

Event Title: CMCS Webinar Series: Coordination Across Medicaid, CHIP, and the Affordable Insurance Exchanges

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>>(Kirk Schwyn): Good day, ladies and gentlemen, welcome to the CMS webinar series: Coordination across Medicaid, CHIP and Affordable Insurance Exchanges webinar. I would now like to turn the call over to Vikki Wachino, director of the Children and Adults Health Programs Group in CMCS. Vikki, please go ahead.

>>Vikki Wachino: Thank you and thanks everyone for joining us this afternoon for part 3 of our webinars discussing provisions of our Final Medicaid and CHIP Eligibility and Enrollment Rule which was published on March 23rd. Today's discussion is focusing on one of the most critical issues, one that's central to success in enrolling people in coverage in 2014, which is the coordinated eligibility and enrollment process that applies across Medicaid and CHIP and the Exchange.

Success in fully enrolling people in 2014 really hinges on having a coordinated process between different insurance affordability programs. Last week, we talked with you about one of the key business rules that ensures seamlessness in coordination, which were our rules around modified adjusted gross income. This week's webinar really focuses on the process and the mechanisms that the Rule establishes for ensuring that different entities – Medicaid, CHIP and the Exchange – coordinate across each other. We have a very distinguished panel of guests and experts here to talk with you today. I am going to kick us off, not that I'm a distinguished expert, but I am joined by several. I'll kick us off and then I'm going to hand it over to Amy Lutzky, a Project Officer in our CHIP division who was the lead author of the eligibility coordination provisions in our Final Rule. We're also joined today by Ben Walker, who directs the Eligibility Policy and Operations Branch in the Center for Consumer Information and Insurance Oversight who is going to describe the role of the Exchanges in conducting eligibility determinations.

We have a couple other experts here on hand to help answer questions. Anne Marie Costello, the Director of our Division of Eligibility, Enrollment and Outreach, and Stephanie Kaminsky, Senior Health Policy Advisor here, are both here on hand as well to help field questions. We do welcome your questions at any time during the presentation. You just heard how you can send a question our way. We will likely save all questions to the end. We're going to try to get to as many as possible. We found in these

presentations that the questions are very, very helpful and we try to get to as many of them as we can.

If we find, during the course of reviewing the questions as you are hearing the presentations, if there is a point of clarification we might just jump in and ask the speakers a question right then to make sure everything is moving along and you all are getting the information you need.

So, let's go ahead and get started.

Going to our first slide, you can see that overall, to put today's presentation in a larger context, the Final Rule that we released last month does 3 things. It expands access to affordable coverage, particularly for low income childless adults. It simplifies Medicaid and CHIP eligibility and ensures a seamless system of coverage across Medicaid and CHIP and the Exchange; and, that's really, that final point, is the focus of today's discussion.

Over the course of today's presentation you'll hear exactly how we establish that seamless process and the importance, as I said earlier, of having coordination across insurance affordability programs to both the success of the overall coverage expansion and also to ensuring that administrative burdens on consumers and states are minimized.

One set of options established in the Final Rule allows states new flexibility in how they configure their approaches to determining eligibility for Exchange, Medicaid or CHIP determinations and so you'll hear a little bit about that. But one point to underscore about it is, well, the reg provides for additional flexibility. Those flexibilities are really designed to retain the core principle that Medicaid and CHIP in the Exchange are following one set of business rules whenever possible and ensuring a seamless consumer experience.

We'll also touch today on how eligibility determinations are coordinated, not just for people who are eligible based on modified adjusted gross income, but also those people who are excepted from modified adjusted gross income; those people, largely seniors and people with disabilities who we talked about last week.

Finally, one thing to note is that many of the provisions you will hear about today are put out for an additional 45 day comment period in our final regulation, so if you wish to comment on them you have until the end of April to do so.

This next slide shows what a coordinated process looks like from the consumer's perspective. You can see here that the streamlined enrollment process is designed to really meet an applicant for coverage where they are. They can submit one single streamlined application to all insurance

affordability programs and each of those programs will accept the application. Those applications could be filed online, by phone, in mail or in person; really allowing the beneficiary and applicant to choose the means that works best for them.

Once the application is submitted, the Medicaid/CHIP agency or the Exchange determines eligibility after verifying the sources of the elements of eligibility. They can use a federally managed Hub to do that and there are also key provisions of our regulation that we will talk about in two weeks that establish verification processes. And, once someone is determined eligible either for Medicaid or CHIP or for an advanced premium tax credit, or simply to enroll in a qualified health plan in the Exchange without a premium tax credit, the individual can select their plan and enroll in a plan very quickly.

The next slide shows what coordination – what a coordinated process looks like from a national perspective. One reason I like this slide is I think it does a good job showing how the different pieces of eligibility established under the ACA relate to each other. So you can see that Medicaid and CHIP serve as the base of coverage; Medicaid, particularly, for low income adults and kids below 133 percent of the poverty level. Medicaid and CHIP providing coverage largely for kids at higher income levels. And, building on top of that, there are people who are eligible for assistance through premium tax credits to enroll in Exchange coverage at incomes below 400 percent of the poverty level can enroll in qualified health plans without financial assistance.

To me this picture really embodies seamlessness and you can see that the different layers of coverage build on each other and that there are no gaps. And to really realize the solidity of that picture and the streamlined nature of that picture, the coordinated processes that Amy and Ben are going to describe to you today are really key to make sure there are no inadvertent gaps in coverage and that everything is working as seamlessly as possible. There are many elements to coordination. And before we jump into some of this particular mechanisms of coordination established in our Final Rule, I wanted to note a few of the key elements of coordination that we won't spend as much time on today. One of them, of course, is the single streamlined application and there will be more to come on that topic in next week's webinar – I mean the webinar two weeks from now, excuse me. Having web sites that provide all program information and facilitates enrollments in different affordability programs is another key element. Our Final Rule also establishes coordinated verification policies across Medicaid and CHIP and the Exchanges. That's also a topic for a webinar

two weeks from now. And underscoring it all is a shared eligibility service that facilitates eligibility determinations across Medicaid and CHIP and the Exchange.

Our Final Rule also establishes standards and guidelines for timeliness and performance standards around eligibility determinations. And that will be a subject of a future webinar and that is also one of the provisions, one of the three provisions, of the Final Rule that we issued as interim final with comment.

So, with that overview complete, I will turn it over to Amy Lutzky to talk about the coordination provisions of the Final Rule.

>>Amy Lutzky: Thank you, Vikki.

So to really understand the coordination regulations I think it's helpful to know the relevant Medicaid, CHIP and Exchange provisions. Right up front I'm just going to run through the relevant regulations so that as I go through the slides I can be a little bit more conservative with including the relevant citations.

