CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Sarah deLone
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2:00 p.m. ET

Operator: Good afternoon my name is Alicia and I will be your conference operator today. At this time, I would like to welcome everyone to the NPRM audio conference call. All lines have been placed on mute to prevent any background noise.

After the speaker's remarks, there will be a question-and-answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key.

Thank you, Ms. Sarah deLone, you may begin your conference.

Sarah deLone: Hi, good afternoon or good morning, depending on what coast time zone you're in. Everybody – this is Sarah deLone with CMS and welcome to our – what I'm sure will not be our final audio conference on the implementation of the ACA but it's certainly our final audio conference before the close – on the NPRM – before the close of the comment period coming up on Monday, October 31st.

So, just as a reminder, in case it's not first and foremost on anybody's mind, please, we're looking forward to your comments and that deadline is COB, I don't know how they define COB actually, but Monday, October 31st, don't wait until the very last minute because I think if there's a rush on the electronic submission, you can run into a problem. So, don't count on doing it at 11:59 midnight or 4:59 if that's the actual latest hour.

I'm joined also by a number of colleagues here at CMS, I'm not going to go through everybody in the interest of time, so the other people who will be

participating and giving answers to the questions with me here are Chris Gerhardt and Stephanie Kaminsky.

We'll also be joined by Anna Wolke from CCIO who will help, because a number of these questions actually span the regulation issued by CMS Medicaid and CMS CCIO so we're fortunate to have Anna joining us to help address the calls that really – the questions that really deal with the Exchanges.

I also wanted to sort of let you know a little bit about the process of what questions got selected for answering. We received many questions – I don't know how many – lots of questions through our NPRM mailbox that was set up and those questions have been enormously helpful to us.

We have done our best to answer the questions that have been submitted throughout the calls that we've done, some head-on during the question and answer call that we held on MAGI a couple of weeks ago and some just sort of throughout the presentation on the other subject areas.

What we did was take the remaining questions that we felt hadn't been addressed. And there were too many of them to answer we think in a two-hour call, and we regret that we're not able to actually – we just simply don't have the people power. I'm sure many of you can appreciate, to actually get out, written answers on each and every one.

So, we asked – and don't have time on this call to go through them all – so, we asked our E-TAG, our Eligibility Technical Advisor Group which is a group of State representatives who sort of collectively represent all of the eligibility operations of the State Medicaid programs, to prioritize the questions for us. So, we used that representative body to go through the remaining questions and let us know which they felt were the most important for us to address.

And those were the questions that we sent out. They did a Tier 1 and Tier II. So, the Tier 1 are the ones at the beginning of the list and the Tier II are at the end. And we will do our best to get through them all. But wanted to let you all know that those were the questions that have been selected.

So, if you submitted a question that you don't feel was answered on one of the previous calls and is not answered today, it doesn't mean that we didn't receive it, it doesn't mean that it wasn't important for us to receive, but we simply aren't able to give an answer to it today and you should absolutely raise the question in your comments with whatever thoughts you have to accompany the question that can help us inform our final rulemaking process.

So, with those just preliminary introductory remarks, let's dive into the questions. You should all have them. Barbara Washington here at CMS sent out, either late yesterday or early this morning, a copy of the questions that we would be addressing. So, we will jump into them.

And actually I think questions one, four, and ten hit a sort of some similar kind of theme. And Stephanie Kaminsky is going to field them. I don't know – if you can, I think you can just characterize the questions if you want, instead of reading them all verbatim.

Stephanie Kaminsky: OK sure, so these questions are, I think, about how States will be able to gather the data necessary to kind of populate the data fields needed to come up with the point-in-time MAGI number?

As we've said repeatedly, the MAGI-based methodology is just that – it's a financial methodology. It is not a number on a tax return, even though we do also talk a lot about the number on the tax return because the tax return can be one of various verification documents that we use.

But the first order of business or the kind of directive at least in terms of what we proposed is – and what we believe the statute requires – is that States need to come up with a point-in-time MAGI number, which essentially takes the input that would go into a tax return, but brings them into the current moment.

The questions are about whether the IRS has an online calculator for this; whether or not CMS will be putting out some kind of national business rules or giving permission for a certain commercial off-the-shelf tax preparation product to help with this. Then the question number ten is about – was it

number ten that was the last one? Number ten was about, something similar, the pre-tax dollars.

How will States get the information for figuring out what is pre-taxed and therefore not counted – the kinds of things that today are taken out of income, for example, health insurance premiums – that may not be the right example for this particular exercise – but other types of pre-taxed deductions, which will be important to have a handle on when coming up with an ultimate MAGI number.

So, these are understandable questions, as everybody's grappling with how they're going to operationalize the MAGI-based methodologies – MAGI-based methodology, I should say. And I have to say that we are grappling with them, too. We will be – these are areas that we think are very good for sub-regulatory guidance and we're continuing to explore how this information will be best procured by States when they're trying to populate the point-in-time MAGI, whether it's something that would go into the application.

We've got an application team that's working on application development – whether there are other electronic sources for some of these. Whether self-attestation is going to be the mechanism to get this information? How States will do it, as part and parcel of what we're working on right now.

At this point, there are no firm plans to have a federal online calculator to do this. We certainly think that – we've heard that request and we think it's an interesting proposition. And we are considering that along with all other requests and possibilities for how are we going to operationalize the MAGI-based method. But at this point there is no firm plan to put something like that out.

So, I think that the point here is just that we're looking also to States to help us understand what data is potentially available to help populate and we'll be working together with you beyond Monday the 31st to operationalize this key piece of the transition to 2014.

Operator: Pardon me, Anna Wolke has joined the conference.

Sarah deLone: Wonderful, great. Hey Anna, thanks for joining us.

Anna Wolke: Hi, sorry I had some technical difficulties but glad to be here.

Sarah deLone: No problem, understood. We just really got started, Stephanie just—we answered questions one, four and ten sort of together as a common theme. The second, the next question, number two has to do with recoupment possibilities. A Medicaid client does not report a new job, and their MAGI is above the Medicaid standard. Is there a recoupment process for Medicaid? And Chris Gerhardt is going to field that one.

Chris Gerhardt: There is – this is a very short question so we had to infer a little about what the question might be about when it states that the individual's MAGI is above the Medicaid standard. The questioner might have been inferring that they would have been eligible through the Exchange for a premium tax credit.

So, if this question is about whether or not the Medicaid Agency – if there is a change in income that's unreported and the person would have been eligible for tax credits but instead receives Medicaid throughout that year. If the question is, is there any recoupment through the Exchanges or through the money that's aside for the premium tax credit, the answer to that is no.

There is no recoupment provision if the person should have been in a different program rather than Medicaid. If the question was simply about recoupment from the individual, the Medicaid regulations regarding recoupment and recovery from individuals have not changed and we don't anticipate changing them prior to 2014.

So, the treatments of adjustments for cases of adjudicated fraud are the same as they are now. And what I would say to this question, since that is the case, that States would really be wise to take advantage of the various data matches that are available to them and to determine the circumstances under which the matches are useful, because although beneficiaries are advised that they need to report changes, as we all know, they don't always do that.

So, it kind of behooves the States, since there aren't any easy recovery methods here, something the States should think about, the circumstances

under which they utilize resources and using other data matches periodically to try to avoid a situation where they would be making overpayments to an ineligible individual.

Sarah deLone: Great, thanks Chris. The next question is also going to be – Chris is going to address, and I guess that's the question as to whether or not, in a household that's applying for Medicaid, can the most recent tax data on Modified Adjusted Gross Income be used to determine the individual's or the family's eligibility if the family attests that that prior year's income tax return represents their current situation.

Chris Gerhardt: Under the regulations, the Medicaid programs still have to use a point-in-time income and how the agency determines that point-in-time income. You need to look at the flexibilities that are there in the income verification regulations and think about how you will want to apply the reasonable compatibility standards; how you want to utilize the various methods of verification that are available to you—self attestation, as well as data matches, and of course as a last resort, paper documentation. So, States need to consider the circumstances under which they want to use the various techniques for verifying income. And things they might think about is whether the sources of income are stable sources of income—a regular job, it's been unchanged for a year or more, as opposed to more volatile income, such as self-employment or people who do occasional jobs and then have significant fluctuations in their income.

So, States needs to think about the methodologies that they'll apply. CMS has not issued guidance at this time to dictate to States exactly how and in what circumstances they'll use the various techniques available to them. Something that we encourage States to be thinking about as we also here at CMS need to think about is what would be useful guidance for you in the future.

Sarah deLone: So, this is a really important question, Chris. So, I wanted to try and capture in a sort of a couple of nuggets what you – what I think that you're saying, in case that's helpful to people. And you tell me if you think I'm getting it right or not. But that it's not – the question sort of sets up that can we use last

year's tax return data – last year's tax return income instead of current income to determine Medicaid eligibility or CHIP eligibility? The same question would apply. And we think that that's not – it's a frequent question but the framing is not so much – at all what Chris is saying.

