CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Christine Gerhardt
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Operator: Good afternoon, my name is Jerica, and I will be your conference moderator today. Welcome to the Eligibility Simplification and Eligibility of the Disabled. All lines have been muted to prevent any background noises. After the speaker's remarks, there will be a question and answer session. If you would like to ask a question at that time, press pound-7-1 on your telephone keypad.

Chris Gerhardt: Okay, thank you, Jerica. This is Chris Gerhardt speaking, and in the room with me, I have Mary Corddry and Sarah deLone. We're going to be speaking today about the NPRM that was issued on August 17th. Specifically we'll be talking about some of the new information in that proposed rule relating to eligibility groups – the new eligibility groups that have been created, as well as some restructuring of existing eligibility groups, particularly for parents and caretaker relatives, pregnant women, and children. And we will also be talking a little bit about eligibility for the disabled.

Again, Mary Corddry is with me. She is the subject matter expert on this topic of eligibility groups in the NPRM. And I'm Chris Gerhardt, Technical Director. And we have Sarah deLone also in the room, who is one of the master writers of this NPRM.

Each of you should have received slides for today's presentation. Initially, the title was "Simple, Seamless, and Affordable Coverage," which is kind of our mantra for this NPRM and our mantra for 2014. The goal of many of these regulations, particularly this portion of the NPRM, was to simplify eligibility, and of course, to fill in some of the gaps that currently exist among the eligibility coverage groups.

So I'm going to begin. In the August 17, 2011 NPRM, there are three main actions that took place with respect to eligibility groups. First, the rule expands eligibility to 133% of the federal

poverty level for all individuals under age 65. When I say all individuals, I mean all qualified individuals, and we'll talk later about what those qualifications are.

The proposed rule also provides a State option to cover individuals whose income is above 133% of the federal poverty level. And the proposed rule simplifies eligibility by consolidating certain eligibility categories. The one thing that all of these groups we'll talking about today have in common is that they all use the new MAGI methodology for determining eligibility. And I'll note, we've said it before, but it probably bears repeating, that the MAGI, modified adjusted gross income, in this context, doesn't really refer to a specific number on a tax return. It actually refers to a methodology for computing income for Medicaid eligibility and CHIP eligibility, as well as eligibility under the Exchanges. Those are the groups that we'll be talking about today.

Section 2002 of the Affordable Care Act created a new 1902(e)(14) of the Social Security Act and, effective January 1, 2014, financial eligibility for most individuals will begin. The ones that we're talking about today will be based on the modified adjusted gross income. Medicaid financial eligibility for groups for the aged, blind, and disabled will still be using the methods that you currently use based on the SSI rules.

First, I'd like to talk about the new eligibility group that was created by ACA. The new coverage is under what we're calling the 'adult group.' We've previously called this the 'eight group.' Effective 2014, section 2001(a) of ACA creates a new portion of the Social Security Act that creates this mandatory coverage. And the August NPRM proposes a new 42 CFR 435.119 to address the coverage of the adult group. The adult group is going to cover individuals whose modified adjusted gross income, or MAGI, does not exceed 133% of the federal poverty level, and that's after deduction of a 5% general disregard. So I'll note that in the past you may have heard discussion of a 138% standard. What that really means is the 133% standard along with the 5% general disregard that Congress had included in the statute.

This group includes individuals who are age 19 to 64, not pregnant, not Medicare eligible and not otherwise eligible for and enrolled in mandatory coverage. A parent or caretaker relative

living with a dependent child is not covered under the adult group, unless the child is also enrolled in Medicaid, CHIP, or other minimum essential coverage. So in other words, this group may have caretaker relatives in it, or what we traditionally think of as caretaker relatives or parents in it. In order for them to be eligible, they have to ensure that the child has minimum essential coverage, which would mean Medicaid, CHIP, or other insurance coverage. So this is a special condition for adults with children who are in this new group.

ACA also creates new optional coverage groups, and the new optional group is for individuals whose income is above 133% of FPL, and this will also be effective January 1, 2014. Section 2001(e) of the Affordable Care Act added a new 1902(a)(ii)(XX) and we sometimes refer to this as the 'twenty group,' but these are individuals above 133% of FPL. The August NPRM proposed a new 42 CFR 435.218 to talk about the coverage of this group. And States can use this new optional group to provide coverage for individuals with higher incomes who don't qualify under the 'adult group' or under the 'eight group.' The group covers individuals whose modified adjusted gross income exceeds 133% of FPL, and the States that elect to cover individuals in this group can determine what their income standard is.

Now, that being said, I want to note that throughout our discussion today, that when we talk about the various eligibility groups, most of these groups have minimum standards and maximum standards that the State will select. Some have mandatory standards. We are not going to discuss the actual calculation of those standards today because they're fairly complex, and if you look in the regulation itself, it will clearly state what those standards are. It's our hope that in the future we'll be able to develop some technical assistance tools to help States to determine what their choices are when they establish these various standards. So, that being said, there's no maximum standard for this proposed group. The only rule that there is around this is that individuals with higher incomes may not be covered without a State covering people with lower incomes.

I want to note that for this group, for the people above 133% of FPL, this group is not really exactly like the 'eight group' or the 'adult group' that we just discussed. It is distinct and has

distinct requirements, so it's not simply an extension of the 'eight group' for people with higher incomes. Because this group, unlike the 'adult group,' this group can include individuals who are under 65 with no minimum age. It may include people who are pregnant. It may include people who are Medicare eligible. And to be in this group, people have to be not otherwise eligible for any other mandatory or optional coverage in the State Plan.

Now I want to note that there's a phrase on this slide that says, "Based on the information from the application." As you know, one of our goals in 2014 is to be able to determine eligibility very quickly, and to avoid some of the protracted determinations that we've had in the past that slowed down people getting their Medicaid eligibility. So in order to be eligible in this new optional group, it would be okay for a State just to look at the information they had in front of them and determine that the individual meets the requirements for this group and what we're really getting at is, for example, if a State might look at that individual and think, perhaps this person is disabled and perhaps I should do a disability determination. Well, if that disability is not clearly evident, and I mean a verified disability evident on the application, the State would not be obligated to pursue that disability determination before they went ahead and certified the person in this new optional group. Same thing applies if the State looks at that individual and thinks well, this person might qualify under a spend-down. They might be medically needy. The State is not obligated to make that determination before they go ahead and certify the individual under the new optional group.

Now under this optional group, the State cannot limit coverage to certain target populations, so you can't break out particular individuals, particular groups of people, particular age groups, for example. However, the State may elect to phase-in coverage under this optional group, and they can do that phase-in either by population group, and/or by income limits. In order for a State to do that, they do need to submit a phase-in plan that has to be approved here at CMS. And so they would need to submit that along with their SPA electing this eligibility group.

Next, we want to talk a little bit about parents and caretaker relatives. A parent or caretaker relative living with a dependent child is not covered under this group unless the child is enrolled

in Medicaid, and that's the same as for the mandatory group for people under 133%. And I also want to mention that individuals enrolled in this group will not be mandated into benchmark or benchmark-equivalent plans. Again, that's a difference from the mandatory group of people under 133%. That's a change from that group who is required to be in a benchmark plan or a benchmark-equivalent plan.

Sarah deLone: I'd like to add something here, because that sort of raises eyebrows. Like, what do you mean, we have to mandate – there's a mandate to enroll individuals – adults below 133% FPL into benchmark coverage, but above 133%, if a State covers this new optional coverage group for individuals above 133%, you're telling us that we're not permitted to require that they enroll in mandatory benchmark coverage? And that does seem like quite an anomaly, probably to you. It does to us also. I think it's probably an unintended consequence of the interaction of this new mandatory adult group, which Congress said specifically has to get coverage through a benchmark plan, which by the way, is of course, could be a Secretary-approved Medicaid look-alike plan – but anyway, a benchmark plan. And then the pre-existing section 1937, which creates sort of benchmark coverage and the option for States to require enrollment of certain populations in the benchmark benefit and that has certain exemptions from that. And benchmark coverage under 1937 can only be required for eligibility groups that existed at the time that 1937 was passed. So it's just a quirky interaction of the overlay of the ACA and this new 'eight group' – this new 'adult group' – and the new optional 'twenty group' onto pre-existing 1937 section, which I think probably Congress didn't have in mind when they drafted the legislation. So we sort of feel a little bit constrained by the statute, but it's an area that we call out for comments, because it certainly is an anomaly.

