

So one option the state has is to request an explanation from the individual of the discrepancy and if it's a reasonable explanation determine them eligible. And a reasonable explanation could be that the person's hours were cut, so they're not making as much as what the data showed. And if they decide that the explanation is not reasonable, they could require further verification which could include requesting documentation from the individual if no other data source is available, or on the flip side the state could just simply skip to requesting requiring further verification including requesting documentation if there are no other data sources. And we do note that for separate CHIP programs that require premiums, states may also need to apply this reasonable compatibility standards for the determining the correct premium bans for families when discrepancies arise.

So that concludes my overview of the verification rules.

>>Jennifer Ryan: Okay. Great. So we will pause here to answer some more questions. So we have quite a bit of interest in the Hub and what types of information will be available through the Hub, and what do we know today won't be available through the Hub? Is there anything you

could say about that? Anne Marie can I ask you to give an overview? I will say up front we're not quite finished thinking through the Hub, and there's a lot more work to be done, but I assure you we're fully very much immersed in these discussions right now. But Anne Marie just can share what she can right now.

>>Anne Marie Costello: Sure. I mean what I will say is, Jen, you're absolutely right. We recognize the potential of the data services Hub to serve as a focal point for many points of information. However, we need to start at the beginning, and what we're working towards right -- CMS is working very hard with the federal agencies that Rebecca mentioned - SSA to support verification and Social Security number and citizenship, Department of Homeland Security to Immigration status verification, and the IRS so that we can have access to modified adjusted gross income. That is required by statute that that information be made available as part of this streamlined process. We recognize that in order to -- for an Exchange, and even the federally-facilitated Exchange, to be able to make determinations that additional information is needed. So we're in a process of evaluating the other available data sources, both at the federal level and at the state level, and to look at the feasibility of what can be brought into the federal data services Hub in a timely manner. I think there will be a phased-in approach to the data services Hub about what's minimally required for launch on October 1st for the 2013 open enrollment and see how the data services Hub can be grown over time.

>>Jennifer Ryan: But we do anticipate that a Hub will be available by October 2013?

>>Anne Marie Costello: That's what we are building towards, yes.

>>Jennifer Ryan: Okay. Great. A couple of questions came in on the verification plan. I think there's definitely going to be a lot of interest in those. And we appreciate that verification plan actually was a suggestion that came out of comments on the reg from the Medicaid directors themselves. So we're looking forward to working with States in developing those plans. So what we have decided, and the reg doesn't get into this detail, but what we have decided those verification plans are not part of the Medicaid state plan. They don't need to be submitted through a state plan amendment, but we will be requesting those especially this first time around, and there's a question about whether they'll be available publicly? The reg does not address that issue and I don't know that we've made a determination on that at this point, but certainly we understand the value of transparency on those plans. So we will take that into consideration.

So just moving on into some of the other questions about the scenarios,

Rebecca. So going back to scenario two the question is, "won't the differences affect the amount of benefits that will be made available under the APTC? Who makes the determination of what benefits are available?"

>>Rebecca Bruno: Right. So in that case this was speaking from the Medicaid perspective. So since they were above the Medicaid standard in this particular scenario, they were screened for potentially eligible for the Exchange, and then depending on how the state sets up their system they would be referred to the Exchange for determination of their -- the level of their tax credit.

>>Anne Marie Costello: And the Exchange -- you know, reasonable compatibility. There's a definition for reasonable compatibility for eligibility through the Exchange.

>>Rebecca Bruno: Right.

>>Anne Marie Costello: I am not comfortable speaking on behalf of CCIIO, but we can address that. I think we can make information available on that, Jen, to the audience.

>>Jennifer Ryan: Okay. That would be great.

>>Anne Marie Costello: They have their own definition-- there's an aligned definition of reasonable compatibility, but it gets into percent decreases and income.

>>Rebecca Bruno: Right.

>>Jennifer Ryan: Okay. Great. And then Rebecca with respect to the scenarios about reasonable compatibility and we talk about quarterly wage data and self-attested income. Both of these items are income rather than MAGI, is the question. So how would we compare these numbers for reasonable compatibility? Does that question make sense?

>>Rebecca Bruno: Yeah. Anne Marie.

