

Affordable Care Act: State Resources FAQ

Enhanced Funding for Medicaid Eligibility Systems Operation and Maintenance

Under the Medicaid program, CMS has provided 90 percent federal matching funds for the design and development of new or improved Medicaid eligibility determination systems that states are developing to accommodate the new Affordable Care Act modified adjusted gross income (MAGI) rules and to coordinate coverage with the Marketplaces. States may also receive 75 percent federal match for maintenance and operations. Receipt of these enhanced funds is conditioned on states meeting a series of standards and conditions to ensure investments are efficient and effective. CMS has examined our current practices under Medicaid Management Information Systems (MMIS) rules for approval of 75 percent federal match for maintenance and operations in the context of eligibility determinations and has confirmed that, as with other parts of MMIS operations, certain eligibility determination-related costs are eligible for 75 percent Federal Financial Participation (FFP). Eligibility for the enhanced FFP will be based on state systems being compliant with the Seven Conditions and Standards (see: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/EFR-Seven-Conditions-and-Standards.pdf>), including meeting minimum critical success factors for accepting the new single streamlined application, making MAGI-based determinations and coordinating with Marketplaces starting October 1, 2013. The enhanced 75 percent funding will be available when the approved system becomes operational, with some exceptions outlined below.

This set of FAQs provides general guidelines about what costs are eligible for enhanced funding, and how CMS will work with each state to review and approve the costs that will be covered. As described in more detail in the following FAQs, CMS will use the advanced planning document (APD) process to confirm with states the specific implementation details, before states will be able to start claiming. CMS will also regularly monitor enhanced claims.

1. Can states claim 75 percent FFP for ongoing operational costs of their eligibility determination system? What costs are eligible for the enhanced FFP?

Yes, 75 percent FFP is available for on-going costs of operating approved eligibility determination systems that meet the Seven Conditions and Standards and critical success factors. (see: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/EFR-Seven-Conditions-and-Standards.pdf>)

Section 1903(a)(3)(B) of the Social Security Act provides 75 percent FFP for costs associated with operating an approved Medicaid management information system (MMIS). The Medicaid manual further clarifies at Section 11276.3 A. MMIS Operations, “FFP at 75 percent is available for direct costs directly attributable to the Medicaid program for ongoing automated processing

of claims, payments, and reports. Included are forms, use of system hardware and supplies, maintenance of software and documentation, and personnel costs of operations control clerks, suspense and/or exception claims processing clerks, data entry operators, microfilm operators, terminal operators, peripheral equipment operators, computer operators, and claims coding clerks if the coded data is used in the MMIS, and all direct costs specifically identified to these cost objectives. Report users, such as staff who perform follow-up investigations, are not considered part of the MMIS.”

States may claim 75 percent FFP for the costs of certain personnel closely associated with operating claims processing and related systems under MMIS. As noted in our final rule, Medicaid Program; Federal Funding for Medicaid Eligibility Determination and Enrollment Activities (CMS–2346–F), in response to comments, “enhanced funding is available for staff time spent on mechanized eligibility determination systems in the same manner that they apply to all mechanized claims processing and information retrieval systems, since mechanized eligibility determination systems are now considered to be part of such systems, assuming the requirements of this section are met.”

(See: <https://www.federalregister.gov/articles/2011/04/19/2011-9340/medicaid-program-federal-funding-for-medicaid-eligibility-determination-and-enrollment-activities>)

The table below delineates, consistent with traditional MMIS functions, how states should distinguish between costs that can be matched at 75 percent and 50 percent FFP. States should work closely with CMS during the APD process, as described below in more detail, to provide appropriate documentation concerning their cost allocation and claiming plans. In states where workers determine eligibility or provide customer service for multiple health and human service programs, costs should be allocated across programs, as discussed further in Question 6.

