

## Medicaid, Children’s Health Insurance Programs, and Exchanges:

### Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing

#### Summary

January 22, 2013

On January 22, 2013, the Centers for Medicare & Medicaid Services (CMS) of the Department of Health and Human Services (HHS) published in the *Federal Register* (78 FR 4594) a proposed rule to implement various provisions of the Affordable Care Act (ACA) involving Medicaid, the Children’s Health Insurance Program (CHIP), and Exchanges.

The proposed rule would establish appeals processes for Medicaid and Exchange eligibility determinations, make various other changes related to Medicaid and CHIP eligibility, amend requirements providing for flexibility in Medicaid benefits provided under section 1937 of the Social Security Act (“the Act”), modify regulations related to Exchange eligibility and enrollment, and change limitations on Medicaid premiums and cost sharing. Some of the provisions of this proposed rule would modify the final rules that implemented ACA provisions issued on March 23, 2012 with respect to Medicaid eligibility (77 FR 17144) and on March 27, 2012 with respect to establishment of Exchanges (77 FR 18310).

Written comments, identified by file code CMS-2334-P, may be submitted to CMS. **The 30-day comment period closes on February 13, 2013.**

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## **I. Medicaid Eligibility Expansion Part II**

### **A. Background**

This section of the proposed rule adds new requirements regarding appeals of Medicaid eligibility denials, and makes a variety of other changes to Medicaid and CHIP regulations regarding eligibility standards and procedures, citizenship documentation requirements, and coordination with Exchanges.

### **B. Provisions of the Proposed Rule**

#### **1. Appeals**

The proposed rule would establish a coordinated process of appeals for individuals who have received a denial of eligibility based on modified adjusted gross income (MAGI) from the state Medicaid agency or from the Exchange. The proposed changes would modify numerous regulations, including some that were finalized in the March 23, 2012 final rule implementing Medicaid eligibility changes under the ACA. Among these are rules regarding the delegation of Medicaid eligibility determinations from the state Medicaid agency to the Exchange and other entities. (§431.10, §§431.200-431.234, §435.1200)

*Delegation of authority to conduct fair hearings.* The proposed process would allow a state, as part of its Medicaid state plan, to delegate authority for conducting fair hearings on denial of eligibility based on MAGI to an Exchange or to an appeals entity designated by the Exchange (“Exchange appeals entity”); however the individual would always retain the option of having their fair hearing conducted instead by the Medicaid agency. The state would be required to provide individuals with a notice indicating their right to this choice and the methods by which it may be exercised. In discussing this provision, CMS notes that it is a statutory requirement that individuals have this right, but that they expect most individuals will not opt to have two separate appeals, one by the Medicaid agency for Medicaid eligibility and the other by the Exchange regarding eligibility for premium assistance tax credits and cost sharing reductions. If the Exchange (or Exchange appeals entity) conducts the hearing on a Medicaid denial, that determination would be final, except that a state may exercise the option to review conclusions of law made by the hearing officer. (This option is discussed below.) As described later in this summary, the rule proposes related changes to the Exchange regulations.

The state plan would also indicate the scope of the delegation, namely whether the Exchange would conduct fair hearings for all individuals determined ineligible for Medicaid based on

MAGI or only those determined ineligible by the Exchange. CMS notes that an Exchange would have to agree to any delegation, and that it does not expect that the federally-facilitated Exchange (FFE) or the HHS appeals entity will accept delegation of authority to adjudicate appeals of determinations not made by the FFE.

Under the proposed rule, Medicaid agencies could not delegate authority to conduct fair hearings to other state agencies, such as a sister human services agency or independent state appeals agency, but may request a waiver to do so under the Intergovernmental Cooperation Act of 1968, subject to the state establishing clear oversight over the agency conducting the fair hearings. CMS notes that if a state requests a waiver under the Intergovernmental Cooperation Act in order to delegate authority to conduct fair hearings to an Exchange that is a state agency, the proposed requirement that an individual retain the right to request that the Medicaid agency make the determination would not apply. In light of this, **CMS seeks comments on whether Medicaid agencies should have the authority under these regulations to delegate fair hearing authority to any state agency subject to the same requirements that apply to delegation to a state-based Exchange.**

When a state chooses to delegate fair hearing authority to the Exchange, CMS proposes that the state be given the option of having the Medicaid agency review decisions made by the Exchange with respect to conclusions of Medicaid law, including interpretation of federal and state policies. In this case, factual determinations made by the Exchange appeals entity would not be reviewable by the Medicaid agency. Timeliness requirements for a final decision would still need to be met.

*General rules on delegation of authority.* As discussed further in item 14 below, the proposed changes would also modify more generally the regulations regarding delegation of Medicaid eligibility determinations, including the proposed fair hearing requirements. Under current regulations, states may delegate eligibility determinations to the single state agency for Temporary Assistance for Needy Families (TANF) or to the federal agency administering the Supplemental Security Income (SSI) program. The regulations finalized in March 2012 provided additionally for delegation of MAGI-based eligibility determinations to an Exchange that is operated by a nongovernmental entity or contracts with a private entity for eligibility services. Under this proposed rule, a state plan would need to specify whether eligibility determinations for all or a defined subset of individuals are delegated to the TANF agency, the federal agency determining eligibility for SSI, or the Exchange. Authority for making eligibility determinations or conducting fair hearings could only be delegated to a government agency or public authority which maintains personnel standards on a merit basis.

CMS notes that while it has modified the text of the regulatory language regarding delegation of authority for eligibility determinations, no substantive changes are intended. These provisions require that any agency or public authority to which eligibility determinations or fair hearing is delegated would be required to comply with federal and state laws, regulations and policies (including eligibility criteria), prohibitions against conflicts of interest and improper incentives, and safeguarding confidentiality; and would be required to inform applicants and beneficiaries of how to contact and obtain information directly from the state agency. The Medicaid agency

would be required to exercise oversight to ensure compliance with all requirements and pursue corrective action if necessary, including a rescission of delegation authority.

*Requests for a hearing.* The proposed rule would modify existing regulations regarding hearing requests to provide that the Medicaid agency treat an appeal of a determination of eligibility for enrollment in a qualified health plan (QHP) in the Exchange and for advance payment of the premium tax credit or cost sharing reductions as a request for a fair hearing of a denial of Medicaid eligibility. This is intended to avoid a situation in which an individual who believes they are entitled to more assistance must make separate appeals to the Exchange and the Medicaid agency. **CMS seeks comments on whether a later effective date for this policy, such as January 1, 2015, is appropriate to provide states with sufficient operationalizing time.**

In cases where the Medicaid agency (and not the Exchange) is conducting the hearing of Medicaid eligibility denial, CMS proposes that a decision would have to be issued within 45 days from the time the Exchange appeals entity decision is made regarding eligibility to enroll in a QHP and receive advance payment of premium tax credits and cost sharing reductions. In this way, individuals satisfied with the outcome of their appeal to the Exchange could withdraw their application for a Medicaid eligibility review. CMS believes that, for those states that have not delegated to the Exchange authority for a Medicaid eligibility fair hearing, this sequencing will prevent the Medicaid agency from having to conduct hearings in cases for individuals with incomes substantially above the Medicaid eligibility level. **CMS indicates that it considered a number of approaches for balancing consumer interests in a timely decision with the goal of limiting burden on states, and solicits comments on these alternatives.** They are:

- 1) allowing the Medicaid agency 30 or 60 days instead of 45 days after the Exchange appeals decision to make a final Medicaid eligibility determination,
- 2) extending the timeframe generally permitted for fair hearing decisions from 90 days to 120 days from the date of the hearing request,
- 3) allowing for a decision 45 days from the Exchange appeals determination or 120 days from the date of the fair hearing request, whichever is earlier, and
- 4) maintaining the current timeframe of 90 days from the hearing request.

*Informal resolution process.* In the preamble, CMS indicates its expectation that the HHS appeals entity will have an informal resolution process that will serve as a first level of review prior to the Exchange appeals entity undertaking a formal hearing process. State-based Exchanges would have the option to adopt such a process as well. (This is discussed further in section III of this summary.) CMS indicates that a state that has not delegated authority to conduct Medicaid fair hearings to the Exchange would be able to use the informal resolution process at the Exchange, provided that a Medicaid eligibility fair hearing proceeds automatically if the informal process does not result in Medicaid eligibility. The use of this process would be subject to an agreement between the Medicaid agency and the Exchange, subject to applicable rules for such agreements, and would not change the appeals timeliness requirements.

*Electronic accounts.* The rules finalized in March 2012 define an electronic account to include all information collected and generated by the state regarding an individual's Medicaid eligibility

and enrollment. CMS proposes to modify this definition to include information collected or generated as part of a Medicaid fair hearing process or Exchange appeals process and to afford individuals access to the electronic account as they currently have access to their “case file.”

*Coordination with other insurance affordability programs.* Regulations adopted in March 2012 regarding coordination among Medicaid, the State Children’s Health Insurance Program (CHIP) the Exchanges would be amended to implement the proposed appeals processes. The Medicaid agency would be required to accept a decision of the Exchange appeals entity in the same way it accepts determination of Medicaid eligibility by the Exchange. Where the agency has delegated appeals authority to the Exchange, a combined appeals decision would be made by the Exchange regarding advance payment of the premium tax credit and eligibility for Medicaid. In addition, if after a fair hearing an individual is found ineligible for Medicaid, the agency must assess the individual for eligibility for other insurance affordability programs, following the rules adopted in March 2012 for individuals determined ineligible at initial application or renewal.

Under the previously adopted rules, an Exchange must offer an individual the opportunity to withdraw their application for Medicaid if, based on an initial assessment, the Exchange finds the individual potentially ineligible for Medicaid. The proposed rule would amend this provision to require automatic reinstatement of the Medicaid application if the individual subsequently files an appeal of the Exchange’s determination of their eligibility to enroll in a QHP, or for advance payment of the premium tax credit or cost sharing reductions, and the Exchange appeals entity assesses the individual potentially eligible for Medicaid. In this case, the Medicaid application would be effective as of the date of the original application to the Exchange, and the individuals’ electronic account would be transferred to the Medicaid agency to make an eligibility determination. This situation would only arise in a state that has not delegated authority for Medicaid eligibility determinations to the Exchange.

The proposed rule would also clarify that when a Medicaid agency is determining eligibility of an individual assessed as potentially eligible by an Exchange appeals entity, the Medicaid agency may not request from the individual information or documentation that is in the electronic account or provided to another insurance affordability program or appeals entity. The agency must also accept any finding relating to a criterion of eligibility that was made by another insurance affordability program’s appeals entity if the finding was made in accordance with the Medicaid agency’s policies and procedures.

Under the proposed rule, regardless of whether a Medicaid agency delegates authority to conduct fair hearings to the Exchange, the agency would be required to establish a secure electronic interface that allows for transfer of an individuals’ electronic account between programs or appeals entities and through which the Exchange appeals entity can notify the agency that an appeal has been filed when such appeal triggers an automatic Medicaid fair hearing request. The interface established between the Exchange and the Medicaid agency could be used for this purpose, or a separate interface between the Medicaid agency and the Exchange appeals entity may be established. CMS notes that where the Exchange appeals entity conducts the Medicaid fair hearing, no transfer of information is required at the time the individual files an appeal.

The Medicaid agency would be required to transmit to the Exchange an eligibility fair hearing decision in cases where 1) an individual was initially determined Medicaid ineligible by the Exchange and 2) an individual was initially found ineligible for Medicaid by the state agency and a fair hearing was conducted while the individual's account was transferred to the Exchange for evaluation of Exchange eligibility.

CMS notes that under the proposed Exchange rules (discussed in section III), when an Exchange appeals entity decision regarding Medicaid eligibility conflicts with a decision made by the state, the state's determination takes precedence and is binding on the Exchange.

## 2. Notices

CMS seeks to avoid circumstances under which an individual could receive multiple notices regarding their eligibility for insurance affordability programs. As an example of the potential for multiple notices, CMS offers that an individual who the Exchange finds potentially eligible for Medicaid could receive 3 notices: a denial of eligibility for advance payment of tax credits from the Exchange, a denial of Medicaid eligibility from the Medicaid agency and a subsequent reversal of the Exchange's original eligibility denial.

*Combined notice and coordinated content.* (§435.1200) CMS proposes that beginning January 1, 2015, to the extent feasible after all MAGI-based eligibility determinations have been made for an individual (or family), the last agency to make a determination would issue a combined notice of eligibility for each of the insurance affordability programs for which an eligibility determination was made. The later effective date is proposed to provide time for needed systems to be put in place; implementation could occur earlier. **CMS seeks comment on an alternative effective date of October 15, 2015.** Agreements between Medicaid agencies and other insurance affordability programs would be required to delineate the responsibilities of each program to provide combined eligibility notices and, where combined notice is not possible, coordinated content. Coordinated content refers to information included in an eligibility notice relating to the transfer of the individual's electronic account to another program, and the status of that other program's review of the account. CMS indicates that under the agreements, the Medicaid and CHIP agencies and the Exchange would have to work together to provide a single notice of eligibility for all family members of a household applying for coverage together.

With respect to an individual who is found ineligible on the basis of MAGI, a combined notice would not be required, and the Medicaid agency would notify the individual that eligibility on the basis of MAGI is denied but the agency is continuing to consider eligibility on other bases. Following previously finalized rules, in this case the Medicaid agency would determine potential eligibility for other insurance affordability programs and transfer the individual's electronic account as appropriate while the continuing Medicaid eligibility determination is underway. If an individual is ultimately found eligible for Medicaid on a non-MAGI basis, the Medicaid agency would notify them of their eligibility and of the termination of their eligibility for another program if they are so enrolled.

CMS discusses other situations in which a combined notice would not be feasible, involving 1) situations where family members are found eligible for different programs, and 2) cases where

an individual is found eligible for the premium tax credit and seeks a full determination of Medicaid or CHIP eligibility by the state agency, as permitted under the previously finalized rules. **Comments are welcomed as to whether there are additional situations for which a combined notice would not be feasible.**

*Content and accessibility of eligibility notices.* (§435.917, §435.918) Standards are proposed for the content and accessibility of all Medicaid eligibility notices. Under these requirements, notice of eligibility (including a denial, termination, suspension or change in benefits and services) would have to be written in plain English, be accessible to individuals with limited English proficiency and disabilities, and comply with requirements for electronic notification described below. Eligibility notices would have to include information on the basis and effective date of eligibility; the circumstances under which the individuals must report changes that may affect eligibility; if applicable, the amount of medical expenses that must be incurred to establish eligibility; information on the level of benefits and services approved including any premiums, enrollment fees and cost sharing; and the right to appeal the level of benefits and services approved.

Notices of adverse action related to MAGI would be required to include information on bases of eligibility other than MAGI; the benefits and services available under these other bases sufficient for the individual to make an informed choice as to whether to request an eligibility determination on another basis; and information on how to request a determination on another basis. **CMS solicits comments on the level of detail that should be required for inclusion in this notice.**

A combined eligibility notice issued by the Exchange or other insurance affordability program would satisfy these Medicaid program requirements except that the Medicaid agency may be required to provide a supplemental notice if all the information is not provided. For example, a supplemental notice would be required if the combined notice issued by the Exchange does not include information on the level of benefits and services approved (including any premiums, enrollment fees and cost sharing) and on the right to appeal the level of benefits and services approved.

CMS intends to release in 2013 model language that could be used by states for delivering combined eligibility notices. This language is being developed in consultation with states, consumer groups and plain-language experts. State Medicaid and CHIP agencies would need to work with the Exchange on any state-specific content to be included in a combined notice or may issue supplementary notices.

*Electronic notice option.* CMS proposes new requirements regarding electronic communication of notices. States would be required to provide individuals with the option to receive notices through a secure electronic format in lieu of a written notice by regular mail, which would remain the default requirement for providing notice. If an individual elects the electronic notification option, the state would confirm this by regular mail; inform the individual of their right at any time to receive notices through regular mail; post any notices to the individual's electronic account within 1 business day, and notify the individual by email, text or other electronic communication that a notice has been posted to their account, with no confidential



information in the email; and send any notice by regular mail within 3 business days if any electronic communication is undeliverable. **CMS considered permitting individuals to confirm their election online but believes that confirmation by mail is a stronger consumer protection; comments on this and other consumer safeguards are welcomed. Comments are also sought on whether other communications should be made available electronically through an individual electronic account, including requests for additional information, annual renewal forms, and premium payment information.**

*CHIP eligibility notices.* Similar changes are proposed to CHIP regulations regarding notices. CMS also clarifies that the requirement (§457.350(f)(3)) that a state find an individual ineligible, provisionally ineligible or suspend the application unless and until the individual's Medicaid application is denied applies only at initial application. States have expressed concern that applying this provision to CHIP enrollees at redetermination could result in coverage gaps.

