

Event Title: CMCS Webinar Series: Seniors and Individuals with Disabilities in the New World of MAGI

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>> Jennifer Jaques, Webinar Producer: Good afternoon. Welcome to the Seniors and Individuals with Disabilities in the New World of MAGI webinar. The webinar materials including an audio file and transcript will be available on Medicaid.gov after the event. During the presentation all participants will be in a listen only mode.

We have just a few housekeeping items before we begin. If you experience technical difficulties with the webex platform, you can call support at 866-229-3239 or message the webex producer using the Q and A panel. During the presentation, all participants will remain in listen-only mode as this event is being recorded for replay. We encourage you to submit questions at any time using the Q and A panel at the bottom right of your screen. Type your questions in the space at the bottom and click the send button, and please be sure to direct your questions to "All Panelists" in the drop down menu. Your questions will not be seen by other members of the audience, and will be addressed during Q and A at the end of the presentation.

I would now like to turn the call over to Jennifer Ryan, the Deputy Director for Policy in the Children and Adults Health Programs Group in CMCS. Jennifer, you have the floor.

>> Jennifer Ryan: Thanks very much Jennifer. Thanks for joining us today for our next in our series of webinars related to the Medicaid and CHIP eligibility Final Rule. Pleased to be with you today. Today we're going to be talking about kind of -- one of the major changes that we made in the final rule compared to the proposed rule, and so we thought it warranted a webinar unto itself to talk a little bit about treatment of seniors and individuals with disabilities in the new world of MAGI. So our speaker for today's call -- we have two speakers. The first will be Sarah deLone who's the Senior Policy Advisor in our Children and Adults Health Programs Group here at CMCS. And she is also joined by Anne Marie Costello who's the director of our Division of Eligibility, Enrollment and Outreach in the Children and Adults group. So I will turn things over to Sarah to begin the presentation. And as always we will be stopping part way through to give you all a chance to submit some questions. And I know you will be doing so during the course of the presentation as well through the Webex function. And we'll be sure to try to address your questions on a rolling basis as best

we can. So thanks very much, and I'll turn to over to Sarah.

>> Sarah deLone: Great. Thanks Jenn. Just a quick sound check. I'm coming through okay?

>> Jennifer Ryan: You sound good to me.

>> Sarah deLone: Great. Okay. For those of you on the line I'm in a separate location so just wanted to make sure everyone could hear me okay. So I just want to give a quick, little note about the title to be clear, so the expectations are clear about what we're covering today. It's entitled "Seniors and Individuals with Disabilities in the New World of MAGI" and it is about both of those populations, but the focus is really going to be on individuals who can be eligible, both based on MAGI and potentially on a MAGI excepted basis. So while the processing and policies that we're gonna talk about do, you know, seniors are sort of put through the same kind of process. The bulk of the presentation and the discussion is really focused on those who can be eligible on both bases. There is a small slice of seniors who can be eligible based on MAGI, and we'll get to that in a second, but I just sort of wanted to be clear on what we're really going to focus on today.

I also thought it would be good to warm up and start out the conversation -- next slide Jen, with a slide that any of you who were on the MAGI methods webinar -- were participating in that would have been seen already, and that's whose eligibility is based on MAGI. And I think it's just useful to remind ourselves of the MAGI excepted populations because while we think in a sort of a policy and real world way about the implications of our policies, and we think in terms of the different populations that are affected: people with disabilities, people who need long-term care services, elderly individuals. The statutory sort of framework in which the policies are developed really revolve around whose eligibility is determined using MAGI methodologies, and who's excepted from the MAGI methodologies. So I just wanted to pause to remind ourselves that on the MAGI column on which will be the bulk of individuals who are found eligible and enrolled in the Medicaid or CHIP programs are adults -- your new adult group, parents and caretaker relatives, children being determined eligible as a child, and pregnant women being determined eligible on the basis of being pregnant, and then MAGI excepted. Those for whom current methodologies, generally SSI method-based methodologies, are used for anybody for whom that the Medicaid agency isn't required to make a determination of income such as SSI recipients or federal foster care adoption assistance recipients, individuals who are eligible on the basis of being aged, blind and disabled. That's obviously a big one for today's call. Individuals with

long-term care needs, also sort of fundamental here today. Individuals eligible as medically needy, and then Medicare eligible individuals who are looking for help with their Medicare premiums or other cost sharing charges.

One policy to note before we jump into the MAGI screen and the focus of today's call is to note a change that we did make from the proposed to the final rule with respect to the exception from MAGI methodologies for seniors. The statute, the plain language of the statute, and what was reflected in the proposed rule just is an across-the-board blanket if you're 65 or older MAGI methods do not apply. We were able to clarify that and shift the policy a little bit in the final rule to indicate that as with individuals with disabilities that exception applies only when -- to seniors only when age, so only when being 65 or older is a factor of eligibility. So the main situation, which this is important, is for caretaker relatives who are -- who may be eligible under the caretaker relative group, which is 435.110 or maybe a state which has adopted an optional coverage group for caretaker relatives as well. And in that case we didn't want -- if you exempted senior caretaker relatives from MAGI methods what would you be left with? Well, you would be left with the old AFDC methodologies and that seemed from an administrative standpoint a nightmare to have to maintain AFDC methods just for that narrow population. So we were able to in the Final Rule provide for the MAGI exception for the elderly only to apply in situations in which age is a factor of eligibility, not when an elderly person is being determined under the caretaker relative for which their age is not relevant.

Okay. So jumping into the main topic for today's webinar, and this is the significant policy change that Jen referenced from, the proposed rule to the final rule. Under the final rule, eligibility for mandatory eligibility group based on MAGI -- for example, the new adult group, does not preclude eligibility for a particular person for coverage under an optional group that might be exempted from MAGI methods. For example, a disabled adult with MAGI-based income at or below 133% of federal poverty level so the income then for the new adult group who meets the criteria then for coverage on to that new adult group can still be determined eligible for an optional group based on disability, and be enrolled in that optional coverage group.

Similarly adults with MAGI based income at or below 133% of the federal poverty level who meet the criteria for an adult group; so they're under 65, they're not on Medicare, but who need long-term care services which are not provided under the adult group can be determined eligible for and enroll in an optional eligibility group that better meets their needs. If the

state, for example, has a home and community based waiver services program that attaches to one of the optional eligibility groups covered by the state.

So going to the next slide. How do we effect -- how is this policy effectuated? This sort of overarching policy that you can -- you're not precluded from going into an optional MAGI exempt group. How do we effectuate that in the regulations? How does the policy actually work? The way that our regulations are set up, and these are the regulations at 435.911, if an individual meets the criteria for eligibility based on MAGI, the state agency needs to promptly enroll that person in coverage. So if you have an adult under 65 not eligible for Medicare, income under 133 percent FPL, you know that person is eligible for something. They need to be promptly enrolled in coverage.

The agency, though, must also pursue eligibility on a MAGI excepted basis, for example, based on disability, if the individual indicates the potential for eligibility on another basis on the single streamlined application that's submitted. Of course, if the individual had submitted an application that's physically designed for a MAGI basis of eligibility, determination of eligibility on the basis of disability, for example, or if the individual requests a determination on a MAGI accepted basis they say, you know, "I want a full Medicaid evaluation even though you may think I'm not eligible. I want to go through that process. I want to be considered," or if the agency might have information indicating that the person might be eligible on another basis. So I want to pause here actually and turn it over to Anne Marie to talk a little bit about what -- how we're thinking about the application, the single streamlined application and the application process in order to identify people for whom -- what we refer to as the deeper dive, may be required. Anne Marie.