Chris Gerhardt: Thank you. I want to move on to talk about the eligibility groups that we've simplified and consolidated in the proposed rule. And this would be the groups pertaining to parents and caretaker relatives, pregnant women, and some of the children's eligibility groups. These consolidations are addressed in the proposed rule at 42 CFR 435.110, 116, and 118.

First, we want to talk about the section 1931 low income families. The statute requires that States cover low income families, including parents and other caretaker relatives, pregnant women, and minor dependent children. This is mandatory coverage that States must continue to cover. The ACA added certain eligibility groups – the two that we just talked about – but it did not take away any of the mandatory or optional eligibility groups. So we continue to cover 1931.

We also have to retain what's in the statute the definitions regarding a dependent child and caretaker relative. I want to note – and this is not a new piece of policy – I want to note that as far as dependency, and that being based on a child being deprived of parental support by virtue of death, absence, unemployment or underemployment of the parent or caretaker relative, States do have the flexibility to define what unemployment means. And States may eliminate the 100-hour rule, which has traditionally been used to determine whether a person is fully employed or not. And if a State decides to eliminate the 100-hour rule, that effectively says that any employed parent or caretaker relative can't be considered unemployed. This effectively eliminates the deprivation factor. And again, I want to say that that is a State option, but if there are States that haven't taken that option up, it's something to consider because it certainly goes a long way in streamlining and simplifying eligibility determinations under 1931.

So under 435.110, the proposed rule would cover parents and other caretaker relatives, and if there is a spouse, the spouse is the caretaker relative. Again, eligibility is based on the MAGI income for that household, which is at or below the State-approved income standard. And again, I'd refer you directly to the NPRM to look at what those standards – the limitations on those standards – and, again, hopefully, we'll be discussing those in more detail in a later call. The State specifies an applicable MAGI standard for this group between the minimum and the maximum standard in the NPRM. And, as for all MAGI determinations, there is no resource test for this group.

In this particular group, the 435.110, the only people in this group are the 1931 parents and caretaker relatives. There have been no additional groups collapsed into this particular group. It does just address the parents and caretaker relatives under 1931, not children, not pregnant

women. And it's important to note that because the transitional medical assistance, the TMA, eligibility also springs from those who are certified in this group, so individuals in this group have the advantage of being eligible for transitional medical assistance if they have new employment or income – increased income – that makes them no longer qualified for this group.

Next we'd like to talk about 435.116 for pregnant women. A pregnant woman is defined in the proposed regulation, and it includes a woman both during pregnancy and post-partum period. Again, we're looking at MAGI-based household income and the income needs to be at or below the income standard approved for this group. The State specifies applicable MAGI standard for pregnant women between the specified minimum and maximum standard. And again, you need to refer directly to the rule to determine what those minimum and maximum standards are.

Under the pregnant women group, the proposed 435.116, we're proposing to consolidate six different groups, under which pregnant women are currently covered. And I have lifted those six different groups in your slides – slides 19 and 20. They are essentially the 1931 pregnant women, qualified pregnant women, the poverty-level-related pregnant women, optional pregnant women, financially eligible for AFDC, optional pregnant women who would be eligible for AFDC if not institutionalized, and the optional poverty-level-related pregnant women. So all of these groups have been consolidated into this one group under the proposed 435.116.

Section 435.116 provides that the benefits for a woman eligible under this group can – there are various options that the State has. It has a fair amount of flexibility for determining the benefits available to these women. A State could provide full coverage for all the mandatory and optional services covered under the Medicaid State Plan to women eligible under this group. They could give them all the benefits currently available to anyone else under the State Plan, or they can limit the full package of Medicaid services just to women whose income does not exceed a specified standard. And that standard is the 1931 standard and the qualified pregnant woman standard. So that standard may vary from state to state. States also have the option to give certain enhanced pregnancy-related services to pregnant women under this group. So under this new group, where we've consolidated these six pregnant women groups, States still retain

the flexibility they have today to provide full benefits, benefits to certain women only for the pregnancy-related services, and also to give enhanced services.

Under 435.118, we're proposing to cover infants and children under age 19 whose MAGI income is at or below the income standard approved for this group. And again, I want to note here that this includes actually three groups – the children under age one, the children aged one to five, and the children aged six to eighteen. These are the mandatory poverty-related children, children from low-income families, the 1931 low income families, and qualified children. So based on age, depending on how your income standards are structured today, it is conceivable that in this single group, children in different age levels could wind up with different income eligibility standards if that's how your State is currently operating today. A State currently is under the constraints of the maintenance of effort provision, so children have to continue to be covered at least at today's levels up through September 30, 2019.

And so in the slides, again – slides 23 and 24 – we actually list out the various groups that are consolidated. Again, it is I think seven groups that are consolidated under this one children's group. And I want to note that effective on January 1, 2014, ACA also increases the income standard for mandatory poverty-related children age 6 through 18, up from 100% to 133% of FPL. This is consistent with the minimum income standard for poverty-related children under age 6 and pregnant women. Each State does need to establish its applicable MAGI standard for each age group of children under age 19, and again, between minimum and maximum standards that are specified in the rule. And again, I'll note that the MOE currently prevents States from making any reduction in any coverage of children – any reduction of the income standards until after September 30, 2019.

Okay, Jerica, if you like, we could open the floor for questions at this point.

Operator: If you'd like to ask a question at this time, please press pound-7-1 on your telephone keypad. We will pause for a moment to allow you time to get in line. Again, that's pound-7-1 on your telephone keypad.

Chris Gerhardt: Hi, what's your question?

Indiana: Hi, this is [INAUDIBLE] from Indiana. I have a few questions here. My first one is around pregnant women. If they came into presumably one of the adult categories and then become pregnant, what are your recommendations in terms of how a State would handle that. I mean, are we supposed to – how are we supposed to account for that. That's my first question.

And then, secondly, maybe a more basic question is that the category for people above 138% of poverty – presumably most of those individuals would be eligible for a tax credit, so is there some overlap and what was envisioned by CMS in terms of how that would work? Would individuals essentially have a choice between Medicaid coverage or tax credit eligibility? And is there a way to have a limited benefits plan to maybe provide some wrap-around coverage for services that wouldn't necessarily be provided through the Exchange?

Chris Gerhardt: Okay, with respect to your first question, which is if a woman is in one of the adult categories, either the mandatory category for people under 133% of FPL or the optional category for people above, and an adult in either of those categories becomes pregnant, and how does the State handle that? I don't know that we particularly considered that transition. I'll pause here for a moment to invite anybody here in the room with me if they have a supplement.

Sarah deLone: This is Sarah deLone talking. I'll give you my thoughts, and know that they are just that, my thoughts, because this is definitely kind of an operational question – how you actually implement the rules. And there are probably issues that you face today when people maybe move from one category to another which is different – the new category would be different in the eligibility hierarchy in terms of what coverage becomes what. As a technical matter, if somebody is, let's say, in the new adult group, and she becomes pregnant, technically, she is statutorily excluded from coverage in this new adult group and she should be moved into the pregnant women's group. As a practical matter, I think that we would say if what she's going to be entitled to and her benefits are not going to change – let's say, to make it simple,

under your pregnant women's group, you cover the exact same thing as is covered under your – you have a Secretary-approved benchmark benefit plan that looks like your State Medicaid benefit, and you don't offer any enhanced pregnancy-related services to pregnant women in the pregnant women's group, so everybody gets the same thing in these two groups, it's not really worth the effort. Nobody is harmed if she's not moved.

If on the other hand, let's say, the coverage is different. Maybe you offer enhanced pregnancy-related services to low income pregnant women in the pregnant women's group, then she would be better off moving. And if you're notified – you have reason to know or understand – she either said "I'm pregnant" or you otherwise have a communication – you get some information that you know she's pregnant. Maybe it's fee-for-service and you have a claim or something that you've reviewed, whatever, then you would sure have an obligation to shift her because she would be – she should get those enhanced pregnancy-related services.