>>Anne Marie Costello: So we've been trying to do a lot of thinking now about how -- you would assemble income based on -- modified adjusted gross income. As Sarah deLone has taught us well, it is not a line item on the tax return, but rather a methodology that looks at a number of different sources of income, and a number of different adjustments to the income, all of which are on the front page of the 1040. We recognize that there are not electronic sources for all lines associated or all points of income or adjustments that are part of the modified adjusted gross income. So what we've been thinking about is what the person attested to, what is their income, and also looking at the available electronic data sources. And then for where there is not an available electronic data source, we're considering whether you just pull in the individual's attestation for those other lines, so that you're able to actually build an electronic income, an electronic -- you

would -- I'm sorry. You would be able to compare an individual's entirely self-attested income to what is available from the electronic data sources, supplemented if needed by what they attest to, so this way we're able to compare apples to apples and oranges to oranges. So we're not thinking that you would compare line by line of what they attest to in their individual electronic data sources, but rather the compilation as information.

>>Jennifer Ryan: Okay. Great.

>>Anne Marie Costello: And I will say that is what we have been working through now, and have been started to discuss that in a work group that we have with a number of states to see how that works. So that will be adjusted all the time as we test it out, and ensure that approach get -- you know, works towards goals of program integrity, and there will be future guidance on that.

>>Jennifer Ryan: Great. Another question about the verification plan. I think I will throw this one to Anne Marie as well. Anne Marie, will CMS be providing a model verification plan for use by states, and how are we approaching that? And what kind of elements are we thinking about for that verification plan?

>>Anne Marie Costello: Well, I think I'll tag team this with Rebecca, and she can talk a little bit about the elements. But yes, it will definitely be a template that CMS will produce. We will work with states to get their input on the elements to be included and the format for the verification plan. I think it's important for us to have the state input, particularly since it was a suggestion made by states. But Rebecca I think you could say a few words about the key elements to be included.

>>Rebecca Bruno: Yeah. This is -- we're envisioning at least as a start that the verification plans would be the place that a state identifies which data elements are eligibility elements they're planning on accepting self-attestation for, and how they will determine what data sources are useful, and which ones they intend to use for verification purposes. And if they may decide that they may want to use other sources or for some reason want to use a mechanism other than the Hub this is where they would identify that, and those sources and their -- that they meet those requirements that I had laid out before. But, as Anne Marie said, I think it's something we definitely want to work with states on and get their feedback on these specific elements in the plan.

>>Jennifer Ryan: Great. There was a question about whether we will have an avenue for consumer input into those verification, the template for the verification plan, and I think the answer to that is yes. CMS will seek consumer input into that process as well.

Okay. Another question about -- so there's a couple of questions have come in about how our rules around verification align with the Exchange final rule. So Rebecca, I don't know if you want to hit on any high points of sort of where the points of alignment and any points of differentiation there? And then just to give you a more challenging question: Does reasonable compatibility, the concept, apply to everybody up the income scale up to 400% of the poverty level where assistance is available?

>>Rebecca Bruno: Yeah, I think, as Anne Marie mentioned, for the most part in terms of the reasonable compatibility standard, we, you know we align, but they do have their own reasonable compatibility standard in certain circumstances; so which I don't think I want to speak to too specifically, but they do have that in their regs as well. And we try to align as much as possible, and the Exchange does accept self-attestation for most elements of eligibility, and for some more they're actually required. But again for citizenship and immigration status, they are not -- and they also have the same stipulations and protections. Their goal is very much not to have paper documentation as well; so they have put that in their regs as well.

>>Jennifer Ryan: I just want to stop for a minute and ask if Sarah deLone -- Are you on the line and can you speak up if you are?

>>Sarah deLone: I am. Can you hear me?

>>Jennifer Ryan: I can hear you. Great. So Sarah deLone is our senior policy advisor and was the policy lead on this reg. And you've heard presentations from Sarah already in our series here. Sarah, did you want to comment at all on the alignment and the differences between CCIIO and our rule on the verification issue?