>> Anne Marie Costello: Thanks Sarah. I think it's important to note that we see the single streamlined application as a pathway for those that need to be considered on a basis other than MAGI, and we are working to develop a very short set of questions that will be included on this single streamlined application that look at three key factors that Sarah's described: Disability, blindness, and need for long-term care services. We also believe that in addition to these questions that will be on the application, particularly in an online application, we will also need to provide a significant amount of information education on the website, and also embedded as help text as part of the online application, so that people understand why they're being asked these questions, and the advantage of taking the time to answer those questions, and then what to expect next.

Once someone has completed the application and it is submitted, whether it's submitted directly to a Medicaid agency, a CHIP agency, or to an Exchange if that information -- if there is an indication on the application that someone has answered -- for example, "yes" to any of these questions that point to potential eligibility, the agency processing that application, in addition to determining eligibility on a MAGI basis, would then also pass this application information to the Medicaid agency. Of course, if it's the Medicaid agency processing the application they will continue to pursue additional information. But, for example, if an application were submitted to a CHIP program or to the Exchange, they would take that information, and in addition to processing it and looking at Medicaid eligibility based on MAGI, they would also, for those people indicating potential eligibility on another basis, pass that information back to the Medicaid agency. So that the Medicaid agency could work with that individual, and request the additional information needed to make a determination based on something other than modified adjusted gross income.

So we think the key components of this process are appropriate, well-worded questions that people can understand and answer appropriately, and also support so they understand what it means - so significant amount of information, education, available both on the online application and also on the paper application - but they're able to do much more on an online application. So should we stop there and take questions? Are there questions? I don't know if it's appropriate now.

>> Jennifer Ryan: Sure. I just have a couple questions here. So I invite you, if you would like to ask any questions at this point to go ahead and submit them to the Webex vehicle. We have one question for Sarah, I think. Would a 65 year old who is not eligible for Medicare and who is not a caretaker relative still be eligible for an APTC tax credit?

>> Sarah deLone: That's actually a question really for CCIIO, and Anne Marie you can back me up if you think my -- I'm right on this. I am fairly certain that such an elderly person as long as their income isn't at least 100% FPL, which is the floor for APTC eligibility. I believe that elderly individuals who can't get Medicare can get APTC.

>> Anne Marie Costello: Sarah, I would agree with you.

>> Jennifer Ryan. Okay. Great. That's actually the only question I have at this point, so Sarah you want to go and turn back to you to get into your presentation.

>> Sarah deLone: Yeah, great. So picking up -- thanks Anne Marie. So picking up where we left off. So basically if the information -- if the agency

has information, either from the -- you know, most likely from the application, but could be from another source, or the person actually, you know, specifically asks for a full determination. The agency needs to request additional information from the person which is needed to make a determination on the MAGI excepted basis. And here's where the individual choice really comes in. The individual is not required to go through that so called deeper dive. They're not required to provide the additional information that's needed by the agency, whether it's about their disability, their medical condition, their resources. If they decide: you know what, the benefits that I get in the adult group are meeting my needs, this is all I want, I don't want to go through the rest of this process. Maybe they feel like the adult group will better meet their needs for whatever reason. They're not obligated to complete that process.

As long as the process is continuing, the other thing that's critical is that enrollment on the basis of MAGI. So in a typical example, enrollment through the new adult group will -- should proceed pending completion of the determination of eligibility on the MAGI excepted basis, on the basis of disability, for example. I also want to note here that the rule is not rigid in terms of you know, you have to enroll adult in the new adult group first, and then you make the determination based -- you know, let's say for example, disability -- if that's going to be a relatively quick process. So for some individuals, determination of eligibility based on disability may not take that long. It can happen -- I understand -- I don't have direct experience at this, but I understand it could happen quite quickly in some cases, and in other cases it can be months. And if it's gonna be quick then there is no need for the administrative gymnastics to enroll the person in the new adult group, and then only to switch their enrollment category, you know, a couple days or week or something thereafter. And, so what's important is that if they are eligible on the basis of MAGI, enrollment on some basis has to happen promptly. And those timeliness and performance standards about what it means to be prompt -- that's what's addressed in our regulations that were included for the first time in there published as an interim final rule with a comment period at 435.912. So the performance and timeliness standards for processing applications and making eligibility determinations that states need to develop should take into account, you know, can take into account situations in which the MAGI excepted determination happens quickly, and so they can -- you know, don't have to, sort of, necessarily always enroll somebody first in the adult group provided that at the end of the day everybody is getting enrolled promptly if we know that they're eligible on the basis of income.

So then going to the next slide. Thanks Jen. You anticipated me. If the agency approves ultimately - so you have gone through the process - if the agency approves eligibility on the MAGI excepted basis the individual must enroll on that basis, and eligibility based on MAGI is discontinued. So this is where the choice -- once the determination is made the choice is not -- the individual no longer has a choice. At the point at which eligibility on a MAGI excepted basis is made, the person, under the statute and therefore under the regulations, is exempt from MAGI methodology. Cannot use MAGI methodology to determine their eligibility and that person therefore cannot be eligible under the MAGI base group, under the new adult group, for example, and will need to enroll in the group that was determined, the optional group determined on a MAGI excepted basis. So obviously it's going to be very important to be providing good information up front to individuals so they can make a good informed choice about whether they should go through with the MAGI excepted determination or not. If an agency finds that an individual is not eligible on the MAGI excepted basis, or cannot complete the determination, for example, because the person doesn't provide all of the information that is needed. They decided they don't want to go through with the process. Then the individual would remain eligible in the MAGI-based group.

So again, just to re-cap. So individual choice: the individual can choose to pursue or not pursue eligibility on the MAGI excepted basis and good information is key. Once determined eligible on a MAGI excepted basis they need to go -- they need to be enrolled in Medicaid on that basis. You know the choice is not sort of forever. The possibility of enrolling based on MAGI is not forever foreclosed to them. On the next renewal, the person has again the opportunity to exercise choice because they could not complete the renewal, provide the information that's needed to renew eligibility on the MAGI excepted basis, and then they would be able to shift back. Then, they would at that point would no longer be eligible on the MAGI exempt basis; freeing them up to become eligible once again based on MAGI. And, of course, if their circumstances change in the middle of the year such that they no longer meet the eligibility criteria to be eligible on the MAGI excepted basis, then they can again be determined and considered eligible for the eligibility based on MAGI in the new adult group. So before we break again for questions, we thought it might be useful to take a simple scenario and walk through how this would work for a particular person. So we're going to use a very creative name here. John Jones. And John is a single, 25 year old adult living on his own. He has some medical conditions, but he's able to hold down a part-time job and he

earns about a thousand dollars per month. He submits a single streamlined application online, and he indicates, along the lines that Anne Marie was talking about before, that he has some need for supportive services. There's something that he answers that triggers that information for the state. The state has a home and community services waiver program that could potentially meet John's needs. So the first thing that we're going to do is look at whether or not John is eligible on the basis of MAGI under the new adult group. So John's got a pretty simple MAGI household. His household for determination based on MAGI is just himself. His household income is \$1,000 a month, which is 110% of the federal poverty level; doesn't really affect his eligibility, but we take off the 5% across the board disregard and we end up with an income for John of 105% of the federal poverty level. So John is eligible for Medicaid under the adult group based on MAGI.