It's not so much that you're using last year's tax information instead of current information. But what are the circumstances in which last year's tax data is sufficient to verify what somebody's current income? And so then the question is looking at our verification regs. Well there's other data sources that are available, those that are listed in 1137 – maybe other data sources that you have – TALKS, or whatever, that are available to verify current income.

And is it useful or not to access those data sources to verify somebody's current income if you already have an attestation from them that the prior year's tax data is good enough. And that, I think, that's the way to think about the question, not as using old income as opposed to current income. It's really what do you need in order to verify current income. That's…

Chris Gerhardt: Absolutely correct. Yes.

Sarah deLone: Okay. So, moving along. Next – so, Stephanie already answered question four. So, now we're at question five; a couple of questions on the MAGI screen. Can you explain how the MAGI screen can be used if point-in-time Medicaid eligibility rules still exist?

I think this actually gets at, and this may become a recurrent theme in our call here today. It really comes back to this very fundamental point – idea that MAGI is not just the old tax return data, so we – information. So, we think that what this question is driving at is – how can you do a screening based on the number on the tax return – the MAGI from the tax return – if current income eligibility rules still apply? And so, the answer…

Stephanie Kaminsky: And particularly, maybe, how can the Exchange do that since we know that the Exchanges will likely grab that tax return number as its first point in determining income.

Sarah deLone: So, thank you. Good clarification. So, right, so especially, how can the Exchange do that, and – so then, there's two points to make. One is to reiterate that MAGI – and the use of MAGI here also, is a methodology. So, whether it's a – so that's one point.

And the second point is that the Exchange has to determine Medicaid eligibility using the same standards and rules that the Medicaid agency does. So, the – and the way the Exchange regulations are set up, it requires the Exchanges to determine – make the Medicaid eligibility determination based on current income, same as the Medicaid agency has to or CHIP – for the CHIP agency. And, even also to use verification procedures that are – that are followed by the Medicaid agency.

So, that – then the MAGI screen really just – think of the MAGI screen instead as a simple income test and that's the way it would be used. The income is going to be – the current income is going to be determined – it'll be a number at the end of the day. A given household has a particular income, a particular MAGI determined using MAGI methodologies, and that would be compared to whatever the applicable income standard is. For adults, it will be 138 percent of the federal poverty level. For children and pregnant women, it will be something higher and it will vary from State to State.

So, that's how we see the MAGI screen working – using current income eligibility rules. The next question – does anybody have anything to add or clarify? Okay, the next question, number six, "Does the NPRM require that everyone below age 65 go through a MAGI screen for determining eligibility for Medicaid based on income, regardless as to whether or not they have a disability?" And the very – with Medicaid, right, there's always the rule and then there are always exceptions, but the basic answer to that question is yes.

And it is yes, specifically with respect to the issue as to whether or not somebody has a disability or not. So that, everybody under 65 – almost everybody under 65 – has the potential to be eligible for Medicaid based only on their income, without respect to their disability status. And so – so, that's the major expansion into the new – with the new adult group. And that's

always been true for children and pregnant women, and now it's true for adults as well.

You no longer have to be disabled, blind, aged, or a parent or caretaker relative to be eligible based on income alone. There are, of course, a couple of exceptions to that, and the exceptions would be somebody who comes through as an SSI recipient. They don't need to go through the MAGI screen. They're eligible based on the fact that they're an SSI recipient.

There will be a slightly more elaborate conversation with a 209(b) State, or a State that's a criteria State that doesn't hook up automatically, but the basic concept still applies. But –we, Oregon, and I don't know if they're on, raised the question, and we had our own sidebar conversation. There are maybe different ways to think about it if you're a 209(b) State or criteria State and we would be happy to engage in a conversation with any other State to that situation about how the screen works for their SSI recipients.

And then there's also adults who – non-pregnant, non-parent, not caretakers relatives, and not children – who are eligible for Medicare. They can't be eligible under the new adult group, so they would sort of get pulled out of the MAGI screen also. You might put them through the MAGI screen, but they're not eligible and it's not because of their income, it's because they get Medicare. Of course, if it's a child with Medicare or a pregnant woman or a parent with Medicare, they could still go through the MAGI screen. So, that's sort of the basic answer – yes, and then the somewhat nuanced exceptions.

Stephanie Kaminsky: And there's a second question there, Sarah.

Sarah DeLone: And then, on…

Stephanie Kaminsky: So, therefore, if someone has a disability, is it – it is possible that they would only be enrolled in an SSI-related optional Medicaid program if they are above 138 percent of the FPL – it's the flipside of the MAGI Screen.

Sarah DeLone: Right. So, if somebody has a disability and they are not in the mandatory group, say they're not an SSI recipient, or they are not covered in the mandatory coverage group in 209 (b) States, then that's correct. They could

go into an optional SSI-related group and eligibility group for individuals with disabilities only if they are above – the person has 138, it's –we tend to use 133 percent, and then the 138 comes in because of the application across the board 5 percent disregard. So just, don't – anybody be misled by the 138; 138 or 133 – it's really the same. It just depends on whether you're incorporating the 5 percent disregard into your income standard or you're incorporating it into your methodology in calculating somebody's income.

So, moving on then to questions seven and eight about the new eligibility group. Number seven, "if a client under age 65 is eligible for Medicare and has income under 133 percent, can they receive benefits under the newly eligible program?" I assume by the newly eligible program we're talking about the new adult group – and the answer to that is no.

Individuals receiving, eligible for Medicare are expressly excluded from coverage under the statute and therefore under our regulations from coverage under the new adult group. They may be eligible for another group – they may be eligible as a parent or a caretaker relative, or a pregnant women, but they're not eligible for the new adult group.

Current rules state that if a person is being evaluated for the Medicare Savings Program, they are excluded from the MAGI methodology. We're unclear as to what this means. If a new person – if a person under age 65 has Medicare and is under 133 percent, can they receive Medicare under the newly eligible program?

Okay, and so I think the other part of that question is, how does the exemption for MAGI for determining eligibility for the MSP program work? And it's really very – the proposed rule which tracks the statutory language – no, actually, I'm sorry – it doesn't actually directly track it but we've interpreted in the proposed rule to limit the exemptions from MAGI methodologies to the actual determination of the eligibility for [INAUDIBLE] coverage.

The MAGI exemptions, although they are very similar to the exemptions from coverage under the new adult group, they're not the same. You sort of have to break it apart and look at somebody case-by-case and look at the applicability

of the MAGI exemptions separately from whether or not somebody can get coverage in the new adult group or some other group.

So, in this case, you've got somebody who's eligible for Medicare. They absolutely need to be evaluated for the MSP program, and in making that evaluation, to see if they are a QMB, a SLMB, or QI, QDWI. They are not exempted from MAGI methodologies, so you would use current methodologies which are based on the SSI Program.

Then you want to look and say, "Is this person eligible for something else or are they a full dual? Well, they can't be eligible under the new adult group because individuals who are on Medicare can't be eligible under that group.

But if they are – let's say they're a parent who's receiving Medicare – if their income is low enough that they qualify as a parent under Section 1931 or under our proposed 435.110 – is that right? Yes, under 110, then they would not – you would use – just because they're Medicare doesn't mean they are exempt from using MAGI methodologies for purpose of determining eligibility under those groups.

So, you would use the MAGI methodologies to figure out if they've got coverage as a parent under 435.110. So, just the overarching – biggest point is that – don't conflate the exemptions from coverage under the new adult group with the exemptions from MAGI. They are very similar, but they are not identical and you just have to analyze them separately.

Stephanie Kaminsky: Isn't there another point here about being in multiple groups, Sarah? And analyzing from different situations?

Sarah deLone: Yes, so in that case, right. So, you would use different methodologies. You would evaluate the person for MSP coverage, exempt from – and, I guess, the point is that that's okay. This is something that might be difficult to operationalize at a certain level, but is permitted and, indeed, is required today and would be required in 2014 also as a policy matter. That somebody can be – and this is probably the only example actually where this would be the case – but somebody can be evaluated for two different eligibility groups using two different methodologies. Because, under the proposed rule, the only group

that carries its MAGI exemption with it everywhere are the elderly – 65 and over. Under the statute, if you're 65 or over, you're exempt from MAGI and it's not connected to an eligibility determination.

Otherwise, under the proposed rule, that's the way the exemptions work. So, yes, you're looking at what eligibility groups could this person be evaluated for and what's the methodology that has to be used?

Stephanie Kaminsky: And they could be eligible for multiple groups at the same time, using different methodologies.

Sarah deLone: Right. As with today, you might have a parent who's eligible for 1931 using AFDC methods, and they're on Medicare. Or maybe a pregnant woman and they can also be eligible for the MSP program based on the SSI methodologies. So, it's really no different than what exists today.