So for the Medicaid and CHIP regulations we're looking at 42 CFR 435.1200 and 457.348 and 457.350. And for the Exchange regulations we're looking at 45 CFR 155.345 for the coordination with Medicaid and CHIP regulations. And two other provisions that are an important part of this picture are 155.302 and 155.305.

Now on to the key coordination provisions that apply to all Medicaid and CHIP agencies. We know there are a few approaches for coordinating eligibility with Exchanges but regardless of the approach, Medicaid and CHIP have certain responsibilities that ensure that they are working in partnership with other insurance affordability programs. The Medicaid or CHIP agency determines eligibility for individuals transferred from another insurance affordability program and evaluates an individual for potential eligibility for other insurance affordability programs.

In addition, the agency certifies, for the Exchange or other insurance affordability programs, the criteria applied in determining Medicaid eligibility. And the fourth provision gets its own slide. The Medicaid and CHIP agency need to establish an agreement or a Memorandum of Understanding. This is at the heart of making sure that there is a working partnership among the insurance affordability programs and making sure that there is a seamless system of eligibility enrollment and renewal no matter what door you came in, as Vikki described earlier.

The Medicaid and CHIP agency will establish an agreement or agreements with the Exchange and entities administering other insurance affordability programs. This agreement needs to specify the responsibility of each

program to minimize burden on individuals, ensure compliance with other eligibility coordination requirements of the provision, such as MAGI screen, and ensure prompt determination for eligibility and enrollment consistent with the timeliness standards established in the re-designated 435.912. And a good side note here is that we felt the time limits and performance standards now in 435.912 really could use some special focus. So that will be an important topic that we will address in the last webinar session, because we felt we could not do it justice by trying to include it in today's discussion.

Medicaid and CHIP have certain responsibilities for those that are not Medicaid and CHIP eligible. For individuals determined as not eligible for Medicaid and CHIP, the agency evaluates the individual for potential eligibility for other insurance affordability programs and promptly, without undue delay, transfers the individual's electronic account to the appropriate insurance affordability program. Since electronic account is a new concept for many agencies, we wanted to note that the electronic account includes all information or documentation that's collected to determine eligibility. And we now have definitions for electronic account in 435.4 and for CHIP in 457.10.

The exception to these responsibilities is if, upon agreement with the Exchange, Medicaid or CHIP elect the option to make eligibility determinations for the advanced premium tax credits or cost sharing reductions. And now, in keeping with the spirit of coordination, I'm going to pass off to Ben and he is going to talk through the next slide.

>>Ben Walker: Thank you, Amy, and it's a privilege to be here today. We really value the cooperation and coordination that occurs on the Medicaid and CHIP and Exchange side federally and also we know that that's a real big piece of success in states as well and we appreciate all the work folks are doing in all those respective agencies and entities to coordinate with one another.

So, as Amy mentioned, the Exchange and Medicaid Final Rules do provide a new option for Medicaid and CHIP eligibility determinations for applications that are submitted to Exchanges. The new option was based on feedback from states and was discussed in a November questions and answers document. It also, and I'll note, it's provided on an interim final basis so that means that this new option, which I'll describe here in a moment, is subject to comment and we, you know, encourage, encourage you to submit comments on that.

The first option that's available is the Final Rule maintains an option that was available in the proposed rule for the Exchange to determine eligibility

for enrollment in a QHP and all insurance programs including Medicaid and CHIP based on MAGI; either directly or, I should mention, through a contract with an eligibility entity. In addition to this integrated approach, the second option is available, which is shown on this slide, under which the Exchange can, instead of performing determinations for Medicaid and CHIP based on MAGI, can conduct assessments of eligibility for Medicaid and CHIP with the state Medicaid and CHIP agencies making final determinations. And for each of these options, as Amy mentioned and we'll go into in a little bit, there are provisions in both Medicaid and Exchange Final Rules regarding ensuring that the options don't have adverse effects on the consumer experience and that roles and responsibilities of the respective entities are clearly defined.

So under the first option, again, which was provided for in the proposed rule, the Exchange will determine Medicaid and CHIP eligibility final determinations based on MAGI only for applications submitted to the Exchange. These determinations will be made using the state's eligibility rules and policies and using a standard set of verification procedures that are accepted by the state so that they can result in final determinations.

And once the determination is made that somebody is eligible for Medicaid or CHIP, the Exchange will notify the state Medicaid or CHIP agency, as applicable, of those applicants and provide the electronic account and all supporting information to the relevant agency for enrollment without further eligibility processing.

>>Amy Lutzky: So with the approach that the Exchange makes Medicaid and CHIP eligibility determinations, the agency has a certain responsibility and certain standards to follow. The Medicaid or CHIP agency needs to accept the electronic account through a secure electronic interface, follows the Medicaid/CHIP eligibility determination and enrollment provisions to the same extent as if the application had been submitted to the Medicaid or CHIP agency, maintains proper oversight of the Medicaid and CHIP determinations, and for Medicaid, the agency needs to comply with the single state agency requirements which are described in 431.10.

And now I'm going to shift back to Ben.

>>Ben Walker: And so the second option, in addition to the determination option, and this is the new one, this is in 45 CFR 155.302B, is that the Exchange can, instead of conducting determinations, make what we're calling assessments of eligibility for Medicaid and CHIP based on MAGI, with the final determinations being made by the state Medicaid and CHIP agency as applicable. What the rule says about these assessments is that they will be made based on the applicable Medicaid and CHIP MAGI-based

income standards, as well as citizenship and immigration status, and then using verification rules and procedures that are consistent with Medicaid/CHIP regulations.

The specific rules, and again roles and responsibilities, will be defined in agreements to make it clear, you know, where the responsibilities lie. In addition, the way this process will work in the Final Rule is that the Exchange, to the extent that it's found somebody based on an assessment to be potentially eligible for Medicaid or CHIP based on MAGI, the Exchange will notify the state Medicaid or CHIP agency, you know, similar to how it would work for determinations and will provide the electronic account and all the supporting information so that the relevant agency can apply any additional rules that are needed to be applied. And we also clarify in the rule that to the extent that the Exchange looks through this assessment lens and finds that somebody is – or does not find that somebody is potentially eligible for Medicaid or CHIP, what they are going to do is they are going to, you know, notify that person but they are not going to, by default, transmit that person to the relevant state agency. Instead, that person will have the opportunity to the extent that he or she desires, to request a full and complete determination by the respective agency.