### **3. Medicaid Eligibility Changes under the ACA**

Changes are proposed to implement Medicaid eligibility provisions under the ACA providing Medicaid eligibility to former foster care children and an optional coverage category for family-planning services.

A new mandatory eligibility group is created (§435.150) for individuals who are under age 26, not eligible for Medicaid through certain other mandatory categories (excluding the new ACA expansion group for adults), and enrolled in both Medicaid and foster care assistance either at the time they turned 18 or at the age when foster care assistance ends. CMS notes that an alternative interpretation of the statute would limit eligibility to individuals who “age out” of foster care. **CMS seeks comments on its interpretation of the statutory requirement for Medicaid enrollment to give states the option to cover individuals who were in foster care and Medicaid in any state, not only the state in which coverage is sought.** No income or resource requirements apply to eligibility for this group, and the ACA provides that this category, which imposes no income or resource requirements, takes precedence in the case of individuals who would also be eligible under the new ACA adult expansion group. CMS notes that in accordance with longstanding general Medicaid policy and reflected in §435.916(f) finalized in the March 2012 Medicaid eligibility rule, if an individual loses eligibility under this group, coverage is not terminated unless the individual is also ineligible under all other groups.

States would be given the option at §435.214, as required under the ACA, to provide coverage, for family planning services only, to individuals (including males) who are not pregnant and have incomes up to the highest level established by the state for pregnant women under Medicaid or CHIP, which CMS interprets to include eligibility levels under a section 1115 waiver. Income eligibility would be determined under MAGI-based methodologies. CMS proposes to codify (at §435.603(k)) the policy outlined in the July 2, 2010 State Medicaid Director letter with respect to this eligibility group, under which states may consider the individual's household to consist only of the individual, may consider only the income of the individual applying for coverage (while retaining other household members for the purpose of determining family size) and may increase the family size used for determining eligibility for coverage under this group by one, similar to the family size increase provided for pregnant women. CMS also proposes to amend the

definition of targeted low-income child to indicate that eligibility for limited coverage of family planning services does not preclude an individual from eligibility for CHIP.

Technical changes are made to various regulations to make required distinctions in the application of financial methodologies related to MAGI-based eligibility and those used for individuals excepted from application of the MAGI-based methodologies.

#### **4. Medicaid Enrollment Changes under the ACA Needed to Coordinate with the Exchange**

*Certified Application Counselors.* Rules at §435.908 providing for assistance to Medicaid applicants would be revised to provide states the option of certifying staff and volunteers of state-designated organizations to act as application assisters and to establish standards for such certification. The proposed standards would require application assisters to be authorized and registered by the Medicaid agency, be effectively trained in the eligibility and benefits rules and regulations governing all insurance affordability programs in the state, and be trained in and subject to regulations relating to the safeguarding and confidentiality of information and conflict of interest.

Application assisters could be certified to act on behalf of applicants and beneficiaries with respect to one or more of the following tasks: providing information on insurance affordability programs, helping individuals complete applications and renewals, gathering required documents, submitting applications and renewals, assisting individuals with responding to requests from the agency and managing their case between the eligibility determination and regularly scheduled renewals.

A state electing to certify application assisters would be required to establish a web portal to which only certified application assisters have access and through which they could provide assistance. The portal would need to be secure so that assisters could only perform the tasks for which they are certified. In addition, the state would need to establish procedures that would inform applicants and beneficiaries of the functions and responsibilities of application assisters, and provide assisters with confidential information related to an individual's application only when authorized by the applicant or beneficiary. Application assisters would be prohibited from charging fees to applicants or beneficiaries. Similar regulations for certified application counselors are proposed for the Exchange, discussed below (§155.225), and CMS notes that to achieve a seamless and coordinated process, a state could create a single certification process that would apply to both programs. Alternatively, each program could recognize counselors certified by the other.

In discussing this proposal, CMS describes the long history in many Medicaid and CHIP programs of enabling providers and other organizations to serve as application assisters, which are also referred to in the proposed rule as “application counselors,” that provide direct assistance to individuals seeking coverage. The proposed standards are intended to ensure that application counselors have the training and skills to provide reliable and effective assistance and that they will meet confidentiality requirements, in particular with respect to confidentiality rules under the Internal Revenue Code.

CMS reminds Medicaid and CHIP agencies of the obligation to ensure that programs, including application counselor programs, provide equal access to individuals with limited English proficiency and individuals with disabilities under applicable civil rights laws. These obligations could be met by referral of individuals to appropriate application counselors.

*Authorized representatives.* Current rules providing that a Medicaid agency must accept an application from an authorized representative acting on behalf of an individual would be revised, establishing minimum requirements for designation of authorized representatives. Under these proposed rules (at a proposed new §435.923), an agency would be required to accept an individual's designation of an authorized representative if the designation was in writing, (including the individual's signature) and submitted at the time of application for eligibility or at another time. Legal documentation of authority to act on behalf of an applicant or beneficiary under state law could serve in place of the written authorization. The authorization would remain in place until a written notification provides otherwise. The agency would be required to accept electronically submitted signatures.

Authorized representatives could sign an application or submit a renewal form, receive notices, and act on behalf of the beneficiary in all other matters. The representative would be required to fulfill all responsibilities to the same extent as the represented individual and would be required to maintain confidentiality of any information provided by the agency about the applicant; a written confidentiality agreement is specified in the proposed regulation.

*Accessibility for Individuals who are Limited English Proficient.* CMS proposes to clarify existing requirements (§435.905) regarding provision of information to individuals with limited English proficiency to specify that providing language services means providing oral interpretation, written translations, and taglines in non-English languages regarding the availability of language services. Similar modifications are proposed with respect to CHIP. For additional information CMS cites guidance published on August 8, 2003 (68 FR 47311) and a State Health Official letter dated July 1, 2010 regarding the availability of federal matching funds for these services. Proposed modifications to additional rules would be made to align with Exchange regulations, and CMS indicates the intention is to provide that all notices and communications across regulations at part 431 subpart E be accessible to people who are limited English proficient and with disabilities.

## **5. Medicaid Eligibility Requirements and Coverage Options Established by other Federal Statutes**

*Eligibility pathways.* CMS proposes new or amended regulations regarding eligibility pathways established by federal statutes other than the ACA. In some cases, the proposed rule would codify eligibility rules that states have been implementing for many years under federal guidance, (i.e., optional eligibility for individuals needing treatment for breast or cervical cancer). Other changes are proposed to eliminate duplicative or obsolete rules or to reflect required alignment with the MAGI-based financial methodologies or with other requirements.

The affected categories and associated proposed regulatory sections are:

- mandatory coverage of children with Title IV-E adoption assistance, foster care, or guardianship care under Title IV-E (§435.145);
- extended eligibility for low-income families (§435.112 and §435.115);
- extended and continuous eligibility for pregnant women (§435.170) and hospitalized children (§435.172);
- optional eligibility for parents and other caretaker relatives (§435.220);
- optional coverage for reasonable classifications of individuals under age 21 (§435.222);
- optional eligibility for individuals needing treatment for breast or cervical cancer (§435.213);
- optional eligibility for independent foster care adolescents (§435.226);
- optional eligibility for individuals under age 21 who are under state adoption assistance agreements §435.227);
- optional targeted low-income children (§435.229);
- optional continuous eligibility for children (§435.926 and §457.342); and
- optional tuberculosis (TB) eligibility group (§435.215).

**CMS specifically requests comments with respect to proposals for two of the areas listed above:**

1. The alternative eligibility requirement in existing regulations at §435.227(a)(3)(ii) for optional eligibility for individuals under age 21 who are under state adoption assistance would be deleted. This deletion is proposed because CMS believes the eligibility requirements at §435.118 adopted in the March 2012 Medicaid eligibility rule are more expansive.
2. The proposed changes with respect to eligibility for coverage of TB-related services for infected individuals not otherwise Medicaid eligible would codify statutory eligibility for this group at §435.215. The statute limits eligibility in this group to individuals whose incomes and resources do not exceed the maximum amount for a disabled individual in a mandatory coverage category (Part 435, subpart B) under the state plan. CMS notes that the statute provides no exception for TB-infected individuals with respect to application of MAGI rules, and therefore proposes that effective January 1, 2014, income eligibility for this group must be determined in accordance with MAGI rules. **CMS seeks comments on an alternative interpretation of the statute it considered which would except from the MAGI rules individuals eligible on the basis of TB infection because the statute links income eligibility for the TB group to disability income standards.**

*Presumptive eligibility.* (Subpart L of part 435) Regulations are proposed to implement options for Medicaid presumptive eligibility that were enacted in the ACA and earlier statutes, and to revise existing presumptive eligibility requirements (and related federal financial participation rules) with respect to children to reflect the adoption of MAGI-based methodologies and ensure consistency. Changes for consistency and other technical modifications are made to regulations regarding presumptive eligibility under CHIP (§457.355).

The revisions to current rules regarding presumptive eligibility for children (§435.1102) would clarify that an entity designated by the state as a qualified entity providing presumptive eligibility may not delegate to another entity the authority to determine presumptive eligibility. In addition the state would be required to establish oversight mechanisms to ensure the integrity of presumptive eligibility determinations. A state could require as a condition of presumptive eligibility that an individual (or another person who attests to having reasonable knowledge on an individual's status) attest to be a citizen or national of the US or in satisfactory immigration status, or a resident of the state. The state may not impose other conditions on presumptive eligibility or require verification of conditions for presumptive eligibility. Notice of fair hearings would not apply to determinations of presumptive eligibility. **CMS seeks comments on whether the provision that permits another person with reasonable knowledge to attest to citizenship status should be a requirement or a state option.**

A new section 435.1103 would provide for presumptive eligibility for individuals other than children, as provided by the statute. Requirements for presumptive eligibility for pregnant women would parallel those for children except that pregnant women are only eligible for pregnancy-related services, and CMS proposes that they only be permitted one presumptive eligibility period per pregnancy. As provided in the statute, a state that has elected to provide presumptive eligibility to pregnant women or children may extend the election to include additional populations: parents and other caretaker relatives, adults and former foster care children. Optional presumptive eligibility is also proposed for individuals eligible for coverage of treatment of breast or cervical cancer and those eligible for family planning services.

*Presumptive eligibility determined by hospitals.* As required by the ACA, CMS proposes to allow a hospital to elect to determine presumptive eligibility for Medicaid as of January 1, 2014. This is not a state option, unlike the other presumptive eligibility provisions. Hospitals would have this option even in a state that does not elect, as described above, to cover presumptive eligibility for children or pregnant women or other individuals.

Under the proposed regulation (§435.1110), the state would be required to provide Medicaid during a presumptive eligibility period determined by a qualified hospital on the basis of preliminary information in accordance with presumptive eligibility requirements generally applicable to children (§435.1102) and other individuals (§435.1103). A qualified hospital would be defined as one that 1) participates as a provider under the state plan or a section 1115 demonstration and notifies the agency of its election to make presumptive eligibility determinations, agreeing to do so consistent with state policies and procedures, 2) at state option assists individuals in completing and submitting the full application for Medicaid and understanding any documentation requirements, and 3) has not been disqualified by the state.

The state could elect to limit the determinations of presumptive eligibility by hospitals to determinations based on income for children, pregnant women, parents and caretaker relatives, and other adults. Alternatively, the state could choose to permit hospitals to make presumptive eligibility determinations on additional bases under the state plan (or section 1115 demonstration), such as eligibility determinations based on disability.

CMS proposes that the state may establish standards for a qualified hospital related to the proportion of individuals determined presumptively eligible for Medicaid by the hospital who submit a regular application before the end of the presumptive eligibility period or the proportion that are determined eligible by the Medicaid agency based on such applications. **CMS seeks comment on whether such standards should be a state option (as proposed), a federal requirement, or neither, and what a reasonable standard would be.** The Medicaid agency would be required to take action, including disqualification, if it determines that a hospital 1) is not meeting these state-established standards, or 2) is not making or capable of making eligibility determinations in accordance with state policies and procedures.

*Medically needy.* The ACA provided that income determinations for the medically needy be exempt from MAGI-methodologies. CMS proposes that states have the flexibility to apply either methods under the Aid to Families with Dependent Children (AFDC) program or MAGI-based methods for determining income eligibility for medically needy pregnant women, children, and parents or other caretaker relatives. The reason is that the MAGI-based methods are generally used for these groups and some states may find continued use of AFDC-based methods burdensome since that program has been eliminated. CMS discusses restrictions under the statute in how the MAGI-based methodology could be applied for determining medically needy eligibility. In particular, under the maintenance of eligibility requirements, which apply for children through fiscal year 2019, states would have to ensure that the application of MAGI-based methodologies is no more restrictive than current methods.

*Optional eligibility of lawfully-residing non-citizen pregnant women and children.* CMS proposes to implement (§435.406 and §457.320) the option enacted under the Children's Health Insurance Reauthorization Act of 2009 (CHIPRA) permitting states to provide Medicaid coverage to children or pregnant women who are lawfully residing in the US and otherwise eligible for Medicaid. CMS states that the proposed regulations are consistent with the policy included in the July 1, 2010 State Health Official letter offering guidance on implementation of this provision. Several changes proposed to the definition of "lawfully present" at §435.4 are discussed; CMS does not believe these changes would substantially affect eligibility or impact state costs. Parallel changes would be made to CHIP regulations. **CMS solicits comments on the proposed definition of lawfully present,** and notes that codification of other statutes relating to Medicaid eligibility of non-citizens (including Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and subsequent federal legislation) are not included in current regulation or this proposed rulemaking.

*Deemed newborn eligibility.* CMS proposes to modify existing requirements (§435.117 and 457.360) regarding deemed Medicaid or CHIP eligibility for newborns to reflect statutory amendments enacted in CHIPRA and to make other changes. Among the other proposed changes, states would be given the option to treat as a deemed newborn in Medicaid, a baby born to a mother covered as a child under a separate CHIP plan for benefits on the date of birth. CMS believes this would simplify administration and be in the best interest of beneficiaries. (States would also be given the option to extend deemed newborn eligibility under a separate CHIP plan to the extent that the state has not provided Medicaid eligibility for these babies.) **CMS seeks comments on whether states should have the option to extend automatic Medicaid enrollment to all babies likely to meet Medicaid eligibility requirements who are born to**

**such mothers or only such babies if the state has elected to cover targeted low-income pregnant women, or no babies born to mothers who do not qualify as a targeted low-income pregnant woman.** CMS also proposes to give states the option of recognizing the deemed newborn status from another state for the purpose of enrolling babies born in another state without need for a new application. In addition, states would be directed to promptly issue a separate Medicaid identification number for the infant prior to the child's first birthday or termination of the mother's Medicaid eligibility, whichever is sooner, unless the child is determined ineligible.

## **6. Verification Exceptions for Special Circumstances**

CMS proposes an exception to the previously adopted rule (§435.952) permitting states to request additional information and documentation from individuals if the data obtained electronically by the state is not reasonably compatible with attested information. The exception would provide that except as specifically required under the Act (such as with respect to citizenship and immigration status) states may not require documentation from individuals for whom documentation does not exist or is not reasonably available at the time of application or renewal, such as individuals who are homeless or who have experienced domestic violence or a natural disaster.

## **7. Verification Procedures for Individuals Attesting to Citizenship or Satisfactory Immigration Status**

A process is proposed to provide that, if verification of citizenship and immigration status is not available through the federal data services hub created under §435.949, the state would verify citizenship through an electronic data match directly with SSA and immigration status directly through the Department of Homeland Security (DHS) SAVE system under existing regulatory procedures. CMS proposes that if the agency cannot promptly verify citizenship or immigration status through the federal data services hub or otherwise, it would have to provide notice to the individual and, beginning 5 days after the date on the notice, provide a 90-day reasonable opportunity period during which it may not delay, deny, reduce or terminate benefits for an otherwise eligible individual. (Benefits could be provided earlier at state option.) The reasonable opportunity period could be extended at state option if the individual is making a good faith effort to obtain information or the agency needs more time to complete the process. The reasonable opportunity period would encompass all aspects of the process to verify citizenship and immigration status, including time for the individual to provide documentation and time for the agency to resolve inconsistencies or conduct the electronic verification process. If at the end of the period verification has not been made, the agency would be required to act within 30 days to terminate benefits. CMS proposes that the 90-day reasonable opportunity period apply to all citizenship verification procedures; this is consistent with both the statute and the period provided for Exchanges.