>>Sarah deLone: Sure, I can say a little bit more to elaborate on what Rebecca said. I wish one of us had sort of thought to study their reg ahead of time. We know ours much, much better obviously than theirs, and we can commit I think to going back and doing a much more careful sort of comparison and read of them. But at a sort of high to medium level I mean a couple of other things to know in addition to what Rebecca said is two things. One is that where the Exchange is either doing a Medicaid or CHIP determination or where it's assessing the eligibility for Medicaid or CHIP, it will be using -- although not necessarily the identical verification policies and procedures as the state Medicaid or CHIP agency - it will need to use policies and procedures that are consistent with the federal regulations governing them. So they will certainly be within the universe of what are acceptable verification policies and procedures, sort of, under the federal regulations.

And then the other sort of high level point to note is that they have sort of a two track verification process. One where they -- if they're not -- don't have the -- sort of the consistency or they have a departure from "change in circumstance" I think is the buzz word that they use from what the tax data shows, the sort of two year old tax data shows, it kicks them into what they call the alternative verification process. They by and large aligned with using the same sort of data sources. I am really talking about income here, which is really sort of the most complex to verify. Their alternative verification process really looks to the data sources that are available to and currently used by the Medicaid programs.

>>Jennifer Ryan: Great. Thank you Sarah. Sarah, actually while I've got you -- already having the floor here, can I ask you question about -- this is a slightly off the -- about household composition. So as we all know the makeup of a family's household can change from year to year. How does changes in household composition impact the use of MAGI income from the prior year to the current year?

>>Sarah deLone: Well, as I have said sort of my -- you know. I don't know anybody who's on the line who remembers Judy Rose, right, and she had the three basic rules you had to remember, and she would just come back with them again and again and again. I think my one basic rule for MAGI that I will probably state until I die is gonna be that MAGI is not a number that you pull off the tax return. And so if there's -- MAGI is going to be -- it's what the tax data is is useful for verification purposes, and what the MAGI that is gonna come back -- figure that is gonna come back from the IRS is gonna be attached to an individual or maybe a married couple if they filed jointly. And so as people household's -- the relevant household composition for somebody's Medicaid eligibility today is what their household composition is today, which is what the question sort of recognizes. So if somebody had a different household composition -- let's say the year before last when the most recent tax data is available. Let's say they were a child and the parents were still married at this point, so you had -- you had a MAGI that reflects both parents' income and they filed jointly, but now you have a divorced couple and the child lives only with the mother that joint MAGI is actually not going to be particularly useful to verify the family's household -- the current household information. So the way to think about it is is just think about this is the tax data, and I welcome Anne Marie to jump in if she has a different sort of spin on this at all, but the tax data is really used -- does this help us to verify what somebody's current situation is? And it may or may not be, and in this case it might be an example where it's not. Whereas if you had, let's say, two unmarried

parents living together with a child two years ago, and then they've split up, and the child is still residing with one of the parents, you could still use the MAGI information for the parent that's the two year old tax data could be relevant to verify the household income today because the child is still living with that parent. The other parent is not even in the household, and so their information is just -- it's not useful. It's not relevant. So I hope that's helpful to the questioner.

>>Jennifer Ryan: Great. Thanks Sarah. Okay. Switching back kind of over to verification again. Anne Marie, here's a question for you. Can states use earned income reported for other public benefit programs such as SNAP as a data source for purposes of verification?

>>Anne Marie Costello: So I think our final rule addresses the use of information of other public benefit programs and I believe it specifically called out SNAP. We think that is something -- particularly in states that have an integrated human services eligibility system that that would be an important source of income information. It may not be complete enough to determine a household's MAGI, but it could certainly be used to support an individual in constructing their income through the application process or as a source of verification.

>>Jennifer Ryan: Great. Okay. At that, I'm going to stop with the questions again and I'm going to turn it back over to Dena Greenblum who is going to pick up with renewal.

>>Dena Greenblum: So another thing that's addressed in our final rule are periodic renewals, and this is in 435.916 for Medicaid and 457.343 for CHIP. So the process for -- an important part of our rule for people who are beneficiaries with eligibility based on MAGI is that eligibility must be renewed by the agency once every 12 months and no more frequently than once every 12 months except in the case in which there's a change in circumstance for that beneficiary in terms of something that will affect their eligibility that becomes apparent during that 12 month period. And we'll get into more detail about what happens when there's that kind of change in circumstance during the year, but the principle rule is the once every 12 months and no more frequently than that if someone's eligibility is based on MAGI.