Indiana: The match rate would be different in the adult group for some States that are already covering pregnant women. In the first scenario, if you're saying that the packages are the same, there's no real incentive for her to move, it's okay if she's staying in that adult category. But in terms of the FMAP rate, wouldn't that be different, and wouldn't that be a reason why we would have to know?

Sarah deLone: That's a good point. We could think about – these are great questions, so we're thinking it through, whether it matters or not matters. What we've proposed for the FMAP is to definitely not require States to be making a case-by-case individual-by-individual determination as to whether or not, if they are in this new adult group, they are newly eligible or oldly eligible. Clearly, if you were making a case-by-case determination, this woman would suddenly shift into the oldly eligible category because she would meet the eligibility requirements in effect pre-ACA, which is the dispositive question, not so much whether or not she meets another eligibility group today. But we don't – in our proposal around FMAP, we specifically are looking for methodologies that do not require a case-by-case determination. And so the question then becomes to make sure that this kind of situation is accounted for in the interaction between the

eligibility rules and the placement of individuals in the correct eligibility group and the enhanced matching that is available. It probably depends on how frequent of an occurrence this is. I mean it's a great question to think through. But I would just say that with the FMAP, we're not looking at a case-by-case determination, so I'm not sure what the ultimate outcome will be.

Stephanie Kaminsky: This is Stephanie Kaminsky. I think on FMAP also, there may be some language in the NPRM – I do not have the NPRM in front of me – that addresses this very issue and I think we talk about the fact that if somebody does change midstream, we don't require a State to – we wouldn't require a State to change their status from oldly to newly, or the other way, from newly to oldly. Once they're sort of categorized, I think that we are proposing to allow a State to leave them in that category for the year. But again, it's kind of all tied into which FMAP methodology is used, et cetera, et cetera. But I do have a recollection that that's addressed somewhere in the NPRM.

Sarah deLone: That's an even better answer. I'm so glad you joined us.

Indiana: I mean, that would mean that you're going to have – I mean most presumably a lot of people, or a lot of women are coming to the Medicaid program because they become pregnant, but in this new world, they would already be eligible beforehand. And so, unless there's some incentive for movement, you talk about not having to make a change in midstream, I guess we wouldn't really be accounting for – you wouldn't see as many people in the pregnancy category then.

Sarah deLone: Maybe, to the extent to which there's a significant portion, and maybe there is. That's right. But as long as – I mean our goal is to not – our goal would be to minimize the times where you have to shift somebody's category purely for, sort of, accounting, technical – you know, this is technically where they belong, as opposed to requiring that you move them if it's going to make a difference, either to the beneficiary or as we addressed the FMAP question, if that was an issue because of claiming purposes. There needs to be a reason to –

Indiana: Okay, got it, okay – something valid, like a benefit, a different benefit package or something.

Chris Gerhardt: And then your second question pertained to individuals who might be in the optional group over 133%, and the overlap on the interaction if they could become eligible for premium tax credit.

Sarah deLone: The basic rule is that there's no overlap. So while it's true that – actually, we're a little out of the scope of our reg here, because we're talking about the interaction of our – the Medicaid/CHIP regulation with the Exchange regulation, and actually also the regulation published by the Treasury Department on premium tax credit. But Medicaid eligibility for children and pregnant women in many States will be above – it is today, and will continue to be above 133% of the federal poverty level.

States that adopt this new optional coverage group that Chris talked about earlier for individuals above 133% – even though somebody might – that's their – the income eligibility range for getting a premium tax credit is between 100 and 400% of the federal poverty level, so there's overlap actually between both those who are above and below potentially, but there's a clear hierarchy that's established in the Affordable Care Act that if you are eligible for Medicaid, you are not eligible for premium tax credit. It's actually, if you are eligible for minimum essential coverage, which is defined actually in the Internal Revenue Code. It was a new section of the Internal Revenue Code that was added by – I'm going to forget the section of the ACA – I think it's 1401 –

Stephanie Kaminsky: It's 1501.

Sarah deLone: 1501 – I think that's right – 1501 added a new section. It's 5000(a) – something. And it defines minimum essential coverage and it lists Medicaid, CHIP, Medicare, TRICARE, I think maybe employer-sponsored coverage that meets a certain threshold that's specifically called out. And there are other ones also. And if you are eligible for any of those, you are not

eligible to receive a premium tax credit. You could enroll in the Exchange and pay full freight, if you wanted to, as far as the Exchange is concerned, but you can't get a premium tax credit.

Indiana: But if the State has any program for Medicaid eligibility above 133 or to wherever that overlap is, then the individual would have to enroll in Medicaid, and they would not be able to get a tax credit.

Sarah deLone: That's right. Now the exception is – and actually the rules for that are actually in the IRS Treasury reg that was published on the same date as this Medicaid reg, because it's their reg that defines who is eligible for the premium tax credit and who is not. It's sort of – the exception is in this gray area of individuals who may be eligible for Medicaid on a basis other than modified adjusted gross income, where you don't actually know. Many States cover disabled individuals above 133% of the federal poverty level using their MAGI. So you're using a different financial methodology to determine their eligibility, but the reality is that they are within the – they're not eligible for Medicaid based on MAGI, and there's a question mark as to whether or not they may be eligible on another basis.

The preclusion for – the prohibition for that person getting advanced payments for the premium tax credit to enroll in the Exchange occurs at the point at which actually they have been determined eligible for Medicaid based on MAGI. So if it's a – they *might* meet those eligibility requirements, and you're pretty sure they do, but you're not *actually* sure – they haven't had the disability determination done. They haven't confirmed the asset/resource eligibility under that group. That person is not yet eligible for Medicaid, so they could enroll. And if that person – this is actually not crystal clear I think in the way they wrote the reg, but it's what they told us was their intention when we asked them, and I think it's an area that would be good for people to comment on the IRS reg – it's to be clear that if somebody is undergoing the disability determination process for Medicaid and decides for whatever reason that they don't want to complete that process, they are not going to be penalized and told – well, you can't enroll in the Exchange and get the premium tax credit, as long as they're otherwise eligible. That's maybe a little bit more than you wanted to hear, but –

Indiana: Are you expecting States to – I know there's a maintenance of effort until 2014 for the adult populations – are you expecting States to change their eligibility so that these people would not be Medicaid eligible and then eligible for a tax credit?

Chris Gerhardt: I don't think that we have an interest in, either way, pressing the States to do one or the other. I will say this, one thing that we have talked about as we were preparing for today's session is that – of course, we've known this for quite some time – is that while the statute – there are some statutory required rules that dictate the hierarchy in which eligibility is determined and that dictate how you determine eligibility when there's a change in circumstances like a person becoming disabled, or a person turning 65, or a child aging out of one of the poverty-related groups, that each State now operationally has a set of hierarchy rules that you use, in addition to the specific rules that are in statute. We recognize that we will need to, again, provide some technical assistance to States regarding these hierarchy rules. And, of course, it will be different from State to State depending on the options that States choose. But we do recognize that's one of the tasks ahead of us is to do some more analysis on the relationship of one group to the next and how, as you determine an individual's eligibility, how you travel through the various income levels and the various eligibility tests to determine which group the individual lands in. And we refer to that here, informally, as the hierarchy, and again, we hope we can develop some materials to provide States with technical assistance as we move forward in developing these regulations and future regulations.

Indiana: Thank you.

Sarah deLone: The other question that you had asked was whether States could have sort of wrap-around the Exchange coverage. That's really beyond the scope of our area of sort of expertise and sort of policy development, but just because I hate to sort of leave a question without an answer where I at least had a feeling about it – I know this is an issue that's been raised and discussed in other contexts, I think it's highly unlikely, or let's just say, unlikely, let me not say highly unlikely. Because it's a bright line test in what's considered to be minimum

essential coverage that would preclude somebody from getting a premium tax credit in that section 5000(a) of the Internal Revenue Code that we talked about before. And if you're eligible for Medicaid, you can't get a premium tax credit, sort of, period – not if you're eligible for something that's considered to be a robust benefit package, or something else. So I don't personally see a way you could do that interaction, but it can't hurt – that would actually be really a matter of sort of an adjustment or a clarification. To get that you'd have to be in the IRS reg. So if you even want to throw that out as a suggestion for the possibility of it being accommodated, you should comment on the IRS reg for that. You could add it to our comments also, but we couldn't change their – we couldn't actually make it be so, even if it could statutorily be made so.