Situations that may trigger the reasonable opportunity period include situations in which the federal data services hub or electronic SSA or DHS services are unavailable, the individual is unable to provide a SSN requiring electronic verification with SSA, there are inconsistencies in the information provided by the individual and the electronic data, or the verification is

unsuccessful and additional information is needed. **CMS seeks comments on this proposal and an alternative which would provide the agency a specified number of business days to resolve any information inconsistencies.**

CMS also proposes to codify provisions of CHIPRA following guidance provided in a State Health Official letter issued on December 28, 2009. These provisions would exempt deemed newborns from citizenship verification requirements (§435.406) and eliminate non-statutory requirements related to the types of acceptable documentary evidence of citizenship and identity (§435.407). Related changes are proposed to CHIP regulations.

## **8. Elimination or Changes to Unnecessary and Obsolete Regulations**

The proposed rule identifies a variety of regulations that are proposed for deletion or modification because they have been rendered obsolete or require revisions due to eligibility changes under the ACA, the de-linkage of Medicaid and AFDC, the implementation of MAGI-based financial methodologies in FY 2014, or the consolidation of eligibility groups.

## **9. Coordinated Medicaid/CHIP Open Enrollment Process (§435.1205)**

Requirements are proposed under which Medicaid and CHIP agencies would begin accepting a single streamlined application for eligibility under all the insurance affordability programs (including the Exchange), effective with the initial open enrollment period beginning on October 1, 2013. In addition to the application, the agencies would be required to accept the electronic accounts transferred from agencies administering other insurance affordability programs. They would begin making eligibility determinations based on MAGI and eligibility criteria effective January 1, 2014. For individuals found not eligible for Medicaid (or CHIP), requirements on the agencies include assessing potential eligibility for the other insurance affordability programs, and transmitting the electronic account appropriately. Requirements regarding notice and fair-hearing rights (as modified in this proposed rule) would apply.

Individuals found eligible for coverage effective January 1, 2014 would be required to report changes in circumstances that may affect eligibility, and the agency would be required to evaluate the effect of these changes. The first regular renewal could be scheduled anytime between 12 months after the date of application or January 1, 2015.

Although Exchange coverage will begin on January 1, 2014, Medicaid and CHIP coverage could begin earlier, and CMS provides states with several options for ensuring prompt enrollment for individuals eligible under 2013 rules. A state could determine eligibility under 2013 rules based on information submitted on the application, request additional information needed to determine 2013 eligibility, or notify the individual of the opportunity to submit a separate application for 2013 coverage and information on how to obtain and submit such application. With respect to the last option, **CMS seeks comments on whether states should only notify a subset of applicants about the process for applying for 2013 coverage, for example, only those who appear on the basis of the single streamlined application to be potentially eligible under 2013 rules.**



CMS intends to work with states that wish to avoid having to make eligibility determinations during the open enrollment period under two different sets of rules. For example, some states are interested in using section 1115 demonstration authority to apply MAGI-based methodologies effective with the October 2013 open enrollment period. **CMS seeks comments on the best way for states to handle situations in which individuals seek coverage for 2014 using 2013 state Medicaid applications.**

In light of the open enrollment period, **CMS seeks comments on whether October 1, 2013 or January 1, 2014 is the appropriate effective date for some regulations finalized in March 2012 or proposed in this rule.** They are: §435.603 (MAGI-based methodologies) and §435.911 (MAGI screen); §435.907 (use of the single streamlined application); §435.908(c) (use of application assisters) and §435.923 (use of authorized representatives); §§435.940 et seq. (verification of eligibility criteria); §§431.200 et seq., §435.917, §435.918 and §435.1200 (coordination of eligibility and enrollment, notices and appeals between the Exchange, Medicaid and CHIP); and corresponding CHIP regulations in part 457 (§§457.315, 457.330, 457.340, 457.348, 457.350, 457.351, 457.380 and 457.1180).

## **10. CHIP Changes**

Changes are proposed to CHIP regulations regarding the imposition of waiting periods for enrollment, and enrollment “lock-out” periods resulting from failure to pay premiums.

*Waiting Periods (§457. 805).* CMS reports having received a number of comments regarding the implications of the waiting period required for CHIP coverage on coordination with other insurance affordability programs. Waiting periods are currently employed in 38 states as a means of ensuring that CHIP coverage does not substitute for (“crowd out”) coverage under group health plans. In light of other rules under the ACA affecting group and individual coverage, starting in 2014, CHIP would be the only program using waiting periods in excess of 90 days. The current waiting periods range from 1 to 12 months, with state-specified exemptions.

In response to these comments, CMS proposes to require that individuals subject to a waiting period be included among those for whom the CHIP agency must screen for eligibility for other insurance affordability programs. In addition, CMS proposes limitations on waiting periods in CHIP effective January 1, 2014. Waiting periods would be limited to a maximum of 90 days, and may not be applied to children losing eligibility for other insurance affordability programs.

Exemptions from waiting periods would be required in the following situations:

- (1) The cost of the discontinued coverage for the child exceeds 5% of household income;
- (2) The cost of family coverage that includes the child exceeds 9.5% of the household income;
- (3) The employer stopped offering coverage of dependents;
- (4) A change in employment, including involuntary separation, resulted in loss of access to employer-sponsored insurance (ESI) (other than through payment of the full premium by the parent under COBRA);
- (5) The child has special health care needs; and
- (6) The child lost coverage due to the death or divorce of a parent.

CMS notes that these are common state exemptions; states could grant additional exemptions.

It is also considering whether to add an additional exemption for situations in which the child's parent is determined eligible for advance payment of premium tax credits because the family's employer coverage is determined unaffordable.

Additional limitations under consideration would apply waiting periods only to children with family incomes above 200% or 250% of the FPL, only allow waiting periods based on evidence of substitution in a state, or prohibit CHIP waiting periods beginning in 2014. CMS solicits comments on the viability of alternative strategies for balancing the goal of reducing coverage gaps for children while ensuring that CHIP does not substitute for group health coverage.

Finally, CMS proposes that if a state has a premium assistance program under CHIP, any waiting period must also apply to the same extent to the premium assistance program.

*Lock-out periods (457.570).* Most states operating separate (non-Medicaid) CHIPs require families to pay premiums or enrollment fees, and policies vary with respect to re-enrollment after termination of coverage for nonpayment. Some states impose a "lock out period" ranging from 1 to 6 months during which a child must wait to re-enroll, in some cases even if the back premiums have been paid.

CMS proposes to permit states to impose a premium lock out period during which a child may not reenroll in coverage only if families have outstanding unpaid premiums or enrollment fees, and only up to a 90-day period. Past due premiums or fees must be forgiven if a child has been subject to a lock-out period, regardless of the length. **CMS invites comments from states on alternative late payment strategies that encourage timely payment of premiums and avoid gaps in coverage.**

## **11. Premium Assistance**

CMS proposes to implement statutory authority for states to provide Medicaid or CHIP coverage through premium assistance, including support for enrollment of Medicaid and CHIP-eligible individuals in plans in the individual market, including enrollment in QHPs in the Exchange. (The statutory authority authorizing premium assistance for group coverage under Medicaid (§§1906, 1906A) and CHIP (§§2105(c)(3), 2105(c)(10)) is described.) Premium assistance is viewed by CMS as a means of facilitating coordinated coverage among Medicaid, CHIP and the Exchange, as families in which different family members are eligible for different insurance affordability programs may be allowed to enroll in the same health plan, even if financed by from multiple programs. CMS believes this could also help individuals whose eligibility moves among programs to maintain enrollment in a single health plan. **CMS seeks comments on how Medicaid and CHIP agencies can coordinate with the Exchange to establish and simplify premium assistance arrangements, and how they can be operationalized.**

Under this proposed regulation, a state could provide for premium assistance for plans in the individual market if certain conditions were met. The insurer would be primary payer to Medicaid for all items covered under the insurer's plan. Because a Medicaid-eligible individual enrolled in a premium assistance plan would remain qualified for all Medicaid benefits, the Medicaid program would have to supplement the private coverage, if necessary. In addition,

Medicaid cost sharing limits would apply. Finally, the cost of the coverage, including the administrative expenses and the cost of wrap-around benefits, would have to be “comparable” to the cost of providing direct Medicaid coverage. Enrollment would be voluntary for individuals – a state could make premium assistance a condition of Medicaid eligibility.

CMS notes that the statutory provisions related to premium assistance for group coverage provide that premium assistance may include payment of premiums for non-Medicaid eligible family members if their enrollment is necessary for enrollment of the Medicaid-eligible individual as long as the cost effectiveness test is met. **No parallel proposal is offered here with respect to individual coverage, but CMS seeks comments on the applicability of this provision.**

## **12. Electronic Submission of the Medicaid and CHIP State Plan**

CMS proposes revisions to the requirements for submission of Medicaid and CHIP state plans in accordance with the movement away from paper submission to use of the Medicaid and CHIP program (MACPro) system to electronically receive and manage state plan amendments and other program documents. States would be directed to use the automated format for submission of state plan amendments and a transition period for making this change would be provided, with technical support from CMS.

## **13. Changes to Modified Adjusted Gross Income and MAGI Screen**

CMS proposes several changes to the regulations finalized in March 2012 regarding MAGI. These involve the 5% income disregard, the exception from MAGI for individuals needing long-term care services, and other technical changes not summarized here.

- Under the March 2012 Medicaid eligibility rule, the 5% disregard is applied in every calculation of eligibility under MAGI, which can affect which category of eligibility applies to an individual. Under the proposal, which is based on a new interpretation of the statute, the disregard would only be applied when it affects eligibility on the basis of MAGI. That is, it would only be applied to the highest income threshold eligibility category available to that person.
- The rule providing an exception from MAGI-based methodologies for individuals needing long-term care services would be modified to clarify that the exception does not apply to individuals seeking long-term care services that are covered through an eligibility group for which MAGI-based methodologies are applied. The exception would only apply in the case of individuals who are seeking Medicaid coverage in an eligibility category that conditions eligibility on needing a level of care or a category that covers long-term care services that are not covered for MAGI-based eligibility groups.
- The March 2012 rule at §435.911(c)(1) excludes individuals age 65 or older and younger individuals eligible for Medicare from the new adult eligibility group. The proposed rule would clarify that there is generally no MAGI standard for these individuals unless they are also pregnant or are a parent or caretaker relative. In the case of these pregnant women, the applicable MAGI standard would be the standard for pregnant women and in the case of a parent or caretaker relative, the higher of the MAGI-based income standards established by

the state under the mandatory and optional groups for parents and caretaker relatives would apply.

**CMS seeks comment on additional revisions they are considering addressing circumstances in which an individual may be counted as part of two households both seeking Medicaid eligibility.**

**14. Single State Agency: Delegation of Eligibility Determination to Exchanges (§431.10, §431.11 and §155.110)**

As discussed earlier with respect to appeals, CMS proposes to limit the ability of Medicaid agencies to delegate authority for making eligibility determinations or to conduct fair hearings for denials of MAGI-based eligibility only to those Exchanges that are government agencies or public authorities maintaining personnel standards on a merit basis consistent with section 1902(a)(4) of the Act. The March 2012 rule provides for delegation of Medicaid eligibility determination to Exchanges, including those that are nongovernmental entities or that contract with private entities for eligibility services. CMS points out that this provision of the final rule was broader than initially proposed, and after its promulgation many commenters requested that CMS reconsider the decision. The concerns raised were that eligibility determinations are an inherently governmental function and under the final rule provisions, the Medicaid agency would have limited oversight because they would not have a contractual relationship with any private entity contracting with the Exchange to provide this function. CMS believes the proposed change is consistent with current state practices and plans.

**CMS seeks comments on ways states can engage nonprofits and private contractors in the process of supporting Medicaid and CHIP agency eligibility determinations while ensuring that the final determination is made by a government agency.**

The proposed provision would make explicit that the Medicaid agency remains responsible for all eligibility determinations and for conducting fair hearings. A state electing to delegate authority to one or more governmental entities for one or more eligibility groups would be required to delineate these delegations and populations in the state plan. If authority is delegated, the single state agency would be required to enter into written agreements regarding the relationships and responsibilities of the parties, reporting requirements and assurances that oversight requirements will be met.

**CMS seeks comment on its proposal to delete requirements at §431.11 that the Medicaid state plan include a description of the Medicaid agency's organization and personnel and that provide for a medical assistance unit within the Medicaid agency.** CMS believes this would provide states with maximum flexibility in organizing program administration.

**15. Medical Support and Payments (§§433.138, 433.145, 433.147, 433.148, 433.152 and 435.610)**

CMS proposes to modify implementation of the statutory requirement that parents seeking Medicaid coverage must cooperate with the state in establishing paternity and in obtaining

medical support and payments. CMS says that in some cases Medicaid enrollment for parents subject to the cooperation requirements is delayed until the parent can demonstrate cooperation with the child support agency, which undermines the goal of real-time processing of applications. Because cooperation is not required for eligibility for other insurance affordability programs, CMS is concerned that Medicaid eligibility determinations should not be slowed for this reason.

The proposal would require individuals to attest on their application that they agree to cooperate with the state in establishing paternity and obtaining medical support payments, but CMS says the state should not wait until actual cooperation begins before finalizing an eligibility determination and furnishing benefits. If the individual does not cooperate, the agency would have to take action to terminate eligibility, subject to notice and fair hearing.

## **16. Conversion of Federal Minimum Income Standards for Section 1931**

CMS proposes that states be required to convert the federal minimum income standard for parents and caretaker relatives under section 1931 to a MAGI-equivalent minimum income standard based on the income disregards currently used in the state. In the 2012 rulemaking process, CMS discussed this issue and concluded that while this conversion would maintain Medicaid eligibility for some individuals it would also result in different minimum income standards being applied across states and reduce eligibility simplification. The March 2012 final rule provides that states would retain the federal minimum income standards with the flexibility of setting new standards using MAGI that would take into account a state's current rules for counting income.

The reason for the proposal is that the Supreme Court decision on enforcement of the mandatory ACA coverage expansion results in uncertainty regarding the availability of the new coverage for parents and caretaker relatives with incomes under 133% of the FPL but who do not meet financial eligibility under section 1931. Commenters responding to a CMS solicitation on conversion of net income standards to MAGI noted that eligibility for coverage of these parents could be restricted if minimum thresholds are not converted. The proposal would also require conversion of income standards for pregnant women at \$435.116 because pregnancy benefits are tied to the same AFDC income standards as the federal minimum for parents and caretaker relatives.

## **II. Essential Health Benefits in Alternative Benefit Plans**

This section of the proposed rule would modify the requirements for benchmark and benchmark equivalent coverage under section 1937 of the Act, which would be referenced as "Alternative Benefit Plans." The proposed changes would implement amendments made to section 1937 in the ACA and make other modifications. Regulations implementing section 1937 coverage are found in 42 CFR Part 440, Subpart C. A CMS letter to State Medicaid Directors on these issues was issued on November 20, 2012.

*Implementing ACA Requirements.* The requirements for Alternative Benefit Plans would be modified to include the new ACA eligibility group for low-income adults; the ACA requires that

states provide this group with medical assistance through an Alternative Benefit Plan, subject to the requirements of section 1937. In addition, the proposed rule would modify the benefits in section 1937, as required by the ACA. These changes add mental health benefits and prescription drug coverage to the list of benefits that must be included in benchmark-equivalent coverage; require the inclusion of Essential Health Benefits (EHBs) beginning in 2014; direct that section 1937 benefit plans comply with the Mental Health Parity and Addiction Equity Act of 2008; and require coverage of family planning services for individuals of childbearing age.

Other ACA changes exempt the eligibility group of former foster care children under age 26 from mandatory enrollment in an Alternative Benefit Plan and prohibit the design of an Alternative Benefit Plan from discriminating on the basis of age, expected length of life, disability, degree of medical dependency, quality of life or other health conditions. CMS notes that the non-discrimination requirements do not prevent states from exercising section 1937 benefit targeting criteria.

In making these implementing changes, CMS proposes that if an Alternative Benefit plan is determined to include EHBs as of January 1, 2014, it would remain effective through December 31, 2015 without need for updating, at the state's option. CMS intends to consult with states and stakeholders to determine the frequency of state updates to Alternative Benefit Plans after that date.

*Coordination with EHB Requirements.* CMS reviews the two-step process described in the November 20, 2012 State Medicaid Director letter that discusses the intersection between Alternative Benefit Plans and Essential Health Benefits (*Federal Register*, November 26, 2012, 70644-70676). Under this process, states will select a coverage option from the choices available under section 1937 and then determine whether that coverage option is also one of the base-benchmark plan options identified by the Secretary as an option for defining EHBs. If so, the standards for both Alternative Benefit Plans and EHBs would be met. If not, the state must identify one of the EHB base-benchmark options and supplement the Alternative Benefit Plan as needed to meet all requirements.

A proposed modification to the rules for Alternative Benefit Plans would provide states that are targeting Alternative Benefit Plans under section 1937 to specific populations with the option of selecting different base-benchmark plans in establishing EHBs for different Alternative Benefit Plans.