>>Amy Lutzky: So if the Exchange makes the initial assessment, the state Medicaid and CHIP agency: accepts the electronic account, does not request duplicative information or documentation, promptly and without undue delay determines the Medicaid/CHIP eligibility without requesting a new application, accepts any findings made by another program with no further verification, notifies the other program of the receipt of the electronic account - this is to help ensure that people don't get lost in the transition between programs - and, in certain cases, notifies the other program of Medicaid's final eligibility determination, and that's in the case of whether – when an individual is receiving coverage through another program which is a perfect segue to the next slide, since this concerns individuals who are being determined for Medicaid on a basis other than MAGI.

So the coordination requirements apply for both MAGI and non-MAGI populations but we want to devote a few distinct slides to this population. When Exchanges transfer applications to the state Medicaid agency for determination of Medicaid on a basis other than MAGI, there can be a few additional notification requirements. So specifically the Medicaid agency needs to notify the other agency of the final determination of eligibility for those individuals who are participating in the other insurance affordability program. And I think this is best explained through an example.

So if, for example, I submit a single streamlined application to the Exchange and it is determined that I am eligible for APTC and I decide to enroll in a qualified health plan, but I have also either self-designated myself on the application or through questions have indicated that I am interested or might be eligible for Medicaid on a basis other than MAGI, the Exchange would then transfer my electronic account to the Medicaid agency. The Medicaid agency would then have the responsibility, just as with any account that's transferred to Medicaid, to notify the Exchange that they received the electronic account and, because I have decided to enroll in another insurance affordability program, Medicaid would also need to notify the Exchange of the final Medicaid eligibility determination.

Now, in the case of an individual who submits an application to the Medicaid agency or renewal form for a Medicaid determination on a basis other than MAGI, the Medicaid agency determines potential eligibility for the other insurance affordability programs, promptly transfers the individual's account to the agency administering the other program, provides timely notice to the agency administering the other program, and this notice needs to include that the individual is not Medicaid eligible on a basis of MAGI and notify the program of Medicaid's final determination.

Again, this opportunity, it's important to note, exists that the individual has an ability to enroll in another insurance affordability program while their Medicaid application is still pending.

Now, you might have noticed through some of the slides that there was some notes about interim Final Rule with comment. When considering the public comments to the proposed rule, we found that some commenters identified options and policies that we didn't specifically address in the proposed rule. And these comments generally pertained to the areas of eligibility determination, coordinating eligibility with Affordable Insurance Exchanges, timeliness standards and performance standards. These comments were a logical outgrowth of the proposed rule, but we really wanted to provide a full and fair opportunity for public input since the issues were not specifically addressed in the proposed rule. And, in addition, as Vikki described earlier and Ben in more detail, new options emerge for structuring the eligibility system across the insurance affordability programs. Consequently, we are issuing the provisions, that are noted on this slide, as an interim Final Rule with comment. And we do welcome your comments on these provisions until May 7th. Although I should note, I believe the Exchange comment date is May 11 and Ben can correct me if that's not accurate.

Moving on to the last slide, I would also like to note that our next webinar is going to be on application verification and renewals on April 19th at 3:00 PM and more information can be found at [Medicaid.gov](https://www.Medicaid.gov). And I believe now we're going to move on to discussion.

>>Vikki Wachino: Great, thanks, Amy, and thanks, Ben, for your tag team presentation. You did a great job and we have plenty of time for questions so I wanted to invite people to send their questions in and while people are submitting their questions I can turn to some of the ones we've already received.

First question is will agreements between Medicaid and CHIP agencies and the Exchanges, these agreements that really establish coordination between the agencies, be open to the public? Will they be publicly disclosed and/or open for public comment?

>>Stephanie Kaminsky: The requirement in the single state agency piece of the rule which - this is Stephanie Kaminsky speaking - and the requirement in the single state agency part of the rule, which is 431 part 10 or section 10 of 42 CFR, talks about the agreement between the Medicaid agency and any entity, actually, that it's delegating an eligibility function to. I don't see the question in front of me, but in the situation where the Exchange would be doing I think what's called option 1, making an eligibility determination, we have said in our Final Rule that that agreement must be available to the public upon request. So certainly in that situation we were intending there to be transparency for those agreements.

In situations where it's not a full-fledged delegation, it's just I think an MOU or the relationship between the two entities, I don't think --.

>>Vikki Wachino: Amy is going to jump in.

>>Amy Lutzky: It's available to the secretary upon request.

>>Stephanie Kaminsky: It's available to the secretary upon request, but not necessarily to the public.

>>Vikki Wachino: Good question. Here is another good question. Can a government agency other than the Exchange or the Medicaid agency conduct eligibility determinations for the Exchange, Medicaid, CHIP or basic health plans using the rules set by the Medicaid agency, the CHIP agency, or the Exchange?

>>Stephanie Kaminsky: So again, this situation I think is contemplated at least from the Medicaid perspective in our single state agency part of the rule - I'm just looking at the question again to make sure I've got it clear -- I'm just trying to figure out if this is making, which kind of eligibility determination. So I'll speak from the Medicaid perspective and maybe Ben can talk about it from the Exchange perspective.

From the Medicaid perspective we allowed in this rule for Medicaid agencies to delegate to Exchanges, wherever that Exchange – whatever kind of entity is running that Exchange, the authority to make Medicaid eligibility determinations. So that could be another governmental entity, it could be a non-profit or it could be that certain eligibility functions are even delegated or contracted to private for profit entity and we are allowing for the sake of coordination a full-fledged delegation to such entities.

So – but the question is specifically about a government agency, not the non-governmental entities. And certainly Medicaid for a long time has allowed other governmental entities, sister agencies or County agencies, to make Medicaid eligibility determinations. So that really is still, that's intact. That has not changed with this Final Rule.

I don't know, I'm going to turn it to Ben for the specific question about conducting the QHP part of the determination but as far as I know – but I'll have Ben confirm, Exchanges certainly, you know, there's a wide range of governmental entities that can be involved with the structure of an Exchange but I'll turn that to Ben just to confirm.

>>Ben Walker: Yeah, we have language in our Final Rule, it's 45 CFR 155.110. There's actually provisions in the Affordable Care Act specifically relating to authorizing Exchanges to contract out some of their functions and it has a little bit of a description of eligible entities for contracting one of those eligible entities that was explicitly mentioned in the statute and is in the regs is the state Medicaid agency and we've expanded that in the Final Rule to also say that it can be any other state agency that meets sort of broad requirements. And the requirements that we have in the statute is that the entity has to have demonstrated experience in the individual and small groups health insurance markets and either can't be a health insurance issuer. So there's pretty broad flexibility for the Exchange for any of its functions to engage in contracting arrangements, those, of course, the responsibilities for carrying out the activities legally would still reside with the Exchange. But, you know, that, for example, would allow an Exchange if it so desired to decide to contract eligibility operations to its Medicaid or CHIP agency.