However, because John has indicated that he has some extra health care needs, which might be met under the state's waiver program, the agency needs to request additional information from John to determine his eligibility for that program - questions about his medical condition, his level of care need, resources, whatever's required. And here it would -- Anne Marie, maybe you want to step in again and talk a little bit about the two options that states have for collecting additional information, and for people to get a determination based on MAGI?

>> Anne Marie Costello: So --

>> Sarah deLone: MAGI excepted basis. I'm sorry.

>> Anne Marie: So the options for collecting additional information - I think the agency would send -- would request information; the individuals would be able to provide that information online, through the mail, in person. They have the option to provide information over the telephone, but they are likely to need some documentation. So I think that will need to come in.

>> Sarah deLone: And they could do it by using supplemental forms to supplement the single streamlined application, or maybe they might take the information from the single streamlined application and populate an alternative application that is used, and have John finish that, complete that, that application.

>> Anne Marie Costello: Right.

>> Sarah deLone: Those would be two possible ways that they could do it?

>> Anne Marie Costello: Yes.

>> Sarah deLone: So, and then of course, as mentioned before, the agency will need to provide John with the information he needs to decide

whether or not to complete the MAGI excepted determination. What might he be eligible for in terms of benefits and services if he is determined eligible for the waiver program? What information is he gonna need to provide? What's the process going to be like? And what will he get in terms of coverage if he just remains in the adult group? Again, pending completion of the determination of eligibility for the waiver program, John can be enrolled, needs to be enrolled through the adult group, unless the determination is quite prompt and not so complicated. In which case, he could be enrolled directly into the waiver program; of course, if eligible. If he's approved for eligibility for the waiver program, he completes the process and he's approved. Again, he must enroll in that program. If John doesn't provide all the information needed to determine eligibility for the waiver programs, he will remain in the adult group. And then, just to note, because it's not that much of a difference on process in terms of the -- that states -- that the state agencies need to do if somebody is not eligible based on MAGI. So somebody is an adult, say, who is above 133% FPL based on MAGI. The state agency again will need to - based on whether or not it has information through the single streamlined application or other information, or the person has said "I want to be considered for other eligibility on other bases". Somebody is over income based on MAGI would need to be evaluated on the MAGI excepted basis in any of those cases. They indicate on the application that they might be so eligible or they otherwise requested, so the process and sort of the treatment on what happens for somebody in terms of the MAGI screen really is the same in terms of whether they're eligible for Medicaid based on MAGI or not. The difference will be if they are under income -- if they're under the income standard based on MAGI, they're eligible for prompt enrollment in the Medicaid program. If they're over the Medicaid, and in the case of a child, the CHIP MAGI standard, then they would have the possibility of enrolling through the Exchange and getting advanced premium tax credits if they're otherwise eligible. They don't, for example, have access to affordable employer sponsored insurance, et cetera, so the Exchange would need to be making that determination; but, if they're eligible -- otherwise meet the eligibility criteria for advanced premium tax credit support, they could get that while the Medicaid agency is determining their eligibility on the MAGI excepted basis. So similar process. I think we're going to break now, Jen, if there's -- have more questions come in?

>> Jennifer Ryan: Yeah. This is probably a good time to pause for questions. First of all, thank you Sarah and Anne Marie.

First of all, I'm going to ask a question and then I'm going to answer it

because I have the answer just handed to me. So someone asked about whether CMS has thought about how and when the Administration on Aging and CMS funded Aging and Disability Resource Centers might be able to help with assisting people who get flagged for this deeper dive eligibility determination. And I just would respond that we are in fact working with the Administration on Aging on how this could work, and how the ADRCs can actually collaborate with us to assist people in making sure they get access to the most appropriate services that they need. So yes. Thank you. That's a good comment and we are in fact on the case.

So the next question is: "Is the state required to pursue eligibility -- required to pursue eligibility for a MAGI exempt group when the individual does appear to be eligible under a MAGI group?"

>> Sarah deLone: Yes, if it's gonna matter for the person, and there's -- you know, if everything is the same for somebody then there is no difference in coverage in terms of being -- what group somebody is eligible for. Then I think as sort of a practical matter why go through the more laborious process. The individual is not being harmed at all. But on the assumption that there is some difference to being eligible on the basis of disability, or there's an optional group that covers long-term care services that the person needs that aren't available in the MAGI-based group; then yes, the agency needs to initiate the process if there's indication that the person might be eligible in any of the ways that we have discussed. There is an obligation on the part of the agency to initiate that process. If the individual chooses not to complete the process, isn't interested, doesn't want to provide the information that's needed; then, of course, the agency can't complete the process and the determination doesn't have to be made, and the person would remain in the MAGI-based group.

>> Jennifer Ryan: Great. This is a question for Anne Marie. Anne Marie when you were talking about the application you know there are going to be three specific questions targeted towards people who have disability, who are blind, and who have long-term care needs. What about individuals who have may be breast and cervical cancer or individuals that are medically needy? How will those individuals be able to be captured on the application?

>> Anne Marie Costello: We're trying to think those issues through now. The question is -- we don't know exactly yet what the questions will be; so I mean we want to look at three main factors. It may take a little more probing to get the right answer in order to do that. For people with breast and cervical cancer; typically, they come in through a particular provider, so we're talking to a number of states about -- not just what the application

should look like, and the best way to ask a number of questions, but also what are the ways that they traditionally work with individuals and organizations and providers to receive applications? Because in these existing relationships there maybe ways to tag applications that you know that they come from say a qualified entity or provider that's in -- working in the breast and cervical cancer treatment program. So I think we look at those avenues so we make sure we capture all the appropriate populations. We try to work through the issue of the medically needy.

>> Jennifer Ryan: Great. Yes; more to come on medically needy. Sarah, in terms that you mentioned the timeliness standards for enrollment. How does CMS define 'promptly' at this point?

>> Sarah deLone: We -- I mean that's part of what needs to be -- I mean there's flexibility there, so we will be looking at -- we are developing more guidance on performance metrics and performance standards. We don't have a firm -- you know, we don't have guidance to provide as of yet, but that's in process. Jen, you may actually be able to say more about that than me, if you can, or else we need to get back to the questioner with a little bit more details about where we are at in that process. And it's also -- there's going to be sort of a -- it's going to be -- I'm looking for the right word -- A sort of dynamic sort of relationship. There's going to be some back and forth, or synergy if you will, between the guidance that we provide and also the obligation under the state under 435.912 regarding the development of standards, timeliness standards that will apply to the agency and conformance with that regulation. So I would encourage everybody to read closely what we included as interim final at 435.912 and get us your comments on that particular question and any other issues that you would want to comment on.

>> Jennifer Ryan: May 7th is the date for those comments to come in please. Anne Marie did you want to jump --

>> Anne Marie: I wanted to say maybe it's also important to note in that section of the interim final we did maintain the 45 days and 90 days timeliness standards that exist today, and while we work towards, you know, in the longer term figure out what the performance metrics is, so there is a protection for individuals.

>> Sarah deLone: That's right. Thank you Anne Marie. And fair game for comments is whether those outside time limits should be changed.

>> Jennifer Ryan: I will just add to your point, Sarah, about timing of that. We are going to be releasing for public comment, actually hopefully in the next several weeks, the set of the proposed performance standards. So we'll be announcing those when they are posted and available for public

comments. So keep your eyes open for those.