With respect to habilitative benefits, which are an EHB requirement, the proposed rule would require states to define this benefit for Medicaid. Under the EHB proposed rule, "Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation" (77 FR 70644), states could either define the habilitative services category or leave it to issuers. **CMS seeks comments on whether the state defined habilitative benefit definition for the Exchanges should apply to Medicaid or whether states should be allowed to separately define habilitative services for Medicaid.** CMS notes that resolution of this provision will depend on the final decisions regarding the EHB rule.

In the preamble, CMS clarifies issues regarding pediatric services and outpatient drug coverage with respect to coordination between Medicaid and EHB requirements. No regulatory modifications are proposed. First, CMS states that any limitation relating to pediatric services that may apply in a base benchmark plan in the context of the individual or small group market does not apply to Medicaid because medically necessary services, including pediatric oral and vision services, must be provided to eligible individuals under the age of 21 under the Medicaid Early Periodic Screening, Diagnostic and Testing (EPSDT) benefit. Second, CMS states that the section 1927 requirements relating to outpatient drug coverage and rebates apply to Alternative Benefit Plans. In general, CMS indicates that all provisions of title XIX apply to Alternative Benefit plans under section 1937 unless a state can satisfactorily demonstrate that implementing a provision would be directly contrary to their ability to implement Alternative Benefit Plans.

CMS also clarifies that preventive services as established in the EHB proposed rule would apply to Alternative Benefit Plans. The required preventive services include: “A” or “B” services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by the Health Resources and Services Administration’s Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

*Other proposed changes.* CMS proposes additional changes to the requirements for Alternative Benefit Plans that it says would make the rules simpler and clearer and would offer states more flexibility with respect to benefit options. As summarized below, these proposed changes would 1) modify the definition of Secretary-approved coverage, 2) apply the section 1937 exemptions to the new ACA adult eligibility category, 3) change the definition of medically frail, 4) modify public notice requirements, and 5) conform the definition of preventive services.

1. The definition of Secretary-approved coverage (§440.330(d)) would be modified in two ways. First, Secretary-approved coverage could include benefits of the type which are covered in one or more of the section 1937 commercial benchmark plans. (Parallel changes would be made in §440.335(c) and §440.360.) Second, Secretary-approved coverage could, at state option, include Medicaid state plan benefits or benefits available under the EHB base benchmark plans (§156.100). When including these benefits, the state would have to comply with all applicable statutory and regulatory requirements. In submitting a description of the coverage proposed for Secretary-approved coverage, a state would be required to include a benefit-by-benefit comparison of the proposed plan to one or more of the benchmark plans or the state’s standard full Medicaid benefit package.
2. CMS proposes an exception to benefit requirements for the ACA expansion adult eligibility category. The ACA requires that this group is eligible for benefits only through the benchmark or benchmark-equivalent coverage. CMS proposes that the statutory exemptions from mandatory enrollment in such coverage apply to individuals who are eligible under this category. CMS believes this is consistent with congressional intent.
3. The definition of “medically frail” (at §440.315(f)) would be expanded to include references to individuals with disabling mental disorders, and individuals with a disability determination based on Social Security criteria or in States that apply more restrictive

criteria than the Supplemental Security Income program, the State plan criteria. CMS' goal in proposing this change is ensuring that all people with disabilities are included in the definition, and therefore exempted from mandatory enrollment in an Alternative Benefit Plan. **CMS specifically solicits comments on whether individuals with a substance use disorder should also be added to the definition of "medically frail".**

4. Public notice requirements regarding Alternative Benefit Plans would be modified so that notice would be required prior to implementing a state plan amendment when the new Alternative Benefit Plan provides individuals with a benefit package equal to or enhanced beyond the state's approved state plan, or adds additional services to an existing Alternative Benefit Plan. The current requirement for notice of reduced benefits would be retained.
5. The definition of preventive services within Alternative Benefit Plans would be conformed to the statutory requirement that preventive services must be recommended by a physician or their licensed practitioner of the healing arts acting within the scope of authorized practice under State law. (The current requirement says preventive services must be provided by a physician or licensed practitioner.)

### **III. Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges**

#### **A. Background and Legislative Overview**

This proposed rule supplements and, in some respects, amends provisions originally published as the March 27, 2012 final rule on Exchange Standards for Employers (77 FR 18310). The provisions encompass key functions of Exchanges related to eligibility and enrollment. CMS notes that since states have relied on the Exchange final rule to plan their systems for 2014, it intends whenever possible to provide some type of transition in the final rule. **CMS welcomes comments on its design and the length of the transition.**

The sections of the ACA that would be further implemented under this proposed rule include: 1321 related to state flexibility in the operation and enforcement of Exchanges and related policies; 1401 which creates new section 36B of the Internal Revenue Code (the Code), providing for a premium tax credit for eligible individuals who enroll through an Exchange; 1402 which establishes the cost sharing obligations of individuals enrolled in a QHP through an Exchange; and 1411, which directs the Secretary to establish a program for determining whether an individual meets the eligibility standards for Exchange participation, advance payments of the premium tax credit, cost-sharing reductions, and exemptions from the shared responsibility payment under section 5000A of the Code. In addition, the proposed rule relates to sections 1412 and 1413 regarding eligibility for advance payments of the premium tax credit and cost-sharing reductions, as well as provisions regarding simplification and coordination of eligibility determinations and enrollment with other health programs. Unless otherwise specified, the provisions in this proposed rule related to the establishment of minimum functions of an Exchange are based on the general authority of the Secretary under section 1321(a)(1) of the ACA.



CMS notes its consultations with stakeholders for input into the design of policies related to the eligibility provisions and Exchange functions.

CMS indicates the sections of 45 CFR part 155 that are proposed to be amended. These include subparts A through H.

## **B. Provisions of the Proposed Regulations: Part 155- Exchange Establishment Standards and Other Related Standards under the ACA**

Throughout this proposed rule, CMS proposes technical corrections to regulation sections in part 155 to replace references to section 36B of the Code with the corresponding sections of the Department of Treasury's final rule, Health Insurance Premium Tax Credit (26 CFR 1.36B), published in the May 23, 2012 *Federal Register* (77 FR 30377).

### **1. Definitions (§155.20)**

CMS proposes and explains the rationale for technical corrections to the following definitions: “advance payments of the premium tax credit,” “application filer,” “catastrophic plan,” and “lawfully present.”

### **2. Approval of a State Exchange (§155.105)**

CMS proposes to make a technical correction to cite to the applicable Treasury regulation instead of section 36B of the Code.

### **3. Functions of an Exchange (§155.200)**

CMS would clarify under “general requirements” that an Exchange must perform the minimum functions described in subpart F.

### **4. Consumer Assistance Tools and Programs of an Exchange (§155.205)**

CMS proposes a clarifying change in subsection (d). To provide consumer assistance, an individual would have to be trained regarding QHP options, insurance affordability programs, eligibility, and benefits rules and regulations governing all insurance affordability programs operated in the state, as implemented in the state. This is consistent with proposed §155.225(b)(2), and is designed to ensure that all types of assistance provided by the Exchange are provided by individuals who are appropriately trained, in order to ensure quality.

### **5. Certified Application Counselors (§155.225)**

CMS proposes a new section providing for certified application counselors, based on authority under §1413 of the ACA which directs the Secretary to establish, subject to minimum requirements, a streamlined enrollment system for QHPs and all insurance affordability programs. CMS notes the experience of state Medicaid and CHIP agencies offering application assistance programs through which application counselors have played a key role in promoting

enrollment for low-income individuals seeking coverage. CMS believes that making such assistance available for Exchanges will be critical to achieving a high rate of enrollment. CMS notes that the proposed standards for such counselors “closely track” those for Medicaid application counselors “so that the training can be streamlined.”

CMS notes that application counselors will provide the same core application assistance services that are also available directly through the Exchange as well as through Navigators and licensed agents and brokers. The distinction between these entities is that the application counselors are not funded through the Exchange, through grants or directly, or licensed by states as agents or brokers. CMS says that this separate class of application counselors is important to ensure that skilled application assistance is available from entities like community health centers and community-based organizations that may not fit into the other categories. Given the overlap in responsibilities, a state could develop a single set of core training materials. CMS also plans to make selected federal training and support materials available that can be used by states, without the need to develop their own, to the extent that the states use the model application established by HHS.

An Exchange would have to certify staff and volunteers of Exchange-designated organizations (which the preamble says may include health care providers and entities, as well as community-based organizations) and organizations designated by state Medicaid and CHIP agencies to act as application counselors to: (1) provide information about insurance affordability programs and coverage options; (2) assist individuals and employees to apply for coverage in a QHP through the Exchange and for insurance affordability programs; and (3) help to facilitate enrollment of eligible individuals in QHPs and insurance affordability programs.

An Exchange would have to certify an individual to become an application counselor if he or she: (1) registers with the Exchange; (2) is trained regarding QHP options, insurance affordability programs, eligibility, and benefits rules and regulations governing all insurance affordability programs operated in the state prior to functioning as an application counselor; (3) discloses to the Exchange and potential applicants any relationships the application assister or sponsoring agency has with QHPs or insurance affordability programs, or other potential conflicts of interest; (4) complies with the Exchange’s privacy and security standards; (5) agrees to act in the best interest of the applicants assisted; (6) complies with applicable state law related to application counselors, including but not limited to state law related to conflicts of interest; (7) provides information with reasonable accommodations for those with disabilities, as defined by the Americans with Disabilities Act, if providing in-person assistance; and (8) enters into an agreement with the Exchange regarding compliance with these standards. **CMS seeks comments on whether the Exchange should have the authority to create additional standards for certification or otherwise limit eligibility of certified application counselors beyond what is proposed here.**

An Exchange also would have to establish procedures to withdraw certification from individual application counselors, or from all application counselors associated with a particular organization, when it finds noncompliance with the terms and conditions of the application counselor agreement.

An Exchange would have to establish procedures to ensure that applicants are informed of the functions and responsibilities of certified application counselors; and provide authorization for the disclosure of applicant information to an application counselor prior to a counselor helping the applicant with submitting an application.

Finally, certified application counselors could not impose any charge on applicants for application assistance.

## **6. Authorized Representatives (§155.227)**

Under existing regulations, the Exchange must accept applications from application filers, including authorized representatives acting on behalf of an applicant. CMS proposes to add a new section that specifies minimum requirements for the designation of authorized representatives who may act on an individual's or employee's behalf as they relate to Exchanges. CMS says that these "closely track those for Medicaid."

Specifically, an Exchange would have to permit an individual or employee, subject to applicable privacy and security requirements, to designate an individual or organization to act on his or her behalf in applying for an eligibility determination or redetermination and in carrying out other ongoing communications with the Exchange. The Exchange would have to ensure that the authorized representative agrees to maintain, or be legally bound to maintain, the confidentiality of any information regarding the individual or employee provided by the Exchange. Also, the Exchange would have to ensure that such person is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation to the same extent as the individual he or she represents. An Exchange would have to permit an individual or employee to designate an authorized representative at the time of application and at other times and through methods as described in 45 CFR 155.405(c)(2).

An Exchange would have to permit an individual to authorize their representative to carry out specified functions, including signing an application on the individual's behalf; submitting an update or respond to a redetermination for the individual; receiving copies of the individual's notices and other communications from the Exchange; and acting on behalf of the individual in all other matters with the Exchange.

An Exchange would have to permit an individual or employee to change or withdraw their authorization at any time (with appropriate notice to the Exchange). The authorized representative also could withdraw his or her representation by notifying the Exchange and the individual.

CMS further proposes that when an organization is designated as an authorized representative, staff or volunteers of that organization that exercise that capacity for an applicant before the Exchange and the organization itself would have to enter into an agreement with the Exchange to comply with the requirements set forth at §155.225(b) (relating to the requirements to be a certified application counselor). **CMS seeks comments on applying these protections to authorized representatives more broadly.**

Finally, an Exchange also would have to require an authorized representative to comply with applicable state and federal laws concerning conflicts of interest and confidentiality of information. Designation of authorized representatives would have to be in writing including a signature or through another legally binding format.

## **7. General Standards for Exchange Notices (§155.230)**

CMS proposes a technical change to paragraph (a) to clarify that the general standards for notices apply to all notices sent by the Exchange to individuals or employers. The section is further amended and reorganized so that a notice must include: (1) an explanation of the action reflected in the notice, including its effective date.; (2) any factual findings relevant to the action; (3) citations to, or identification of, the relevant regulations supporting the action; (4) contact information for available customer service resources; and (5) an explanation of appeal rights, if applicable.

CMS proposes a new paragraph (d) to allow the Exchange to provide notices either through standard mail, or if an individual or employer elects, electronically, provided that standards for use of electronic notices are met as set forth in §435.918, which contains a parallel provision.

CMS says that these standards will ensure that individuals have the ability to control their preferences regarding how they receive notices; additionally, since notices will include personally identifiable information, they must ensure that proper safeguards for the generation and distribution of notices are met. Providing an option for individuals and employers to receive notices electronically allows the Exchange to leverage available technology to reduce administrative costs and improve communication. These standards would generally apply to notices required throughout 45 CFR part 155, including notices sent by the SHOP Exchange. However, CMS proposes that they not apply to the SHOP Exchange, “because of the distinct nature of the relationship between the SHOP Exchange, employers, and employees.” An alternative rule would apply the same requirements but CMS expects that the SHOP Exchange may rely more heavily than the individual market on electronic notices than written ones. **CMS seeks comment on this policy decision.**

## **8. Definitions and General Standards for Eligibility Determinations (§155.300)**

CMS proposes to make a technical correction to paragraph (a) related to definitions. It would remove “adoption taxpayer identification number” because it will not be used in the income verification process for advance payments of the premium tax credit and cost-sharing reductions, in accordance with the proposed rules issued by the Secretary of Treasury at 77 FR 25381. Also to conform to the Treasury’s proposed rules, CMS would correct the definitions of “minimum value,” “modified adjusted gross income,” and “qualifying coverage in an eligible employer-sponsored plan.”

## **9. Options for Conducting Eligibility Determinations (§155.302)**

Current §155.302 provides that an Exchange may conduct eligibility determinations directly or through contracting arrangements. Alternatively it may conduct an assessment of eligibility for Medicaid and CHIP, rather than an eligibility determination, following specific criteria and procedures. CMS proposes to amend the provisions, established in an interim final rule (77 FR 18451-52) without finalizing them at this time.

Specifically, CMS would make a technical correction in (a)(1) to align the language regarding the Exchange's ability to make eligibility determinations for Medicaid and CHIP with language proposed in §431.10(c)(2), which specifies that Medicaid eligibility determinations may only be made by a government agency that maintains personnel standards on a merit basis. Paragraph (b)(4)(i)(A) would be amended by adding language to provide that the withdrawal opportunity is not applicable in cases in which the Exchange has assessed that the applicant is potentially eligible for Medicaid based on factors other than MAGI, in accordance with 45 CFR 155.345(b). CMS explains that, in this situation, the application will already be sent to Medicaid for a full determination that includes a determination based on criteria identified in 45 CFR 155.305(c) and (d) and other eligibility criteria not generally considered by an Exchange, such as disability. Therefore, withdrawal of the application in this instance is not applicable. An individual's application would not be considered withdrawn if the individual appeals his or her eligibility determination for advance payments of the premium tax credit or cost sharing reductions and the Exchange appeals entity finds that the individual is potentially eligible for Medicaid or CHIP. CMS says that the added language preserves an individual's right to a Medicaid or CHIP eligibility determination based on the initial date of application, as well as any appeal rights related to that determination.

Paragraph (b)(5) would be amended to require that the Exchange adhere to the appeals decision for Medicaid or CHIP made by the state Medicaid or CHIP agency, or the appeals entity for such program. This compares with the previous language which only specified that the Exchange adhere to the initial eligibility determination for Medicaid or CHIP made by the state Medicaid or CHIP agency.

## **10. Eligibility Standards (§155.305)**

Current regulations set out the requirements for eligibility for enrollment in a QHP through an Exchange, such as citizenship or a person lawfully present in the U.S., not incarcerated and meeting specific residency requirements. CMS proposes to add to paragraph (a) language to prohibit an Exchange from denying or terminating an individual's eligibility for enrollment in a QHP through the Exchange if the individual meets the other eligibility standards in (a)(3) but for a temporary absence from the service area of the Exchange and intends to return when the purpose of the absence has been accomplished. The exception to this rule is if another Exchange verifies that the individual meets the residency standard of such Exchange. CMS says that this is designed to align the Exchange eligibility standards regarding residency with those for Medicaid. The intent is to protect an eligible individual from losing access to health care during a period of temporary absence as well as prevent the administrative burden associated with termination and reenrollment.