>>Stephanie Kaminsky: And then for the basic health plan part of that question I should just say that, you know, our basic health plan policy is still under development at this time so stay tuned.

Vikki Wachino: Ben, we have a couple of questions coming your way. One is why do Exchanges need to follow Medicaid and CHIP verification rules and procedures consistent with federal regulations? First is the specific

verification rules and procedures in use by the Medicaid or CHIP agencies in this state.

>>Ben Walker: Yeah, that's a good question. That's really at its core kind of the difference between the assessment and the determination. And so I think as we looked at it and there was a desire expressed for a meaningful, meaningful new option as opposed to just the prior option, which is the Exchange makes a determination.

So if indeed the Exchange is following every single state rule down to the letter, well, then, that's determination. And so this option, again, trying to be meaningfully different allows some state flexibility to utilize existing options under federal regulations. The idea is that the assessment process would have to be, you know, pretty robust in that it's using those applicable MAGI-based standards, it's using citizenship and immigration status, it's using, you know, federally accessible verification procedures, but that the space between the assessment and the determination, if you will, is such that a state could choose to take different verification options from what is necessarily applied by the Exchange if it so desired.

>>Anne Marie Costello: So – Ben, it's Anne Marie Costello. I just wanted to add --.

>>Ben Walker: Please.

>>Anne Marie Costello: Differences per an assessment, the standard is that the Exchange will have the standard verification process to make an eligibility determination, the state will accept that verification process. In making an assessment, a state, once someone has been assessed to be potentially Medicaid or CHIP eligible and the Exchange provides all of the information it gathered and the verifications that were available to it, it would then pass that electronic account to the Medicaid or CHIP agency who could then complete the determination which may include any additional verifications that the state requires that was not completed by the Exchange.

>>Vikki Wachino: We have another question on Medicaid and Exchange coordination. In situations in which an Exchange makes a Medicaid eligibility assessment rather than a full determination, is it still envisioned that the determination can happen in realtime?

>>Ben Walker: Well, I think that it – we would hope so. I think it presents an additional challenge. I think that one of the things that's going to be very important is that to the extent a state is evaluating taking an option really to have the Exchange do assessments instead of determinations, there needs to be a close state-specific examination of the additional rules that are going to be applied to determine how those can be integrated in such a

way that the process remains streamlined and remains minimally burdensome.

>>Vikki Wachino: Great, and we have a question that I think is, falls into Anne Marie's bailiwick. Will CMS draft a standard agreement for states to use establishing coordination between Medicaid and the Exchange?

>>Anne Marie Costello: It's one of the tools that our Coverage Expansion Learning Collaborative is working on, to develop a model agreement that can be used between the state Medicaid and CHIP agency and either the state-based Exchange and the Exchanges. But, It is something we are working collaboratively with states to develop.

>>Vikki Wachino: Great, so that's something that once it's finalized a state can use if it wishes to, but it's not required.

>>Anne Marie Costello: Exactly. Right, and it will be broadly available once it's done.

>>Vikki Wachino: Great. Another question around the Exchange's role, and Ben, maybe I'll send this one your way, can the Exchange determine Medicaid eligibility for populations whose eligibility is not based on MAGI?

>>Ben Walker: Yeah, and I think that there is no base line requirement for the Exchange to determine eligibility based on non-MAGI categories. However, to the extent that state Medicaid agency wants to work with the Exchange to provide it with that authority I believe, and will also solicit input from other CMCS folks on the phone, that is an option available to a state in terms of how to configure the overall eligibility operations.

>>Stephanie Kaminsky: This is Stephanie Kaminsky, I just want to jump in to add that's true, provided the Exchange is a governmental entity.

>>Ben Walker: Okay, thank you.

>>Vikki Wachino: We continue to get questions on the realtime nature of eligibility determination. I think I'll jump in on that one myself.

I think the goal is even with these new options to have the same seamless experience and to have determinations made as quickly as possible regardless of the approach that the state elects with regard to having its determinations made by the Exchange or assessed by the Exchange and handed off to the Medicaid agency and I think as we establish our timeliness and performance standards we'll have more to say on what that experience looks like. But, again, same consumer experience, just with additional flexibility regarding how determinations are made.

Another question we have is will the data sources available to the federal Exchange be the same as those available to the states in making that Medicaid or CHIP determination? Anne Marie, you want to jump in on this one?

>>Anne Marie Costello: I think I will tag team this with Ben Walker. I think that we know that it lays out in both the Medicaid/CHIP rule and in the Exchange rule that certain data will be available through the federal data services Hub to support verification of citizenship, immigration status, federal tax information to support an income eligibility determination and also SSN validation.

I think the other electronic sources of data that could be available, you know, we know states today, state Medicaid agencies in particular, use a number of sources of electronic data including quarterly wage reporting data, data from their departments of labor related to unemployment insurance benefits, information from Social Security Administration on different sources of Social Security income and I think that we're working to look to see how that, those electronic data sources might be made available more broadly.

But, Ben, I'll see if you have anything to add.

>>Ben Walker: That is exactly what I would have said.

>>Anne Marie Costello: Great. That's a good check for me, thank you.

>>Vikki Wachino: It's good to know we're coordinated here at the federal level.

Okay, we have some questions, Ben, about the requirements for people who are applying to the Exchange who have incomes above 400% of the poverty level, who are applying solely for it to use the Exchange as a risk pooling mechanism and a purchasing mechanism. Can you speak briefly to the eligibility requirements for that group?

>>Ben Walker: Sure, there are a set of very basic, kind of limited eligibility requirements specified in the statute for folks. and just to be clear, you know, a person at any income level, what we've said in our regs can come in and say, I am not whatsoever interested in financial assistance and if that occurs, the only 3 things that we need to evaluate in accordance with the statute to see if they are eligible to purchase coverage through the Exchange is to make sure they are a citizen, a national or a non-citizen who is lawfully present; make sure they meet the residency requirement for the Exchange for which or to which they are applying, which is really just kind of a sorting mechanism; and then, lastly, that they are not incarcerated other than incarceration pending the disposition of charges.

And so there are no questions about income, no connections with IRS for data, nothing about other health insurance and so we hope to make that, you know, a pretty expedited process for those folks who aren't interested in financial assistance.

>>Vikki Wachino: And, Ben, there's a related question that I'm not sure whether we've addressed yet. Can people who are applying and have incomes above 400 percent of the poverty line use pretax funds like a health savings account to pay for qualified health plans or have we not spoken to that issue yet?