Indiana: Okay, thank you.

Operator: Now leaving the floor – Indiana. Now joining the floor – Oregon.

Steve Novak: Hi, this is Steve Novak in Oregon, and if you don't mind, we're going to tag team you a bit. I've got one question, and Dale Miranda has got a question, and then Vonda Daniels has a list of programs that she thinks still exists that haven't been consolidated. We wanted to give you that list and see if they do still exist.

My initial question is why do we still have a parent/caretaker relative category if all the parents/caretaker relatives would be below 133% of FPL? Why aren't they just – you know, they're not part of the one 133 category and we don't need to worry about deprivation and all that stuff anymore?

Chris Gerhardt: Well, for one thing, the category was not eliminated by ACA. It's still there in the statute, so we don't have authority to eliminate it.

Steve Novak: But why would we have to keep track of it? I mean if people are eligible for Medicaid and they're below 133, yeah they exist for purposes of determining FMAP and we do

that through statistical sampling, but do we have to keep on keeping track of what people fall into?

Sarah deLone: I'll tell you why for two reasons, one of which you could, as a State, eliminate yourself and for that reason, you wouldn't have to. And the other one requires Congressional action, so you should take up your views with your Congressional delegation. The two reasons are – one is parents and caretaker relatives eligible under section 1931 are exempt from mandatory enrollment in benchmark benefits and that's in section 1937. So if you have a benchmark benefit package for your new adult group that doesn't look like your Medicaid State benefit package, parents and caretaker relatives eligible under 1931 would be treated differently under your new adult group than they would be if they were being covered as parents/caretaker relatives, because under the 1931 group, under 435.110 in our reg, they would be exempt from mandatory enrollment and benchmark benefit package. You could resolve that at the State level by adopting a benchmark benefit package that looked just like your Medicaid State Plan, so Secretary-approved benchmark benefit package that covered your State Plan services.

The other reason is TMA. Congress did not get rid of TMA, either under 1925, or if that's allowed to sunset, under 1902(e)(1), or the other TMA, which I always forget to give the statutory cites for – they're not on the top of my head – for the TMA that you get if you lose 1931 eligibility because of an increase in spousal or child support, although child support is no longer an issue under MAGI because child support doesn't count as income. But anyway, there are these three TMAs – the big one, 1925, and the little ones that exist. 1925 TMA is scheduled to sunset every year and it gets extended every year, and I think many people feel that it no longer has great utility value and it should be permitted to expire at the end of 2013. But that requires Congress to not extend it again. The other TMA is in 1902(e)(1) and Mary Corddry could probably tell you where the spousal support TMA one is. You have to go back to the old AFDC statute. But that would require Congressional action to actually repeal it. So that would be good, if you think those should go away, you should talk to your Congressional delegations. And we certainly will weigh in at the federal level with sort of legislative possibilities on that end, but it's good to come from all directions. But if that were to happen and we deal with the

FMAP, if you say we're not going to require a case-by-case, and you align the benefits, then you wouldn't have to keep track of it.

Steve Novak: Thank you.

Sarah deLone: You're welcome.

Steve Novak: Okay, our next question is – Are SSI recipients going to be part of what you're calling the 'eight group,' since they're definitely going to be under 133%, they're going to be assumed eligible for Medicaid, so can we just shuffle them through with the 'eight group' in our application process?

Chris Gerhardt: They won't be part of the 'eight group' if they're currently eligible in your State as an SSI recipient, because you can't be in the 'eight group' if you are already eligible under one of the mandatory groups.

Steve Novak: But if somebody applies – if there's a new applicant who happens to be an SSI recipient, can't they be found eligible just because they're under 133?

Chris Gerhardt: I think that's going to depend on whether you're a 1634 State or not.

Roy Trudel: Is this question from Oregon? You're a 209(b) State, so basically, that provision for 209(b) States and people who are SSI recipients but not necessarily eligible in a 209(b) State, is not going to apply to Oregon.

Sarah deLone: So for the most part – we do not envision that States would end the pathway – the eligibility pathway for SSI recipients is the feed you get from SSA that says we've got an SSI recipient, stick them on your role. We wouldn't envision that changing – we wouldn't envision SSI recipients having to submit the single, streamlined application and coming through that door. If you happen to get somebody who's an SSI recipient that somehow you didn't get them on

your feed from SSA; again, if your benefits are all aligned and there's no different treatment of somebody, then we wouldn't see why – fine – but it just doesn't make sense as a practical matter. You're still going to get your SSI recipient from SSA.

Chris Gerhardt: I don't agree.

Roy Trudel: They are a criteria State, I believe. I don't think we –

Steve Novak: Yes, we're a criteria State, Roy, so we make our decisions. We don't get a feed from you. So the question is, for administrative simplicity, if someone comes in, regardless of the source of their income, if they're under 65 and they don't have Medicare, and they just say – yeah, I'm under 133%, does it really matter what the source of their income is? Can't we just put the SSI recipients through like anybody else who has $674 in income?

Roy Trudel: I would draw the distinction between the source of the income and the fact that these people are receiving an SSI benefit which in turn entitles them to Medicaid – that's the screen-out factor. You get to that point before you get to the new adult group.

Sarah deLone: I think actually, we should have a long – it's a very – it's a detailed – and I think that we – you can see we have different perspectives here – and thinking at it at a – to think through all the potential ramifications and in terms of particularly what this individual is eligible for. And again, the one that jumped out at me is the benchmark coverage. If you have a 1915(c) waiver, there may be a synergy there in terms of somebody if they're in the SSI group, maybe they are eligible for C-waiver services. There are all sorts of potential stuff that might attach to being in the SSI mandatory group that covers SSI recipients which does come above in the eligibility hierarchy, above coverage in this new coverage group. So we can't tell you on the phone today that there's no reason that – if at the end of the day, it really doesn't matter, then my inclination would be to say, yeah, okay. But I can't believe that it really doesn't matter.

Roy Trudel: It doesn't really not matter. Okay, if they're SSI recipients, they will not be in the 'eight group.' For example, they will not be in the benchmark plan. They can get the waiver services. So, yeah, it matters. It makes a difference.

Sarah deLone: Exactly. It matters, and it certainly can't – we certainly – so it would be – we could talk on a one-on-one State TA kind of more call to talk about Oregon-specific constellation of programs, these synergies and the interactions, in terms of how it could be implemented in Oregon, but we definitely couldn't across the board say, no this group no longer matters.

Steve Novak: Well, it might matter for Oregon-type States. There's a few of us that do our own determinations. And yeah, we know, Roy, that the C-waiver people, the long term care people, that's not the question. The question is are straight-up SI – our 30,000 straight-up SI clients – who don't have waiver services. And we can't wait too long on this because we're putting together our Internet portal and we have to know what order to ask questions, who gets screened out, when. Who gets dumped in the old Medicaid, if you will, who goes through as assumed eligible, and who do we have to tinker with somewhere down the road? So it is a question we need answered.

Roy Trudel: If you have a potential aged, blind, or disabled person coming in, frankly, I think the first question you should be asking is – Are you receiving SSI?

Sarah deLone: Let me – see, let me just – we're not going to get to a definitive answer today. I think we should move to the next question. Let me follow up with you after – I probably won't reach you today, but you call me, or I'll call you tomorrow and we'll touch base and talk a little bit more and figure out a way that we can provide you with the assistance that you need going forward.

Steve Novak: And Sarah, we also wanted to just – Vonda is going to rattle off the list of programs that she thinks still exists, just for you to say yes or no.