CMS proposes a number of technical corrections in paragraph (f) to cite to applicable Treasury regulations instead of section 36B of the Code. CMS would also clarify in (f)(3) that the Exchange may provide advance payments of the premium tax credit on behalf of a tax filer only if one or more applicants for whom the tax filer attests that he or she expects to claim a personal exemption deduction for the benefit year, including the tax filer and his or her spouse, is enrolled in a QHP that is not a catastrophic plan, through the Exchange.

CMS proposes to add a new (h) relating to eligibility for enrollment through the Exchange in a QHP that is a catastrophic plan. (Such plans are not eligible for the premium tax credit.) The Exchange would have to determine an applicant eligible for enrollment in a QHP through the Exchange in a catastrophic QHP if he or she: (1) has not attained the age of 30 before the beginning of the plan year; or (2) has a certification in effect for any plan year that he or she is exempt from the shared responsibility payment based on a lack of affordable coverage or hardship. The Exchange would make eligibility determinations for enrollment through the Exchange in a QHP that is a catastrophic plan, as opposed to enrollment in such a plan that is offered outside of the Exchange. (The eligibility standards for affordability and hardship exemptions will be discussed in future regulations.)

## **11. Eligibility Process (§155.310)**

Current §155.310 sets forth the process that an Exchange must follow to determine eligibility for participation, including the nature of the information that must be collected, the timing for accepting applications, and rules related to advance payments of the premium tax credits. Under §1411(e) of the ACA, an Exchange must provide a notice to an employer if one of his or her employees has been determined eligible for advance payments of the premium tax credit or cost-sharing reductions. It also calls for the establishment of a system of notice to employers and an employer appeal when an employee's eligibility for the advance payments is based on either the employer's decision not to offer minimum essential coverage to that employee or the plan sponsored by the employer does not meet the minimum value standard or is unaffordable.

CMS explains that §4980H of the Code limits the employer's liability for payment under that provision when the employer offers coverage to one or more full-time employees who are "certified to the employer under section 1411" as having enrolled in a QHP through the Exchange and for whom an applicable premium tax credit or cost-sharing reduction is allowed or paid. Accordingly, CMS proposes to add new (i) "Certification program for employers," directing the IRS as part of its determination of whether an employer has a liability under §4980H to adopt methods to certify to an employer that one or more employees has enrolled for one or more months during a year in a QHP with respect to which a premium tax credit or cost-sharing reduction is allowed or paid. CMS notes that this process tracks both those individuals who receive the advance payments and those claiming the premium tax credit on their tax returns.

CMS proposes a number of additional changes relating to duration of eligibility determinations without enrollment affecting old paragraphs (i) and (j) which now would become new (j) to align with proposed changes in §155.335.

## **12. Verification Process Related to Eligibility for Enrollment in a QHP through the Exchange (§155.315)**

Current §155.315 in general requires an Exchange to verify or obtain certain information (valid social security number; verification of citizenship or lawful presence; verification of residency; and incarceration status) in order to determine that an applicant is eligible for enrollment in a QHP through the Exchange. It also provides for a process to reconcile inconsistencies in information (e.g., information attested to by an applicant versus information from approved data sources).

CMS proposes several changes, many technical or clarifying. One change (paragraph (f)) would ensure that an Exchange complete all possible electronic verifications after the two-day period before requesting additional information from an individual. CMS notes that to the extent that efforts to reconcile inconsistencies in information are unsuccessful, the Exchange would be required to maintain the eligibility determination through the 90-day period that is provided for an individual to provide satisfactory documentation or otherwise resolve an inconsistency.

CMS also proposes to add paragraph (j) concerning the verification process related to eligibility for enrollment through the Exchange in a QHP that is a catastrophic plan based on the applicant's age, lack of affordable coverage or hardship status. The Exchange could accept the applicant's attestation of age without further verification, unless information provided by the applicant was not reasonably compatible with other information previously provided by the individual or otherwise available to the Exchange. Alternatively, the Exchange could examine available electronic data sources approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently current and accurate and minimize administrative costs and burdens. The Exchange also would have to verify that an applicant based on an exception from the shared responsibility payment due to lack of affordable coverage or hardship has a certification of such an exemption issued by the Exchange. This could be accomplished either through use of the Exchange's records, if the exemption was issued by that Exchange, or through verification of paper documentation if the certificate was issued by a different Exchange. An applicant would not be determined eligible through the Exchange in a QHP that is a catastrophic plan until verification of necessary information was completed.

## **13. Verification Related to Eligibility for Insurance Affordability Programs (§155.320)**

Under current §155.320, an Exchange may only verify information for an applicant or tax filer who requests an eligibility determination for insurance affordability programs (i.e., premium tax credits and cost-sharing assistance). Certain procedures are set out for verification of information related to establishing such eligibility, including household income and family/household size.

CMS proposes a number of technical corrections and other modifications. One technical change relates to the need for an Exchange to obtain data on certain taxpayers who have non-taxable social security benefits from the Social Security Administration (SSA) to support verification of household income. The revised language in (c) establishes a system through which the Exchange

contacts HHS and HHS secures the annual household income data available from IRS and SSA for purposes of determining MAGI. CMS anticipates that SSA will provide the full amount of social security benefits to HHS for disclosure to the Exchange as part of the verification process described in §155.320(c).

A new (c)(3)(i)(E) would be added requiring the Exchange to verify that neither advance payments of the premium tax credit nor cost sharing reductions are already being provided on behalf of an individual. CMS says this is an important integrity measure. The Exchange would have to use information from HHS to support the verification.

Another significant modification would affect (c)(3)(iii) to clarify procedures that the Exchange has to follow when an applicant attests that his or her annual household income has increased or is reasonably expected to increase from the annual household income computed based on available data. The proposed language does not modify the general approach of accepting an applicant's attestation to projected annual household income when it exceeds the amount indicated by available data regarding annual household income. Instead, it provides additional detail regarding the Exchange's procedures to ensure that such an attestation does not dramatically understate income. The Exchange would have to check whether available data regarding current household income indicates that projected annual household income may exceed the person's attestation by a significant amount. If so, the Exchange would have to follow procedures spelled out in §155.315 to verify the applicant's attestation. CMS notes that it has developed these procedures in conjunction with states to clarify an existing provision such that it can be effectively implemented. (See pages 78 FR 4637-4638 for more information.) **CMS seeks comment regarding whether there are ways to further simplify the process.**

CMS also proposes changes related to the verification for enrollment in an eligible employer-sponsored plan and for eligibility for qualifying coverage in an employer-sponsored plan. CMS says that the proposed new (d) "streamlines the process, provides further detail regarding the standards for these verification procedures, and proposes a process under which an Exchange may rely on HHS to complete this verification." CMS notes that its April 30, 2012 *Request for Information* sought out a potential resource that comprehensively supports verification of employer-sponsored coverage. The agency has now concluded that such a data set will not be available from a single source by October 1, 2013. The currently available information and its limitations are described. CMS continues to examine ways, both administrative and legislative, by which employer reporting under the ACA can be streamlined both in timeframe and in the number of elements to prevent inefficient or duplicative reporting. **Comments are requested on policies to promote these goals.**

CMS describes the data source that it will make available for federal employee coverage for verification purposes and proposes that an Exchange use SHOP records to verify enrollment in an eligible employer sponsored plan. CMS proposes in (d) a process for verification that will apply for now with the possibility that the approach for plan years 2016 and beyond will depend on the identification and or development of one or more data sources to promote a more comprehensive and automated pre-enrollment verification process.



Under proposed new (d), an Exchange would have to verify whether an applicant reasonably expects to be enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested. (A general principle throughout is that an individual should be determined eligible based on his or her attestation during the period in which the Exchange is seeking additional information for purposes of verification.) In the following paragraphs, CMS sets forth a series of data sources to be checked for verification and the verification procedures for situations in which data are unavailable or inconsistent with an individual's attestation, and an option for the Exchange to rely on HHS to complete this verification (see 78 FR 4639-40). Since the data sources do not directly address enrollment in an eligible employer-sponsored plan or eligibility for qualifying coverage in an eligible employer-sponsored plan, **CMS seeks comment on whether they should only be used as a point of information for applicants, and not as a point of comparison for the purposes of identifying inconsistencies as part of the verification process. CMS also asks for comment regarding the feasibility of making the necessary data connections by October 1, 2013, and whether alternative approaches should be considered for the first year of operations.**

CMS further proposes in (d) to require that the Exchange accept an applicant's attestation regarding employer-sponsored eligibility/coverage status without further verification with certain exceptions. It also sets out a process for the Exchange to check a random sample of applicants with inconsistent information, including required notice to the applicants. The proposal also includes notice requirements when information provided to an Exchange by an employer changes the applicant's eligibility determination. A final section of new (d) would prohibit an Exchange from disclosing any information about an individual to an employer that is not necessary for the employer to identify the employee. CMS notes that an Exchange can elect to have HHS conduct the entire verification process described in this paragraph, including sampling and inconsistency resolution. **Comments are requested on these proposed procedures, on a methodology by which an Exchange could generate a statistically significant sample of applicants and whether there are ways to focus the sample on individuals who are most likely to have access to affordable, minimum value coverage. Comments are also sought on:** ways the Exchange may communicate the sampling process to consumers with the intention of minimizing confusion; options for obtaining employer/eligibility coverage information while minimizing burden on consumers, employers and Exchanges; and ways Exchanges may most efficiently interact with employers, including other entities that employers may rely upon to support the verification process, such as third party administrators.

As a final part of its discussion of this section, CMS notes that other sections of the Exchange final rule and the proposed regulation (relating to notice to employers of their employee's eligibility for premium tax credits or cost-sharing reductions; and the ability of a employer to appeal the finding that an employee's coverage is unaffordable or does not meet minimum value) ensure that eligibility determinations "are being made based on the most accurate information available regarding enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan." The verification procedures presented in this section along with the notice and appeals provisions "will ensure that employers can challenge eligibility determinations for advance payments of the premium tax credit that are made based on the Exchange's findings about the coverage they offer to their employees. This

entire system, taken together, ensures that consumers and employers are protected from adverse consequences of inaccurate determinations.”

In addition to the verification procedures proposed this section, CMS advises that it is taking steps to help consumers provide information related to access to employer-sponsored coverage on their application. CMS suggests the use of a voluntary pre-enrollment template (that could be downloaded from the Exchange web site) to assist applicants in gathering the required information about access to coverage through an eligible employer-sponsored plan to determine their eligibility for advance payments of the premium tax credit and cost-sharing reductions. Alternatively, an employer could voluntarily download and populate the template with information regarding its coverage offerings and distribute to employees at hiring, upon request, on the employer intranet or benefit site, or in conjunction with other information about employer-sponsored coverage provided by the employer to employees. When an individual completes his or her Exchange application, he or she would provide the information from the completed template in response to relevant questions on the single, streamlined application. **CMS seeks comments on the use of this pre-enrollment template and ways it can be used to assist consumers with providing the necessary information to complete the verification while minimizing burden on employers.**<sup>1</sup> CMS intends to release the template for comment in the near future.

As noted above, an Exchange could rely on HHS to complete the verification of employer coverage. To do this, it would have to provide all relevant information to HHS through a secure, electronic interface, promptly and without undue delay. The Exchange and HHS would enter into an agreement specifying their respective responsibilities in connection with the verifications. CMS anticipates that, under this option, the Exchange would collect an individual’s attestations regarding eligibility for qualifying coverage in an eligible employer-sponsored plan and integrate the verification outcome into the eligibility determination for advance payments of the premium tax credit and cost-sharing reductions. HHS would provide the other components of the process.

#### **14. Eligibility Redetermination During a Benefit Year (§155.330)**

Current §155.330 requires an Exchange to redetermine eligibility of an enrollee in a QHP through the Exchange during the benefit year if it receives and verifies new information reported by the enrollee or identifies updated information through certain data matching. CMS proposes some clarifying as well as policy changes.

**CMS seeks comment on adding a provision such that if an enrollee experiences a change in his or her level of cost-sharing reductions as a result of a redetermination occurring under 45 CFR 155.330(e)(1) or 155.335(c), the notice issued by the Exchange will describe how the enrollee’s cost sharing would change as a result of the change in level of cost-sharing reductions if the enrollee stays in the same QHP (and only changes plan variations).** An enrollee who experiences such a change in the level of cost-sharing reductions qualifies for a

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<sup>1</sup> Elements of this tool can be commented upon as part of the information collection request related to the Supporting Statement for Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Health Benefits Exchanges, Medicaid, and Children’s Health Insurance Program Agencies (CMS-10440).

special enrollment period to change QHPs. CMS says that including this information in the notice will be particularly important in the event an individual does not decide to change QHPs during the special enrollment period.

In paragraph (e), CMS proposes changes to clarify how the Exchange should proceed when data matching indicates that an individual is deceased and as other events necessitate. CMS proposes to amend (f) to incorporate changes as a result of an eligibility appeals decision, as well as changes that affect only enrollment or premiums, but do not affect eligibility. Effective dates would also be modified to accommodate the limited situations in which retroactive eligibility may be necessary. (For more information, see 78 FR 4642-4643.) In this latter context, CMS notes that in the case of birth, adoption or placement for adoption, the Secretary of Treasury will provide through subsequent guidance that a child may be eligible for the premium tax credit for the month the child is born or is adopted, placed for adoption, or placed in foster care. CMS will amend its regulations in final rulemaking to match the Treasury's guidance. CMS notes that the special enrollment period in §155.420(b)(2)(i) does not currently address children placed in foster care, and it **solicits comments regarding whether CMS should expand it to cover children placed in foster care, and then make a corresponding change to eligibility effective dates in this paragraph.** (See below related to §155.420.)

#### **15. Annual Eligibility Redeterminations (§155.335)**

With exceptions, §155.335 requires that an Exchange redetermine the eligibility of an enrollee in a QHP offered through the Exchange on an annual basis. In addition to technical changes, CMS proposes to make a wording change in paragraphs (a), (b), (c), (e), (f), (g), (h), (k), and (l) to specify that subject to the limitations on redetermination in (l) and new (m), the Exchange will conduct an annual eligibility redetermination for all qualified individuals, not only those who are enrolled in a QHP. The modification accommodates situations in which an individual submitted an application prior to the annual open enrollment period, was determined eligible for enrollment in a QHP with or without advance payments of the premium tax credit and cost-sharing reductions, and did not meet the criteria for a special enrollment period. This proposed change would mean that the Exchange would provide such an individual with an annual eligibility redetermination notice. Thus, the individual would not have to submit a new application to obtain coverage for the following benefit year. CMS says that the annual eligibility determination notice projects eligibility for the upcoming benefit year, and provides a streamlined process for individuals to select a QHP for the upcoming year during the annual open enrollment period.

Proposed new paragraph (m) "Special rule" would provide that if a qualified individual does not select a QHP before the redetermination described in this section, and is not enrolled in a QHP through the Exchange at any time during the benefit year for which such redetermination is made, the Exchange must not conduct a subsequent eligibility redetermination for a future benefit year. CMS explains that the provision is designed to ensure that a qualified individual who never selects a QHP is not redetermined every year, minimizing burden on the Exchange. An example is provided.

## **16. Administration of Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions (§155.340)**

CMS proposes technical corrections to cite to the applicable Treasury regulation instead of Section 36B of the Code.

## **17. Coordination with Medicaid, CHIP, the Basic Health Program and the Pre-existing Condition Insurance Plan (§155.345)**

Section 155.345 generally requires an Exchange to enter into agreements with agencies administering Medicaid, CHIP and BHP as are necessary to fulfill the requirements related to Exchanges, administration of premium tax credits, etc. and provide copies of any such agreements to HHS upon request. CMS proposes several technical and clarifying changes. It also proposes to add a new (a)(3) to ensure that, as of January 1, 2015, the agreement provides for a combined eligibility notice to individuals and members of the same household to the extent feasible, for enrollment in a QHP through the Exchange and for all insurance affordability programs. In most cases the combined notice would be issued by the last agency to determine the individual's eligibility (not taking into account eligibility determinations for Medicaid on a non-MAGI basis), and regardless of which agency initially received the application. CMS says this process would reduce the occurrence of an individual receiving multiple eligibility notices from agencies administering insurance affordability programs based on a single application. To the extent that the eligibility determinations reflected in a combined notice are not made by the agency issuing the notice, the notice should identify the agency that made each eligibility determination that is reflected in the combined notice.

CMS acknowledges that there are situations in which the provision of a combined eligibility notice may not be appropriate. Agencies administering insurance affordability programs are expected to limit the use of combined eligibility notices to only those situations in which it is beneficial to the applicant. (The preamble associated with §435.1200 describes situations in which the combined eligibility notice may not be appropriate.) **CMS requests comments on situations in which the combined eligibility notice may or may not be particularly appropriate.**

Since CMS recognizes that it may not be operationally feasible for the Exchange and relevant state agencies to deliver combined eligibility notices by October, 1, 2013, CMS proposes a phased-in approach for the provision of a combined eligibility notice in cases where the Exchange is performing assessments of eligibility for Medicaid and CHIP based on MAGI. More information on this phased-in process is at 78 FR 4644) (CMS intends to release model notices in early 2013 for use by states that want to rely on HHS' templates for notices instead of developing their own.)