General Allocation Approach

<p align="center">Eligible for 75/25 Application, On-going Case Maintenance and Renewal*</p>	<p align="center">Eligible for 50/50 Policy, Outreach and Post-eligibility</p>
<ul style="list-style-type: none"> • Intake - Application/data receipt (i) • Acceptance- Edits, verification and resolution of inconsistencies (ii) • Eligibility determination (iii) • Outputs- Issuance of eligibility notices to customer, file updates and transactions to partners (iv) • On-going case maintenance activities, including intake activities related to renewals (v) • Customer service, including call center activities (vi) and out-stationed eligibility worker activities (vii) related to eligibility 	<ul style="list-style-type: none"> • Outreach and Marketing – General public outreach, beneficiary education and outreach, including explanation of eligibility policies, program and benefits. • Policy development and research even if related to eligibility determination standards and methodologies • Staff development and training even if related to eligibility determination, except for Operational Readiness training as defined in the response to question 3 below. • Community-based application assistance

<p style="text-align: center;">Eligible for 75/25 Application, On-going Case Maintenance and Renewal*</p>	<p style="text-align: center;">Eligible for 50/50 Policy, Outreach and Post-eligibility</p>
<p>determination.</p> <ul style="list-style-type: none"> • Maintenance and Routine Updates, including routine system maintenance, security updates, and other routine maintenance activities related to the Eligibility Determination System. 	<ul style="list-style-type: none"> • Program integrity, including auditing efforts • Appeals of final eligibility system determinations • On-going case maintenance activities, including plan choice/counseling and enrollment • Customer service, including call center activities and out-stationed eligibility worker activities, related to beneficiary education, benefits, plan choice/enrollment, and civil rights complaints.

*Includes line staff, supervisory staff and support staff for the activities listed.

- i. Activities related to receipt of the application or data related to applications.
- ii. Manual and automated edits and verification of data.
- iii. Activities related to assisting the automated eligibility determination system in the evaluation of the edited, verified data to make an eligibility determination.
- iv. Includes the issuance of the eligibility notice to the beneficiary, file updates and all activities related to notification to partners of the decision (e.g. Federally-facilitated Marketplace, SBMs, MCOs, POS, etc.).
- v. Includes receipt of data related to the ongoing-eligibility and maintenance of a beneficiary’s eligibility, such as annual renewals, address changes, income changes, household composition changes, etc. and the related steps as described in notes i, ii, iii & iv above.
- vi. Costs of call center staff should be allocated based on the portion of staff time spent performing functions eligible at the 75 percent versus 50 percent FFP levels. Those call center functions related to benefits, general beneficiary education, plan choice and enrollment would only be eligible at the 50 percent FFP level.
- vii. Costs of out-stationed eligibility workers entering eligibility application data also would be eligible for 75 percent FFP. Costs of workers conducting consumer assistance would only be eligible for 50 percent FFP.

2. When will states be eligible to claim the 75 percent FFP for ongoing maintenance and operations of eligibility determination systems? Does the 75 percent FFP expire?

Eligibility for the enhanced FFP will be based on state systems being compliant with the Seven Standards and Conditions, including meeting minimum critical success factors for accepting the new single streamlined application, making MAGI-based determinations and coordinating with Marketplaces. The 75 percent FFP will generally be available when the approved system becomes operational. The 75 percent FFP will not expire.

The start date for the 75 percent FFP for maintenance and operations would be October 1, 2013 or the actual start of the operations of the approved eligibility determination system, whichever is later.

We recognize states may be phasing in system upgrades that implement modified adjusted gross income (MAGI)-based eligibility determinations first, with subsequent releases to include non-MAGI and/or other human services programs eligibility. We will allow the 75 percent FFP to begin with the start of the approved MAGI shared eligibility service, based upon an approved Operations APD, that meets the critical success factors. Further, states with challenges in meeting critical success factors at the expected service level must have approved mitigation strategies in order to qualify.

In order to begin claiming, states should submit an Operations APD to CMS that clearly identifies the functions, staff and costs to be charged at the 75 percent FFP level, and it must be approved by CMS before a state can begin claiming the enhanced match.

3. Can states use enhanced funding for staff that they will need to bring on prior to the October 1, 2013 start date in order to train them to be ready for the start of operations?

Costs associated with the training of eligibility workers directly engaged in the operation of the new eligibility system may be eligible to be matched at the enhanced rate during the three months (or less) prior to the start of operations. An APD update would be required to document the costs, scope and timing of the training period, which will be reviewed and approved by CMS prior to a state being eligible to claim the enhanced match. States must be able to demonstrate their eligibility determination system will be operationally ready, comply with the Seven Conditions and Standards, and meet minimum critical success factors by October 1, 2013 in order to claim the enhanced funding during this training period.

4. Would the 75 percent FFP for eligibility workers (i.e. salaries/benefits) also include other resources needed to do the job (such as the phone lines for the call center, rent, computers, etc.)?