The next question – hoping I'm going to get somebody besides me – the next question is actually a pretty short question. Oh no, I didn't do number eight – I'm sorry, number eight. "Since the new eight adults" – "the new adult group are entitled" – "only entitled to benchmark coverage – as long as the ESI, employer-sponsored insurance, meets or exceeds the benchmark benefits, is it correct that the State would not have to provide any additional Medicaid wrap benefits for individuals in the new adult group who are enrolled in cost-effective ESI where Medicaid is paying the premium?"

The answer to that question is if the ESI meets the benchmark benefits requirements that have been established by the State, consistent with our regulations, then that's correct. You don't need to provide a wrap. "Would the rule be different for a disabled individual for whom Medicaid was paying for cost-effective ESI?" No, there's no difference in the treatment of – if the disabled individual is enrolled in the benchmark benefits, and that's what they get. If they're in the eight group, then that's what they get. Side note that we have not developed guidance yet. Guidance will be forthcoming on the benefits for individuals in the eight group and the issue that's out there that we've acknowledged before about the applicability of the exemption

benchmark benefits. That issue has not been finally decided and guidance will be forthcoming on that, so just bookmarking that.

But just take it for purposes of this question that you've got a disabled individual in the eight group and what they get is the benchmark benefits. There's nothing in a premium assistance program that treats disabled individuals any differently than nondisabled individuals.

Mary Corddry: What about the issue of kids been covered for EPSDT?

Sarah deLone: We're – there's an open question as to where you've got 19 or 20-year-olds. We're grappling with under 21-year-olds who are entitled to EPSDT benefits and you will have 19 and 20-year-olds in the new adult group. And we're grappling right now and don't have a firm answer as to how to reconcile the requirements that the eight group gets benchmark benefits with the – and the prohibition, the conforming amendment that created a prohibition on any – on FFP for any benefits that aren't provided through a benchmark package with – so on the one hand, with the requirement that EPSDT be provided to individuals under 21.

As you probably know currently, if there's benchmark benefits provided under Section 1937 of the Act, and a child is required to enroll in the benchmark benefits, EPSDT has to be provided either as part of the benchmark or most commonly it's done as a wrap. So, we have a little bit of homework to do on our end for making sure – how to reconcile those different provisions and what exactly will be the expectations and requirements for 19 and 20-year-olds in the new adult group.

Next question is number nine, "Has the requirement in Section 2101(f) of the ACA been address in the proposed regulations?" You all can read the questioner has put the statutory language down. The answer to that question is yes, it's in the definition of – it was added to the definition of a targeted low income child. So, it's on page 51196 of the proposed rule, the August rule and its 457.310(b)(1)(iv). So, it begins at the bottom of the second column on that page. And that's where that statutory provision has been codified in the proposed regulation. We actually searched the preamble and it appears that

the explanation of that section was inadvertently cut from the preamble language. So, it's not discussed in the preamble language, but that's where it's codified in the regulation.

I'm tired of talking so I'm going to – Stephanie's already answered ten – I'm going to ask if we can go to twelve and then we'll come back to eleven. So, number twelve is for Chris.

Chris Gerhardt: Okay, and so the question is "How does CMS envision requirements involving Medicaid third party health coverage to be operationalized in the context of real-time eligibility and enrollment determination? Does CMS anticipate issuing guidance on TPHI in the context of ACA?"

Well ACA hasn't change, and our regulations haven't changed any of the requirements around third party liability and cooperation with the assignment of health insurance. And we expect that since there really are no fundamental changes to this, that when the new streamlined application form is developed, that it will include questions about other health insurance and other potential liable third parties, just as applications do today. And that presumably when we develop that application, there will also be language on the signature section that will include information about assigning those rights to the State in cooperation with third party liability.

So, we really don't anticipate any changes with that. We don't feel that it should interfere at all with the concept of a real-time eligibility determination because in the world of the third party liability and confirming health insurance, most of that happens post eligibility. Once eligibility has been determined, then States go about their work of doing data matches, identifying liable third parties and taking appropriate steps to make sure the State recovers where it is appropriate.

And so we don't envision any of that changing and we don't envision it actually impacting at all the real-time eligibility decisions. We had not discussed issuing guidance on this particular topic, but if we find that as we go forward in fielding questions and answers from States and other entities about our processes, if this is something we need to address more clearly as we go

forward, then certainly we'll do so. But right now, I don't think we had targeted this for a particular area of new guidance because really nothing has changed in relation to this. I don't know if anybody else in the room has anything to add?

Sarah deLone: Great, thanks Chris. Related is number eleven relating to the requirements to cooperate and establishing fraternity and obtaining medical support orders. "Does CMS plan to repeal regulatory provisions regarding referral of Medicaid cases involving non-custodial parents for medical support enforcement? Can States determine that it's not useful under 1137 and/or under (r)(3)?"

I'm not sure actually what exactly (r)(3) refers to, but to make referrals for medical support enforcement, given the new ACA framework of mandated coverage, penalties and ability of parents to enroll in Medicaid apply unless children are enrolled in coverage.

"Could a State potentially receive a waiver to apply ACA requirements in lieu of existing medical support enforcement provisions?" So, there's a couple different pieces to this question. The ACA did not – the medical support enforcement provisions, the requirement to cooperate in establishing fraternity and obtaining support orders was not – is statutory and was not repealed by the ACA.

So, there's not a – it's not like we can just sort of flat-out eliminate that requirement through regulation. At the same time, we recognize that there are some potentially thorny operational challenges to this requirement, particularly were you've got an Exchange making the Medicaid eligibility determination.

States implement this provision in different ways. Some States do it much more as part of the application process. Other states do it more as a post-determination process, very similar along the lines to what Chris was talking about with the third party liability. What I can say is that we would really – a great concern is the operational challenges to the medical support enforcement rules. And we would welcome, both in your comments as well as after the

fact – it's not just limited to the comment period here, because this issue was not addressed in the proposed regulation – but what the operational challenges to you are and how we can work on that. So, it's an issue that we'll be working with States throughout the process of the implementation. And it would be very helpful for us to hear from you about both the challenges that you think it poses, as well as ideas that you have to address it.

There's another question about – "Could a State potentially receive a waiver to apply the ACA requirements in lieu of existing medical support enforcement provisions?" Not sure which – there's two possible waiver provisions that a State – that the questioner might have in mind. One would be an 1115 waiver, and I'm not a waiver expert. In the best of all possible worlds, I would've been able to go and have a consultation with our waiver division people and sort of iron out a proposal, an answer. I don't see any reason why not, though. I think that our thinking – sort of the group that we have here is that – sure, that seems like fair game for an 1115 waiver. And we'd be happy to talk to any States who would be interested in pursuing that idea.

The other kind of waiver – it's really not a waiver that a State applies for – there is a sort of a general waiver provision in the new 1902(e)(14)(A) that was established by Section 2002 of the ACA and that – I forgot to bring my statute with me, but that basically at the end of subparagraph A provides for a general waiver authority that the Secretary can exercise to waive other provisions of Title 19 or Title 21 that – I'm going to get the exact language wrong here – Stephanie is trying to quickly look it up fast enough. But it's sort of – that undermines the achievement of a coordinated and seamless system of eligibility and enrollment. And that's again where –

Stephanie Kaminsky: That protects beneficiaries.

Sarah deLone: That protects beneficiaries, thank you. So, it has to be – for those two things it has to be waivers to protect beneficiaries and that relate to the system of eligibility – coordinated system of eligibility and enrollment. And that again is where your comments and thoughts about the operational challenges that you face with this particular issue can be helpful to us.

Stephanie Kaminsky: I just want to chime in – operational challenges, specifically that, ultimately fly in the face of a streamlined eligibility system since that is sort of the statutory framework that our NPRM is written to try to effectuate and that's what this waiver language is talking about. It can be framed in terms of the problems with creating this seamless system. That's something we're very interested in hearing about.

Sarah deLone: Thank you. Helpful clarification. So then we did twelve, so jumping to question thirteen, Stephanie.

Stephanie Kaminsky: "Will States retain the authority to establish enforceable timeliness requirements for Medicaid processing by vendors, local districts, et cetera, in the absence of any specific federal processing timeliness requirement?"

So, when I read this question, I felt like there were couple of different pieces to it and the biggest piece that's near and dear to my heart is the single State authority requirement that is still alive and well in our NPRM and in the statute – in the Social Security Act and in the law. And so, of course, States will retain the authority to establish enforceable timeliness requirements for any entity—vendors, local districts, et cetera, who are – who the State has delegated some piece of, if not all of, an eligibility determination responsibility to.