For all beneficiaries including those with eligibility based on MAGI or based on another basis, the first step that the agency takes to renew eligibility is to look at the data sources that they have available. And that can be information from data sources we were just discussing from SNAP, from the quarterly wage, from IRS, from any type of information that's available to the state through the Hub or other sources. And if that information is

sufficient for the agency to be able to renew eligibility on the basis of that information, then the agency has to go ahead and do so right then. And it would then send a notice to the individual, to that beneficiary - letting them know what information was used to make that renewal; but the individual doesn't have to take any action. They don't need to send back that form that lets them know they have been renewed for another 12 months or for a different period if their eligibility is based on a factor other than modified adjusted gross income. And this renewal of coverage once per 12 months - - that also, I just wanted to mention, that aligns with what is the rule for Exchange, advance payments of the premium tax credit eligibility as well. It's a line that says "coverage periods".

So for people in -- in the case that that eligibility can't be renewed, that there isn't sufficient information from the existing data sources to renew eligibility then -- this is where the process varies a little bit or could vary for state option between MAGI eligible individuals and non-MAGI eligible beneficiaries. So for people whose eligibility is based on MAGI, and they can't be renewed from the available information, then what the agency does is they pre-populate a renewal form. And this is something a lot of states are doing today with success for some of their beneficiaries. And what happens is the agency basically takes the renewal form which, as we mentioned before, can only include the information which is necessary to determine eligibility, or for another purpose directly connected to the administration of the state plan and they put in the information that they do already know. So if they know already about some sources of income, but there's one thing that they're missing, then they would really put in everything that they need including such as the name and address and Social Security number. And then the individual sends back that form. And when we say the word "send," we really mean they return that form through any of the modes that someone can return -- can respond, so that would include online, phone, other commonly available electronic means, in-person, and mail.

So the individual, that beneficiary, would correct the information on the form, fill in anything that's missing. They wouldn't be required to do something like put in -- do something with their Social Security number because that's not something that's changed. It would really just be the information, something that might have changed since their last determination or renewal, and they would sign and return that form to the agency. So this is a process that has been -- we described this particular process about pre-populating renewals and also the process for making determinations on the basis of available information and previous state

Medicaid director letters. And we really think that these are the ways to reduce administrative burdens and keep people from falling off the programs and then having to get back on right away which really is a problem, both for beneficiaries and for states.

And once the state receives back that pre-populated form they then would verify the information that the beneficiary provided, and they would do so through this same data driven approach that occurs at application and at renewal and they need to wait at least 30 days once they've sent that pre-populated form for a response back. They have to give beneficiaries at least that long. And then, once they have the information verified they notify the beneficiary of their decision on the basis of the updated information.

And let's now talk a little bit about what happens if there's a change during the year; so something that is not the regularly scheduled renewal, but something changes in between. So that can result from either a change in circumstance that's reported by the beneficiary, such as them letting the agency know that a new child was born, or there was just a change in address, anything. Or a change that the state becomes aware of because of data matching that they're doing during the coverage year. So what happens is that the state would -- again based on that new information they can renew eligibility right away, then they go ahead and they don't need to send anything. They can continue eligibility. If they need more information on the basis of that change reporting, so something that affects the eligibility for that person, and they're not sure whether or not the person will be able to continue coverage, then they are allowed to request more specific information from the beneficiary but only on that eligibility factor that changed. So if someone has a change in income that's been reported, or it's received through a data source, then the state can request additional information about that family's current income, but they can't require the individual to re-verify their residency. So it's really just has to be specific to what the agency knows might have changed or did change.

And then what the agency can do is if they have enough full information about all factors about eligibility to renew for another 12 month period, even though it's in the middle of the year, the agency can choose to renew for a full new 12 month period if they have enough sufficient information to do so.

So then we get to what happens if at the renewal either during the year or at the 12 month regularly scheduled renewal someone does not appear to be eligible for Medicaid or CHIP any longer. And some important things to keep in mind when that situation occurs is that first the agency does need

to consider all bases of eligibility. So that means for Medicaid, for example, renewal forms would probably need to include questions that get to the basic screening questions for bases of eligibility other than MAGI; so questions about disability in order to consider all these bases when deciding that someone might not continue to be eligible.

