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M E M O R A N D U M

TO: Members

FROM: Karen Lipson
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SUBJECT: CMS Final Rule Governing Medicaid and CHIP Eligibility Coordination with Exchange; Essential Health Benefits in Alternative Benefit Plans; Premiums and Cost Sharing; Exchange Eligibility and Enrollment

On July 15, CMS published a lengthy Final Rule governing several matters related to the expansion of Medicaid under the Affordable Care Act (ACA) and the operation of health benefit exchanges (henceforth "the Exchange" or "Exchanges").[1] This memorandum provides highlights of provisions of the Final Rule most likely to impact providers of long-term care services, focusing on the Medicaid-related provisions. These provisions represent only a small subset of those included in the Final Rule. The complete text of the Final Rule can be found here.[2]

NEW ADULT CATEGORY OF MEDICAID BENEFICIARIES

The ACA created a new Medicaid eligibility category for adults under age 65 who are not covered by Medicare and who have income at or below 133% of the federal poverty level (henceforth "the new adult category"). Under the Final Rule, eligibility for this category commences on January 1, 2014.[3] Medicaid eligibility under this category and under most other categories (except for the over age 65, SSI-related, spend-down, Medicare Savings Program, and long-term care beneficiary categories) will be determined using Modified Adjusted Gross Income (MAGI) budgeting. MAGI budgeting: (i) is based on income only (not assets), (ii) defines household income as the sum of the MAGI-based income of every individual in the

[1] Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment, 78 Fed. Reg. 42160, 42174(July 15, 2013).

[2] The Final Rule modifies regulations adopted in March 2012 and proposed regulations published earlier this year. Most of the proposed regulations were adopted in the Final Rule without changes. However, the Final rule did include some significant clarifications and modifications. CMS indicated in the preamble that some of the proposed regulations were not finalized and remain under review.

[3] 42 CFR §435.119.

household (with certain exceptions), and (iii) provides for an income disregard of 5 percentage points of the federal poverty level (FPL) instead of the many income disregards available under traditional Medicaid budgeting.[4] With the creation of this new category, New York's Family Health Plus program will be phased out. Individuals with income between 133 and 150 percent of the FPL, who were previously eligible for FHPlus, will be eligible for subsidies to cover premiums and cost sharing associated with the "silver plan" available through the Exchange.

As discussed further below, Medicaid beneficiaries in the new adult category (adults under age 65 with income at or below 133% of the FPL) will be eligible for all Medicaid state plan benefits except institutional long-term care. *Thus, it appears that in New York State, under the new adult category, adults under age 65 who have income at or below 133 percent of the FPL (and are not covered by Medicare) will be eligible for Medicaid coverage of community-based, long-term care services without regard for their assets.*[5]

ALTERNATIVE BENEFIT PLANS (ABPs)

1) Beneficiaries Required to Enroll in an ABP:

The ACA requires that Medicaid beneficiaries in the new adult category be enrolled in a Medicaid benchmark or benchmark equivalent plan, referred to in the Final Rule as an "alternative benefit plan" (ABP).[6] Certain other categories of Medicaid beneficiaries may also be required to enroll in an ABP at the option of the state.[7] The Final Rule clarifies the populations that are exempt from mandatory enrollment in an ABP.[8] New York has opted to require enrollment in an ABP only for Medicaid beneficiaries in the new adult category.

2) Essential Health Benefits in ABPs:

The Final Rule provides standards for the Essential Health Benefits that must be covered by ABPs. It gives states substantial flexibility in designing their Medicaid ABPs, provided that they include the ten specified "essential health benefits," cover family planning services and supplies and federally-qualified health center/rural health clinic services, and comply with mental health parity.[9] New York State has adopted an ABP that includes all Medicaid state plan benefits, except for institutional long-term care.[10]

AUTHORIZED REPRESENTATIVES

The Final Rule requires states to permit applicants and beneficiaries to designate authorized representatives to act on their behalf in assisting with Medicaid application and renewal submissions. Organizations may serve as authorized representatives. In the preamble to the Final Rule, CMS indicated that a nursing home may serve as an authorized representative.[11]

Designations of authorized representatives may be made via telephone, fax or other electronic transmissions. Court orders appointing an individual or organization to act on behalf of an applicant or beneficiary must be accepted as a designation to serve as an authorized

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[4] 42 CFR §435.603.

[5] Disabled caretakers of children, pregnant women and children are eligible for MAGI budgeting, even if they are receiving Medicare, but childless adults are not.

[6] 42 USC 1396a (k); 42 CFR §440.305.

[7] 42 CFR §440.305.

[8] 42 CFR §§440.330, 440.335, 440.347, 440.360.

[9] *Id.* at 42306.

[10] NYS Public Health Law §366(1)(a).