That is a fundamental premise of single State authority concepts and it's hopefully retained loud and clear – hopefully clearly stated in the NPRM that it is our intention to retain that. In terms of the absence of any specific federal processing time requirements, the current application standards are still in effect—the 45 days for a non-disabled application and the 90 days for disability-related applications—those timeliness standards are still in effect. The NPRM that we issued in August didn't do anything to change those.

Though I will say that we are doing a lot of – the Affordable Care Act has opened up a variety of changes in the way that we do business, kind of leading to – it aggregates major culture changes in the way that Medicaid will be doing business after 2014.

And we are looking at – coming up with some performance standards or trying to refine whatever performance standards are out there now to address some of the changes that we see as part of the new picture, part of the new world order if you will. Maybe that's a little bit to lofty to call it the new world order, but it's part of the way that things would be done differently.

I think that I will say – maybe I shouldn't, but I'll go out on a limb and say that I think that folks around here at times have wondered that if we're dealing with applications online, using electronic data sources, et cetera and we're trying to come up with a real-time world, a kind of way of processing applications, I think people – we've had conversations internally that question 45 and 90 days as appropriate for sort of the future.

But at this point, those are the standards that are in effect and certainly the Medicaid agencies need to have retained all the authority they need to establish enforceable time limits requirements for anybody who's processing or taking on that eligibility determination function.

Sarah deLone: Thanks, Stephanie. To the next four questions, fourteen through seventeen, from the same questioner, relate to a scenario in which a single person files an application through the Exchange. Their MAGI is at a 140 percent FPL, so the client is over income for Medicaid based on MAGI.

And then there is a series of questions about what does the Exchange have to do, specifically with respect to what sort of data sources have to be looked at to verify the income? Does the income have to be point-in-time? Does point-in-time income have to be looked at or not?

And I want to first – we can walk through the questions in a second, but they all make a couple of reflections on – sort of the questions as a whole. One is again, we come back to this notion, I think that what is implicit in the question is the idea that again that the MAGI in this scenario that 140 percent of the FPL, we're thinking that the questioner is assuming that's MAGI, the number that's pulled from the old tax return.

If it's not, then you've actually gone through the Exchange or the Medicaid agency in this hypothetical – the Exchange has actually gone through the

process of determining the MAGI that's going to be used, the income that's going to be used for determining eligibility.

Now for the Exchanges, in many cases that may well be the number off of the tax return, but not always. And in the case of Medicaid, as Chris talked about earlier, while the old tax return MAGI may be an important and perhaps potentially the only source of electronic data that's used to verify income, it's still being used as a verification tool to measure current income.

So, we come to sort of that basic point. The other thing that is sort of, I think again, is really the question that's being driven at by all of these questions, is that they're really asking about how are States going to integrate the income determination process between, when the Exchange has to be determining eligibility for three potentially four programs – tax subsidies, Medicaid, CHIP and possibly the basic health program – when you've got different point-in-time rules. You've got the Medicaid rule that's always current income. You've got – it's arguable whether you want to say that the – certainly the tax, the Exchange is annual income you're looking at, and there's a very just different approach to sort of defaulting to the former tax year data, as opposed to trying to figure out what somebody's current annual income is going to be.

But there are certainly plenty of cases when that's actually what the Exchange needs to try and do. When they've got a change of circumstance, for example, that's triggered and, Anna, I will give you a chance to correct anything that I'm misstating about the Exchange regulation. I always get a little nervous when I'm trying to talk about something that spans our two regs because each has its own set of weeds to dive into.

But, so the question is really getting at – so you've got what Chris earlier talked about – the basic structure and the rules and the approach for verifying income for purposes of Medicaid, and those same rules under the NPRM apply to CHIP in 2014.

And you've got a different set of rules – expectations with some significant areas of overlap, but nonetheless different standards and rules that apply in

determining – making a final income determination and eligibility for the advance payment for the premium tax credit and cost sharing reductions.

And to be honest, we sort of – we've, Chris has explained how our regulation is sort of structured, the Medicaid regulation, and Anna could walk through a little bit how the Exchange regulation is structured at the highest level. As it relates to a Medicaid eligibility determination or a CHIP eligibility determination, the Exchange is required to follow the same rules and processes as the Medicaid agency. So, it would be no different. If the Exchange is going to determine somebody eligible or ineligible for Medicaid, they have to be looking at current point in time income. And so, that's sort of at the end of the day, that's what has to happen.

The way the Exchange rule is set out, the Exchange is going to be pinging the same data sources actually that are available to the Medicaid agency or the CHIP agency to ping, which is the old IRS data, the 1137 data sources, and maybe other data sources that are State-specific. Of course, they'll all have access to stuff through the hub, but will be pinging those data sources and if before it can finalize a Medicaid determination, it's going to – the Exchange rules cross-reference the Medicaid rules, and also cross-reference the Medicaid standards that apply.

Medicaid rules and processes have to be complied with before the Medicaid eligibility determination can be finalized. And similarly, somebody before finalizing eligibility for the premium tax credit, the Exchange regulation for that, in terms of determination of income and how the different data sources are used – and when they're used, have to be applied.

What is not in the regulations, and frankly it's what we're still working out, and it's very related actually to the issue that Stephanie was talking about in terms of developing business rules for calculating the MAGI, because here we're talking about it with the Exchange and Medicaid together where they have to coordinate. We're working through with States and other stakeholders and we will before the comment period closes and this work really is going to be continuing after, and this is sort of really – one of the parts, there's many

parts probably today to the implementation of the regulations and the health care reform.

But this is certainly a very key issue that's not – that's not worked out in great detail in the regulations and I think frankly many of us thought it would be foolish to try to do so, because it's so nuanced and there may be so – and there may be variation from State to State as how it's going to work.

It's really at the heart of it and a very detailed process and what can I say – we're wrestling with it, you're wrestling with it. We will be wrestling together with it in the months to come to figure out those business rules and whatnot.

Anybody? It's a tricky one. Anna, in particular let me turn before we go to sort of the particular questions to see if you have anything you want to add?

Anna Wolke: No, I think you did a great job, and it's just, it is really at the level written in the reg. We explained the two processes that the Exchange would go through in order to determine MAGI for Medicaid and CHIP eligibility and MAGI for premium tax credit eligibility.

And like you've said, it's not really a level of detail that we felt was really appropriate for the rule. This whole question goes to how those processes meet and how the actual verification of the income is – actually occurs.

So, I just want to echo the we're – it's definitely one of our biggest, most complicated issues and while we're all working together on it at the federal level, we're obviously looking to States to help us think about questions such as – like some of the questions that have come up in this – in this list about certain thresholds or ranges where income ranges where we may put certain people down a path of either Medicaid or the Exchange eligibility, and other certain questions or best practices that they may have to offer. But otherwise. I think you did a great job, a great summary of our – of how we walk through it in our rule.

Sarah deLone: Okay, thanks. Anybody else here who may want to add anything at this point? Okay, guess not. So, let's just see – let's just look at the particular questions, just to make sure we've answered as thoroughly as we are able to.

So fourteen, it appears, we must look at point-in-time income for this client. Is that correct? Anna feel free to chime in. You've got to look at point-in-time. You've got to look at current income. The Exchange has to look at current income in determining the Medicaid eligibility.

So, you can't deny Medicaid eligibility based on an annualized income or – and certainly not based on just prior year's tax data if that's not representative of the current income, and so it doesn't matter that current income has to be determined in order to rule somebody in or out of Medicaid based on MAGI or CHIP based on MAGI.

"If the client's income is 350 percent of the FPL based on MAGI, can this client be moved directly to the Exchange without looking at point-in-time income? Can we consider premium tax credit for the client without putting them through a Medicaid determination?" Anna was really just talking about this. This gets to – you can – that sort of the basic stark answer is no.

You always have to sort of – the Exchange always has to ask what's this person's current income? How am I going to verify that? Now, if somebody says – somebody has – let's take an extreme example. Somebody has had a very steady employment history and they're at 350 percent of the Federal Poverty Level, and they say that's consistent with my prior year's tax data. It seems sort of reasonable for – to say that's sort of – that should be good enough in that kind of a situation.

But again, as Chris was talking about earlier, we sort of don't have – when that situation applies and when it doesn't apply, is open to question. So, it's a verification issue, it's an issue of making that final determination as to what somebody's current income is. And if you, if you've done that and the person is 300 percent FPL then they can go to the Exchange unless the State has a very generous Medicaid program or CHIP program which they do for kids. Some states are that high for kids.

So, and "Can we consider premium tax credit for the client without putting them through the Medicaid determination?" Similarly, the answer is really no. Now, in any number of cases that may be a very quick determination because it may be reasonable to make a very quick assessment based on what somebody says their income is, and what their prior year's tax data is. In some cases that's going to be murkier. So, I think that sort of answers those two questions.

Chris Gerhardt: And, Sarah, let me just add again as the application form is being developed and of course envisioned primarily as an electronic application form with drop down menus and so forth, there will be questions on that application form about whether or not that MAGI is reflective of current income; and depending on that response, that should help to guide States through their decisions about whether or not they need to go further in exploring other data sources or asking more questions.