>>Ben Walker: Yeah, I'm – you know, I'm not sure what the answer to that question is, but it's something that we can take back and see if someone has the answer to that.

>>Vikki Wachino: Very good, thank you.

Now, there will be an open enrollment period between October of 2013 and December of 2013, and one person has been reading our regs is wondering we've established this coordinated system and MAGI requirements that clearly pertain, starting on January 1st, 2014. What happens in that 3-month open enrollment period? Anne Marie, could you field that one?

>>Anne Marie Costello: I will start by – and Ben, correct me – I think the initial open enrollment period will run from October 1st, 2013 through March, 2014. I think there's an extended open enrollment period for the first year to accommodate the large number of people that will be coming in to apply for coverage. So that's, I think, there's a longer open enrollment period in the first year.

So I should stop and say, Ben, is that correct?

>>Ben Walker: Yes.

>>Anne Marie Costello: Okay, great.

The second part is in this – the second part is what to do on October 1st, 2013 when someone walks through the door and they may be potentially Medicaid eligible but before the MAGI rules apply or the new adult coverage group is available for participation. That is the very thing we're doing lots of thinking about now and really looking at what are the options available that we can do. We absolutely want Medicaid agencies to be able to accept application. Medicaid and CHIP agencies, look at maybe a process of prescreening those applications to look for people who will be newly eligible on January 1st. What can we do to sort of pend those applications. Those are the kinds of things we're working through now. We also want to make sure that there will be people who will come in during that time frame that will be, that will already be eligible for coverage. I think we've seen in states that have done coverage expansions that when you launch a coverage expansion the people that come in to enroll are not just the newly eligible but people who had been previously eligible and not

enrolled. So we also want to ensure if someone could be enrolled then that we have that opportunity to have their eligibility determined.

We've started to have some discussion with states to see how they think that might work, almost running two parallel sets of, you know, eligibility rules for a short amount of time and we're looking to see how we can simplify and streamline that process. So – and I think we will be reaching out to discuss that more with a number of states.

>>Vikki Wachino: Great, thank you.

Here's a question I know we don't know the answer to yet but I'll ask it anyhow. In a state in which an Exchange is making Medicaid and CHIP determinations, who's going to be responsible for holding fair hearings and appeals? And so, since we don't know the answer to that yet, I will say that that's a topic we are going to address in our next eligibility rule which we are working on right now. So more to come on the whole question of appeals and notices as well is a subject future rule-making.

Someone's asked about the shared eligibility service which I think we all know is an absolute key underpinning of the coordinated system and they're wondering, does a shared eligibility service mean that the Exchange and the Medicaid agency literally need to have the same system? Anne Marie, do you want to jump in on that one?

>>Anne Marie Costello: So I'll start it and others can chime in.

I think what we know is that the Exchange, Medicaid and CHIP will need to have a common set of services and that those services should be a single service available to both the state-based Exchanges, the Medicaid and CHIP agencies and that's what we consider to be sort of a set of shared eligibility services. So those can include things like the rules engine for MAGI determinations, that we need to be the same across all the entities. And Medicaid and CHIP and Exchange will also need all the different components of a system, so it would be ideal to have a single eligibility system because that will negate the need to transfer electronic accounts. They would be there in the system but when there is not a single system there will need to be a set of shared services that all entities can access and use. What we want to avoid are multiple agencies in the same state building the same tools and products that, you know, need to be shared by all. So that's the concept of the shared eligibility services when there's not a single system.

>>Vikki Wachino: Thanks. Ben or Amy, anything to add on to that or shall we move on?

>>Ben Walker and Amy Lutzky: No. No, thanks.

>>Vikki Wachino: Sounds like we're ready to move on.

Another question about the distinction between people who are MAGI eligible and non-MAGI eligible and what the experience is for them.

Can a state require Medicaid applicants who are applying to a state Medicaid agency to apply using the single streamlined application and therefore not get screened for a non-MAGI category? How is that whole MAGI/non-MAGI process going to work for someone who submits a single streamlined application?

>>Anne Marie Costello: Well, I'll start.

I mean, for those – the single streamlined application, there will be several questions on it to try to identify those who may be eligible for Medicaid on a basis other than MAGI. Many states simplify Medicaid applications today already have a question, a basic question, that asks about disability status or about the need for long-term care, and we know that we'll have similar types of questions on a single streamlined application to help identify those individuals who may need sort of as referred to, a deeper dive on their Medicaid eligibility.

>>Stephanie Kaminsky: In which case, if they are identified in that way, there would be a next step for them.

>>Anne Marie Costello: That's right.

>>Stephanie Kaminsky: They would be asked to fill out a supplemental application.

>>Anne Marie Costello: Right.

So if someone could be determined eligible based on modified adjusted gross income they can receive that eligibility determination, but if there was an indication – and that may mean the Medicaid, for CHIP, for coverage for enrollment in a qualified health plan, but as Stephanie points out, if there is an indication on the application that they might be potentially eligible on another basis, that information would be sent to the state Medicaid agency and they would do the follow-up with the individual to gather the required information to make that determination.

>>Stephanie Kaminsky: And certainly, especially with our Final Rule and our modified policy around the disabled, individuals can elect to do that on their own. For sure we want to be, we want to make it as easy as possible for individuals who want to be evaluated on other means than MAGI, to have that evaluation done and I know we're going to be talking a lot more about the MAGI screen, which is what we call this, and how it works in a future webinar.

>>Vikki Wachino: Yeah, as we've talked about in previous webinars, We've tried to set up in the Final Rule a process for making sure people are

quickly and effectively screened both for coverage in the adult group, as Anne Marie said, and get enrolled, as well as for non-MAGI categories.

I'm going to move now to a question about the ability of the Exchange to work with non-governmental entities. One questioner asked us to go back to that slide and, Ben, I wonder if you could just spend a moment talking about what the law and the regulation permits in terms of an Exchange contracting with non-governmental entities. So I'm back on slide 10.

>>Ben Walker: Sure, so the regulation – and again, this is 45 CFR 155.110, which talks about effectively, you know, the methods through which the Exchange can get its, accomplish its business. It talks about the authority of the Exchange to contract out and this is something that in the statute itself, and I apologize, I don't have the statutory reference in front of me, but it says that the Exchange can enter into agreements with eligible entities is what it's called, to carry out one or more of the responsibilities of the Exchange. So that's really everything that the Exchange is responsible for doing, from certifying qualified health plans which, for example, is something that I know many departments of insurance have expressed interest in working on through a contracting relationship, disseminating consumer information or getting into some of these eligibility operations.