Chris Gerhardt: Before we go on to that question, let me just say that this discussion about the SSI individual is, again, part of that larger hierarchy discussion that we said we still are developing some technical assistance tools for States to use, because it is going to vary from State to State based on the difference choices that are available to States in their State Plans. So I think that we will be able to provide technical assistance, not only on that SSI question, but as I said, that's one of many that comes up when you consider the hierarchy of the various eligibility groups and how that falls out in different States based on the options that they took. Okay, your next question.

Vonda Daniels: I just want to clarify that other than the changes made in the NPRM, we still have all the mandatory populations that we have always had. For example, do we still have to cover children – newborns – born to Medicaid eligible mothers for a year?

Sarah deLone: Yes.

Vonda Daniels: Thank you.

Sarah deLone: Let me say we are working on guidance that's going to further – that we think that there are a number of eligibility groups that sort of no longer – regulatory sections that implement sections that now are either defunct or that have been subsumed and we're developing clean-up guidance, if you will, on that. But eligibility groups that are not identified in the NPRM as being subsumed in these groups that continue to be – that also aren't sort of – haven't expired, if you will, like qualified families to give an obvious example – it's a defunct eligibility group – we can get rid of that one. So deemed newborns, mandatory coverage for foster care children, optional coverage for IV-E foster care kids, optional coverage for State adoption assistance children if your State covers those. Those groups continue to exist. And we are working on guidance to specifically identify the other eligibility groups for families and, in particular, children, that persist. They exist today and will continue to exist. We're looking at the guidance regulations for those.

Steve Novak: Thank you.

Operator: Now leaving the floor – Oregon.

Sarah deLone: Jerica, do we have more questions?

Operator: Sarah, there are participants on the floor to ask a question.

Chris Gerhardt: Do we have other questions queued up?

Operator: Yes, there are participants on the floor to ask a question at this time.

Chris Gerhardt: If there are no more questions right now, then we'll go on to the second part of our presentation. Sarah?

Sarah deLone: One of the other things you got was the handout, and I'm looking for my own copy. Here it is. It is entitled "Individuals living with disabilities in the world of MAGI." And what we thought we would do is – there's been a lot questions about how does this – and there's some confusion about how does the interaction of MAGI work for individuals whose eligibility will be based on factors other than their modified adjusted gross income – so a disabled individual, for example. So I thought what we did was sent out both a scenario that's got sort of a couple of different components of it that I hope will illustrate for you how this interaction works. We also sent out the questions that directly asked about this question, which I hope for the most part, are actually answered by going through the scenario. And then I also wanted to just identify and share just a few higher level thoughts about some potential issues, problems, complications, for making sure that individuals with disabilities are no worse off in 2014 than they are today that I invite everybody to think about and comment on, minimally to flag in your comments that you think this is a problem, and to the extent to which you dig in and think of ways that we might want to modify our proposed reg in the final rule, to give us those recommendations.

So first, let's just look at the scenario. And I did a couple of different variations on it, but let's look at scenario 1(a). So we have Bob, age 40, who gets Social Security disability and he is on Medicare. He's working and he has a wife, Mary, who does not work, and he has a child, Jane, age 10, who doesn't have any earned income, although both Bob and – Bob receives the Social Security disability benefits and Jane also receives Social Security benefits under Title II because of her father's disability. Bob and Mary, husband and wife, file a joint tax return. Their joint modified adjusted gross income is $27,500. And in this hypothetical State, the State covers adults under the new adult group up to 133% FPL, which is the required level, and of course, that will be for all States. The State covers children up to 200% FPL. And the coverage level for parents and caretaker relatives in this hypothetical State is 100% of the federal poverty level, and again, that would be based on MAGI.

So if we're going to look at evaluating the eligibility of everybody in this household for Medicaid, the first step is to evaluate their eligibility based on modified adjusted gross income. Nobody in this household is 65 or older, so there's no sort of across the board bar against their being eligible based on MAGI. It's possible for everybody in this household, even though Bob is disabled, and even though they have these different kinds of income stream, it's possible that they all might be eligible based on MAGI.

So first, let's look at the MAGI household composition, and income of each member of the household. So this is a little bit of an overlap with the call that we had last week, and I'm guessing and hoping that many of you were on that call. So Bob and Mary are both taxpayers. They file a joint tax return. They are both considered to be taxpayers under our proposed rule, and so their household is themselves and Jane, whom they claim as a tax dependent – their daughter. Jane's household – she's being claimed as a tax dependent so her household is the same as her parents. So Bob, Mary and Jane are in the household. Their household income is – I'm sorry, I think I'm looking at an old copy of my scenario. That's why it's not – thank you. Oh, I apologize because you all got one, too. I didn't – I'm not sure what happened here. We have a little bit of a mistake. I've got blanks in it, when you should've gotten an actual amount,

but that's okay. The amount to fill in the blank is $27,500. Everybody is using – we're all confused here. Here we go – okay, you all do have the right one.

So their household income based on MAGI is $27,500, which is 120% of the federal poverty level for a household size of three. So now we're going to evaluate the eligibility of each individual based on MAGI. Mary – she's just an adult under 65 – no exclusions from the new adult group apply to her. The income is below 133% of the federal poverty level. She's eligible under the new adult group. Jane, similarly, she's eligible for Medicaid as a child.

But Bob is eligible for Medicare, so he's excluded from the new Medicaid group for adults under 65. His income based on MAGI is above the level for parents and caretaker relatives, and therefore, he is not eligible as a parent or caretaker relative. Side note – this is another reason we need the parent/caretaker relative group that didn't sort of pop into my head when answering the first question, which is that you do have parents and caretaker relatives who are excluded from the new coverage group for adults because they are receiving Medicare, but if they're low income enough to be eligible as a parent or caretaker relative, they have that eligibility package available to them. So their income, though, is 120%. He's not eligible as a parent or caretaker relative. There's no other possible eligibility group for him based on MAGI, so he's not eligible for Medicaid based on MAGI.

So then we would go to step two and we would look at evaluating eligibility for Bob on other bases. So Bob should be – he's a Medicare recipient, so he should be evaluated for eligibility for MSP, Medicare Savings Program coverage as a QMB, SLMB, QI, et cetera, or QDWI, as well as eligibility under any optional groups that the State may cover for disabled individuals – perhaps your Medicaid buy-in groups. In evaluating his eligibility for those groups, current methodologies based on, which sort of start with the SSI methodologies for the most part, would be used. So the exclusion for his SSDI income as a matter of determining his or his other family members' eligibility for Medicaid based on MAGI – that sort of – set that aside. Now you treat SSDI income however it's treated today under SSI methodologies. I'm not an expert on SSI methodologies. I'm not going to try and walk us through Bob's potential eligibility based on

that, but you basically sort of set aside the fact that you just looked at all these individuals' eligibility based on MAGI and now you're looking at Bob. Now we're going to use current methodologies and whatever allocation and disregards and income counting rules apply today – those would continue to apply in 2014 in evaluating Bob's eligibility for Medicaid on a basis other than MAGI.

So let me actually just – I want to – let me go through – I'll go through all this – let me go through the next scenario, and then I'll pause and see if people have any questions. Because I think the first two really illustrate the most fundamental stuff.

So scenario 1(b) is just a variation on 1(a). And this time, everything's the same except that Bob is in his 24-month waiting period and is not yet eligible for Medicare. So in this case, you're going to have the same MAGI household for everybody. Looking at Mary and Jane, they're still eligible for Medicaid under the new adult group and under the children's group, respectively.

Bob, this time, is not yet on Medicare. He's eligible for the new coverage group for adults, so he is eligible for Medicaid during that 24-month waiting period. So let me pause there and just – we are going to have an opportunity to talk about it – hear from you if you have any questions or comments on what happens to the disabled individuals who end up in the 'eight group' or the new adult group. But if you can hold onto those questions and those comments right now and just – if you have any questions about how does this interaction work for when you've got somebody in the household when their own eligibility is or potentially could be determined on a basis other than MAGI – how do the MAGI rules work? So Jerica, if we could open up the phones to see if people have any questions about that, that would be great.

Operator: If you would like to get in line to ask a question at this time, please press pound-7-1 on your telephone keypad. We will pause for a moment to give you a moment to get in line. Once again, press pound-7-1 on your telephone keypad.