Another thing to keep in mind is that if it appears that a person is ineligible at renewal because they haven't responded to that pre-populated renewal form, and coverage is then terminated on that basis, what our rule says is that if the person, after that termination, responds to the renewal request that they had received just by giving some updated information, either online, phone, paper, mail, in-person, then they -- if they do so within at least a 90 day period then that additional update of information should be good enough to reactivate their eligibility without being required to submit a new application. So if that additional information does indicate that the person should still be eligible then the agency is -- this is called a reconsideration period - that they reconsider their eligibility. And this could be longer than 90 days at state option, and some states might find that's the best way to keep people on the program without it being a burden to really require a new application when it's unnecessary.

So the other thing is just that if a beneficiary is not eligible for Medicaid or CHIP because of an increase in income, then the agency takes the additional step, not just terminating their Medicaid eligibility, but also determining potential eligibility for other insurance affordability programs, and then transmitting that electronic account for that beneficiary to the other programs as appropriate. So to go over what we just talked about, we've a couple of quick scenarios that demonstrate the use of these principles of -- if there's sufficient information, then renewing, and if not, what you do?

The first scenario -- if the initial application shows that the beneficiary is a citizen and has two jobs and at that initial application the income was verified based on quarterly wage data, and it's a MAGI determination. So at annual renewal what the state does is check the quarterly wage data base again and if they find out that it looks like the income from those same two jobs is similar to what it was before, still within the Medicaid range, no new jobs have shown up on the data match, then the state doesn't have to check citizenship because it's not subject to change. The state can renew eligibility for that beneficiary right then, and just send the notice to that beneficiary letting them know about the information used, and what they've determined. And the individual would also be notified that if indeed there has been a change that the agency doesn't know about, they should report

that as always is required people do have the responsibility to report changes to the Medicaid agency or CHIP agency if anything is incorrect or has changed. But the state doesn't need to wait for any sort of response to effectuate that round.

Okay. The second scenario shows what might happen when the state does not have sufficient information. So in this case, the initial application showed that a beneficiary is self employed, and they didn't have -- there was no external source that verified their income. So at annual renewal, the state would go out and check the data sources to make sure, to see if there is any income information available. But in this case, the state didn't find any information from the data sources, so what it chooses to do is to pre-populate a renewal form with the available information, and send it to the beneficiary for a review and response.

The state has to give that beneficiary at least 30 days or more for a response before either renewing coverage at that point, or starting to take action that is necessary for a termination if they are not able to show that the individual is still eligible.

>>Jennifer Ryan: Great. Okay. That concludes our presentation. Thank you both. Great job. I thought that was very informative. Hopefully everyone on the line did as well. We have 400 people with us. I guess that's a good thing. (Laughter)

And so I think we do need a little clarification on the change in circumstance by data match. So I think several questions are kind of flying in asking about if that's something that's available then doesn't that mean you could have a state doing a data match throughout the course of the month and people having their eligibility change of circumstances happening frequently? Either does the rule provide any parameters around when that is appropriate?

>>Dena Greenblum: So the state is only allowed to reach out to the individual when a data match shows that something has changed that affects eligibility. So if the state does a data ping that shows that the income went up, you know, \$5 this week because they worked an extra half-hour, something like that, then there would not be grounds for conducting a renewal at that point. It's only if there's a change available through a data match that affects eligibility.

>>Sarah deLone: Jen, can I just point people to this completely supports -- this is Sarah talking. That this is where there's an example of an interface between the renewal regulation that 435.916, and I am sorry I don't know the CHIP cite, and the regulations on verification at 435.952 which talk about what the responsibilities of a state are when it receives information

and taking action on it. So those are where the regulations are that say if a state gets information, through say an electronic data ping, before it can act if that information is going to affect someone's eligibility, before it can act on it, it has an affirmative obligation actually to go and contact the person because you're not going to terminate somebody based just on an electronic data ping. So there's some synergy between the two sets of regulations.

>>Jennifer Ryan: Okay. We have about 10 minutes left and a lot of questions to go through, so I want to make sure we don't lose the question that came in earlier during the webinar about just -- again Sarah Spector, if you could just kind of again go over the rules about collection of SSNs for applicants now. You mentioned non-applicants earlier, but if you could do those distinctions again I think that would be helpful.