And what it says is that eligible entities and, again, this is statutory language, are effectively one of the following. It's either basically any entity that has experience in health insurance but isn't an issuer under the control of an issuer, or the state Medicaid agency or another state agency that meets the qualifications specified previously, which is around, again, sort of familiarity with the health insurance market and not having a conflict of interest.

And so there's broad flexibility for the Exchange to use different contracting relationships to accomplish its work and fulfill its responsibilities, again provided that the Exchange remains the accountable party.

>>Stephanie Kaminsky: Ben, this is Stephanie. I just want to give you that statutory site. I think you are thinking about 1311(f)(3) of the Affordable Care Act, which is where that, who the eligible private entities are is defined. And also just to supplement your answer, there is a piece here for Exchanges. There is a permission in the law both in the statute and in the – and in the Exchange regulation that allows Exchanges to be non-governmental entities themselves. They can be nonprofits, right?

>>Ben Walker: Yes.

>>Stephanie Kaminsky: So that's a piece of the Exchanges being run by non-governmental entities that was being asked about.

>>Ben Walker: Uh-huh.

>>Vikki Wachino: Anne Marie, as always on these calls, we have a lot of interest in the model application and I know you spent a little bit of time on it last week, but if you could just give folks a preview of the coming attractions on the model application?

>>Anne Marie Costello: Sure. So we've done a tremendous amount of work looking at the data elements that would be required both for an online application and for the paper application based on both the Medicaid, CHIP and Exchange rules. We've also are working with a sort of large work group of states, I think there's 14 states on our work group, reviewing and critiquing those data elements, helping this thing through the best way to craft questions and, I think, most importantly, the best way to flow the information required to make an eligibility determination. We think that many people apply online and that the online application should be a smart, dynamic application that really includes -- embeds the verification process to the greatest extent possible within the online application so that this way we can work towards achieving realtime determinations for as many individuals as possible.

The other thing that allows that embedding, the verification process within the online application, it allows you to tailor the application and the consumer experience. So based on the information that the individual provides and the verifications that you're able to do electronically, you'll be able to make an assessment throughout the application preparation process about the kinds of questions that need to be asked of individuals in part based on how they answer a question. You may be able to skip particular questions because it's not material to the eligibility or based on an answer you may need to ask some additional questions.

We also think that at a point in the online application process that a good practice would be to include a preliminary eligibility determination so that you can identify who on the application may be potentially eligible for Medicaid, CHIP or coverage through the Exchange and then you would be able to tailor the remaining questions based on their potential eligibility. So we really think having a smart, dynamic application that includes the verification process will really enhance the consumer experience and allow them to move more quickly through the application process.

>>Vikki Wachino: Very good, thank you.

Ben, we have two qualifying questions for you about the provision of the Exchange reg 155.302. The first question is that the rule states that the Exchange will assess Medicaid and CHIP eligibility using rules and procedures consistent with the Medicaid and CHIP regs, but, quote, without

regard to how such standards are implemented by the state Medicaid and CHIP agencies.

Can you clarify that provision?

>>Ben Walker: Sure – sorry – but, you know, again, this is about kind of the difference between the assessment and the determination. And so under a determination the process is exactly the same and there's no kind of air space there. Under an assessment the option that we've put in the interim Final Rule is that the process that the Exchange would go through for the assessment has to be robust enough such that all the verification procedures used must be something that is permissible under federal Medicaid and CHIP regulations, but doesn't exactly have to match what the state does. So that creates the, again, sort of air space, if you will, where the Exchange could do something that's a little bit different albeit within a limited scope of difference because it has to be something that's compliant with federal Medicaid and CHIP regulations only around verification procedures. And so if there is a gap there, that's what would result in an assessment instead of a determination and that with also frame, you know, what a state would then do with further processing.

>>Vikki Wachino: Great, thank you.

Another questioner is asking for clarification about what the provision is also in 155.302 that allows individuals to withdraw their Medicaid application. Can you expand a bit on what that means?

>>Ben Walker: Sure. And so, again, in a situation when – and just to describe this a little bit for folks, what we're talking about is the option where the Exchange is making assessments and not determinations and what we said in 302(b)(3) is that if the assessment reveals that somebody is potentially eligible for Medicaid or CHIP, the Exchange transmit that person to the Medicaid or CHIP agency for additional processing. If the assessment instead finds, you know, well, the Exchange doesn't think that that person is eligible for Medicaid and CHIP; well, under the assessment the Exchange doesn't have the ability to actually formally deny Medicaid eligibility. again, because it's not a determination, it's just an assessment.

And so there's a provision there which is (b)(4) which says that in this type of situation, the Exchange has the responsibility to notify the applicant and provide them with the opportunity to either say, I would like to press on and get a real, you know, Medicaid denial here, or to the extent that, you know, it's an approval, fair enough, or to say, no, actually your assessment is good enough for me; I'm willing to take that as my determination which effectively the way that that happens is through the withdrawal of the

application; again because the Exchange can't make an approval or a denial under this assessment.

The other thing that I want to stress here is that what that provision says is that from the perspective of the Exchange, you know, one of the factors in determining eligibility for advanced payments of the premium tax credit and cost sharing reduction, which is the financial assistance available for Exchange coverage, is making sure that somebody is not eligible for Medicaid. And what we've said here is that for purposes of eligibility for advanced payments and for cost sharing reductions, the assessment that somebody, we don't think they are potentially eligible for Medicaid or CHIP is good enough. And so what that does is it allows the person to be able to say, yes, it's okay, I'm good with your assessment and for the Exchange to immediately be able to provide financial assistance to purchase coverage through the Exchange without having to persist and wait for that final Medicaid assessment to happen.

But, again the thing that sort of girds all this together is the fact that assessment is going to be robust. It's going to be something that, you know, uses the state's standards in terms of applicable MAGI of standards and citizenship and immigration standards and also certification procedures that because they meet the federal rules will hopefully be pretty close to, you know, what the state would be doing and thus we have a high degree of confidence that, you know, these assessments will be pretty accurate.

>>Vikki Wachino: Great. And we had a follow-up question on that which we may not have addressed yet, but people are wondering how will that option to withdraw an application be communicated to a beneficiary?

>>Ben Walker: Yeah, and I think – go ahead.

>>Anne Marie Costello: No, Ben, you go ahead and then I'll jump in.

>>Ben Walker: I was going to say this is, it's the responsibility is described in 302(b)(4). It says the Exchange must notify such applicant.