[11] 78 Fed. Reg. at 42174.

representative. Authorized representatives may be authorized to sign applications, complete and submit renewal forms, receive copies of communications, and act on behalf of the applicant or beneficiary in all matters or may be authorized to perform a subset of those responsibilities. They must adhere to laws and regulations governing conflicts of interest and confidentiality.[12]

ELIGIBILITY ASSESSMENTS AND DETERMINATIONS

Under federal regulations, eligibility and enrollment processes must be coordinated between state Medicaid agencies and the Exchanges, in relation to Medicaid, CHIP and insurance affordability programs available through the Exchanges, and must include the use of a single streamlined application.[13] The Final Rule provides that an Exchange may conduct assessments of Medicaid and CHIP eligibility based on MAGI standards *and* make eligibility determinations or conduct assessments only. However, only Exchanges operated by a government agency with a merit-based personnel system may make eligibility *determinations*. [14] In New York, the Exchange will conduct assessments, and the Department of Health will make MAGI eligibility determinations for new MAGI applicants beginning on January 1. At least in the short run, non-MAGI eligibility will continue to be determined by local social services districts.

The Final Rule requires states to begin accepting the single streamlined application and electronic transmissions from the Exchanges beginning in October 2013.[15] For individuals determined eligible for Medicaid based on MAGI between October and December 2013, states may require renewal of coverage any time between 12 months from the submission of the application or 12 months from January 2014.[16]

Eligibility assessments by an Exchange must consider both MAGI-based eligibility and non-MAGI Medicaid eligibility (e.g., eligibility based on disability or residency in a nursing home). If an application includes factors that would trigger non-MAGI eligibility, the application must be forwarded to the appropriate Medicaid agency for a traditional eligibility determination. In addition, the Exchange must provide applicants and beneficiaries with an opportunity to request a full Medicaid eligibility review and determination.[17]

The Final Rule authorizes states to delegate the eligibility fair hearing process to Exchanges that are operated by government agencies with a merit-based personnel system. However, states that delegate eligibility fair hearings to Exchanges must also provide applicants and beneficiaries with the opportunity to request a fair hearing conducted by the state Medicaid agency. In New York, fair hearings of MAGI eligibility determinations will be administered by an appeals office within the Exchange. The fair hearings office will continue to administer non-MAGI appeals.

MEDICAID PREMIUMS AND COST SHARING

The Final Rule provides states with increased flexibility to impose co-payments and premiums on Medicaid beneficiaries. It sets maximum cost sharing levels for outpatient services and inpatient stays for beneficiaries in three income bands: those with income at or below 100% of the FPL, those with income between 100% and 150% of the FPL, and those with income above 150% of the FPL. It also sets maximum cost sharing levels, based on income for preferred and

[12] 42 CFR §435.923.
[13] 42 CFR §435.907.
[14] 78 Fed. Reg. at 42300-42301.
[15] *Id.* at 42305.
[16] *Id.*
[17] 45 CFR §155.345.

non-preferred drugs and for non-emergency use of the emergency department. For beneficiaries with income above 150% of the FPL, there is no federal limit on the cost sharing that may be imposed for non-emergent use of the emergency department.

Under the Rule, several categories of beneficiaries are exempt from cost sharing, including:

- Most children;
- Pregnant and post-partum women, except for certain premiums and cost sharing that is not pregnancy-related;
- Individuals receiving Medicaid for services in an institution or home and community-based setting whose eligibility requires contribution of available income in excess of personal needs;
- Individuals receiving hospice care;
- Native Americans receiving services through the Indian Health Service; and
- Individuals receiving Medicaid through the breast and cervical cancer expansion.

Although commenters sought an exemption from cost sharing for long-term services and supports (LTSS), CMS did not mandate such an exemption. Instead, the Final Rule adjusts the aggregate annual limit on cost sharing (5% of family income) to apply to all Medicaid beneficiaries regardless of income. States are required to implement a mechanism to track premiums and cost sharing to ensure that the aggregate limit is not exceeded. States also have the option to exempt LTSS from cost sharing requirements. In the preamble to the Final Rule, CMS reminded states of their obligations under the *Olmstead* case and cautioned against cost sharing requirements that might incentivize institutionalization.

In New York, maximum copayments for Medicaid-covered services, based on the cost of the service, are set forth in statute at section 367-a of the Social Services Law. Any significant changes in New York's copayment requirements would require a change in statute.

CONCLUSION

As noted above, this summary covers only a small portion of the provisions set forth in the Final Rule. Generally, the Final Rule leaves a great deal of discretion to the States. Although New York State has already made many of the key decisions concerning the operation of its Exchange and the implementation of its Medicaid expansion in anticipation of the adoption of the Final Rule, the State's response to some of these regulations remains to be determined.

If you would like additional information, please contact Karen Lipson at klipson@leadingageny.org

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