Operator: Now joining the floor, Barbara Otto.

Sarah deLone: Hey, Barbara.

Barbara Otto: Hey, how are you?

Sarah deLone: I'm good. How are you?

Barbara Otto: Good. I have a question, and my question is what would happen if they were living in a 209(b) State for scenario 1(b)?

Sarah deLone: I don't think any difference. Why are you thinking there might be a difference?

Barbara Otto: Well, I kind of heard earlier that if they were in a 209(b) State, they would go – well, he would go into an adult group – you're right, I'm sorry. What if – can we go back to that 209(b) question that we had earlier? Because I think that's something that folks are very confused about.

Sarah deLone: What's the question? I'm not sure what the issue – is it whether SSI recipients in a 209(b) State can be eligible?

Barbara Otto: Yes, sorry.

Sarah deLone: Okay, it's a different question, but let me answer it. So let me state the question you're asking, and you can tell me if I've got the right question. The question is – Are SSI recipients who are not eligible in a 209(b) State today, because they do not meet the more restrictive criteria applied by the 209(b) State – are they eligible for coverage in the new adult group? Is that the question?

Barbara Otto: Yes.

Sarah deLone: The answer to that question is yes. And the answer to that question for any 209(b) States on the line, the answer to the question – Is enhanced match available for those individuals? The answer to that question is also yes, because they are not eligible today. So they will be in the new SSI recipients who are not eligible today in a 209(b) State, but will be eligible in the new coverage group for adults. An enhanced match is available for those individuals. They're considered newly eligible.

Barbara Otto: So, similar to the question of Bob being put into the adult group because he is in his 24-month waiting period, what happens if the benchmark plan doesn't have all the services and supports that he needs?

Sarah deLone: I specifically asked you to hold your questions for that after – [laughter].

Barbara Otto: Okay [laughter].

Sarah deLone: We'll get there – we'll get there [laughter]. So hold that question. Queue up again when we get to it. I just want to see if anybody else has questions on the – sort of how – under the – what I'm trying to explain now is just how it works under the proposed rule, and then we can look at what are some of the potential pitfalls for disabled individuals, so that you all can give us comments on (a) just you're concerned about this pitfall; and ideally, (b) here's what we think you should do about it. But let's hold that. Can you sign off and then we'll see if anybody else has any questions about how the interaction of the actual eligibility rules and sort of the hierarchy, if you will, and the interaction between MAGI and non-MAGI methodologies in these kind of mixed households – how that works.

Operator: Now leaving the floor – Barbara Otto. Now joining the floor – North Carolina.

North Carolina: This is North Carolina. I was going to just defer our question for later, because it's not appropriate for this part of the conversation.

Sarah deLone: Okay. Jerica, do you want to let people know how to de-queue themselves in case they want to get out of the queue if they have a question that's really appropriate for later?

Operator: If you would like to remove yourself from the queue, please dial pound-7-2 on your telephone keypad.

Sarah deLone: Thank you. Jerica, do we have anybody else lined up for a question?

Operator: Now leaving the floor – North Carolina. Now joining the floor – California.

Sarah deLone: Hi, California.

California: Hi. We're wondering about the part about not looking beyond what's on the application and how that applies to somebody who's enrolling in the Exchange for the premium tax credit. He's undergoing a disability evaluation in the scenario, and we're just wondering how that meshes and what about the medically needy program in terms of being minimum essential coverage? And how would the medically needy program fit in here?

Sarah deLone: Okay, so let me do separate questions I think here, although related. The first one – how does, sort of not needing to evaluate – only based on the information on the application question. So I think we could look at, just sort of think about separately what Chris was talking about before was what is the State's responsibility in evaluating eligibility for other, predominantly really other optional eligibility groups is really what it's going to come down to – before determining somebody's eligible for Medicaid under the new optional group for individuals over 133% of the federal poverty level. And so what that rule is about – you've already gone – you've figured out that somebody's not eligible for mandatory coverage – they're not an SSI recipient, they're income is above, if they're an adult, it's above 133% of the federal poverty level, and the State has adopted this optional group. Let's say the State has adopted the coverage group up to 150% of the federal poverty level, and here you've got somebody whose income based on MAGI is 140%. Can the State put them in that group, or do they have to turn

over every stone, and see whether there is another optional eligibility group, for example, based on disability? We have to make sure they're not eligible for that other group before we put them in this group. And if you read the statutory language creating this new optional eligibility group, you could come to that conclusion. You have to do due diligence and you have to figure out if this person is disabled and could go into this disabled group, and we're saying – No. If you have enough information on the application to determine somebody eligible under another optional eligibility group, that's what you have to do. Because that's sort of as far as we could go with the statutory language we have. But if you can't tell based on the information on the application, you don't have to do that. So that's sort of – that's what Chris was talking about.

You're also raising – I just think you have to think about it and analyze it separately, which I think it can – because I think you're talking about a different process and a different concern. At the point of application – and we're in the process now of trying to figure out what should the simplified application look like. What questions do we need to ask in order to adjudicate somebody eligible for Medicaid or eligibility for premium tax credits?

So there are some basic questions, obviously, that we're going to ask – name, age, birth date, or something – you're going to need to know, because eligibility levels differ by age. You need to know what State that somebody's a resident of – some obvious things. And we're going to be able to figure out – you're going to need information about their income. And it's actually pretty involved and we're far from knowing exactly what those income questions are, but anyway, you're going to need to have enough information to figure out what somebody's income based on MAGI is to figure out whether they're in a MAGI eligibility category or not. If they're not – let's say you've got an adult who's over 133% of the federal poverty level, we also need to be able to identify as best we can and have a screening question or two to flag – hey, this is somebody who might be eligible for Medicaid on another basis. Here we've got a working disabled person – maybe they've – an easier case might be they actually have an adjudication of disability already. They have a formal disability determination, and maybe because they get SSDI, which you could get through a match or something. But we also need to have questions on the application that might flag for the Exchange or for the Medicaid agency – here's

somebody who might be eligible for Medicaid based on disability, and then you want to allow that person to go through that. You don't want to flat-out deny them for Medicaid based on modified adjusted gross income, because they have another avenue of eligibility that's potentially available to them.

So that's sort of an application design question, and then a process question – what are you going to do with that information and how do you follow through and make sure that somebody's been fully evaluated for all potential Medicaid eligibility categories even though their income based on MAGI is too high for that simple coverage category. So that could take some time, and so we have also in the proposed rule, and this is in the Exchange rule, and the Treasury rule – this is an area where the three rules coordinate – while that longer process is happening, we allow – somebody is allowed to enroll in the Exchange and get advance payment for the premium tax credit while that longer, more elaborate, involved Medicaid eligibility determination, for example, based on disability is happening.

Does that help, or have I really muddied the waters?

California: Well, let's say that you know he's disabled, so you're not looking at having to complete a disability evaluation, but the State has a medically needy program with the income spend-down. Where does he go? Does he go to the Exchange or does he go to the MN? Is the MN program considered minimum essential coverage?

Sarah deLone: He would only – actually, that's probably the one area where there's going to be an element of individual choice. If the person thinks they'll be better off spending down – you know the medically needy program doesn't go away – so if somebody thinks they're better off spending down to medically needy eligibility, they can do that. If they don't want to do that, they don't – they haven't – until you've met your spend-down, you're not eligible for Medicaid, so that person can go into the Exchange. Forget about spend-down. They don't have to spend-down and be eligible for medically needy. So even though they have the potential to be eligible for Medicaid as a medically needy individual, the rules don't require that they do so.

California: Okay, great. Thanks.

Operator: Now leaving the floor – California. Now joining the floor – [INAUDIBLE] in Honolulu, Hawaii.

Sarah deLone: Hi, go ahead.

Hawaii: Hi, I just want to confirm that I think a lot of the issues for us is going to really depend upon exactly what you said – what is our model application going to say – and what is it going to have to be able to provide us with some guidance – some direction of where we go? But in your scenario 1(b), I just want to confirm this – in that case, Bob is not receiving Medicare, so we're going to give him – he's going to be eligible under the 'eight group.' As a State, though, once he begins to receive Medicare, I have to take him out of the 'eight group'?