>>Sarah Spector: Sure. Thanks Jen. The changes we made around provision of Social Security numbers by applicants were really very minor. So the rules, our current rules in 435.910, remain largely unchanged in that applicants are required to provide their Social Security numbers, and indeed that's the key obviously for the data matches for income, citizenship, all sorts of things that we've been talking about today. The exceptions that we added were - - build upon the exception that was already in our current regulations about not requiring individuals who have a religious objection to provide an SSN when obviously they don't have one, and we added two more to that that were just sort of codification of policy to just serve -- have it all operationalized and make sense, and those were for people who are not eligible for an SSN. You wouldn't require them to furnish or provide one or therefore verify it, or for individuals who are -- who were furnished SSN's only for a non-work purpose. Obviously that SSN isn't yielding any income data information. And then some very small modifications were made to align our rules, so that you wouldn't verify an individual's SSN who didn't have one, for example. And that -- Just trying to think; there is one other. I think -- oh, and the last piece is that the rules of reg -- not delaying or denying eligibility would all just carry through to conform.

>>Jennifer Ryan: Great.

>>Sarah deLone: Sarah, can you comment on the CHIP policy for SSN's?

>>Sarah Spector: Yeah. Thank you Sarah. So CHIP aligned its rules with ours in this respect so any individual who is not eligible for an SSN similarly is not required to provide one.

>>Jennifer Ryan: Okay. Thanks Sarah. Dena, getting back to renewals for a moment. Can you -- so when we're talking about the renewal form being signed and returned for those enrollees whose information the state can't

verify through electronic sources. Is a return form required if the information can't be verified electronically?

>>Dena Greenblum: In order for those individuals to have their coverage renewed and continued the state does need to see a response from them if the state believes that it can't renew them without such a response.

>>Jennifer Ryan: Okay. And a few questions came in about the reconsideration period. So during that period if a person goes through the reconsideration process and ends up re-enrolled are they eligible to receive retroactive eligibility for that 90 day period that passed?

>>Dena Greenblum: They might be. It depends on whether they – would have been eligible during that 90 day period just in the same way that retroactive eligibility occurs at initial application.

>>Jennifer Ryan: Okay. Great.

Sarah deLone, I have a question for you here. Is CMS planning to publish standards for the potential eligibility assessment for the APTC's?

>> Sarah deLone: Is CMS gonna -- can you say that again Jen?

>>Jennifer Ryan: Will CMS publish standards for potential eligibility assessment for the APTC?

>>Sarah deLone: Well, there are standards that are written into the regulations. This is actually more of a Exchange regulation question than Medicaid if I'm understanding the question correctly; so there are standards. I mean the Exchange needs to apply the -- for the MAGI populations needs to -- in making an assessment and I feel -- I'm a little bit -- you know, we certainly work closely with CCIIO in developing these, so my comfort level is pretty high here, but I just want to emphasize that this is actually CCIIO has the lead on this policy, not CMCS. But the basic, you know, cut is that -- rule is that the eligibility criteria need to be applied in making that assessment, and but -- and it will be a robust assessment, so that in terms of the verification process for making the assessment need -- whether it's a determination that's being made or whether it's an assessment of likely eligibility that's being made based on MAGI that process will be need to be in compliance with the federal Medicaid/CHIP verification regulations. So we have I think issued -- the basic standards have been published in terms of I'm sure there will be more sort of sub-regulatory guidance and discussion as we all drill down in terms of operationalizing the rules and actually doing the builds, but I think the basic standards are there. Anne Marie, do you have anything to add?

>>Jennifer Ryan: Yeah, Anne Marie is going to jump in.

>>Anne Marie Costello: Yeah, I think, Sarah, I think the question might be related to when someone is found ineligible for Medicaid or CHIP at

renewal. What is the need to assess them for APTCs and I think in general we're really looking at -- since it's a rules engine that can evaluate someone to look at their potential income eligibility. So they look potentially income eligible then -- if you're not eligible for Medicaid, the Medicaid agency has the obligation to look at the MAGI income of that individual, and then it says whether they're potentially eligible for CHIP, if they're a child or for coverage through the Exchange either with an APTC or cost sharing reductions and they get into the appropriate agency.