CMS proposes to add new language at (g)(2) to require the Exchange to notify the transmitting agency of the receipt of an electronic account when another agency is transmitting the account to the Exchange in the situation in which an application is submitted directly to the transmitting agency, and a determination of eligibility is needed for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions. Additionally, the Exchange would have

to notify the transmitting agency of an individual's eligibility determination for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions. CMS says that this aims to ensure that the Exchange can provide effective customer service, while also aligning with proposed §435.1200(d)(5).

## **18. Special Eligibility Standards and Process for Indians (§155.350)**

CMS proposes to make a technical correction to cite to the applicable Treasury Regulation instead of section 36B of the Code.

## **19. Enrollment of Qualified Individuals into QHPs (§155.400)**

CMS proposes to add language to clarify that the Exchange must send updated eligibility and enrollment information to QHP issuers and HHS promptly and without undue delay. CMS notes that it interprets the requirement concerning “updated eligibility and enrollment information” to mean all enrollment-related transactions, including, but not limited to, enrollments sent to issuers for which the qualified individual has not yet remitted premiums; enrollments for which payment has been made on any applicable enrollee premium; cancellations of enrollment prior to coverage becoming effective; terminations of enrollment; and enrollment changes (to include terminations and cancellations initiated by issuers).

## **20. Special Enrollment Periods (§155.420)**

Current §155.420 requires the Exchange to provide special enrollment periods during which qualified individuals may enroll in QHPs and enrollees may change QHPs. CMS proposes a number of clarifying and technical changes.

Among the changes, CMS seeks to clarify the status of dependents so that the rule limits the availability of special enrollment periods to dependents for whom the selected QHP would provide coverage. CMS notes that the proposed change would mean that those special enrollment periods that specifically mention dependents would be evaluated on a plan-by-plan basis for a given set of individuals, and that a special enrollment period may be available for an individual in some plans but not in other plans.

An additional proposed change addresses the special enrollment period related to birth, adoption, or placement for adoption, to clarify that this special enrollment period is applicable for either a “qualified individual or an enrollee.” **CMS solicits comment on whether this special enrollment period should be expanded to cover children placed in foster care.**

A number of proposed changes would be made relating to effective dates for qualified individuals or enrollees eligible for a special enrollment period for “error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange, HHS, or its instrumentalities”; when “the QHP ... substantially violated a material provision of its contract in relation to the enrollee”; and the special enrollment period for “exceptional circumstances”. The modified policy will include, in accordance with any guidelines issued by HHS, providing, when applicable and on a case-by-case basis, that coverage will be effective in accordance with the regular effective dates

specified in paragraph (b)(1) or on the date of the event that triggered the special enrollment period. CMS says in the preamble that the nature of the circumstances that will trigger these special enrollment periods make it necessary to provide the Exchange with appropriate flexibility regarding coverage effective dates.

CMS further proposes a change to require an Exchange to ensure that advance payments of the premium tax credit and cost-sharing reductions adhere to the effective dates as provided in §155.330(f). Although this concerns redeterminations and other changes during the benefit year, CMS clarifies that the effective enrollment dates apply to both qualified individuals first enrolling in a QHP through the Exchange via a special enrollment period, as well as to current enrollees. Additional related technical changes are proposed.

Under another change, a qualified individual or enrollee who experiences the triggering event for a special enrollment period would be eligible for such special enrollment along with any dependents able to enroll in the plan selected for the qualified individual or enrollee. If, for example, a 25 year old loses access to minimum essential coverage, he or she will qualify for a special enrollment period, along with his parents and any other dependents who may enroll in the plan selected. CMS proposes several technical changes to accommodate situations in which all members of a household would likely need to enroll in or change QHPs in response to an event experienced by one member of the household. Other changes are proposed to clarify the triggering events associated with a qualified individual or his or her dependent losing minimum essential coverage.

CMS would also amend this section to require that the Exchange will provide a special enrollment period for:

- (1) an enrollee in a QHP who is determined newly eligible or newly ineligible for advance payments of the premium tax credit or experiences a change in eligibility for cost-sharing reductions,
- (2) his or her dependent who is an enrollee in the same QHP and who is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost sharing reductions, or
- (3) a qualified individual or his or her dependent enrolled in qualifying coverage in an eligible employer sponsored plan who are determined newly eligible for advance payments of the premium tax credit based in part on a finding that such individual will cease to be eligible for qualifying coverage in an eligible-employer sponsored plan in the next 60 days, and is allowed to terminate existing coverage.

CMS explains that the new language differs from existing language in that it allows the qualified individual or his or her dependent to be determined eligible for this special enrollment period and the opportunity to enroll in a new QHP prior to the end of his or her employer-sponsored coverage. However, he or she would not be eligible to receive advance payments of the premium tax credit until the end of his or her coverage through such eligible employer-sponsored plan. CMS explains that the existing language provided this special enrollment period regardless of an

individual's current coverage status which invited the potential for adverse selection. (See 78 FR 4647 for additional explanation of CMS' concerns.) CMS proposes this special enrollment period for the dependent of an enrollee determined newly eligible or newly ineligible for advance payments of the premium tax credit or an enrollee experiencing a change in eligibility for cost-sharing reductions "to account for situations where members of different tax households are enrolled together in the same plan and otherwise would be prevented from enrolling together in a new plan during the special enrollment period."

A final proposed addition would provide a special enrollment period for a qualified individual, or his or her dependent, who is enrolled in an eligible employer sponsored plan that does not provide qualifying coverage and is allowed to terminate his or her existing coverage. The Exchange would have to permit such an individual to access this special enrollment period 60 days prior to the end of his or her coverage in an eligible employer-sponsored plan. CMS says that this protects those qualified individuals from potential gaps in coverage and ensures that a qualified individual and his or her dependent would not be prevented from enrolling together in a QHP during the special enrollment period. An individual's eligibility for advance payments of the premium tax credit and cost-sharing reductions would still be subject to termination of existing enrollment in an eligible employer-sponsored plan.

## **21. Termination of Coverage (§155.430)**

An exchange is required under this provision of the rules to determine the form and manner in which coverage in a QHP may be terminated. Termination events are specified, such as obtaining other minimum essential coverage or loss of eligibility for coverage in a QHP through the Exchange.

Under the existing rule, enrollees who do not initiate a termination upon gaining other minimum essential coverage would maintain coverage in a QHP without advance payments of the premium tax credit. CMS believes that the majority of individuals who gain other minimum essential coverage will not want to maintain coverage in a QHP without advance payments of the premium tax credit and cost-sharing reductions. To accommodate this anticipated preference, and allow individuals to maintain enrollment in a QHP in the limited number of situations in which they want to do so, CMS proposes that, at the time of plan selection, the Exchange provide a qualified individual with the opportunity to choose to remain enrolled in a QHP if the Exchange identifies that they have become eligible for other minimum essential coverage through data matching and the enrollee does not request a termination.

## **22. Subpart F—Appeals of Eligibility Determinations for Exchange Participation and Insurance Affordability Programs**

CMS proposes the addition of this subpart to provide standards for eligibility appeals, including appeals of individual eligibility determinations and employer determinations as required by §1411(f) of the ACA, which directs the Secretary to provide for an appeals process. In what follows, CMS proposes to provide Exchanges with options for coordinated appeals to align with the options for eligibility determinations. In addition, standards are proposed for appeal requests,

eligibility pending appeal, dismissals, informal resolution and hearing requirements, expedited appeals, appeal decisions, the appeal record, and corresponding provisions for employer appeals.

### **23. Definitions (§155.500)**

CMS proposes definitions for the following terms: appeal record, appeal request, appeals entity, appellant, de novo review, evidentiary hearing and vacate (see 78 4648; 4719).

### **24. General Eligibility Appeals Requirements (§155.505)**

CMS proposes that unless otherwise specified, the provisions of this subpart apply to Exchange eligibility appeals processes, regardless of whether the appeals process is provided by a state-based Exchange or by HHS.

Applicants and enrollees would have the right to appeal eligibility determinations made in accordance with subpart D (including initial eligibility determinations for enrollment in a QHP, Medicaid, CHIP, and the BHP, if applicable, and for advance payments of the premium tax credit, and cost-sharing reductions as well as eligibility for QHP enrollment periods and eligibility for enrollment in a catastrophic plan), and redeterminations made pursuant to §§155.330 and 155.335. Applicants and enrollees could also appeal the amount of advance payments of the premium tax credit and level of cost-sharing reductions for which they are eligible. Applicants and enrollees also could appeal an eligibility determination for an exemption made in accordance with future guidance. If the Exchange failed to provide timely notice of an eligibility determination or redetermination under §§155.310(g), 155.330(e)(1)(ii), or 155.335(h)(1)(ii), such failure would also be appealable.

CMS proposes that final eligibility determinations after exhaustion of any inconsistency period under §155.315(f) may be appealed through the Exchange appeals process, if the Exchange elects to establish such a process, or to HHS. (An inconsistency process arises basically when conflicting or incomplete information has to be resolved.) In addition, pursuant to the requirements of §1411(f)(1) of the ACA, all Exchange appellants would be able to have their appeal reviewed by HHS upon exhaustion of the Exchange appeals process. CMS explains that it therefore expects that, where a state based Exchange is operating and has established an appeals process, appellants will first appeal through that process and then, if dissatisfied with the outcome, have the opportunity to elevate the appeal to the HHS appeals process. CMS anticipates that a state-based Exchange may elect to establish the appeals function within the Exchange or to authorize an eligible state entity to carry out the appeals function.

Appeals entities would have to comply with the standards set forth for providing fair hearings established by Medicaid at 42 CFR 431.10(c)(2). Meeting Medicaid due process requirements is part of the minimum standard an entity would have to meet to be eligible to process Medicaid appeals, which CMS proposes may be delegated to Exchange appeals entities.



An appellant could designate an authorized representative to act on his or her behalf, including making an appeal request (as provided in §155.227). CMS anticipates that many appellants will need to or will prefer to rely on an authorized representative to assist them with the appellate process. Further, the appeals processes would have to be accessible to appellants who are limited English proficient, or who are living with disabilities, consistent with the requirements in §155.205(c). An appellant could seek judicial review to the extent allowable by law.

## **25. Appeals Coordination (§155.510)**

CMS proposes the general coordination requirements for the appeals entities and the agencies administering insurance affordability programs. CMS notes that, similar to the flexibility offered to states in choosing an eligibility determination process, the corresponding flexibility for eligibility appeals can ensure that appeals are managed in a seamless, consumer-friendly manner.

CMS proposes in (a) to require that the appeals entity or the Exchange enter into agreements with the agencies administering insurance affordability programs regarding the appeals processes for such programs. Such agreements must clearly outline the responsibilities of each entity to support the eligibility appeals process and should seek to minimize burden on appellants, including not requesting the appellant to provide information previously provided in the process. (In the preamble, however, CMS says that where the appellant has provided information but it cannot be located after a careful review of the appellant's file, including all information transmitted from other entities, it may be reasonable for the receiving entity to request the previously submitted documentation from the appellant.) Finally, the agreements must ensure prompt issuance of appeal decisions and comply with the coordination requirements established by Medicaid under 42 CFR 431.10(d).

CMS proposes in (b) coordination standards for Medicaid and CHIP appeals. Consistent with 42 CFR §431.10(c)(1)(ii) (the proposed Medicaid rule regarding delegations of authority to conduct fair hearings) and §457.1120, the appellant has to be informed of the option to elect pursuing his or her appeal of an adverse Medicaid or CHIP determination made by the Exchange directly with the Medicaid or CHIP agency. If the appellant elects this option, the appeals entity must transmit the eligibility determination and all information provided via secure electronic interface, promptly and without undue delay, to the Medicaid or CHIP agency, as applicable.

CMS further proposes in (b) that the appellant be notified of the option to appeal a Medicaid or CHIP denial to the Medicaid or CHIP agency rather than to the Exchange appeals entity.

CMS is also considering a more specific requirement to align with proposed Medicaid policy in which the appellant would be informed at the time of the eligibility determination made by the Exchange of his or her right to opt into an appeal of the denial of Medicaid or CHIP eligibility with the state Medicaid or CHIP agency. The assumption underlying this approach is that most appellants will not opt into having his or her appeal heard by the Medicaid agency, which would result in two separate appeals (one before the Exchange appeals entity and one before the Medicaid or CHIP agency) and will instead choose to have both Medicaid or CHIP and Exchange-related issues heard before the Exchange appeal entity. If the Exchange appeals entity conducts the hearing on the Medicaid or CHIP denial, that hearing decision is final under the

proposed rule. **CMS seeks comment on the proposed provision and the alternative for this proposed provision.**

Further proposed in (b) is that where the Medicaid or CHIP agency has delegated appeals authority to the Exchange appeals entity and the appellant has elected to have the Exchange appeals entity hear the appeal, that entity may include in the appeals decision a determination of Medicaid and CHIP eligibility provided that: (1) it apply MAGI-based income standards and standards for citizenship and immigration status using verification rules and procedures consistent with Medicaid and CHIP requirements under 42 CFR parts 435 and 457; and (2) that notices required in connection with an eligibility determination for Medicaid or CHIP be performed by the entity consistent with standards set forth by this subpart, subpart D, and by the state Medicaid or CHIP agency, consistent with applicable law.

Where a state Medicaid or CHIP agency has not delegated appeals authority to an appeals entity and the appellant seeks review of a denial of Medicaid or CHIP eligibility, CMS proposes that the appeals entity be required to transmit the eligibility determination and all information provided as part of the appeal via secure electronic interface, promptly and without undue delay, to the Medicaid or CHIP agency, as applicable.

An Exchange would have to consider an appellant determined or assessed by the appeals entity as not potentially eligible for Medicaid or CHIP as ineligible for those programs based on the applicable Medicaid and CHIP MAGI-based income standards for the purposes of determining whether they are eligible for advance payments of the premium tax credit and cost-sharing reductions.

Appeals entities would have to ensure that all data exchanges that are part of the appeals process comply with the requirements of §155.260 (privacy and security of personally identifiable information), §155.270 (use of standards and protocols for electronic transactions) and §155.345(h) (data sharing standards for Exchanges, Medicaid, CHIP and the BHP) and comply with all data sharing requests from HHS. CMS anticipates that appeals related data will need to be passed between the Exchange, Medicaid, CHIP, and the state-based Exchange and HHS appeals entities in order to process appeal requests and implement appeal decisions. Also, specific appeals-related information will be shared with the IRS via HHS in order to facilitate the tax reconciliation process under 26 CFR 1.36B-4.

## **26. Notice of Appeal Procedures (§155.515)**

In (a) relating to the general requirement to provide notice of appeals procedures, CMS would require the Exchange to provide notice of such procedures when the applicant submits an application and again when eligibility determination notice is sent under specified sections of the rules or future guidance related to exemptions pursuant to §1311(d)(4)(H) of the ACA. (CMS anticipates that an Exchange can meet this requirement by including a reference to the process in the single streamlined application and the eligibility determination notices required by certain rule sections and future guidance.)

In (b), CMS proposes general notice content on the right to appeal and appeal procedures. A notice would have to contain: (1) an explanation of the applicant or enrollee's appeal rights under this subpart; (2) a description of the procedures by which the applicant or enrollee may request an appeal; (3) information on the applicant or enrollee's right to represent himself or herself, or to be represented by legal counsel or an authorized representative; (4) an explanation of the circumstances under which the appellant's eligibility may be maintained or reinstated pending an appeal decision; and (5) an explanation that an appeal decision for one household member may result in a change in eligibility for other household members and may be handled as a redetermination.

## **27. Appeal Requests (§155.520)**

CMS proposes to require that the Exchange and the appeals entity accept appeal requests submitted by telephone, via mail, in person or via the Internet. The Exchange and the appeals entity *may* assist the applicant or enrollee in making the appeal request. The proposed rule would prohibit an appeals entity from limiting or interfering with the applicant or enrollee's right to make an appeal request and would have to consider such a request to be valid if it is submitted according to certain requirements included in this section.

The Exchange and the appeals entity would be required to allow an applicant or enrollee to request an appeal within 90 days of the date of notice of eligibility determination. If the appellant disagrees with the appeal decision of a state-based Exchange appeals entity, he or she may make an appeal request to HHS within 30 days of the date of the state-based Exchange appeals entity's notice of appeal decision through telephone, mail, in person, or via the internet.