Sarah deLone: Yes. So another area of sort of making sure that the system is seamless and smooth for beneficiaries is – this is not a new issue, but certainly the magnitude of the number of people whose Medicaid status changes, if you will, because they get out of their Medicare wait period. You'll know when it's coming up. This is going to be a known sort of population and a known end date. And yes, they would need to be transitioned out of Medicaid as they enroll in Medicare. So there will be some transition issues that will be important to work out. And then they also would need to be evaluated – just to make sure that they're not eligible under some other Medicaid group, particularly for QMB, SLMB, QI or QDWI Medicare Savings Program assistance. Because they may well, likely would be eligible for that.

Hawaii: Hawaii is also a 209(b) State, so I understand and it makes sense to me what you just responded in terms of transition. Because we are a 209(b) State, we are going to be very interested in getting – how we determine that with the SSI population as well, because there may be somebody who is not SSI today and three months from now they go ahead and they apply and they get SSI and the State may not have that automatic feed.

Sarah deLone: Yeah, that's a good point. Okay, I don't have a nice, neat answer for you, but that's an excellent issue to work through with us as we operationalize these programs.

Hawaii: Understand. We'd just like to be included. Thank you.

Sarah deLone: Yep, absolutely. Thank you for raising it.

Are there any – I'm not sure if Hawaii, if you hung up yet, because I haven't heard you exiting the conference. And I think nobody else can come in –

Operator: Now leaving the floor – Hawaii. There are zero participants in line to ask a question at this time.

Sarah deLone: No more questions? Okay, so let's just quickly look at 1(c) and 1(d) and then let's shift into some of the concerns and issues that people have with what happens to individuals with disabilities.

So, in scenario 1(c), this time we're the same as 1(b). So Bob is in a 24-month waiting period, but this time, the family's income is higher. They're at 150% of the federal poverty level for a family of three. So in this case, we're assuming we don't have any reason to believe that Mary is – and she's not asking to be determined based on disability or anything like that – so let's just assume for simplicity sake that we don't have that complication. So in this case, Mary – the family's income is above – the household income for Mary is above 133% based on MAGI, so she's not eligible for Medicaid. She needs to go to the Exchange, and she should be eligible for advance payment for the premium tax credit. 150% of the federal poverty level is still under the income standard for children, so Jane – the child – goes into Medicaid. Bob, this time, he's in a 24-month waiting period, but he's got too much income to be under the new adult group based on MAGI, so he's not eligible for Medicaid based on MAGI. And as in scenario 1(b), I'm sorry, not scenario 1(a), but as in scenario 1(b), he should be evaluated for eligibility based on

disability for Medicaid. And he also – at the same time – this is the issue we mentioned before – he should also be evaluated and should be eligible, as is Mary, for enrollment through the Exchange, pending a final determination of Medicaid eligibility based on disability.

And then scenario 1(d) is not sort of anything really to walk through, but it's just to call out as we move into the next portion of the discussion. You sort of get an extra overlay of concerns and issues for how individuals with disabilities are treated and what maybe we need to think about – revisions from our proposed to the final reg if we're dealing with a disabled individual, Bob, who needs long term care services and supports.

So what I wanted to do – we could have – I mean probably hours-long conversations about the concerns that have been raised in a variety of contexts at our eligibility conference and other calls and conversations with States and advocates and other stakeholders about how disabled individuals will fair in the world of MAGI in 2014. I do – a couple of things – I want to just sort of give some reflections and thoughts that we have had at our staff level conversations here, and ways for people to think about it.

There's a lot of different intersecting issues, and there's also intersecting regs that are at issue actually here. The most common question and concern and the first one that's raised is – What about disabled individuals who are put into this new adult group and are going to be – and the benchmark benefit plan doesn't meet their needs – what happens to them? The question of whether or not an individual who is disabled and who's in this new adult group – whether or not the benchmark exemptions that are in 1937 would apply – was not dealt with in this eligibility regulation. It will be addressed in a subsequent regulation. So it's hard – because that issue isn't – we've got two different reg vehicles that are at issue – one of which hasn't been published. You sort of have a little bit of an unknown quantity and a different vehicle in which comments will be required and needed. That said, I will sort of – I've said before, and I'll say again, where that issue is most likely to come down, because of the statutory constraints that we're working with, and that people should feel welcome to comment on that issue if they need to in submitting comments on this eligibility regulation, because it is very hard to separate the issue. But just

know that you will also need to submit those comments on the other regulation when it comes out. And that's that very issue about the application of the exemption.

The concerns that – so there's that issue – so there's the concern that individuals with disabilities won't be able to get the services that they need if they're required to enroll in benchmark coverage. We've pointed out before that States have the flexibility that they do today under the benchmark regulations, and they will continue to have that flexibility in 2014 to design their benchmark benefit packages to look exactly like their State Plan services. So there is State Plan flexibility to address this issue, but not – unless the exemptions are applied, it's not a mandate.

In thinking about this, also I would challenge you all who have a knee-jerk reaction that exemption from benchmark benefits is necessarily better to provide the State Plan benefits than to sort of have the benchmark requirement. The reason – the other side of that point it seems to me – is that benchmark – there's actually a lot more flexibility in benchmark coverage than there is under State Plan coverage, which because of the comparability requirements for benefits provided under the State Plan.

So that the way that most States have used benchmark coverage today, has been to provide extra benefits. So States have a good bit of flexibility to if they want to provide additional services or craft a benchmark benefit package that's more tailored to a disabled population that is covered in this new adult group. They would have that flexibility under benchmark benefits that they don't have under the State Plan. You can't slice and dice populations that way. And I have – in other conversations have had some people say to me, frankly, in my State, I think disabled individuals may be better off in a benchmark plan than under the State Plan benefits, because in their opinion – I'm not making any value judgments myself – but in their opinion, the State Plan benefits are not actually that rich. So I think there's a lot of different factors to think about when you're weighing the balance about what is the best outcome here. The other thing to note – I'm not even sure what order to sort of note these things in – so I'll just sort of say them as they occur – the other thing to note – never mind, I'm sorry, I going to change course.

So I think that sort of disabled individuals, generally, and sort of how they're treated with benchmark and not benchmark is one issue. I think, although, it's very similar, I think you get another sort of overlay of complexity when you think about disabled individuals who meet an institutional level of care and need long term care services. I think there's an extra layer of complication there, because they are not – today, institutional services, certainly nursing facility services are a mandatory benefit under the State Plan, but not home and community-based services. Those are done only through a waiver program, and so there's sort of an extra complication with existing rules and sort of eligibility pathways, if you will.

It is also the case, as with disabled individuals, generally, that States will have the flexibility to cover long term care services under a benchmark benefit plan, which sounds like a great solution until, as any number of States have pointed out – yes, but there's no asset test for this new adult group, and also right now, for home and community-based waiver services – the C waivers – States can impose waiting lists and cap enrollment. So that there is a fiscal concern about just opening up the long term care services to be available to anybody in the adult group who meets the institutional level of care, because there are contained breaks, if you will, on State expenditures. Less of a concern probably for States while there's a 100% federal match for newly eligible, although – but still a concern, and then becomes an increasing concern as the federal match, while still generous, isn't 100% in future years, as it phases down to 90%. So it's a little bit of a different population to think about, and at least when I wrestle with these issues, I feel like I come out differently, in terms of what the potential solution is, and what the best way to address the problem may be in our regulations, depending on whether I'm thinking about people who need long term care services or not.

So the other – from a sort of statutory perspective – the reason to think about it potentially differently is that they are – the exemption from MAGI for the disabled, and the exemption from MAGI for long term care services are two separate exemptions in the statute, so they have a little bit different wording, so they don't necessarily have to travel together. Right now in the regulations, the way we have it proposed, they're both interpreted to mean that you're exempt from MAGI if your eligibility for Medicaid is based on, in the one case, disability; or in the other

case, your need for long term care services. It's that interpretation that requires that people go first into the adult group before looking at whether they're eligible under what is today an optional group for disabled individuals or an optional coverage group for individuals needing an institutional level of care.