We have some work to do here and collectively with CMCS on exactly how all the detailed specifications for notices in terms of, you know, how they're going to be conveyed, the specific information that we provided. I think our highest goal here is making sure that this experience is as straightforward as possible despite whatever configuration is chosen. And so, you know, it's a priority for us to make sure that the work that we do, the notices that are received, aren't things that are horrifically confusing. All we have now is the responsibility to notify and provide this opportunity and I think we have work to do to figure out exactly what that looks like and how it's worded.

>>Vikki Wachino: Very good, thank you. Thank you.

We had another question – a questioner who wanted to know, what happens in a scenario where an Exchange determines someone eligible who is already eligible for Medicaid, perhaps as part of another household? My understanding is our rules have procedures in place to kind of protect against those double determinations – that kind of double determination scenario.

>>Anne Marie Costello: So I'll start.

I think, if I understand the question is so someone comes in, a household comes in to apply, one member already is enrolled in Medicaid. And I think the first thing is we are envisioning in an application process that through that – before that person's determination is made that the data bases available to the state its own eligibility system would be checked to see if someone is already enrolled in an insurance affordability program. So we think that's the first step in really trying to prevent – you can't double enroll somebody. So, you know, really the first step is identifying who was on the application and whether they are already known to the eligibility system.

>>Vikki Wachino: Very good. Thank you.

We have another question about a potential creation on the part of CMS on a MAGI eligibility service so the question is why doesn't CMS create just one service that states can use rather than having 50 states create separate services. And I will, I always choose the easy questions to answer; it's the moderator's prerogative.

We've heard that from a lot of states, we get asked that a lot. It's something we are looking at and thinking about. So more news to come on that part on that question at some point, we hope.

We have many more questions. One of them, Ben, asks about minimum essential coverage. And so the questioner wants to know how the agencies, particularly the Medicaid agency, but I think the question is perhaps even more relevant than the Exchange question of the equation, how will an agency know whether someone has minimum essential coverage which would exclude them from eligibility for advanced premium tax credits?

>>Ben Walker: Yeah, and so I think the approach is a combination of information collected on the application and then external verifications we're working on, and hope to make available through the federally managed data services Hub. So I think we anticipate, one of the things we're going to be doing is asking questions about whether folks have access to other minimum essential coverage which, for folks who aren't familiar with the term, is a term used in the IRS section of the statute. It basically means any type of health insurance, whether it's, you know,

public or private. And so we have delved into that with our federal partners and we're working on, trying to figure out ways we can make various sources of data available. So one of the easiest elements there, and Anne Marie talked about this to some degree, is making sure that we have a good sense when people apply whether or not that person has already been determined eligible for Medicaid which hopefully we'll have pretty ready access to.

We are also as CMS talking to our internal folks about Medicare eligibility records. We have heard from states and are exploring things like veteran's health administration health insurance, tri-care, federal employees health benefits, coverage through the Peace Corps, trying to see what we can do to develop verification strategies that rely on trusted data to the maximum extent possible.

And then there's employer-sponsored insurance, which is, you know, kind of a separate body of work for us. And that's something that we talked about a fair amount in the proposed rule and in the Final Rule, what we're doing a lot of work with employer groups to try to come up with strategies that are minimally burdensome and help us maintain a streamlined and accurate eligibility process to be able to assess whether somebody, you know, who would otherwise be available – eligible for advanced payments of the premium tax credit may have access to employer-sponsored insurance that is affordable and meets the minimum value requirement.

>>Vikki Wachino: Great. Thanks, Ben.

We had another question from someone who wanted to know when resource guidelines will be established by CMS. And so I just wanted to jump in and clarify something that we talked about on last week's webinar, which is that for the population of people whose eligibility is determined based on modified adjusted gross income, there is no assets test.

So moving on, we have a couple of questions about the federal Exchange and I know this is something that both Ben and Anne Marie are doing a lot of thinking about right now. And one questioner wants to know whether we can speak to how the federal Exchange will interact with state Medicaid agencies.

>>Anne Marie Costello: Ben, want to start?

>>Ben Walker: Sure. So, you know, obviously we're working on federally facilitated Exchange right now. We know that folks are very interested in additional detail on exactly how it's going to work and it's, you know, obviously critical for us to develop that and get that information out to states and other folks who are interested.

I think that as we look at the statute and the regulations and we talk to folks in states, you know, it's pretty clear that there are a number of places in which collaboration between the federally-facilitated Exchange and state Medicaid agencies is really going to be important to providing the overall streamlined consumer experience and executing on the vision of the Affordable Care Act. So, you know, the most basic of those is this idea of in that type of situation where there's a federally facilitated Exchange you can have applications that are submitted to the Medicaid agency, you can have applications that are submitted to the Exchange. You can have applications that are submitted to the CHIP agency. Each, based on regulations, has a core set of responsibilities to execute in terms of eligibility steps and then there comes a point at which hand offs may be required.

And so there needs to be a capability, information technology capability, but all of the sort of operational support that fits around that to make it work to be able to pass this information from the Exchange to the Medicaid agency and to the CHIP agency and also back in the other direction. And this is, you know, for situations as straightforward as the Exchange gets an application and it does an assessment and says this person is potentially eligible for Medicaid. It also, in the reverse direction, is similar where the Medicaid agency gets an application and says this person is not eligible for Medicaid but may be for the Exchange.

You know, in addition, what Anne Marie mentioned earlier, this idea of being able to check and see if somebody is present, kind of in the universe within that state, I think is an important area of collaboration and also from that minimum and central coverage perspective when we're looking at advance payments of the premium tax credit. You know, the last thing that I will just mention on this, and there's a lot here and we really look forward to working closely with state Medicaid agencies and state CHIP agencies as, you know, we move closer to October 1st, 2013, and states have a better sense of what direction they're going to go in to make sure that we build a strong relationship. But when the federally facilitated Exchange is serving a state we recognize that it's a, you know, one piece of the continuum of coverage. And so we really do want to, to the best, you know, we possibly can, be able to develop formal and informal working structures with state Medicaid officials and state CHIP officials and other folks on the ground to make sure that, you know, the federally facilitated Exchange works as seamlessly as possible with those state-sponsored programs such that we can fulfill the vision of the Affordable Care Act and make these affordable health insurance care options available.

>>Vikki Wachino: Great, thanks, Ben.

We have one questioner who observed a difference between our current Medicaid regulations and what's in the Exchange regulation. Current Medicaid regulations require applications to be processed within 45 days, and as Amy noted earlier, we proposed, you know, additional and new timeliness standards in this reg.

However, the Exchange rule gives applicants 90 days to respond to requests to resolve information that's not reasonably compatible. Anne Marie, is there a conflict there?