Upon receipt of a valid appeal request, the appeals entity would have to carry out certain notice and other requirements relating to acknowledgement of the request. Communications of appellants' eligibility records between the Exchanges and the appeals entities would have to be transmitted via secure electronic interfaces. (Because an appellant may request an appeal at the Exchange or at the appeals entity, CMS anticipates that in some cases the Exchange will be the initial receiver of the request and thus must transmit the information to the appeals entity for review.) Upon receipt of the notice that an appellant disagrees with the appeal decision of a state-based Exchange appeals entity, that entity must transmit (via secure electronic interface) the appellant's appeal record, including the appellant's eligibility record as received from the Exchange, to HHS.

## **28. Eligibility Pending Appeal (§155.525)**

CMS proposes a process by which an appellant may receive benefits while his or her appeal is pending in specific circumstances. In general, the Exchange or the Medicaid or CHIP agency, as applicable, would have to continue to consider the appellant eligible while the appeal was pending in accordance with this section or as determined by Medicaid or CHIP. The Exchange would have to continue the appellant's eligibility for enrollment in a QHP, advance payments of the premium tax credit and cost-sharing reductions, as applicable, in accordance with the level of eligibility immediately before the redetermination being appealed. (CMS notes that a tax filer may waive receipt of the advance payments. Continued receipt of such payments during the

appeal may affect the amount owed or due at the IRS reconciliation process, depending upon the appeal decision.)

CMS says that its proposed approach would ensure continuity of coverage and care during an appeal and minimize the impact of eligibility errors on beneficiaries. CMS advises that eligibility pending appeal will not be offered to appellants who are appealing their initial denial of eligibility “because of the unique challenges in identifying the appropriate pended benefit (if any) for such an appellant.” Further, “while applicants and enrollees may receive coverage during the inconsistency period prior to receiving their final redetermination, as set forth in §155.315, coverage during this period is based on a different standard than eligibility received while an appeal is pending.” (The distinction in CMS policy is explained more fully at 78 FR 4651-4652.)

### **29. Dismissals (§155.530)**

CMS proposes the circumstances under which an appeals entity would have to dismiss the appeal, for example, if the appellant withdraws the appeal request in writing or fails to appear at a scheduled hearing. An applicant whose appeal is dismissed would have to be provided a timely notice by the appeals entity including the reason for dismissal, an explanation of the dismissal’s effect on the appellant’s eligibility, and an explanation of how the appellant may show good cause why the dismissal should be vacated. If an appeal is dismissed, CMS proposes to require that the appeals entity provide timely notice to the Exchange and to the agency administering Medicaid or CHIP, as applicable, which must include instructions regarding the appropriate eligibility determination to implement and the discontinuation of pended eligibility. Finally, the appeals entity would be authorized to vacate a dismissal if the appellant made a written request, either electronically or in hard copy, within 30 days of the date of the notice of dismissal, showing good cause why the dismissal should be vacated.

### **30. Informal Resolution and Hearing Requirements (§155.535)**

CMS proposes a process for informal resolution of an appeal by HHS or a state-based Exchange appeals entity as part of their respective appeals process. The process of the state-based entity would have to meet certain requirements such as being of limited scope and preserving the appellant’s right to a hearing in any case in which the individual remains dissatisfied with the outcome of the informal resolution process. (CMS considers the appellant in the best position to determine whether he or she is satisfied with the outcome of an informal resolution. Furthermore, this parallels the Medicaid fair hearing requirement that an appellant must be provided a hearing where he or she believes the agency has taken an erroneous action.) CMS expects a significant portion of appeals to be resolved through informal resolution and gives an example of a likely situation for such a formal process to be triggered. Unless an appellant requests a hearing, the decision reached through informal resolution by the appeals entity would be considered final and binding.

CMS also proposes requirements for providing written notice of a hearing to the appellant no later than 15 days prior to the hearing date. The hearings would have to meet certain standards, such as be conducted as an evidentiary hearing by one or more impartial officials who have not

been directly involved in the eligibility determination or any prior Exchange appeal decisions in the same matter. CMS elaborates on its expectations for these hearings in the preamble. For example, the format of the hearing encompasses telephone hearings and hearings held by video teleconference. As part of the proposed regulatory text, certain procedural rights would extend to the appellant. For example, he or she would have a right to review his or her appeal record at a reasonable time prior to and during the hearing; bring witnesses to testify; present an argument without undue interference and question or refute any testimony or evidence. An appeals entity would have to consider the information used to determine the appellant's eligibility and any relevant evidence presented during the course of the appeal, including at the hearing. CMS also proposes that the appeals entity review appeals de novo.

### **31. Expedited Appeals (§155.540)**

CMS proposes that the appeals entity establish and maintain an expedited appeals process. An appellant could request an expedited process where there is an immediate need for health services because a standard appeal could seriously jeopardize the appellant's life or health or ability to attain, maintain, or regain maximum function. If the appeals entity denied such a request, it would have to handle the appeal under the standard process and issue the appeal decision following certain notice procedures. The standards proposed for expedited appeals parallel those contained in the proposed Medicaid regulations in this proposed rule at §431.224 and §431.244.

### **32. Appeal Decisions (§155.545)**

CMS proposes the requirements for the content and issuance of appeal decisions. Such decisions would have to be based exclusively on the application of the eligibility rules established in subpart D of this part or pursuant to future guidance on §1311(d)(4)(H) of the ACA (relating to exemptions from the individual responsibility penalty), as applicable, to the information used to make the eligibility determination as well as any relevant evidence provided by the appellant during the course of the appeal. The content of the appeal decision would have to include the decision with a plain language description of its effect on the appellant's eligibility, a summary of the facts relevant to the appeal, an identification of the legal basis for the decision, and the effective date of the decision. (CMS notes that these requirements are based on Medicaid's fair hearing standards. It intends each piece to assist the appellant in understanding how the eligibility standards, applied to the facts of his or her case, resulted in the appeal decision.) CMS further proposes that if the appeals entity is a state-based Exchange appeals entity, the appeal decision must include an explanation of the appellant's right to pursue an appeal at HHS if the appellant remains dissatisfied with the post-hearing eligibility determination.

CMS also proposes the standards for the appeals entity to issue written notice of the appeal decision, either electronically or in hard copy, to the appellant. The required time for such notice generally would be within 90 days of the date of an appeal request. CMS acknowledges the need for longer timeframes in the event of certain very busy periods such as open enrollment and additional time may also be required due to coordination requirements with Medicaid and other agencies and appeals entities. For expedited appeals requests, notice periods must meet shorter timeframes. CMS also proposes standards for the Exchange of related information among

relevant agencies. The Exchange or the Medicaid or CHIP agency, as applicable, would be required to promptly implement appeal decisions meeting certain timeframes. CMS notes that appeal decisions that overturn the original eligibility determination commonly seek to “right the wrong” by making the appellant whole; CMS believes this includes retroactive eligibility. In the Medicaid context (as with the majority of public benefit programs), 42 CFR §431.246 directs state agencies to “promptly make corrective payments, retroactive to the date an incorrect action was taken.” **CMS seeks comment regarding the operational considerations associated with retroactive eligibility as a result of an appeal, and whether potential operational difficulties, if any, could be alleviated by limiting the policy on retroactive eligibility.** The preamble includes a discussion of CMS policy considerations in this regard. **CMS requests comment on whether the ability to enroll in coverage retroactively should be optional or limited, and if so, in what way.**

CMS also proposes to require that the Exchange or the Medicaid or CHIP agency, as applicable, promptly redetermine the eligibility of other members of the appellant’s household who have not appealed their own eligibility determinations but whose eligibility may be affected by the appeal decision, in accordance with the standards specified in §155.305. CMS anticipates that evidence received during the course of an appeal, for example updated income information, may indicate that a redetermination is required for household members who have not appealed their own eligibility determinations. For such household members, the Exchange, or the Medicaid or CHIP agency, must undertake a redetermination.

### **33. Appeal Record (§155.550)**

CMS proposes that the appeal record be made accessible to the appellant at a convenient place and time subject to the requirements of all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information. The appeals entity would have to provide public access to all appeal records, subject to all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information. This corresponds to a similar Medicaid fair hearing requirements under 42 CFR §431.244(c) and §431.244(g).

### **34. Employer Appeals Process (§155.555)**

CMS proposes the establishment of a process through which an employer may appeal, in response to being notified of its potential tax liability (see §155.310(h)), a determination that the employer sponsored health plan does not provide minimum essential coverage or that it does provide such coverage but is not affordable coverage with respect to the specific employee referenced in the notice. CMS notes that this would be the opportunity for the employer to correct any information that the Exchange received from an employee’s application regarding the employer’s offering of coverage. The review would be de novo of whether the employer’s offer of coverage is sufficient such that the employee at issue is not entitled to advance payments of the premium tax credit or cost-sharing reductions. Where an Exchange has not established this appeals process, HHS would provide it (meeting the requirements of this and other specified sections of the rules).

CMS notes that the employer appeals process is separate and distinct from the IRS's process determining whether an employer is liable for a tax penalty under section 4980H of the Code and any appeal rights the employer may have under subtitle F of the Code. Some employers may receive a notice of potential tax liability from the Exchange even if they in fact do not have any tax liability under section 4980H. This may arise because notices under §155.310(h) must be issued to employers without regard to their size, yet tax liability under section 4980H arises only against applicable large employers, that is, generally, those employers with more than 50 full-time equivalent employees. CMS' goal is to work closely with the IRS to educate and develop notices that help employers understand their potential tax liabilities and the consequences of a successful appeal.

CMS proposes a process and standards for requesting an appeal. An Exchange or appeals entity would have to allow an employer to request an appeal within 90 days of the notice of the employee's eligibility for advance payments or cost sharing reductions being sent. The employer would be allowed to submit relevant evidence to support the appeal request. CMS notes that while employer appeals may be appealed to HHS, if the Exchange has not established an employer appeals process, there is no right established under the ACA for the employer to elevate an appeal decision made by a state-based Exchange appeals entity to HHS.

Additional provisions establish the manner in which an appeal request may be submitted; timeframes; required notifications (including notice of the appeals request to the employee and an explanation that they may experience a redetermination that they are not eligible for the premium tax credit or cost sharing reductions); instructions for submitting additional evidence for consideration by the appeals entity; and procedures for transmittal and receipt of records.

CMS further proposes the process for the dismissal of an employer appeal and the procedural rights of the employer requesting the appeal. The latter includes the right of the employer to review the identity of the employee and information regarding whether the employee has been determined eligible for advance payments of the premium tax credit. In addition, the employer may request information regarding whether the employee's income is above or below the threshold by which the affordability of employer-sponsored minimum essential coverage is measured. The employer may have access to other data used to determine the employee's eligibility to the extent allowable by law, except any tax return information of an employee.

With respect to adjudication of employer appeals, CMS proposes to require that the appeal be reviewed by one or more impartial officials not directly involved in the employee eligibility determinations implicated in the appeal, and that the appeal consider the information used to determine the employee's eligibility as well as any additional relevant experience provided by the employer or employee during the course of the appeal. The appeal would have to be reviewed de novo.

CMS proposes standards for employer appeals decisions. Such a decision would have to be based exclusively on the information used to determine the employee's eligibility as well as any relevant evidence provided by the employer or employee during the course of the appeal, and on the standards for an employer to provide minimum essential coverage that meets both

affordability and minimum value standards through an employer-sponsored plan. Additional requirements are specified.

CMS proposes content and issuance of notice standards of the employer appeal decision. In addition, it proposes that the appeal record be accessible to the employer and the employee in a convenient form and time in accordance with all applicable laws regarding privacy, confidentiality, disclosure and personally identifiable information and the prohibition on sharing confidential employee information.

CMS also proposes requirements for implementation of the appeal decision. If the appeal affected the employee's eligibility, the Exchange would have to promptly redetermine the employee's eligibility. **CMS is considering, and solicits comments on, two alternative options regarding whether the employee may appeal the results from this redetermination.** Under the first option, the employee would be permitted to appeal a change in eligibility reflected in the redetermination notice generated after an employer appeal. However, if the employee were subsequently determined to be eligible for advance payments of the premium tax credit or cost-sharing reductions as a result of such an appeal, the employer would not be able to again appeal that determination to the Exchange. CMS says that this would not foreclose any appeal rights for the employer still available under subtitle F of the Code. Under the second option, the employee would not be permitted to appeal a change in eligibility reflected in the redetermination notice generated after an employer appeal. Instead, the employee would be issued a redetermination notice under this section which would not be appealable. For example, if the employer were able to establish during the appeal that it does provide coverage that is both affordable and meets minimum value standards, the employee would be redetermined as ineligible for advance payments of the premium tax credit and cost-sharing reductions. Because the redetermination would be the result of an employer appeal, the employee would not have the appeal rights associated with redetermination notices, generally. CMS says that the employee's interests would nevertheless be protected by the opportunity to submit information to support his or her eligibility determination during the employer's appeal. Moreover, if the employee's circumstances were to change following the employer appeal decision and redetermination notice, the employee could submit information to the Exchange as a mid-year update under §155.330 and any resulting redetermination would be appealable. CMS believes that either of these two approaches would be effective in limiting recurring appeals among the employee and employer.

### **35. Functions of a SHOP (§155.705)**

CMS proposes standards for the SHOP to coordinate with the functions of the individual market Exchange for determining eligibility for insurance affordability programs. CMS would require that the SHOP provide data to the individual market Exchange that corresponds to the service area in which the SHOP is operating related to eligibility and enrollment for a qualified employee. The intent is to ensure that the Exchange can use SHOP data for purposes of verifying enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan. CMS does not believe that this would create significant administrative burden since the SHOP and individual market Exchange may share core information technology systems and other supporting functionality. Such information would be



subject to certain privacy and security standards. **CMS seeks comment on the feasibility of sharing this data and the usefulness of these data in determining eligibility for advance payments of the premium tax credit and cost-sharing reductions.**

### **36. SHOP Employer and Employee Eligibility Appeals (§155.740)**

CMS would amend subpart H by adding this section to define the standards for SHOP employer and employee eligibility appeals. “Although not expressly required by the Affordable Care Act, we believe that SHOP employers and employees should have the opportunity to appeal determinations of ineligibility to participate in the SHOP.”

A state establishing an Exchange would have to provide an eligibility appeals process for the SHOP. In states that do not establish an Exchange, HHS would provide for such an appeals process. The SHOP appeal entities would have to comply with the requirements set forth in this section. An employer or employee could appeal a notice of denial of eligibility or the failure of the SHOP to make an eligibility determination in a timely manner. Certain notice requirements would have to be met. The SHOP and appeals entity would have to allow an employer or employee to request an appeal within 90 days from the date of the notice of denial of eligibility and comply with certain procedural standards, including transmittal and receipt of records via secure electronic interface; and provision of certain procedural rights to employers and employees. An appeal would have to be reviewed by an impartial official who has not been directly involved in the eligibility determination subject to the appeal. Also, appeals would have to be reviewed de novo. Appeal decisions would be effective retroactive to the date the incorrect eligibility determination was made, if the decision finds the employer or employee eligible, or effective as of the date of the notice of the appeal decision, if eligibility is denied. The SHOP would be required to implement the appeal decision upon receiving notice of the decision.

## **IV. Medicaid Premiums and Cost Sharing**

### **A. Background**

CMS proposes to modify long-standing regulations regarding requirements and limitations on Medicaid cost sharing, citing two goals. First, CMS seeks to clarify ambiguities between the regulations implementing section 1916 of the Act and those implementing section 1916A, which was added by the Deficit Reduction Act of 2005. Second, changes are proposed to provide states with additional flexibility in imposing cost sharing requirements. The proposed changes would replace in its entirety the existing regulations at §447.50 through §447.82 with a new set of rules §447.50 through §447.57. The sections cited below reflect the proposed new structure; §447.50 would continue to set out the statutory basis and purpose of premiums and cost sharing.

An attachment at the end of this summary shows current and proposed cost sharing limits.