So, in the world of online applications, we envision drop down questions based on certain answers so that you wouldn't have a long application form if the answer is – yes, this is reflective of my current income. You can go with that, but if the answer is – no, this is not reflective, or they – if it says, state your current income and they put something that's radically different then that's the key that would elicit more information and be a signal to the State or to the Exchange to go forward and look for a little more information.

Sarah deLone: Right, so in terms of the process of when you need more information from individuals.

Chris Gerhardt: Right.

Sarah deLone: Yes.

Anna Wolke: And I, I'm sorry, just really quick. I just want to make a quick plug for I know we're talking more about process and how it's actually operationalized, but of course the underlying provision in the IRS rules is that you cannot have access to advance payments to the premium tax credit or cost sharing reductions if you have access to minimum essential coverage. So, the State is still going to need to do that check and to check that box, but of course the

underlying verification is – I think more of the question was getting at but I just had to throw that out there.

Sarah deLone: Right, thank you. Number sixteen, is just sort of the reverse. Somebody's tax data says they're at 125 percent of the FPL. And again, no – you still – a State or an Exchange still has to look at what the current income is because it might have gone up. And this might be a case where somebody actually should be in the Exchange even though their tax return data would be getting premium tax credit even though last year their income was below 133 percent FPL and that really sort of handles seventeen also, too. It's really variations on the same question, got to look at point-in-time to evaluate Medicaid.

So, number eighteen. Chris was going to answer that one for us.

Chris Gerhardt: And the question is – "Are States expected to pay for verifications or transactions with the federal data hub or with federal agencies through a State hub for verification transactions related to Exchange eligibility determinations? And if so, how would such costs be determined?"

And the answer is – we don't know. At this time, the federal hub is still under development and in its very early stages so we really have not discussed internally whether or not there would be any costs passed on to the States. But I would think that we would not want to begin charging for data that's currently available for free. For example, the SSA data that there's no charge for; some of the data that you get through PARIS, there's no charge for that. This is some of the same data that will be coming through the hub. So, certainly I would not anticipate any imposition of charges that don't currently exist. Whether or not there will be other charges that are passed on to States, we simply don't know that at this time.

Sarah deLone: Yes, I'm not sure I totally understood and follow it, so I just want to be clear. We don't – the bottom line, as Chris says, we don't know whether there will be charges or not and it's – I think there has been some research that has been done to help inform the discussions.

I think it's a question that's been raised. Anna, I think you guys have been involved in some of this – in discussions and thinking about this. So, it's one

that we know the states are asking, and it's one we are thinking about. But, and we've looked at – what States currently have to pay for. And sort of has been discussed, and there will be an answer at some point obviously, but just not yet.

Question nineteen – "When will the data dictionary for the single application be available to the States? States will need to procure eligibility systems that will be able to receive on the backend the data entered into a single app and accommodate the business logic of the way the data is entered into an interactive application."

So, yes, we are very aware and working hard to nail down those. I think what the person is asking about, assuming by data dictionary they mean what are the data elements that are going to be required in the single application and – as soon as we can. We're working on it now. We are reaching out to States and others, having conversations and trying to nail that down. We understand that States need that information ASAP.

But also I want to add that there is – that this is not to relieve us of the obligation and the need and we understand it is a pressing need to get that to you as soon as possible. But the – you – that other – many States have begun sort of their procurement process even without having that – those data elements nailed down so we would encourage you to sort of move forward and we're certainly – CMS staff are available to work with you to sort of figure out how to do that even as you are waiting for us to sort of nail down the final decisions on those data elements.

Okay, question twenty – benchmark coverage. "Under the Deficit Reduction Act, regulations and guidance, ten classes of Medicaid beneficiaries are exempt from mandatory benchmark including a whole list of people which includes disabled and medically frail individuals. A State can offer but not mandate enrollment in a benchmark plan to these classes of beneficiaries. How does CMS contemplate aligning or modifying existing benchmark provisions to enable States to appropriately provide benchmark coverage to the new adult group, while also ensuring that disabled individuals and those

with special health care needs in the new adult group are enrolled in full or equivalent Medicaid and have access to the services they need?"

We've talked about this question on a previous call. We've had a number of different forums over the last couple of months where we've talked about this question. It's one we are wrestling with. As I said earlier in the call, guidance on the application of benchmark benefits to the new adult group is still being developed and will be forthcoming.

So we do not have a definitive answer on the specific question about the applicability of benchmark benefits. We are very concerned – a number of many people from different perspectives -- States, advocates, other stakeholders have raised concerns and we are very aware of them and take them to heart as much as you take them to your heart to make sure that individuals living with disabilities, individuals needing long term care services are able to access the benefits that they need.

It's certainly – don't think it was anybody's intention in enacting the ACA that individuals with disabilities would end up worse off somehow under the ACA than they are today.

Let me just say, so we're aware of the issue and we are looking at ways, possible policy solutions to address it. I think it might be helpful. I think I did try and lay this out on a previous call but maybe it would be helpful to lay it out again because it's hard to wrap – you know it's hard to, it's a hard issue for us all to wrap our minds around and figure out what the solution is, the best solution is because we do have, unfortunately that pesky statute that we have to adhere to. And there are some, collision maybe too strong of a word so I'm struggling for a different word.

But how to sort of, you've got an overlay of eligibility rules with benefit rules that don't mesh in as graceful a way as we might hope. Under the proposed rule and I would emphasize that it's the proposed rule, so this is an area we repeatedly say – we really want your comments because we are willing to look at all – everything that's proposed in our rules and this is one that we are particularly focused on.

But under the proposed rule, individuals who are eligible under the new adult group have to go into that group. They cannot choose to go into an optional eligibility group for disabled individuals.

If they are an SSI recipient, then they would go into the mandatory SSI group. But if they are not an SSI recipient and they meet the eligibility requirements for the new adult group, that's the eligibility group that they go into. That's the way the eligibility hierarchy is established in Title 19.

You can't be in an optional group if you're eligible for a mandatory group. Just for purposes of argument, because the concern that people have is if individuals with disabilities are required to go into benchmark benefit coverage, there's the concern certainly that they are not going to get the benefits that they need.

One thing, so we are looking at that, so that's sort of point one, that's being examined. Guidance will be coming out. Assume for purposes of today's call that they will end up in benchmark benefit coverage. Know that States have the flexibility under benchmark benefit to – they don't have to – they can craft, they can carve out different populations within a group and provide different benchmark benefit packages. And States can adopt Secretary-approved benchmark benefit packages which could target a disabled population in the new adult group to meet their needs.

Currently, under the current benchmark benefit regulations, long term care services that are covered now through a 1915(c) waiver typically are not – cannot be covered under a benchmark benefit package. But CMS has made it clear that we are revisiting that issue and have every intention of modifying those regulations to provide that flexibility, so that States could provide under a benchmark benefit package, any and all benefits that disabled individuals need. So, instead of having to put them in the optional group, they could meet their needs through the mandatory group. It's not a mandate, it's an option but it's also optional to cover individuals in the – to adopt the optional group.

So we're not sort of changing the terrain there. Particularly though, I want to acknowledge, particularly where it comes to meeting the needs of individuals

who need long term care services, and so those individuals, for example, who are getting coverage through a 1915(c) waiver today. There's two things about the new adult group that become challenging from the State fiscal perspective which is that there's no asset test for the new adult group nor can you – can States impose a waiting cap for services that are provided under the new adult group.

So that, while States will have the flexibility to address the problem, it particularly, once the 100 percent federal match phases down to – although it's still a generous match, but 10 percent of a very expensive case load is still a significant amount of money for many States.

It's not necessary – there are some fiscal concerns that States will have in terms of picking up that option under our current, the structure of our current regulation. We are looking at what other possible interpretations of the statute might we pursue to address the problem and we welcome your comments on other possible interpretations. Looking at, for example, how we interpret the exemption from MAGI for individuals with disabilities and for individuals needing long term care services.

We are looking for the magic bullet that's going to – I think the goal that most people have is to maintain the status quo for people who are able to access specialized services either through a buy-in program or Home and Community Based Waiver Services Program, but at the same time not preclude other disabled individuals who may not be eligible for anything today from enrolling and getting coverage at least under this new adult group.

So there may be some tradeoffs that people have to look at and we would welcome comments and input into those sort of tradeoffs. I mean, one to give the sort of opposite interpretation that we proposed in the regulation for the exemption from MAGI for disabled individuals or individuals needing long term care services. For example, let's say, this would be a question we'd have to make sure we could do this, had legal authority to do this, we had – there are all sort of policy discussions so I'm kind of going out a little bit on a limb here trying to provide you with as much information and our thinking as I can so that you can think about it and then give us your thoughts.