>>Anne Marie Costello: No, I think there's a difference but I don't think there's a conflict. The 45 day limit for Medicaid is the outer boundary limit by which a state must determine eligibility. Even within that the Medicaid program has two options available to it, two reasonable opportunity periods for individuals whose citizenship or immigration status can't be verified by the time of the eligibility determination.

For all other factors of eligibility, they must be verified in order for the eligibility determination to be made. A difference with the Exchange rule is that they have the ability to have a 90-day reasonable opportunity period for all factors of eligibility. But what I would say is they have determined eligibility already and then they must follow up with any required additional information. So it's not a conflict in the 90 days in that the individual already has an eligibility determination and the reasonable opportunity period really is the time to provide them the same information.

>>Vikki Wachino: Great, so we can still provide a realtime eligibility determination, even while the 90 day period is going on.

>>Anne Marie Costello: Yes. Uh-huh.

>>Vikki Wachino: I have another question here that I think probably falls within Amy's bailiwick. They note, the questioner notes that part of the CHIP regs 457.340(d)(2) allows states to define a date of application for CHIP and the questioner is wondering is this a CHIP-specific provision or is there something comparable in the Medicaid regulations?

>>Amy Lutzky: No, I think – I think that's an important point to clarify because both the CHIP and the Medicaid coordination regulations reference the 912 section, which is the timely determination of eligibility. But CHIP has and continues to have the ability to define the date of application and that is a unique to CHIP provision.

>>Vikki Wachino: Very good.

Another question which I think either Amy or Stephanie could speak to is about the 5 percent of income disregard. And the questioner is wondering

is this a percentage of income or does it effectively increase the poverty level eligibility for people from 133 percent to 138 percent?

>>Stephanie Kaminsky: We love softballs. (laughter) The latter, it's an increase in the FPL level from 133 to 138 percent.

>>Vikki Wachino: Okay, very good.

Anne Marie, I know you've done a lot of thinking, although we haven't issued guidance yet, on how to help people with limited English proficiency. But one questioner wants to know in the whole streamlined simple world what can we anticipate might be done for people who are LEP?

>>Anne Marie Costello: I think we're looking now around the regulations and guidance that already exist around accessibility, readability, and we also will be issuing future guidance on readability and accessibility of applications, forms and notices. I think, you know, the ability for an individual to have access to translation services as needed whether an interpreter or a live interpreter if they come in for in-person assistance or the ability to use a language line, materials to be available in multiple languages.

And, then I think the other thing that has proven to be an effective tool is the application assistance networks that exist. State Medicaid and CHIP agencies today in many states have applications – use application assistors whether through a formal contract with a fund organization to do application assistance or their providers who do application assistance required by community health centers, hospitals, other health care providers, and typically those assistors can provide services in many languages because they represent – they come from the communities being served by the program. So they often are able to provide in-person assistance and multiple languages. So we recognize the need to ensure that people with limited English proficiency can access the system in an effective way and we're working through many groups to look at the best way to do that and the parameters to be set up around the application process.

>>Vikki Wachino: Very good, thank you.

We've had a couple of questions from folks wanting to know why in the Final Rule did we establish these, this additional option for Medicaid and the Exchanges and also doesn't that create the potential for delays in the applications or applications being handled twice? And I will jump in on those points and just say that I think the idea behind establishing the option either for the state to create and a configuration where the Exchange makes a full Medicaid or CHIP determination or to assess eligibility for Medicaid/CHIP with the state Medicaid or CHIP agency making the final

determination was really designed to give states some additional flexibility in how they configure things. But, again, all subject to the same goals and parameters around insuring a streamlined consumer experience.

As Amy described in her presentation of what we think of as the guardrails and the provisions around eligibility determinations, duplication of eligibility determinations is a key no-no in the rule, and something that we want to avoid. There should not be duplicative applications, there should not be duplicative requests of – for information from the same beneficiary. Once a beneficiary is provided information, that should be the same and largely the same information that's relevant for the Exchange or for a Medicaid agency. So there shouldn't be multiple requests for information and there should not be delays in applications.

Enough said on that topic, I think, for now. People, we still have about 15 minutes left. If people want to send more questions our way we have time for them.

Ben, in the meantime there's a question around the relationship between Exchanges and employers. And a questioner notes that there's provisions in your regulations that ask Exchanges to notify employers if they have an employee who's PTC eligible. Do we have a sense of how that process between the Exchanges and the employers are going to work?

>>Ben Walker: That is an area on which we have been doing some consultation with employer groups and I think we have more work to do to figure out exactly how it's going to operate. You know, obviously, we want to make sure it's done in as minimally burdensome a manner as possible. You know, we are looking hopefully to be able to use some electronic solutions for that. And so it's an important step of the process, we believe, because it does allow employers to understand, you know, when their employees are receiving a premium tax credit which may be in part based on the fact that employer-sponsored insurance has been found to be not affordable or not meet minimum value. But we do have some work to do to figure out exactly how that process is going to take place.

>>Vikki Wachino: Great, thank you.

And one final question, unless some more come up in the queue. Ben, I think one change in the final Exchange eligibility rule was the provision regarding navigators. And I think that there's a new provision or additional provision that establishes that one of the navigator entities be a consumer advocate, a representative. Could you speak to that or clarify it?

>>Ben Walker: Yeah, I apologize, I don't, I am not an expert on the navigator provisions. I can tell you that indeed in the Final Rule there is a provision that says that the, there has to be, there's a series of categories

in the statute that talks about different categories that navigators – pardon me – entities that can be navigators within various categories. And so, for example, some of the categories that are mentioned, and these are from the statute, are community and consumer focused nonprofit groups, trade industry and professional associations, chambers of commerce, unions, agents and brokers and so on, and so forth. And what we've said in the Final Rule is that the Exchange has to include an entity that is a consumer and community focused nonprofit group entity, that category, as well as one of the other categories. So there's flexibility to expand beyond that but at a minimum there has to be two different categories and one of them has to be a community and consumer focused nonprofit groups. But I'm happy to, you know, go back and get additional information if that would be helpful to further answer the question.

>>Vikki Wachino: Thanks, Ben, and one final question before we wrap for this afternoon. Will the federally facilitated Exchange only do assessments for Medicaid and CHIP eligibility, or can, if a state so chooses, can the federal Exchange do the full eligibility determination for Medicaid and CHIP? Amy, I'll let you jump in on that one.

>>Amy Lutzky: Yes, they can do the assessment or they can do the full determination. So there is that option.

>>Vikki Wachino: Great. Well, thanks, everyone, for joining us today. Just to remind everyone, our next webinar will be on Thursday, April 19th, at 3:00 where we will address 3 topics: the application, the verification process, and the renewal process.

Thanks, everyone, for joining us and have a great holiday weekend.