So when you're thinking about what are the potential solutions here, you can be thinking about – well, is there a way to get around the eligibility hierarchy? I'll tell you, that's a long-standing sort of rule, and it's pretty black and white in the statute, but I would certainly invite people to comment on that and sort of think about that, and offer thoughts about that in their comments as a potential solution.

There's also how have we interpreted the exemptions from MAGI in our proposed rule. And are there changes to those interpretations that might help to protect the individuals that are – that we're concerned about their ability to access the benefits they need without – through the State option – without exposing States to a fiscal burden that they're not going to be able to bear, which would be the solution of simply covering long term care services under the new adult group for everybody who needs them. Are there ways when you think about it, that you think might be possible?

And I'm just throwing out an idea here. I'm not suggesting that this is necessarily a solution that will work, but are there ways to sort of limit the provision of long term care services only to a portion of adults in the 'eight' – in the new coverage group? My gut is – No. But I throw it out there, because I really think we need to as much as we can take away the sort of lines that we've drawn, and think as creatively as we can. And I encourage you to think as creatively as you can, so that you can give us whatever ideas that you may have that might help us to figure out what the best solution is. There's not going to be a perfect solution to these problems. I mean, this is the way the statute was designed and individuals with disabilities, individuals needing long term care services were really fundamentally not addressed in the Affordable Care Act. And so we're struggling as best we can to make the system work the best that we possibly can – protecting people, what people are eligible for today, and keeping the seamlessness and the smoothness,

and the coordination between both Medicaid and the Exchange, as well as within Medicaid between those eligible based on MAGI and those who are MAGI exempt.

So, I'm going to end there. I'm going to ask Roy if he has any other thoughts that he wants to add to this mix.

Roy Trudel: I don't think so. I think you've covered just about everything here.

Sarah deLone: So with that, I want to just open it up now for questions, or perhaps, more likely, comments, thoughts, any of the above. Jerica, can you open up for questions again?

Operator: If you'd like to get in line to ask a question, please press pound-7-1 on your telephone keypad. Once again, if you would like to get in line to ask a question, press pound-7-1 on your telephone keypad.

Operator: Now joining the floor – California.

Sarah deLone: Hi, go ahead.

California: Hello, again. We were wondering about the – why are the ramifications about – why incapacity is missing from deprivation? From 1931(b)?

Sarah deLone: If parental support is deprived because of incapacity?

California: Yes.

Chris Gerhardt: We may have just left it off.

Sarah deLone: We're pausing as Mary is taking a look at – to make sure we're responding directly to what's in the proposed rule.

California: Well, we have another question about that, too.

Sarah deLone: It was left out inadvertently, so comment on it. We'll put it back in if we need it. Thank you.

California: We have another question about deprivation. We have – our definition of deprivation in our State Plan contains the hundred hours, but it also contains an alternate methodology with a hundred percent of the FPL. And I noticed that we are allowed to increase the hours but it made no other provision, so if we decided we didn't want to just stick with the hundred hours, is our only option to just remove that deprivation standard altogether?

Chris Gerhardt: I'm not sure what you're saying you want to do.

Sarah deLone: What's the 100% FPL have to do with the deprivation requirement? Is that the use of a disregard to bring your income standard up?

California: No, it doesn't have anything to do with the income standard. It has to do with our definition of deprivation. We have an either/or deprivation – either you work less than a hundred hours; or you and your spouse's combined earned income minus all disregards is less than a hundred percent of the federal poverty level.

Sarah deLone: I think our intention was not to take away any State flexibility that exists today, so you should please include that in your formal comment so that we can address it.

California: Okay.

Sarah deLone: Thanks.

Operator: Now leaving the floor – California. Now joining the floor – District of Columbia.

Sarah deLone: Hi, go ahead. What's your question?

District of Columbia: If an applicant indicates on their application that they're disabled, what is the criteria that States should use to determine if the person's eligibility should be determined based on their disability or if their eligibility should be based on the new adult group? And qualifying that, should States decide or can the applicant say – okay, I understand that these are two tracks that I could possibly use, and I would like to use the adult group, even though we know that they've indicated on their application that they're disabled or that they have a disability?

Sarah deLone: Under the proposed rule – okay, let's set aside people who are actually SSI recipients, and that's the question that Oregon raised earlier – and that our – certainly as a general rule, maybe not as the exclusive rule, but as a general rule, those individuals need to go into the mandatory coverage group for SSI recipients. And if there are exceptions to that, we would work that out on a State-by-State basis, and it would be because as a practical matter, there's no reason to do so. I think we're skeptical that that's the case, but anyway, we're very happy to have those conversations and certainly willing to be wrong on that. So let's set aside SSI recipients who are disabled, and assume for present purposes that they are going to be put in the mandatory coverage group that covers SSI recipients, which is 1902(a)(10)(A)(i)(II).

So at that point, you've got somebody who's disabled, who says – I'm disabled – and you're really looking at whether they're going to be eligible under the new coverage group for adults, which is a mandatory group, or eligible under an optional group for disabled. They don't have a choice there under our rule. They have to go into the new mandatory coverage group for adults. That's sort of the eligibility hierarchy.

District of Columbia: Okay, I see. So let's say at renewal, a person is under the optional group, and their Medicaid eligibility is based on a disability. At that renewal period, could they then switch or how would that process occur?

Sarah deLone: Well, if they're eligible under the new group for adults at renewal, and their circumstances haven't changed, they would just stay there.

Roy Trudel: No, we're talking about people who are eligible under an optional group currently.

District of Columbia: Exactly.

Sarah deLone: Oh, currently. Oh, yes, they're going to need to – under the rule – they're going to need to shift into the new adult group. Let me say, this goes to the question of one of the things that people should think about. We have interpreted – and I think it's the most straight-forward reading of the statute – but we have interpreted the exemption for disabled individuals – it sort of parrots the statutory language. It's an exemption-based if an individual's eligibility is based on disability.

Any number of people have said, well we don't think that's what Congress intended and why don't you just exempt all disabled individuals – somebody who's disabled by some criteria. We could say it's disabled because they've had a formal disability determination or something – that they should be exempt from MAGI. People should think about that and should submit us comments if that's the way they think it should go. I think that might solve the problem that is of concern to people about individuals who are eligible today under an optional group for disabled individuals who get the State Plan benefits. But you will have individuals who are not eligible today under an optional eligibility group for disabled individuals, maybe because their resources are too high, maybe because their income is too high – who will be eligible under the new adult group as long as they're not exempt from MAGI methods simply because they are disabled. So there's a trade-off there. But I just want to emphasize that what I explained is the way it is under our proposed rule, and it is certainly fair game for people to take issue with how we have interpreted the exemption for disabled individuals. And you should – if you feel strongly about it or you think an alternative interpretation is better – you should submit comments, formal written comments to us.

District of Columbia: And just one last comment/question. So there is a potential that the individual who is now covered under the optional group could potentially lose some type of coverage?

Sarah deLone: Well, the concern that people have is that people who are in the optional coverage group for the disabled who now are exempt from mandatory enrollment in benchmark benefits will be required to enroll in benchmark benefits if they're transferred to the new adult group. And let's say the State does not align the – does not adopt the benchmark benefit package that has – that looks exactly like the Medicaid State Plan benefit package. So that's the concern that's been raised.

District of Columbia: Okay, I see. And I know that you may not know the answer to this, or can reveal it to all of us, but do you know when guidance will be issued regarding the essential health plan?

Sarah deLone: My crystal ball – I lost it a couple of years ago, unfortunately. I don't know. I know that it's not within our division or even our group. I know that people are working fast and furious and the goal is to get it out as soon as possible, but I would be foolish to say I had a clear sense. But it's a high priority. We know that States really want to know the answer to that question, so it's a high priority for the Agency to get that proposed rule out.

District of Columbia: Okay, great. Thank you.

Operator: Now leaving the floor – District of Columbia. Now joining the floor – Medicaid.

Alabama: Hi, this is Gretel Felton with the Alabama Medicaid and I have a [AUDIO GAP].

RECORDING ENDS HERE.