## B. Provisions of Proposed Rule

### 1. Definitions (§447.51)

CMS proposes new definitions for premiums and cost sharing and for items and services for which cost sharing rules vary, namely alternative non-emergency services provider, preferred drugs, and non-emergency services. Cost sharing is defined to include any copayment, coinsurance, deductible or other similar charge, and CMS notes that under the proposed regulations all cost sharing would be subject to a single set of parameters. **CMS solicits comments on the utility of additional definitions that it is considering adding for “inpatient stay” and “outpatient services”; these are being considered in order to capture situations in which an individual might return to an institution for treatment of a condition that was present in the initial period.**

### 2. Cost Sharing (§447.52) – Nominal Amounts

Modifications are proposed to the maximum allowable cost sharing for individuals with incomes below the federal poverty level (FPL), which are generally limited to nominal amounts. For this group, the limits in the first column of the table below would apply, except for drugs and emergency services, for which separate rules would continue to apply as discussed below.

| <b>Proposed Maximum Allowable Cost Sharing (Other than Drugs and ED Services)</b> |   |  |  |
|---|---|--|--|
|   | <b>Individuals with Family Income &lt;100% FPL</b>    | <b>Individuals with Family Income 101%-150% FPL</b>  | <b>Individuals with Family Income &gt;150% FPL</b>   |
| <b>Outpatient Services</b><br><i>(physician visit, physical therapy, etc.)</i>    | \$4   | 10% of cost the agency pays  | 20% of cost the agency pays  |
| <b>Inpatient Stay</b>   | 50% of cost the agency pays for the first day of care | 50% of cost the agency pays for the first day of care or 10% of total cost the agency pays for the entire stay | 50% of cost the agency pays for the first day of care or 20% of total cost the agency pays for the entire stay |
| Dollar amounts indexed annually, starting October 1, 2015, to the CPI-U           |   |  |  |

The proposed limits would change the maximum for outpatient services for those with income below 100% of the FPL. Currently, for this group the cost sharing limits are tied to Medicaid agency fee-for-service payment rates, with a maximum of \$3.90 when the payment rate is \$50 or more. (The \$3.90 nominal limit is indexed annually to the CPI.) **CMS specifically seeks comments on the impact of this proposed limit on individuals with significant service needs such as those with disabilities residing in the community.** The new \$4 nominal dollar limit would take effect beginning in fiscal year 2014, and would be updated annually by the CPI-U beginning in October 2015. In no case could the cost sharing amount exceed the agency’s payment rate for the service.

For inpatient services, CMS proposes to continue current cost sharing limits. **Alternatives are under consideration and CMS seeks comments on the best approach for inpatient cost sharing for very low-income individuals.** Specifically, CMS is considering applying the \$4 outpatient maximum to inpatient services, or a \$50 or \$100 limit, which it says would encompass the majority of inpatient hospital cost sharing currently in effect. If CMS finalizes a new cost sharing limit it intends to provide a transition period, such as through October 1, 2015, to permit states to adjust their cost sharing and payment rate schedules.

CMS is also considering a separate distinction for nominal levels of cost sharing for community-based long-term care services and supports, noting that unlike outpatient care, these services are often furnished over an extended period of time. **Comments are sought on approaches to the treatment of nominal cost sharing for community-based long-term care services and supports, including how these services would be defined and the unit of service subject to cost sharing.** CMS also notes that as states exercise their options with respect to cost sharing they should continue to be aware of their obligations under the Americans with Disabilities Act and the Supreme Court’s *Olmstead* decision.

**3. Cost Sharing (§447.52) – Higher Amounts for individuals Above 100% of FPL**

For individuals with incomes above the federal poverty level, the proposal would continue current policy with respect to maximum allowable cost sharing, combining the requirements of 1916 and 1916A, as shown in the final two columns of the table above. The proposed regulatory text clarifies existing policy under 1916A that permits cost sharing to be targeted to specified groups of individuals with incomes above the federal poverty level. **CMS seeks comment on whether the regulations should specifically address the types of targeting that would be allowed and on state methodologies or administrative processes that would make targeting easier to implement.**

**4. Cost Sharing for Drugs (§447.53)**

CMS proposes to modify existing regulations regarding cost sharing for drugs to consolidate the requirements under sections 1916 and 1916A and to provide for greater state flexibility with respect to cost sharing for preferred drugs.

As under current policy, differential cost sharing would be allowed for preferred and non-preferred drugs. (If no distinction is made between preferred and non-preferred drugs, all drugs are treated as preferred.) The following cost sharing limits would apply:

| <b>Proposed Maximum Allowable Cost Sharing for Drugs</b>                 |  |  |
|--|--|--|
|  | <b>Individuals with Family Income &lt;150% FPL</b> | <b>Individuals with Family Income &gt;150% FPL</b> |
| <b>Preferred Drugs</b>   | \$4  | \$4  |
| <b>Non-Preferred drugs</b>   | \$8  | 20% of cost the agency pays                        |
| Dollar amounts indexed annually, starting October 1, 2015, to the CPI-U. |  |  |

The proposal maintains the nominal limit for preferred drugs at all income levels, but increases the cost sharing limit for non-preferred drugs for individuals with family incomes below 150% of FPL to \$8; currently for this group the same nominal limit applies for both preferred and non-preferred drugs. The dollar limits would be indexed to the annual change in the medical care component CPI-U beginning October 1, 2015.

CMS indicates that states would have the flexibility to apply differential cost sharing for preferred and non-preferred drugs in whatever manner they consider most effective. For example, cost sharing could be \$2 for preferred drugs and \$6 for non-preferred drugs or \$0 and \$8 respectively.

Current requirements are continued that limit cost sharing for a non-preferred drug to the preferred drug limit for an individual if the prescribing physician determines that the preferred drug for treatment of the same condition would be less effective for the individual, have adverse effects for the individual, or both. CMS proposes to modify that language to require that the agency have a “process in place” so that the preferred drug limit is applied in these cases. In addition, proposed additional language to the regulatory text would require that in such cases the agency must ensure that reimbursement to the pharmacy is based on the appropriate cost sharing amount.

### **5. Cost Sharing for Emergency Department Services (§447.54)**

With respect to non-emergency use of the emergency department (ED), current requirements under section 1916 allow states a waiver to impose cost sharing amounts that are up to twice the nominal amount for outpatient services. At the same time, section 1916A allows states to establish targeted cost sharing for these services for individuals with family income between 101% and 150% of the FPL in an amount not to exceed twice the nominal amount for such services. For individuals with incomes at or below the federal poverty level, nominal cost sharing limits apply and for those with incomes above 150% of the FPL, no limit applies. Subject to the nominal cost sharing limit, states may impose cost sharing for these services on individuals otherwise exempt from cost sharing requirements (described below in §447.56).

Under the proposed rule, cost sharing of up to \$8 would be permitted without a waiver for individuals with family incomes up to 150% of the FPL. As under current law, no cost sharing limits would apply for higher-income individuals.

| <b>Proposed Maximum Allowable Cost Sharing Emergency Department Services</b> |  |  |
|--|--|--|
|  | <b>Individuals with Family Income &lt;150% FPL</b> | <b>Individuals with Family Income &gt;150% FPL</b> |
| <b>ED Services</b>   | \$8  | No limit   |
| Dollar amounts indexed annually, starting October 1, 2015, to the CPI-U.     |  |  |

The \$8 maximum would also apply to individuals who are otherwise exempt from cost sharing requirements. It would be indexed to annual changes in the medical care component of the CPI-U beginning in October 2015.

Current requirements for hospital screening and referral would continue to apply, as would language clarifying that nothing in these regulations changes hospital obligations with respect to the Emergency Medical Treatment and Active Labor Act (EMTALA) or any federal or state standards with respect to payment or coverage of emergency services by a managed care organization. Before providing treatment and imposing the cost sharing, the hospital must identify an accessible alternative provider with lesser cost sharing (or for exempt populations, no cost sharing) and provide a referral to schedule treatment. The proposed definition of alternative non-emergency services provider includes a physician's office, health care clinic, community health center, hospital outpatient department or similar provider than can provide clinically appropriate services in a timely manner. In the preamble, CMS provides examples of alternative providers as those that are located within close proximity, accessible via public transportation, open extended hours, and able to serve individuals with limited English proficiency and disabilities.

The preamble also discusses how the EMTALA screening requirements combined with the prudent layperson standard make it difficult to determine a service as non-emergency based only on CPT code. An example offered is a patient presenting with chest pain, which could be considered an emergency condition under the prudent layperson standard while medical screening might find no emergency condition. CMS says "While the applicable CPT code might indicate a non-emergency condition, such chest pains would meet the definition of emergency medical condition and therefore may not be assessed a copayment."

The proposed regulation requests (not requires) that states describe the process by which non-emergency services are identified when submitting a state plan amendment to implement cost sharing for these services. CMS indicates that it will make available to states information on successful approaches. **CMS specifically seeks comments on ways to make cost sharing for non-emergency services in the ED "a viable option" for states and hospitals and in particular on approaches to distinguishing between emergency and non-emergency services.**

## **6. Premiums (§447.55)**

Existing requirements and limitations regarding premiums would be consolidated with a few policy changes. In general, current requirements permit states to impose limited premiums and enrollment fees on certain categories of individuals with incomes above 150% of the FPL; certain disabled working individuals; certain disabled children; and medically needy individuals. Aggregate limits on premiums and cost sharing, discussed in §447.56, apply.

The proposed changes would modify the option that allows states to impose premiums on pregnant women described in section 1902(l)(1)(A) so that instead of applying to women with incomes *equal to or above* 150% of the FPL, premiums could only be imposed on women with

incomes *above* that level. CMS notes with respect to pregnant women (and elsewhere with respect to children) that the statutory references do not line up with the collapsing of eligibility groups as provided in the March 2012 final rule and says it is exploring options for citing the new regulation rather than the statute. Changes are also proposed with respect to infants under age one described in 1901(l)(1)(B) that would 1) result in these infants also being subject to premiums only if family income is above 150% of the FPL and 2) would limit the total premiums on infants to the same aggregate limit of 5% of income that applies to other individuals.

Changes are proposed to the requirements for premiums imposed on medically needy individuals with incomes below 150% of the FPL. Instead of the income scale currently specified in regulations (for which the monthly maximum charge is \$19 for gross family income of \$1,000), the proposed regulations would allow states the flexibility to determine their own sliding scale up to a maximum of \$20 per month. The requirement that premiums be based on gross income would be removed because, beginning in 2014, all income for the purposes of determining income will be based on MAGI.

CMS intends that proposed changes to language regarding the basis for charging premiums to certain working disabled individuals and disabled children are clarifying and not changes in policy.

## **7. Limitations on Premiums and Cost sharing**

In this section, CMS proposes several policy changes with respect to general limitations on premiums and cost sharing and to consolidate existing requirements of 1916 and 1916A where the policies align. Clarifications would be made to the exemption for Indians from cost sharing, and **CMS seeks comments on a possible requirement that it is considering for states to apply a periodic renewal process for exempting Indians from cost sharing.**

CMS proposes to modify existing rules to allow states the option of providing an exemption for individuals living in a home and community-based setting who are required to spend for medical care all but a nominal amount of their income required for personal needs. This proposed option would parallel the existing required exemption for individuals in an institution who must spend for medical care all but a nominal amount of their income.

Other proposed changes would:

- Extend the exemption from cost sharing for individuals needing treatment for breast or cervical cancer to all cost sharing, not just the alternative cost sharing under 1916A as under current regulations. The proposed change would also extend the exemption to include men.
- Revise the exemption for pregnancy-related services so that all services provided to pregnant women are considered pregnancy-related unless specifically identified as otherwise in the state plan. The ACA provision exempting smoking cessation counseling and drugs for pregnant women from cost sharing would be codified.

- Codify the existing statutory requirement for comparability so that states may not exempt additional populations from cost sharing except for targeted cost sharing, and any cost sharing included in a state plan would be applied equally to services provided under fee-for-service, managed care, or benchmark coverage.
- Update the requirements for aggregate limits to reflect household definitions adopted in the March 2012 final rule (and proposed for modification in this rule).
- Clarify that a Medicaid agency must have an automated system to track whether families are at risk of reaching the aggregate limit on premiums and cost sharing. CMS seeks comments on whether there are efficient alternatives to an automated system to conduct this tracking.
- Allow states to establish additional aggregate limits, including a monthly limit on cost sharing for a particular service.

## **8. Beneficiary and Public Notice Requirements (§447.57)**

Current regulations require that a state provide public notice of premiums and cost sharing, and these requirements would be retained under the proposed rule with some modifications. Existing policy would be codified to require that the notice be provided in a manner that ensures that affected beneficiaries, applicants, providers and the general public are likely to have access to the notice. CMS notes that appropriate formats for providing notice might include the Agency website, wide circulation newspapers, web and print media reaching racial, ethnic and linguistic minorities, stakeholder meetings and formal notice and comment in accordance with state administrative procedures. Further, under the proposed change, CMS would no longer consider state legislation discussed at a public hearing or posted on a website to be sufficient notice for a beneficiary or provider.

The proposed changes would also require that advanced public notice with opportunity to comment must be provided prior to submission of a state plan amendment that establishes or significantly changes premium or cost sharing requirements. **CMS seeks comment on a policy it is considering that would require additional public notice if cost sharing is substantially modified during the state plan amendment approval process.**

## **V. Collection of Information Requirements**

The proposed rule includes a table (78 FR 4671) showing estimated annual burden estimates associated with various annual recordkeeping and reporting requirements. For the most part, these costs would be borne by states, Exchanges and Exchange appeals entities. Some estimated costs of notification to employees and the SHOP would be borne by qualified employers participating in the SHOP Exchange.

## **VI. Regulatory Impact Analysis**

CMS refers readers to the regulatory impact analyses published with the March 2012 final rules on Medicaid eligibility and Exchange establishment for discussion of most provisions of this proposed rule. New estimates are provided for the proposed new eligibility group for former

foster care children. The Office of the Actuary (OACT) estimates that by 2017, an additional 74,000 individuals would be enrolled in Medicaid under this new group. Over the four-year period from 2014 through 2017 this would result in new state expenditures totaling \$399 million and new federal expenditures totaling \$528 million. CMS notes that OACT is developing an analysis of the proposed Medicaid premium and cost sharing provisions. In general CMS does not anticipate significant costs or savings from these proposals.

CMS believes that the costs of the proposed appeals process and other proposals related to Exchanges would be covered by the federal grants provided for startup of state-based Exchanges, which total \$2.41 billion over fiscal years 2013-2017. Three alternatives are discussed with respect to the proposed regulations regarding Exchanges: 1) establish only a federal appeals process, 2) require paper documentation to verify access to employer-based coverage, and 3) require the Exchange to send all notices via US mail rather than offer individuals and employers the option to receive notices electronically.



**ATTACHMENT**

| <b>Summary Table</b>   |   |   |   |
|--|---|---|---|
| <b>Medicaid Maximum Allowable Cost Sharing: Current and Proposed Rules</b>   |   |   |   |
| <b>CURRENT RULES <sup>2</sup></b>  |   |   |   |
|  | <b>Individuals with<br/>Family Income<br/>&lt;100% FPL</b>  | <b>Individuals with<br/>Family Income<br/>101%-150% FPL</b>   | <b>Individuals with<br/>Family Income<br/>&gt;150% FPL</b>  |
| <b>Outpatient Services</b><br><i>(physician visit,<br/>physical therapy, etc.)</i><br>State payment for service<br>\$10 or less<br>\$10.01 to \$25<br>\$25.01 to \$50<br>\$50.01 or more | \$0.65<br>\$1.30<br>\$2.60<br>\$3.90                        | 10% of cost the<br>agency pays  | 20% of cost the<br>agency pays  |
| <b>Inpatient Stay</b>  | 50% of cost the<br>agency pays for the<br>first day of care | 50% of cost the<br>agency pays for the<br>first day of care or<br>10% of total cost the<br>agency pays for the<br>entire stay | 50% of cost the<br>agency pays for the<br>first day of care or<br>20% of total cost the<br>agency pays for the<br>entire stay |
| <b>Drugs</b><br>Preferred drugs<br>Non-preferred drugs   | \$3.90<br>\$3.90  | \$3.90<br>\$3.90  | \$3.90<br>20% of the cost that the<br>agency pays   |
| <b>Emergency Department<br/>Services</b>   | \$3.90  | \$7.80  | No limit  |
| All dollar amounts are indexed annually to the CPI-U.  |   |   |   |
| <b>PROPOSED RULES</b>  |   |   |   |
| <b>Outpatient Services</b><br><i>(physician visit,<br/>physical therapy, etc.)</i>   | \$4   | 10% of cost the<br>agency pays  | 20% of cost the<br>agency pays  |
| <b>Inpatient Stay</b>  | 50% of cost the<br>agency pays for the<br>first day of care | 50% of cost the<br>agency pays for the<br>first day of care or<br>10% of total cost the<br>agency pays for the<br>entire stay | 50% of cost the<br>agency pays for the<br>first day of care or<br>20% of total cost the<br>agency pays for the<br>entire stay |
| <b>Drugs</b><br>Preferred drugs<br>Non-preferred drugs   | \$4<br>\$8  | \$4<br>\$8  | \$4<br>20% of the cost that the<br>agency pays  |
| <b>Emergency Department<br/>Services</b>   | \$8   | \$8   | No limit  |
| All dollar amounts would be indexed annually to the CPI-U, beginning October 1, 2015.  |   |   |   |

<sup>2</sup>Source: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Cost-Sharing/Cost-Sharing-Out-of-Pocket-Costs.html>