Sarah, under what circumstances, if any, may states eliminate spend down for people with disabilities in this situation? And if states may not eliminate spend down how might that interplay with this MAGI/non-MAGI eligibility determinations for those individuals with incomes above 100% of poverty?

>> Sarah deLone: Well, we're getting -- I assume the question -- I mean there are two places where spend down emerges and sort of comes into play. So I'm going to talk a little bit, but also say that I need to have a disability eligibility expert sort of to do this with me to actually make sure we're getting a full and complete answer. But let me say what I can say, and then we'll provide more information at a later date if we need to. There's spend down in a 209B state that has opted to use more restrictive methodologies than the SSI program, and in terms of providing eligibility for disabled, aged, blinded individuals on a mandatory basis. And if the state -- if the more restrictive methodology that a state has adopted is a more restrictive income methodology; and maybe somebody else who's from CMS who's on the line can confirm this for me. I do not believe that eliminating spend down is optional there. I think that has to remain. And so then, there wouldn't be that option, but a person would have -- the person say receiving eligible for -- receiving SSI, but who doesn't meet the more restrictive income requirements for the state's mandatory eligibility group for disabled individuals could choose between spending down and going into that group, or being enrolled in the new adult group based on MAGI. So that's my answer assuming that I am correct to say there is no ability to eliminate the spend down requirement, or spend down ability, I should say. The other time spend down comes into play is, of course, with the medically needy and states can eliminate their medically needy programs subject to the maintenance of effort requirements. To the extent to which the medically needy -- to have a medically needy program means you're allowing someone to spend down to Medicaid eligibility. I think as Anne Marie indicated, we have some more work to do, sort of, in terms of operationalizing this MAGI screen policy with respect to the medically needy. The basic principle is that again somebody can choose. They can choose -- if spending down to medically needy income standards better meets their needs. For example, somebody may be -- let's say institutional services are not provided under the benchmark program for the new adult group, and somebody needs that, those services are not otherwise provided under that group, and somebody needs those services. Maybe it would be better for them to spend down and get coverage of the institutional services; but, they don't have to. So somebody doesn't have to

spend down to medically needy income standards. Operationally what we have to work out is what happens to somebody who's sort of -- before they've met their spend down. Somebody who needs institutional services are going to meet the spend down at the beginning of every budget period for medically needy coverage, but somebody who has to incur medical expenses how does that really work? And we haven't actually worked that out yet. So, I expect the questioner is asking about the 209B medically needy situation. But, hopefully, both of those answers are helpful to people.

>> Jennifer Ryan: Great, Thanks Sarah.

Also I have a question -- I just wanted to kind of follow up with this question about the implications for the federal matching rate for individuals who are eligible for the MAGI exempt coverage, but they opt to remain under the regular MAGI coverage. Will that person count as newly eligible? And we aren't able to answer that question right now. It's a great question that we are grappling with, and several states have brought it up to our SOTA team process that we have underway right now. So we've been working on a document, kind of almost like a decision tree, that we would be able to release hopefully to share with states and others to clarify kind of the benefits, eligibility and FMAP combinations that apply to different people. So just wanted to kind of put in a plug that we're working on that, and hope to have something available soon.

Another question -- since there's a match for disability -- individuals with disabilities -- Since there's a match with Social Security for RSDI, if a person is determined disabled by Social Security do they have a choice of not being determined as non-disabled. And this is individuals not receiving Medicare. So I think the question here is does the person have a choice about how their disability status is treated in this situation?

>> Sarah deLone: I don't think they're going to be -- you know, they're disabled, they're disabled; but, there's more than just being disabled obviously to be eligible based on disability. There is still an income and a resource test. The income test -- income eligibility is determined using SSI methodologies which are different than MAGI methodologies. So just knowing what somebody's MAGI is is not going to necessarily let you know whether they meet the income test for a group based on disability status. And, more importantly, you know, there is no resource test for MAGI-based eligibility and so the individual would need to provide information based on assets. So I think, you know, disability determination is what it is, and that would be hard for the person to say "no, I'm not really disabled" But I think there is more that the Medicaid agency would need to know in order to actually determine eligibility for Medicaid on the basis of disability.

>> Jennifer Ryan: So we've got a few questions in here about the kind of the screening process, and how to make sure that individuals understand they kind of have a choice of what they're asking for in terms of their eligibility. So it seems like the question of how the screening is approached will affect how individuals perceive their choice of whether to pursue a non-MAGI determination. So what flexibility and what federal standards do we have planned on the screening process itself? And what can we share about that at this point?

>> Anne Marie Costello: Sure. So what I will say is that to craft the question -- so let me take a step back and say there are two options related to the application. The Affordable Care Act and our regulations stipulate that the single streamlined application used by states can either be the application issued by the Secretary or it can be an alternative application developed by the states and approved by the Secretary. So there will be several questions developed for use on the Secretary's issued application. And if the state seeks permission to use an alternative application, it will then at least need to meet the standards set by the Secretary's issued application and there will be subregulatory guidance that addresses the development of an approval process for alternative single streamlined applications. So that's one thing. So there will be standards. I think it also gets to the heart of - it is really important on how well crafted these questions are. So we will be working with in a couple of different ways in developing the questions. First we have been working with a workgroup of states and really plowing into how states tackle this today. Many, many of the states' streamlined applications, particularly around children and parents, have questions that are similar to this. So we are working with states to see what's been effective so far. We're working with usability experts in developing the application, and we will also go to consumer testing. So I think those will be critical components of developing effective questions.

>> Jennifer Ryan: Great. Thank you very much. That was helpful.

Sarah, here is a question about the scenario. So what if John lived with people who are eligible for MAGI based -- who are MAGI eligible, would his income be considered in the income unit for MAGI services or would John have to be counted in the household size for that MAGI unit even though he himself is not eligible?

>> Sarah deLone: We actually Jen have another scenario at the end the presentation that has a situation just like that. So I will say right now you know John's income counts the same for determining his eligibility based on MAGI as well as other members of his household regardless of whether

or not he ends up being determined eligibility on a MAGI excepted basis or not. That's the short answer. And then, hopefully, the scenario will help to illustrate that and make it easier for people to really, you know, sort of get their minds around it. It's a common question that we're getting.

>> Jennifer Ryan: Great. Okay.

And one last question before we move on to the presentation, I think, we should turn back to that. So in a case where an individual chooses to stay in the adult group, the MAGI group, but they later become eligible for MAGI exempted coverage, what happens to that person? Can they change midcourse in the year? Can they change health plans? Can they change benefits if they have health needs that decline during the course of a year?

>> Sarah deLone: Absolutely. Absolutely. They can always report sort of a change in their situation or maybe they have realized that the coverage that they're getting doesn't meet their needs, and they want to then go through the process, they can absolutely approach the agency and request a further determination based on the MAGI excepted basis.

>> Jennifer Ryan: Okay. Great.

Sarah, are you ready to continue with your presentation at this point?

>> Sarah deLone: Sure.

>> Jennifer Ryan: Okay. Great. Thank you.