>> Sarah deLone: Oh yes, I see there. It's the reverse way so the question is asking about the Medicaid agency assessing for APTC eligibility. I am sorry. I totally flipped it around. Yeah. I think that that's right, and it will be an income -- so it shouldn't be a lot of extra work for the Medicaid agency to do, and it would be the same as at initial application. There will be times when the Medicaid or CHIP agency will be receiving the initial application, and they'll make a MAGI determination, determination of income based on the MAGI rules and then send the person to the appropriate program.

>> Jennifer Ryan: Okay. Great. Dena back to you for a minute. So once -- so this is kind of a question. I think the question is about continuous eligibility versus a 12 month eligibility period; right?

>> Dena Greenblum: Right.

>> Jennifer Ryan: So some states are already -- I should mention actually really I am sure you have all heard us say before, but there is almost nothing in this reg that hasn't already been tested out and successfully implemented by states out there. We really follow state lead on so many of the policies that we developed in this final rule and so in many cases some states certify individuals for a year. They provide 12 months continuous eligibility and during that year changes in income in those states don't impact their eligibility, so they don't have anything really that changes the income. Are states able to continue that practice under the final rule?

>> Dena Greenblum: Right. So that 's a practice under CHIPRA for children, and that continues to be an option for states, but it's not the same as our conduct an annual renewal once every 12 months and no more frequently than that because if there are changes during the year for people for whom the state has not elected continuous eligibility, then they do follow the process that we discussed for changes in circumstance during the year which does necessitate a renewal during the year, where you do send and request more information if needed and act on changes that occur during the year where under continuous eligibility you would not be acting on those changes.

>> Jennifer Ryan: Great. And so also for -- so this is sort of again related to changes of circumstances, so for a person that might have been receiving APTC during the course of a year but then their income reduces, so they lose their job and the income goes down to the Medicaid eligible level, at what point do they renew their eligibility, or is that a kind of a qualifying event for eligibility, so they would be able to re-enroll in Medicaid?

>> Dena Greenblum: So someone who had APTC and their income drops, so what would happen the Exchange would sort of find out about that probably before the Medicaid agency does. So the Exchange has a similar rule for renewals that happen during the coverage year they call it, so the Exchange would have the requirement to do in the same way an assessment or determination of eligibility for Medicaid if the information that is available to the Exchange in the coverage year indicates that person is no longer eligible for APTC because of that change in income.

>>Jennifer Ryan: Great.

>>Sarah deLone: Dena, maybe you could confirm that this is the case -- I believe in the Exchange rule unlike Medicaid where there's an affirmative obligation for beneficiaries to report changes that might affect their eligibility, and whereas the Medicaid agency may, or more importantly, may do periodic data checks to check and see whether somebody's income is going up or down. The Exchange is not -- we're not anticipating that Exchanges will be doing those periodic checks, so it would really a case where they initiated because somebody is experiencing a drop in income, and they want to be considered for the Medicaid program where they're realizing I can't afford my premiums anymore, so they want a reevaluation. Maybe they're looking for more APTC support. Maybe they're looking to move to Medicaid. They don't know. They just know their circumstances change but it's going to be necessarily sort of triggered by action on the part of the beneficiary. Does that sound like an accurate characterization?

>>Jennifer Ryan: Lots of nodding in the room here. So I think we are at -- we're a little past 4:30. So I feel like we better close out the questions at this point. Thank you very much to everyone on the line for your thoughtful questions. They're really helpful and made the discussion very interesting. Thanks again. We will be as always trying to post as quickly as possible the transcript and list of questions and the recordings from this webinar to join the slides which are already there on Medicaid.gov. So I encourage you to look for those, and share that information with your colleagues, and I encourage you to join us for next week's webinar which will take place on April 26 at 3:00 p.m. Eastern Standard Time. And I have forgotten the topic.

Anyone know?

>>It's on MAGI for seniors and people with disabilities.

>>Jennifer Ryan: Okay. It's on the MAGI screening process, specifically related to our new policy related to enrolling seniors and individuals with long-term care needs. So thank you all very much for joining us today and we'll look forward to talking to you next week.