But, so this is, I'm not saying we necessarily can do this but it's certainly seems like a fair, at least a fair idea to put out on the table, would be to interpret those exemptions from MAGI to attach to the individual. Somebody needs long-term care services, for example, therefore they are exempt from MAGI.

Because they are exempt from MAGI, we can't put them into this new eight group, not because people who need long term care services aren't eligible for the new – I'm sorry the new adult group – but because you have to use MAGI methodology to determine eligibility under the new adult group. We're exempting this person from MAGI.

We're sort of saying we're going to pull them out of the whole system and therefore we are going to look at their eligibility under the optional groups the same way as we would today, using the same rules based on SSI methodologies that are used today. That would be a way of maintaining the status quo.

I think the downside to that interpretation and that you would have a similar interpretation for disabled individuals. The downside to that interpretation is that there are many disabled individuals, individuals needing long term care services today, as there will be in 2014, whose income based on MAGI methodologies is under 133 percent of the Federal Poverty Level but they do not meet the requirements of the State's optional programs. And under that interpretation of the exemptions from MAGI then those people would end up with nothing, so and that's also a tough result to swallow.

The ideal would be to allow somebody to choose how they want to present and how they want to be determined. That's not typically the way to – that's not the way the Medicaid statute is structured. But a way so we would welcome sort of your thoughts on how we might reach that result to support whether or not we could reach, we could get there or not. If we can't get there then we need people to input on what's the best that we can do, what are the tradeoffs that we have to – did you want to chime in Stephanie?

Stephanie Kaminsky: The only thing I want to say is just to be clear; our NPRM did not take the approach that Sarah just laid out.

Sarah deLone: Right.

Stephanie Kaminsky: Our NPRM took the approach that anybody who is under 133 gets in, under 133 – disabled or not.

Sarah deLone: That's right. That is the approach and there – under they would – somebody under 133 is still going to be in. It's a question of where they are.

Stephanie Kaminsky: Right.

Sarah deLone: But the way that it's laid out in the NPRM, I was throwing out and I really – I'm talking to 300 anonymous people. I don't know who you are so I'm really going out on a limb here trying to just give you – this is really our staff level thinking.

Under the NPRM, your need for long term care services, your disability status is irrelevant as from a pure coverage perspective, makes the most sense. There's no reason why just because you're disabled you shouldn't be able to get coverage through the new adult group and we don't want to create a coverage gap and that's the approach that we took in the NPRM.

Stephanie Kaminsky: Coverage meaning eligibility?

Sarah deLone: Coverage meaning eligibility, thank you. I hope it's helpful to – so, sort of we want to acknowledge what the rules are in the NPRM. We want to acknowledge what the problems, potential problems are that the proposed rule creates for this population. I wanted to share with you at, this is really at the staff level thinking about, as we're really struggling, trying to be creative, trying to balance the different, both policy concerns as well as the statutory constraints that we have, to reach the best result and give you some of the thinking that we're doing in hopes that it will help you further your thinking and you'll be able to feed that back to us so that we can reach the best results possible with the material that we have. I think that's probably enough. Thank goodness the next question is for Chris.

Chris Gerhardt: Okay. "Does benchmark coverage for the new eight population [which is the adult group] include retroactive Medicaid coverage?" And I'll say yes with a qualification. The new adult group statutory authority for that coverage is effective January 1, 2014, so individuals who apply in January of 2014 and are found eligible, will not be eligible for the three prior months which will be October, November, and December of 2013; because in those prior months, there's no statutory authority to cover those adults. However, for individuals who apply in February, there would be retroactive coverage available to them for the month of January 2014 because, again, statutory authority exists in that month but not for the month of December 2013 or November.

And so there's, kind of a phase-in period from January through April of 2014 where individuals eligible in the adult group might not be eligible for the full three-month retroactive period, but would eventually, starting in April 2014, they would be eligible for the full three-month retroactive period if otherwise eligible and would be eligible for benchmark or benchmark equivalent benefits in that retroactive period.

Sarah deLone: Thanks, Chris. Number twenty-two, I think, Anna, we were going to defer to you to start in on this one and we may chime in.

Anna Wolke: Sure, so the question twenty-two is – "The proposed regs used different FPL dates for tax credits for FPL for tax credits based on the first day in the annual open enrollment period, or annual enrollment period and this is versus Medicaid which uses an FPL based on the date of application." The question is – "What is the rationale for the different dates since people could end up with, well we could end up with a black hole, meaning people ineligible for tax credits based on one FPL amount and ineligible for Medicaid based on a different FPL amount?"

So this really – we – the rationale for this is based on language in the statute for advance premium tax credits – payments for the premium tax credit – we are bound to use the FPL as described in 36B paragraph (d)(3)(B) and so therefore that portion of the statute or of 36B sets the FPL for advance payments of the premium tax credit which is under the purview of the IRS. It

sets it as the first day of the annual open enrollment period and this is really so that for reconciliation purposes we have a consistent FPL for the entire coverage or benefit year.

And as you know, Medicaid uses a different standard which is based on the most recent FPL available at the time the individual is applying which makes sense – most advantageous to the individual. But this is sort of what we're stuck with, and but we really don't see that there will be coverage gaps based on this discrepancy. I think it will – it may present a slight operational challenge but so far we really haven't encountered any huge pitfalls, but regardless we are bound to use these two different FPL definitions.

Stephanie Kaminsky: Thanks, Anna. This is Stephanie and I'm so glad you are able to come up with this citation for FPL because I was struggling to find it this morning. I knew it was statutory. I knew it was in the IRS purview, but I couldn't quite get it, so thanks for that. And I knew it was also tied to reconciliation, but your explanation was great.

And I just wanted to chime in that I think the reason that we didn't see this as creating any kind of a gap in coverage was because in general we've seen the FPL going up every year. So if, in fact, Medicaid uses an FPL that's more recent but is more generous, it would potentially catch more people in Medicaid. And even if they would not have been eligible under the Exchange FPL standard, they are going to get caught by Medicaid.

So we don't see that as being a problem. There might be a problem in a situation where the FPL goes down and Medicaid is using a more stringent FPL and where it doesn't catch as many people as the Exchange wants. Although I'm now sort of thinking that maybe they wouldn't be there, because they would be in the Exchange then –

Sarah deLone: Don't think too much, Stephanie.

Stephanie Kaminsky: Oh, thank you. But those are the reasons why we're not sure that there's a gap there but it's unfortunate that we couldn't get an alignment, a perfect alignment but we think it's going to work.

Sarah deLone: But if you don't think it's going to work, tell us why.

Stephanie Kaminsky: Obviously, I can't tell you why it won't work.

Sarah deLone: The next question is very similar to question 29, so just link that I think, listeners, when we talk about it, so we won't have to sort of repeat ourselves when we get to the next one. But are there any circumstances in which a person who is determined ineligible for or terminated for eligibility for Medicaid on some basis other than their income level. And I might add to the question 'or other eligibility factor besides income.' For example, failure to provide information about employer-sponsored insurance, failure to agree with cooperation with medical support enforcement, some other basis and where the person appears otherwise eligible for Exchange coverage, so they have income above – between 100 and 400 percent FPL, that he or she must be assessed for eligibility for Exchange subsidies.

This is actually really a question that goes to the interpretation of the IRS rule and to the definition of when, well it goes to the question of the definition of when somebody is eligible for minimal essential coverage and that definition is implemented – it's a statutory definition and it implemented in the IRS regulation.

So I think the best that we can do is point you to the relevant provision in the IRS Treasury regs, which I'll do now. It's section 1.36B-2(C)(2)(iii) – "Time of eligibility" is the heading and within that it's actually then sub-paragraph A. So it begins on the top of the first column on page 50941 of the IRS regulation. And in general what it says is that when somebody is eligible for a government-sponsored program, that would include Medicaid and CHIP, on the first full day in which the individual can receive benefits under that program – so somebody applies for Medicaid in May and the determination is made in June and the effective date of – the person can receive premium tax credits as far as the IRS rules are concerned for May and June because the dates that they're considered to have access to minimal essential coverage for purposes of premium tax credits eligibility would be July 1st.

That's the way I read their regulations, but then there's an exception, and that doesn't affect the applicability of when the Medicaid eligibility date is effective. It just says when they are considered to be eligible for a minimal essential coverage for Medicaid or CHIP for purposes of PTC eligibility.

There's an exception in this (iii) paragraph which is when somebody fails to complete the requirements necessary to receive benefits under a government's sponsored program other than the VA program. Then minimal essential coverage is considered to exist as of the first day of the calendar month following the event that establishes eligibility for the program.

That sort of concept doesn't really neatly fit into a Medicaid concept in terms of the event that established eligibility. What is the event that established a child's eligibility if their – or adult's eligibility – if their income is 120 percent of the Federal Poverty Level? There's sort of no clear event. The example that they give in the IRS reg is somebody who becomes eligible for – turns 65 – maybe becomes eligible for Medicare and fails to sign up. So that's really a cut and dry case.