>> Sarah deLone: So just a couple of sort of overarching points to make to sort of around all this stuff. One is in terms of the scope of the policy. It's easiest to talk about the policy in the context of specific MAGI excepted populations, you know, and eligibility on the basis of disability and individuals who need long-term care services that aren't covered for the adult group or the sort of most obvious and the major populations that are of concern -- But the scope of the policy and how it works applies to all MAGI excepted bases of eligibility, so based on disability and being blind, eligibility again for individuals needing long-term care services not covered through the adult group; individuals for whom no income determination by the Medicaid agency is needed. You know, most typically we listed breast and cervical cancer here. I think all states cover this group. There is an income test for them but it's under the CDC program so the Medicaid agency doesn't have to actually make that determination, and typically those women as well as -- you know, obviously SSI recipients, your IV-E recipients -- they're not going to come through the single streamlined application anyway. But if for some reason one did, and breast and cervical cancer seems like potentially the most likely; a women with breast or cervical cancer who's in the new adult group and she's made aware of this other eligibility category that maybe is gonna be -- the full benefits are

going to be more comprehensive and better meet her needs if that is the case she might pursue eligibility by getting the CDC screen, and also as I mentioned medically needy.

The other thing -- one of the other things to mention is that you know we would expect -- states have developed working with their advocacy communities having developed - and other agencies in the state that serve individuals with disabilities, developmentally disabled, et cetera - have established, you know, sort of good pathways for individuals with disabilities or individuals who need home and community based services to become eligible. We would expect those pathways and those processes to remain. But at the same time, we would want those individuals, if it's a lengthy process, for them to get their Medicaid eligibility determined. We would want those individuals to be afforded the same comparable treatment to at least promptly get enrolled based on MAGI if they're eligible as would be the case for anybody who is applying using the single streamlined application. And so that's what the regulations at 435.911 require. So if you have an individual who is coming through another pathway, they're submitting an alternative application that is used by the state for MAGI excepted populations, that person must be promptly enrolled based on MAGI if they're eligible on such a basis, on the basis of MAGI pending the lengthier determination. So if the state has all the information it needs based on the alternative application to make the MAGI determination, great. If it doesn't and that MAGI excepted determination is gonna take some time, it needs to provide the person with the opportunity to provide the additional income information that would be needed to make a determination based on MAGI so that person can at least get the coverage that is available to the MAGI-based eligibility group.

My battery is running low so bear with me a second I'm going to change phones so I don't lose anything. Am I still here?

>> Jennifer Ryan: You're still here.

>> Sarah deLone: Oh good. I am so glad.

>> (INAUDIBLE).

>> Sarah deLone: Okay. I get nervous with anything related to technology. So then of course if it's going to be a quick determination on the MAGI excepted basis then that -- the determination based on MAGI doesn't need to happen. It all comes down to the person getting promptly enrolled in the program in accordance with the performance standards that we issue and the performance standards that are developed by the state under 435.912. Just as there is a synergy between the application process and the renewal process and the MAGI screen, there's also a synergy in the regulations

that we developed for the Medicaid and CHIP programs with the regulations that pertain to the Exchanges because we want to make sure that individuals get the same treatment no matter what door they enter. So for individuals who are applying with the Medicaid program, if they're not Medicaid eligible based on modified adjusted income -- so they're an adult for example with income over 133% FPL, two things have to happen. First the individual must be evaluated by the Medicaid agency for potential eligibility for other insurance affordability programs. If it's a child for CHIP of course, as well as for the Exchange; and, if it's an adult, evaluated for potential eligibility for the Exchange. And I can't think of a situation in which somebody's over income eligible for Medicaid in which, you know, unless they're way, way over income in which they're not screened as potentially eligible for one of those two programs.

At the same time -- so that has to happen and that happens right away and let's say it's an adult, and the agency -- you know, their income based on MAGI is 140% of the federal poverty level -- the Medicaid agency needs to quickly transfer that individual and their account electronically to the Exchange, so that the Exchange can make a determination of eligibility for enrollment through the Exchange and for advanced payment of the premium tax credit.

At the same time, if there's indication that in any of the ways that we have talked about before that the individual maybe eligible for Medicaid on a MAGI excepted basis, then the agency needs to go through that process, and obtain the information that it needs and -- in order to make the determination. And, of course, if the individual doesn't want to go through that process, they're happy with enrollment through the Exchange, then they don't need to complete the process, and they can just get their coverage through the Exchange. But they will be -- so that individual can obtain coverage through the Exchange and can get premium tax credit support while the lengthier determination based on MAGI excepted basis, based on disability, for example, while that is happening.

Similarly you know the reverse is true. If an individual is -- not really the reverse, but the same process and same result will happen if the person has submitted, the family has submitted an application to the Exchange. If the Exchange either -- let's say we're in a state in which the Exchange is making an assessment of Medicaid eligibility based on MAGI and CHIP eligibility based on MAGI, and it assesses the person as potentially eligible, likely eligible for Medicaid based on MAGI. The Exchange is simply going to send that person over to the Medicaid agency to finalize the determination. If it's actually making the determination of Medicaid based

on MAGI it would say here Medicaid. Here's a person for you. They're eligible based on MAGI. It would then be the responsibility of the Medicaid agency to follow up and determine eligibility on a MAGI excepted basis. If there's indication to do so on the streamlined application or other information, or the person simply says "I want to be evaluated based on disability," for example, so they would get the same treatment. Similarly if a person applies for coverage through the Exchange and they're assessed as over the MAGI, applicable MAGI standards for eligibility based on MAGI -- So you're an adult. You apply through the Exchange. Your income is 140% of the federal poverty level. The Exchange would continue to process the person for enrollment through the Exchange and to get premium tax credit support. And at the same time, if there was indication on the application that the individual may be eligible for Medicaid on the basis of disability or some other basis, the Exchange would transmit that person and their electronic account to the Medicaid agency which would then be responsible to follow up and request the information and so on and so forth to make that determination on another basis.

And meanwhile the person would be able to -- if they were otherwise eligible, the person would be able to get coverage through the Exchange with the premium tax credit support. So doesn't matter what door somebody comes in, whether they're over MAGI income standard, under MAGI income standard, the same things happen regardless.

So now we get to our final scenario to illustrate a little bit more of a complicated family scenario, which we'll talk both about -- sort of illustrate both how the MAGI screen works -- where you have family members, some family members are eligible based on MAGI. Some may be eligible on another basis, as well as how the MAGI methodology works when you've got a household with people who may end up in one eligibility basis or another. So in this example, again as you can see I'm very creative with my name. We've got the Smith family. And we've got a married couple. Sally is married to John, and John may be disabled. They have one child; Henry, age six. He's not employed; Henry. Sally works and earns \$1,500 per month. John is self employed. He works out of his home and earns \$1,000 a month. They have no other income and nobody is eligible for Medicare. The applicable MAGI -- they're both under 65 -- the applicable MAGI standard for adults is 133% of the federal poverty level, and this state has a Medicaid expansion program for kids, and children are covered up to 250% of the federal poverty level. This state also has a buy-in program for disabled individuals with income under 250% of the federal poverty level.

Sally completes the online application. So the first thing that we're going to look at -- and on the application she indicates she answers the screening questions that Anne Marie has talked about to flag the potential for John to be disabled.

So the first thing that we're going to do is look at the ability, you know, the right of each person to be promptly enrolled based on MAGI. So we'll look at their eligibility based on MAGI. We got a thankfully simple Medicaid/MAGI household here. A married couple with a child so they all have the same household. Sally, John, and Henry are in each person's Medicaid/MAGI household and the household income for each person is the same. It's Sally's income and John's income combined which is \$2500 per month - equates to 162% of the federal poverty level for a household size of three. We take off the across-the-board 5% disregard, and we end up with a household income for Sally and John and Henry at 157% of the federal poverty level. So based on that, Henry, the six year old, is eligible since the income standard for Medicaid is 250%. So Henry is eligible for Medicaid based on MAGI. Sally and John are not. Their income is over the income standard of 133% of the federal poverty level based on MAGI for the new adult group.