We had conversations, we were concerned about a particular example here where you might have somebody who's being evaluated for eligibility for Medicaid based on disability and we were concerned and we think that somebody who then decides to drop out of that process – decides that the disability determination is too onerous, or for whatever reason, doesn't complete it. We didn't want to see them excluded, precluded from getting coverage through the Exchange with a premium tax credit. My understanding and my interpretation, although I think it would be not bad for the IRS to get comments on this, is that that kind of situation doesn't fall into that exception and in that case, you don't actually really know if somebody is ever eligible for Medicaid based on disability unless they actually do complete that process, the disability determination process.

So there'd be no basis to say, there was an event that established their Medicaid eligibility, and in that kind of a situation, deny eligibility for premium tax credits under the IRS rule, because I don't think, Sarah deLone, I don't think, it would apply.

These other kinds of situations, they fall into the same rule but I think that the sort of the spirit and the intention of the rule – of the IRS rule would be to apply in these kinds of cases where somebody doesn't provide a piece of information that's required of the Medicaid or the CHIP agency to complete their process and that's sort of it's a little bit more ministerial.

I think it might be arguable whether medical child support cooperation is ministerial or not but it is clearly an obligation of somebody to get Medicaid to cooperate in that process and as long as that remains a requirement, my reading of this IRS rule would be that it would apply and I think that they would probably say eligibility for premium tax credit purposes would not be allowed.

But I want to emphasize that it's my reading, I give my reading because I hope it helps you to sort of focus on the statutory provision at issue and I would encourage people to submit comments to the IRS on the regulation on which way you think that question should turn out, whether you agree with my take or not. I don't know whether that's exactly the same as IRS' take. So you should sort of figure out where you think the right line is to draw and submit your comments accordingly.

Stephanie Kaminsky: Can I take a crack at summing that up a little bit?

Sarah deLone: Sure, I do tend to go on and on and on so that would be great.

Stephanie Kaminsky: I think maybe I don't understand it completely but I think what's going on here is that the big rule always to remember, as Anna said earlier, is that if somebody's eligible for minimal essential coverage, which in our world means Medicaid or CHIP – that's the world that we're all studying and analyzing here today – they are not eligible for an advance premium tax credit or for a premium tax credit. The IRS rule says that if you are eligible but fail to finish going through the administrative steps of getting your eligibility taken care of – you don't submit paperwork, you fall down on your responsibility, you (applicant), you (enrollee), of doing your part, we (IRS) are still going to consider you eligible, and therefore you will be precluded from a premium tax credit.

The exception that Sarah talked about is with a disability determination situation where somebody needs to go through sort of the disability determination process. We're not considering that ministerial. We're not saying that you are eligible, but you failed to finish your applying because you didn't get your disability determination. In that situation, it is likely that you can get a premium tax credit or advance premium tax credit while that disability determination situation is pending.

Sarah deLone: Right. Just – and then just to emphasize, thank you, that was a nice, sort of succinct summary, but that's our reading and understanding of the IRS regulation but that – the issue with the disabled individual – potentially disabled individual is not addressed explicitly in the IRS rule and I just want to make that clear. Anna, did you have anything you wanted to add to that?

Anna Wolke: No, I think you guys did a great job.

Sarah deLone: Okay, I think the next one is for you. It involves special enrollment periods.

Anna Wolke: Sure. I'll take it. "Does CMS envision that the special enrollment periods provided for in the proposed Exchange would include all circumstances where an individual would lose eligibility for Medicaid or CHIP or lose any minimum essential coverage as long as such circumstances do not make the person ineligible for Exchange coverage?"

So what I would just point out is that determination of eligibility through the Exchange is going to be separate from a determination of whether a person qualifies for an enrollment period. So, if the person is ineligible for Exchange coverage, they wouldn't therefore be eligible to enroll. They wouldn't even get to that step of being evaluated as to whether they could enroll, so determination of eligibility is independent of qualifying for enrollment period. So, I just want to make that distinction.

However, in our subpart E of the proposed rule, we do have an SEP for individuals who lose minimum essential coverage. So this would include any minimum essential coverage as is defined under the IRS rule. Of course, we're inviting comment, but as is proposed, those individuals would be

eligible as long as they were determined eligible to enroll in a QHP through the Exchange.

The next part of that question is – "Would such circumstances include loss of access to Medicaid premium assistance coverage, even though it may not be minimum essential coverage?" So this is – this again sort of goes to the – speaks to the earlier question under twenty-three – it is sort of out of our scope.

The definition of minimum essential coverage and determining what it means to be eligible for minimum essential coverage is a under the purview of the IRS rule. However, I guess I would assume that whether – if a person were enrolled in Medicaid premium assistance they would have also been enrolled in employer-sponsored coverage which would then be considered minimum essential coverage as long as it meets the affordability and minimum value requirement better explained under the IRS rule.

So, I would say to sum that up, there is an SEP where individuals who lose access to minimum essential coverage have the ability to enroll in coverage through the Exchange. Whether or not premium assistance is minimum essential coverage is outside the scope but, I do believe that would – an individual enrolled in ESI would – the test of affordable and minimum value would apply – affordability, excuse me, and minimum value.

And then finally, the last question – "Would they include life events, such as change in household composition, and in parentheses – now caring for a child as a caretaker relative or pursuant to a guardianship or custody order?" I would point to our regs again in subpart E. So, in subpart E we have in part 155, we have a number of SEPs that are proposed and in preamble we go into a lot more detail about what sort of is captured as qualifying events in each of those categories, and there are a number of qualifying events or life events that would qualify an individual to enroll. So I can't speak to the individual circumstances. I think we're very interested in comment and hopefully in the final rule we'll go into a little more detail but, as it is now, we really in our special enrollment periods are intended to mirror and we're instructed through the statute to mirror the code, the IRS code as well as Part D.

So we had limited flexibility in what types and how expansive and sort of liberal our special enrollment period policies could be so we obviously invite comment on that but I was – for information on what types of enrollment periods are available, obviously take a look at subpart E if you haven't already done so and I think that's it.

Sarah deLone: Great. Thanks, Anna. So, I think we're now onto question twenty-five – "Although the language differs somewhat in the proposed regs, does CMS contemplate that renewals for Exchange, Medicaid and CHIP coverage all basically require a review of the information available to the Exchange electronically, and all require notice to the beneficiary but do not actually require the beneficiary to return anything to the Exchange for renewal to occur?"

Let me first say, in just sort of the setup of the question, under the proposed regulations, once the way the regulations are drafted, once the determination of eligibility is made or CHIP eligibility is made, regardless of whether that determination is made by the Exchange or by the Medicaid or CHIP agency, the case becomes sort of the legal responsibility, if you will, of the Medicaid or CHIP agency. So that the renewal, just because the Exchange made the initial Medicaid determination doesn't mean that the Exchange is going to necessarily handle the renewal process.

A State could decide to set it up that way and that's certainly allowed, but then that would be a deliberate decision by the State to have the Exchange handle the renewal process for those individuals. We could imagine any number of States that would choose to keep that renewal process for Medicaid beneficiaries and CHIP beneficiaries in the – within the Medicaid or CHIP agency – either is fine so I just wanted to delineate that.

Then the question becomes what's the process for renewing that eligibility? And then it doesn't matter if it's a Medicaid beneficiary whether the Exchange is handling it or the Medicaid agency is handling it or if in the case of a CHIP person it's the CHIP agency and if it's a renewal of PTC eligibility then the Exchange rules would need to be complied with. So, in terms of the renewal

for Medicaid or CHIP eligibility, the questioner is basically right, the State agency first has to or the Exchange if the Exchange is handling it, has to first sift through the information available to it through electronic data sources, and other information available to it. If it can determine that that person remains eligible for the program, then that entity determines eligibility and sends a notice to the individual. No return is required unless actually – the notice should say based on that something was actually wrong or different then the person has an obligation certainly to send to respond back in whatever mode, whether it was on-line or telephone or mail or whatever and say no, actually the information you have is wrong.

But assuming the information is correct, the Medicaid and CHIP regulations do anticipate that in those kinds of situations that the renewal would happen without a form having to be returned. And, Anna, I'll turn it over to you to describe the Exchange reg.

Anna Wolke: Great so, I will say that the – while the reg language and the process is slightly different between the Exchange and Medicaid and CHIP renewal procedures, the fundamentals are really the same where we ultimately – the Exchange, Medicaid, or CHIP – will act on data that they've already obtained in the event than an individual does not respond to the notice.

So, that's kind of the – an important take away. The Exchange procedure is similar, but that it's slightly different. The Exchange is going to obtain a limited amount of data at annual redetermination so that is different from the Medicaid procedure, because Medicaid has more flexibility in the amount of data it can obtain prior to redetermination. The Exchange is limited by the statute to only a certain set of data.

So, the Exchange in our reg, we proposed that the Exchange will go out and obtain updated income information on the individual – send the individual this prepopulated notice with the new updated data that they obtained in the prior year's data and the projected eligibility for the individual.

The individual will then be required to return the notice if anything has changed from what the data on the notice says. If anything is incorrect, the

individual will need to respond. In that event, they would be redetermined based and go through the normal verification process. If the individual does not respond, the Exchange will then redetermine the individual based on the updated data they had obtained.

So we know that because the Exchange is only looking at a limited set of data and there are some differences between the Medicaid process and the Exchange process and we want to know through comment really whether this sounds like it could work and whether you see any pitfalls to this.

Unfortunately, the reason why we're slightly different is individuals or folks expressed privacy concerns over this obtaining a wider array of data on individuals and so those really informed the Exchange's policies but, of course, we really want to stress the importance of getting comment on this particular provision from you all.

Sarah deLone: Thanks, Anna. I'm happy to report – I think we actually just made it through the top priority, the sort of first tier questions that our E-TAG very generously, and I should have also as well as identifying them as our sort of helping us out here. Really thank them for, in a very short turn-around, taking our remaining questions and prioritizing them. So, our thanks go out to our E-TAG for doing that. It helps us to at least get to the things that are most important for States to hear and sort of we assume that typically overlaps with what other stakeholders feel as most important to hear also. We have just a few more minutes here, so let's see what else what we can get through.

The next question is about the applicability of alien-sponsored deeming rules which are under the Welfare Reform of 1996. Not all but most legal permanent residents – if they have a sponsor, an individual who is sponsoring their presence in the country, the law requires that the income of the sponsor be deemed, counted, in other words counted in determining the immigrant's eligibility for means-tested federal benefits that includes Medicaid and CHIP.

Those rules were not – they're outside of the purview of MAGI. They were not over sort repealed or erased by the ACA. The directive to use MAGI instead of any other provision within the Social Security Act doesn't reached

to the Welfare Reform law which is outside the Social Security Act. So we believe that those alien sponsoring deeming rules continue to apply, and recognize that it creates some...

Stephanie Kaminsky: Sorry, I don't mean to interrupt. Continue to apply in Medicaid.

Sarah deLone: In Medicaid and CHIP, right. In Medicaid and CHIP, I'm just talking about Medicaid and CHIP. And we will be working with States to sort of figure out what's the best way to operationalize that. We admittedly have never given guidance on those rules. So that States are sort of out there on their own right now with those rules, but so we will do our best to work with you to figure out without limiting your flexibility that you currently enjoy in applying those rules to operationalize them.

Anna, I'm going to turn it over to you to talk about the state of the State with respect to the deeming rules, sponsor deeming rules, and the Exchange and PTCs.

Anna Wolke: Okay, well there's not a whole lot to say but knowing that sponsor deeming rules still do apply to Medicaid and CHIP, there is still and you'll see in the Exchange rule we didn't directly address this issue and for that – that is because we're still – the issue is still under review, legal review so we are – we can't really give a final – we can't give a final determination as to whether it does apply or doesn't apply with respect to premium tax credits.

Part of the reason for this is that we need Treasury to weigh in on the issue but, I will say that we are working on it and we'll hopefully have a decision at some point.

Sarah deLone: And the issue the questioner raised the question about a gap in eligibility and there's a couple of, I think, questions that are being looked at and being examined in terms of whether or not there might be the potential of a gap or not. So, more if it doesn't apply – if it does apply there would be no gap because there'll be alignment there. If it doesn't apply – there will be more to come also in terms of whether that creates a gap in coverage or not. Does that sound fair to say, Anna?

Anna Wolke: Absolutely.

Sarah deLone: So, the next one is – "Who would be in the MAGI household as returned from IRS for non-4E foster care and adoption assistance recipients? So for children who are in State foster care or receiving State adoption assistance, if States are to construct the household and determine MAGI, how are States to do this? How are non-Title 4E, so non-federal foster care and adoption assistance and Kin-Gap payments to be treated?"

So I think this question could be – should be sort of looked at it at two different levels and ways, one is that currently States – so this is really asking about I think how are they – how are we going to treat children who are in State foster care or State adoption assistance, whom States cover as an optional eligibility group today.

And the States that do, fall into two groups and I'm going to look at my colleague, Mary Corddry, to nod her head yes and down to make sure that I'm getting this right. But the States that cover this group today – this group today or maybe it's two different groups. One for foster care, one for State adoption assistance either have very, very low income standards or have no income test.

They use 1902(r)(2) to eliminate the income test for this group. If there's no income test, so that would carry over into 2014. You don't sort of need to worry about a household composition because you don't have an income standard and if you've got a child who's in State foster care or receive State adoption assistance, so they're eligible.

If you – if it's a very, very low income standard, these children are going to – that eligibility group will be folded into the new simplified eligibility group for children at proposed 435.118, right? Yes, 118 and there – so then you are going to ask what's the household composition for this child?

In a case of a child in foster care, presumably by definition they are not living with their parents, and they're going to fall under the non-filer rules. I'm going to assume for the most part, we're talking about children who are not being claimed as tax dependents by their parents if they're in foster care.

So they are not going to be living with their parents and they are going to end up as their own household. They may be, if there are two siblings that are placed together, they may be in their own household. The foster parent's income certainly isn't going to count. I don't actually know off-hand how foster care payments are – whether they're considered to be taxable income; I'm going to venture to guess that they are not. But I don't know, even if they are, I venture just suppose that it's low enough, they're not high enough to push this child out of Medicaid eligibility and the child is going to be eligible under the new children's group.

In the case of children who are receiving State adoption assistance, assuming that they are living with their adopted parents, they will be in the household of their adopted parents and that household's income would be used to determine their eligibility under the new children's group.

We have just of couple of minutes. The next question is about ESI and premium assistance programs. So in the interest of time, to not read the question but one to note is that the question about whether or not employer-sponsored insurance is minimal essential coverage because it's affordable for the employee or not, relates only to the question as to whether or not premium tax credits – the person can get – is eligible or the family is eligible for premium tax credits.

That question – the affordability question is not relevant in terms of that which I think is the crux of the question, which is about the State using a premium assistance program, using ESI and Medicaid. And basically, the rules around ESI and premium assistance programs weren't affected by the ACA.

So all the rules today will continue to exist in 2014. I hope that that answers the question. If not, I don't actually understand – we don't understand the nuance that the questioner is getting at.

Twenty-nine was very similar to twenty-three, so I think we won't repeat that. And, Anna, why don't we let you do one more. I think that's all we probably have time for is the one more, number thirty?

Anna Wolke: Sure and so that was the question about whether – "If an individual lost eligibility for Medicaid based on an increase in income, would he or she be allowed to disenroll from their employer plan in order to find more affordable insurance through the Exchange?" Also seems to be a question getting at special enrollment period.

So again, I want to reiterate what I mentioned earlier, is that determining individual's eligibility is separate from whether they qualify for an enrollment period. So determining eligibility occurs first and second if an individual experiences an increase in income, first I would say, you would want to reassess whether they are now ineligible for premium tax credits based on having affordable ESI. And in that case, the individual would not be eligible for premium tax credits, and then as outlined in subpart E of our rule, there are a number of categories that he or she would apply for – possibly apply for a special enrollment period. And in this case, if the individual was not – did not have access to affordable ESI or ESI of minimum value then he or she would presumably be newly eligible for advance payments of the premium tax credit, so that would qualify them for a special enrollment period. And that's just one example, but you'd have to look at all the different categories in order to determine who – whether that person applies.

Sarah deLone: Great. Thanks, Anna. I'll just mention on the next question that it's just – just because it's on the same theme of sort of premium assistance and ESI that a number of States have asked whether or not you could basically – they could basically do a premium assistance program but using – buying into qualified – for somebody in a qualified health program, and that we are actually we're examining that to see if there's any possibility of flexibility for States to do that.

They certainly couldn't take advantage of the premium tax credit portion if somebody's Medicaid eligible and just pay the individual share but we're examining whether there is flexibility or any possibilities of doing that, so more to come on that later.

So I'm sorry we were not able to get to the end. We got – we did pretty well, I think. And again, our thanks to our E-TAG for helping us to prioritize to at

least get at the most important questions. I'm glad we got through all of their Tier 1 identified questions.

Thank you everybody who has participated in these calls. I think we've actually learned a lot by doing them and hopefully they've been useful to you, and we look forward to your comments coming in and look forward to more discussions and dialog in the months to come. So thanks everybody, and thanks to Anna Wolke, especially, and Chris Gerhardt and Stephanie Kaminsky as well. Bye-bye.

Operator: This concludes today's conference call. You may now disconnect.

END