However, we need to know whether or not we're gonna go farther any additional Medicaid determinations on any other basis for any of the family members. Well, Sally doesn't give any indication on the application that either she or Henry maybe disabled. And just a side note, I don't think it's likely there is a difference in coverage for a child who's eligible based on disability versus a child who's eligible under the children's group. So the question for Henry really may not be a germane one; but if there was, then the question would be relevant for him as well. So she doesn't indicate on the application any reason for the state to think that either she or Henry may be disabled, or that they may be eligible say medically needy, or they have a need for long-term care services; but she does indicate that John maybe disabled. So the agency doesn't need to take any -- doesn't need to initiate any action to further evaluate Sally or Henry on a MAGI excepted basis, but Anne Marie will sort of talk about this at the end. Sally will need to get -- the family will need to get notice when they're told about their eligibility, for whatever it is that they're eligible, about the potential for eligibility on other bases. And given enough information so that at that point they could say -- raise their hand and say "but I want to be evaluated anyway." So they need to be able to be given that opportunity, but at this point in the process there's no reason for the state to initiate anything more with respect to Sally or Henry.

John on the other hand -- Sally has indicated that John may be disabled in the way she's answered the question. So the agency needs to evaluate John for eligibility for the buy-in program for working disabled, or if it had another category for individuals with disabilities, it would need to follow up to determine eligibility for that group. So the agency will need, you know, to put out a request to get additional information from John, or from John through Sally. It will need to provide the information to the family so they can make an informed choice about whether to proceed with the MAGI excepted determination or not. And assuming they want to go -- the family wants to go through with the process for John, the agency will then apply the SSI based methodologies which are used for groups for disabled individuals for the most part. If the state has a different methodology that it uses for whatever reason it would use that methodology; wouldn't use MAGI methodologies. So apply the methodologies used for the group based on disability, including any optional disregards that had been adopted by the state to determine John's income for purposes of the buy-in program. And this is where we come into the question that was asked earlier. The determination of eligibility for John based on disability does not affect the financial eligibility calculation. Does not affect how we determine the household or how we determine household income for either Sally or Henry, nor frankly does it change how we calculated the household or household income in determining John's eligibility based on MAGI. So we've done the MAGI determinations. We set that aside. John's income is what it is. It's counted or not counted according to the MAGI methodologies how income is treated in the tax code with the sort of exceptions that we talked about on the other webinar. And when that's done we set that aside, and now we say, "Okay now we're looking at John's eligibility for eligibility under a different group." A different methodology is used and we're now going to now apply those rules. And so however Sally's income gets counted, however John's income gets counted, whatever gets allocated to Henry in those methodologies -- I'm not an expert on those methodologies. I know it's got its own level of complexity. Whatever those rules are they get applied in the same way they get applied today. And so his eligibility would be determined.

Meanwhile, both Sally and John will be evaluated by the Exchange for enrollment through the Exchange and for advance payment of the premium tax credit and cost sharing reductions. And they both can enroll even as the Medicaid agency continues to determine John's eligibility for the buy-in program.

So Anne Marie did you want to talk a little bit about sort of -- although we

have not given -- we have not provided guidance yet and guidance will be forth coming on notices and coordinated notices. Did you want to talk a little bit -- either re-cap a little bit or add additional points for the screening process for the application, or talk a little bit about the back end process so that somebody can actually raise their hand and say "I want to be -- I wasn't flagged for the agency to take initial action to look at me based on disability or some other MAGI exempt basis but I want to be evaluated by the Medicaid program anyway."

(Inaudible).

>> Anne Marie Costello: Sure Sarah thank you. I think I want to add just a couple of things. The first as we are developing the online application, we are looking to the ease of which we can enable someone to raise their hand, so we could envision that in the online environment someone's eligibility can be determined in real time. So for individuals whose verifications can all be completed through the use of electronic data sources, or the combination of self-attestation, you would envision in an online application that someone could receive their eligibility determination in real time. We're exploring that you could also have the ability to electronically raise your hand to be considered on a basis other than modified adjusted gross income, so there could be a button we could click and "Do you want to consider another determination?" These are all things we are considering in the development of the online application.

I think the second thing I would like to flag is: I focused a fair bit of my comment on the importance of the quality and the completeness and the usability of the screening questions on the application, and the information needed so that someone can answer those questions accurately or appropriately. I also think the second prong to this strategy is the notices. And Sarah you just touched on it briefly. We have not issued new rules on the notices, and it will be a subject of future rule making, but we will be addressing content of notices and ensuring that as part of their notice that individuals are aware that they even if they have their eligibility determined based on modified adjusted gross income, or they're found eligible based on MAGI to Medicaid, or are referred through the Exchange that they will have the right to request an eligibility determination on a basis other than MAGI. So we will be issuing guidance on notices. We're also hoping to develop model notice languages, model notice language, or even model notices themselves that could be adopted by states. And again, that will be a process that we would use, hopefully work with, not just the policy folks that develop but also our literacy consultant, so we can ensure that people understand the information since oftentimes many Medicaid notices are

complex documents. We want to be sure that individuals can understand their options fully.

>> Jennifer Ryan: Great. Thanks Anne Marie and Sarah.

We've got a bunch of really robust questions here. So I think I will jump right into that. So in a case where an individual is enrolled in the new adult group, but is also pursuing getting a disability determination, and if that individual is later found disabled and is actually not financially eligible for Medicaid because of their assets, what happens to them? Can they revert back to the new adult group or are they out of luck because of their assets?

>> Sarah deLone: Absolutely. They stay in the new adult group. The MAGI exemption for individuals with disabilities actually is under 435.603. We changed the paragraph number. I think it's (j) - (j)(3) I think, and it's only for -- it's only if you're -- for purposes of determining eligibility on the basis of disability. So while that process is happening for that purpose, you know, you're exempt from MAGI, but you can still be in the new adult group. And then you're exempt from MAGI if you've actually been determined eligible on the basis of disability. So somebody whose resources are too high to be eligible for an optional disabled group is not actually eligible -- for Medicaid on the basis of disability. They are then not exempt from MAGI and they can stay in the adult group.

>> Jennifer Ryan: Great. We're gonna try and stump you here with another scenario. So if a 65 year old who's not eligible for Medicare, but has income above the state Medicaid eligibility level, say 85%, but below the 100% gross income starting points for APTC eligibility, could they end up being ineligible for Medicaid and ineligible for APTC?

>> Sarah deLone: Yes. Yes, that is a gap in coverage that we were not able to close regulatorially and would actually require a statutory fix.

>> Jennifer Ryan: Right.

>> Sarah deLone: It's a small number of individuals, but it is possible. Somebody who doesn't have -- probably most typically an immigrant, but others -- anybody who doesn't have enough quarters to get Medicare, yeah.

>> Jennifer Ryan: Okay.

A couple more questions. Lots of interest in medically needy coverage. So what happens -- is there a maintenance of effort requirement for the medically needy coverage? States are not allowed to at this point take away that medically needy group; they need to maintain that until 2014, correct?

>> Sarah deLone: I believe that's correct. I'm not the maintenance of effort expert, but I believe that's correct. I don't think -- I think the language

as I recall from the ACA, the Affordable Care Act, on maintenance of effort is not limited to categorical needy eligibility. So yes, I think that's accurate; and if for some reason I am misspeaking, we we'll correct that at a later date. But I'm 99% sure that is correct.

Maybe Jen -- maybe one of you can back me up on that.

>> Jennifer Ryan: We are all nodding here. We think that is correct.

>> Sarah deLone: Okay.

>> Jennifer Ryan: Okay. So another clarification just confirming whether SSI eligibles are part of the MAGI exempted group or not the case?

>> Sarah deLone: If it's in a state that confers Medicaid eligibility to all SSI recipients they -- actually they're not even eligible for coverage in the new adult group. They go into the mandatory coverage group for SSI recipients and they are exempt from MAGI on that basis. They are exempt from MAGI because the Medicaid agency doesn't have to make a determination with respect to them. They just -- they're SSI eligible. They're on the roles automatically. In a 209B state that doesn't automatically confer eligibility for all SSI recipients -- there if you have an SSI recipient who's not eligible for -- let's just take a simple case and say the state doesn't have any optional coverage groups for disabled individuals, the individual is not eligible for coverage under the 209B more restrictive criteria. That individual -- you could apply MAGI -- there is no exception from MAGI methodologies for that person. That person can be evaluated for coverage under the new adult group and presumably is going to be eligible, but of course if there is an option -- if the person either wants -- if it's about income that we talked -- standards that we talked about before and the person wants to spend down to eligibility to get into the mandatory coverage group in the 209B state, the individual can do that. Similarly, if the state does cover some optional eligibility group for disabled individuals if the person meets those criteria that person can avail themselves of the same process as any other disabled individual that we've been talking about, and they can get evaluated for the optional coverage group and if eligible they check from the adult group into that optional coverage group.

>> Jennifer Ryan: Great. All right. Thanks Sarah. I'm going to give you a break for a second. Anne Marie a couple questions for you. Can you just clarify one more time about the different requirements related to submission and approval of the application, the alternative application, and the non-MAGI application?

>> Anne Marie Costello: Sure. So there's two separate sets of rules governing that. So for the single streamlined applications used for the MAGI population an alternative to the Secretary's issued single streamlined

application needs to be submitted by a state for approval by the Secretary in order to be used by the state. For the MAGI exempt population, as Sarah described before, there's a couple options for them. They could choose to start everybody on a single streamlined application, and then use supplemental forms to gather the additional information, or they can have a MAGI exempt application which is tailored to meet the needs of the MAGI exempt population. Oftentimes states have several MAGI exempt -- well today different applications for the aged, blind and disabled. Sometimes there's a shorter Medicare savings program application. In the case for applications served for the purposes of MAGI exempt populations, those applications do not have to be approved by the Secretary, but they have to be submitted to the Secretary. Both the supplemental forms and the MAGI exempt application.

>> Jennifer Ryan: Great. And this could be either for Sarah or Anne Marie. So in cases where an individual is -- ends up not being eligible for MAGI-based Medicaid for whatever reason, do they have appeal rights in going between the eligibility groups?

>> Sarah deLone: So they're not eligible based on MAGI, and so they're -- are they being determined eligible on the basis of a MAGI excepted basis?

>> Jennifer Ryan: I think that's the question. So do they have an appeal right immediately after not being found eligible for the VIII group or do they have to wait to go through the whole determination process before they can appeal?

>> Sarah deLone: You know we're working on it -- this is probably a question that has a clear answer based on today's policy. I'm not sure it would be any different. You know, you might have a parent, say, who is denied eligibility under section 1931 and is being evaluated based on disability and takes awhile. I imagine there's a clear answer. My gut would be if it's going to take awhile, the answer is probably yes. But it's my gut, and I think we ought to -- I think we ought to get with our appeals subject matter expert, Sarah Lichtman Spector, and see if we have a definitive answer for that and if anything would change, might change in the new world. Appeals is one of the issues also for which, you know, additional guidance is forthcoming.

>> Jennifer Ryan: Okay. We will circle back on appeals at a later point for sure. A couple of people have asked about -- I will just read this question related to -- I'm not sure which John. Maybe John Smith. If John enrolled in the Exchange pending a non-MAGI determination would his enrollment later in Medicaid become retroactive, and if so how does that impact the Exchange enrollment or claims that were incurred during that person's

enrollment in the Exchange?

>> Sarah deLone: Yeah. Okay. So retroactive eligibility nothing changed under the ACA with respect to retroactive eligibility, so he would be eligible retroactively for Medicaid, and that could go to three months prior to his actually submitting the application which certainly would not have been eligible for enrollment in the Exchange yet because he hadn't applied for anything yet, and so then there's two sides to the equation to look at. What happens for him with respect to the advance premium tax credits he's received? And does he have any pay back liability there? Or is there anything that happens between the pile of federal money that gets used to pay for premium tax credits versus, you know, the Medicaid agency covering services? And then the other is what is the Medicaid agency cover? What's it from the Medicaid perspective in terms of what he gets retroactively? So from the perspective of the APTC and the Exchange there's no -- he doesn't have to pay anything back. There's no retroactive liability for him and that is under the IRS regulations actually. That's the way it's under their proposed regulations that were published in August as well. Similarly, there's no reconciliation between different insurance affordability programs in a situation like this.

What would happen though then from the Medicaid perspective is that retroactive eligibility would serve to one, cover the services in the same way and costs in the same way it does today for services that he incurred, benefits that were incurred prior to his -- you know, the month of application and to his effective enrollment in the Exchange, and getting into a qualified health plan through the Exchange. And then it would also serve to wrap around. And if there were services that he received that weren't covered under the qualified health plan, or if he had cost sharing that might be in excess of what he incurred in Medicaid, it would serve that way. Much the same as if somebody has any other kind of coverage, and then found eligible retroactively for Medicaid; that there would be that Medicaid would serve as the secondary payer there.

>> Jennifer Ryan: Okay. Great. Sarah, I'm going to turn you back to the slides, on slide 18, right now, the scenario for the Smith family. Just taking a look at them. Is it correct to say that the family would need to be evaluated for eligibility under potentially three different ways of counting income? MAGI title XIX, MAGI exempt title XIX and also MAGI for APTC purposes?

>> Sarah deLone: There's no such thing as MAGI exempt. Well, there is no such thing as MAGI exempt income so there is -- could be -- there is potentially three different calculations that could be made though. Yes, that

would be true, because there is a potential for a little bit of difference in the MAGI methodology that's under 36B of the tax code which is what the Exchanges use, and then there are versus the Medicaid methodologies as was discussed on an earlier webinar. There are three differences in how Medicaid treats income in the MAGI methodologies as compared to the Exchanges, and that relates to American Indian/Alaska Native income, lump sum income and educational grants and scholarships that are used for educational purposes which are taxable. We don't count them in Medicaid, so if they have -- if the family has any of those three types of income there will be a slightly different calculation of their income for purposes of their advance payment for premium tax credit eligibility amount.

So that the three possible -- so then there would be a difference between the MAGI figure for Medicaid versus the MAGI figure for the Exchange. The Exchange would be responsible for doing that second determination and making it sort of a clear amount to sort of determine the amount of the premium tax credit. And then there would be a different methodology that would have to be used for John when he's being evaluated on the MAGI exempt basis. It's going to be an SSI based methodology, most typically, and not going to be a MAGI-based methodology. But, so, I hope that answers the question.

>> Jennifer Ryan: Thanks. All right. One more question related to the Smith family. If John is enrolled as disabled by the Medicaid agency then only one member of the household appears that they would be eligible for APTC. That would be Sally. Would Sally get full APTC for the household applied to her premium or would she get a third share of the APTC?

>> Sarah deLone: I don't know if Anne Marie feels comfortable talking about the calculation of APTC. You know it's going to be for a household size of three; it's going to be based on her income. Only she's going to be enrolling in the plan, so it's going to be based on the premium for her to enroll through the plan except for the period maybe when both John and Sally are enrolling. I don't know the ins and outs of the exact amount of the calculation of APTC though, so maybe we should --

>> (Inaudible).

>> Sarah deLone: Yeah.

>> (Inaudible).

>> Jennifer Ryan: Maybe we can circle back on that and maybe we can get an answer in the meantime from the Exchange and share that at the next opportunity. Back to you Anne Marie for a second. The Secretary's application. What's our plan for that? Will it be distributed in an editable

format so states can just tweak it a little bit and turn it back in, or what's the plan for the release of the application?

>> Anne Marie Costello: We have a fair bit of work to do before we get to that. We have sort of solid set of data elements. We're working now with a contractor. You know, what I should start by saying is this is a partnership clearly with CClIO since it's a single streamlined application. And we're working hand in hand with CClIO and their contractor to develop the online application and a paper based model. We have not -- the drafts will be made available through a PRA process so it will go through a public comment process. We will release the paper, and then hopefully instead of wire frames that people can comment on the potential usability of the online application through a PRA process. Pending, during the PRA process, we will receive the comments, make revisions, get out for consumer testing, and have final versions available. I would envision that it would be in an editable format for paper. For the online, I can't answer yet how much will be made available to States whether it goes to a test site, whether it's wire frames, screen shots or if it gets down to the level of coding, that I don't know yet.

>> Jennifer Ryan: And just for those of you who may be aren't familiar with our wonderful federal acronyms. The PRA is the Paperwork Reduction Act --

>> Anne Marie Costello: Oh, I'm sorry.

>> Jennifer Ryan: And it governs much of our work here in terms of trying to limit the amount of burden we put on states and others in terms filling out paperwork and submitting it back into the federal government. It seems a little ironic that the Paperwork Reduction Act applies to an online application but that's the world we're working in. So that's great. Thank you Anne Marie. Sarah --

>> Sarah deLone: Jen, before you get to the next question I didn't want to run out of time. But there was a little disclaimer I wanted to make around benefits because it's hard to have this conversation without talking about what benefits somebody is getting in one group versus another group. And I just wanted to say what has been said on many occasions but I wanted to make sure it clear this is still the case. That guidance on the benefits to be provided, you know, under the new adult group is forthcoming. So I don't want to anybody to take anything that I said to pre-suppose one policy decision or another. That that issue is still being worked through. It's pretty complex and I just wanted to, like, put that out there that guidance on that issue is still forthcoming.

>> Jennifer Ryan: Soon we hope. Sarah, we caused a little bit of a stir

with our answer to the question about the gaps for individuals between 100 and 133. Can you just kind of restate that unfortunate circumstance for the group?

>> Sarah deLone: For the elderly?

>> Jennifer Ryan: Yeah.

>> Sarah deLone: Yeah, it's actually not between 100 and 133 just to clarify. It's between the effective income standard for eligibility of an elderly person under the - as an elderly person. So let's say typically it's gonna be whatever the SSI level is which equates to roughly -- I'm gonna get this wrong I know, but it's maybe 76 percent federal poverty level for a single person and 84 percent for married somewhere in there and of course that's not necessarily exactly the same as the federal poverty level in calculating using MAGI methodologies because SSI and MAGI are two different methodologies. So an elderly person who's looking for coverage as an elderly, as a 65 or older, let's say through the mandatory group for SSI recipients and has too high an income for eligibility under that group, isn't eligible for SSI. Let's assume there is no optional eligibility group, or if there is they're over income for that eligibility group also. But their income is below based on MAGI methodologies, their income is below 100% of the federal poverty level to receive -- necessary to receive APTC because unlike Medicaid which just has sort of an end income feeling, the Exchange eligibility for advanced premium tax credits, for premium tax credits support on cost sharing reduction actually has a floor also. Your income has to at least be 100% of the federal poverty level unless you fall into exceptions for immigrants who aren't eligible for Medicaid because of their immigrant status. But generally somebody who's under 100% FPL based on MAGI can't get premium tax credit support. So somebody's over income -- an elderly person over income using SSI methodologies for Medicaid, but under 100% of the FPL using MAGI methodologies is gonna fall into a gap. They could enroll through the Exchange but they have to pay the full freight which is, undoubtedly, I would imagine it's going to be unaffordable for them.

>> Jennifer Ryan: Thanks. That's a helpful explanation. All right. So one last question before we close today. This is in relation to sort of the assessment of eligibility between Medicaid and the Exchange. So if a Medicaid agency takes an application for an individual who proves to be over income for Medicaid does the Medicaid agency then have to assess that individual for APTC or do they transfer the file over to the Exchange for that?

>> Anne Marie Costello: (inaudible)

>> Sarah deLone: Did you want to go Anne Marie?

>> Anne Marie Costello: No, I'm sorry.

>> Jennifer Ryan: Go ahead Sarah.

>> Sarah deLone: So yeah the Medicaid agency -- this person's gonna go one place or another. They're either going to go to the Exchange or if it's a kid they may go to CHIP. And the Medicaid agency needs to make that evaluation. And then it sends them to the appropriate entity, either to the Exchange or to the CHIP agency or if the state has a basic health program that's administered out of -- you know, we have no guidance that has been provided yet on the basic health programs; but, if there's a different entity that's making the basic health program determinations to that entity. Let's just assume we're talking CHIP, Medicaid and the Exchange here. It's gonna send it to the Exchange or CHIP and it's gonna do it through the electronic interface. So it's going to be instantaneous and it's going to send all of the information in the application, and all of the information it may have already gathered in the process if it's done any verification of either financial or non-financial factors. It's gonna send that all over, and then it will be -- if it looks like the person is in an Exchange eligibility range, it could be that, for example, a parent goes to the Exchange and a kid goes to CHIP. So they could go in two different directions. Then it would be up to the Exchange for anybody sent to the Exchange to make the determination, the final determination of whether the person's actually eligible for premium tax credit support or not. That includes both the final determination of what the person's income is for tax credit purposes as well as other factors that are relevant to Medicaid eligibility, such as availability of affordable employer sponsored insurance. And then who's making the CHIP determination is gonna depend on how the state has structured its CHIP program. And often that is handled by the Medicaid agency. But if it's done by a separate agency then it would be the separate CHIP agency's responsibility to finalize the CHIP determination. And if the assessment's been wrong, then there's got to be a process to work it out.

>> Jennifer Ryan: Okay. Thank you Sarah. You got us right to the finish line here. So thanks everyone for joining us today.

I encourage you to join us next week for our final eligibility and enrollment wrap up webinar. That was a tongue twister. It will take place next Thursday from three to 4:30 p.m. Eastern Standard Time, as always.

>> (Inaudible)

>> Jennifer Ryan: I'm sorry. Thursday May tenth, not next Thursday. And as always the webinar information's available on Medicaid.gov. For registration and, of course, the slides and other materials are posted on

Medicaid.gov after these webinars as quickly as possible. The slides are already there and the rest of the materials will be up within the next week. So thank you all very much for joining us today and we'll be in touch soon.