Yes. Certain types of personnel costs are eligible for the 75 percent matching rate, subject to current MMIS maintenance and operations claiming rules. The State Medicaid Manual delineates which types of personnel costs can be claimed at enhanced match, including staff direct labor and fringe benefit costs. Only direct costs allocable to the development or operation of an MMIS (including Medicaid eligibility determination system) are eligible for reimbursement at enhanced FFP rates. Such costs include: utilities, rent, telephone service, etc., necessitated by either the development or operation of an MMIS or eligibility determination system. Costs which cannot be specifically identified with the development or operation of an MMIS (including Medicaid eligibility determination system) are matched at 50 percent FFP.

Such costs are usually indirect costs including the staff costs associated with agency-wide functions such as accounting, budgeting, and general administration.

The state must submit an Operations APD which includes an allocation or distribution plan showing the breakout of direct and indirect costs for equipment, supplies, and non-personnel resources it intends to claim, and justification for those.

5. Does the 75 percent FFP apply to program integrity activities associated with eligibility and enrollment?

Verification services that are conducted as part of the eligibility determination process or to validate a client's attestation, after an eligibility record has been entered into the system, will be eligible for 75 percent FFP.

Those verifications performed post eligibility and normally initiated as part of a sampling approach, including audits, PERM or MEQC activities would be considered program integrity activity and eligible for the 50 percent FFP.

6. Do states need to cost allocate eligibility worker costs across programs? Will claiming the 75 percent FFP require new or increased time reporting by employees? What must a state submit in its operations APD and cost allocation plan?

In situations where eligibility workers determine eligibility for multiple programs, all costs must be distributed to the appropriate programs and governing FFP rates (90/75/50) based on approved time study methodologies and/or cost allocation plans consistent with OMB Circular A-87 cost allocation principles. These costs must also clearly differentiate between resources needed for direct data and systems-related activities and resources needed for MMIS and eligibility determination systems versus program management and oversight activities, which are only eligible for 50 percent FFP. State agencies performing eligibility determination currently develop and maintain methodologies for allocating costs among different health and human services programs. CMS does not anticipate the additional reporting required to obtain 75 percent FFP will add a significant amount of time to that process. From 45 CFR §95.507, Plan requirements, the cost allocation support should include the following:

- A description of the procedures used to identify, measure, and allocate all costs to each of the programs
- Conform to the accounting principles and standards prescribed in Office of Management and Budget Circular A-87, and other pertinent Department regulations and instructions;
- Contain sufficient information in such detail to make an informed judgment on the correctness and fairness of the state's procedures for identifying, measuring, and allocating the costs
- The cost allocation plan shall contain the following information:
 - An organizational chart showing the placement of each unit whose costs are charged to the programs operated by the state agency.

- A listing of all federal and all non-federal programs performed, administered, or serviced by these organizational units.
- A description of the activities performed by each organizational unit and, where not self-explanatory an explanation of the benefits provided to federal programs.
- The procedures used to identify, measure, and allocate all costs to each benefiting program and activity (including activities subject to different rates of FFP).

States should consult with their CMS cost allocation leads to determine whether any change to their approved cost allocation plan is needed and work with their counterparts at human services agencies as necessary. The methods of cost allocation should be documented in the state operations APD update submission to support the proposed budget.

7. How will CMS monitor and oversee state implementation? Will CMS ask states to report on enhanced maintenance and operations activities separately on the CMS-64-10 and 37-10? How will CMS verify state reporting?

As noted earlier, states must submit an Operations APD to request this funding. CMS will monitor state implementation of the enhanced 75 percent FFP through ongoing review of state eligibility system implementation and operations, as well as through revised claims reporting. Specifically, CMS is revising the CMS-64-10 and 37-10 forms to separately capture eligibility determination system related maintenance and operations costs. We will separately track costs related to IT systems and eligibility determination staff as follows:

- For the IT and systems maintenance and operations, costs will be reported on the CMS-64-10 and 37-10 on line 28C – Operation of an approved Medicaid eligibility determination system/cost of in-house activities – 75 percent FFP and 28D – Operation of an approved Medicaid eligibility determination system/cost private sector contractors– 75 percent FFP.
- For the Eligibility Determination workers staffing eligible for enhanced match, costs will be reported on the CMS-64-10 and 37-10 on line 28E - Eligibility Determination staff – cost of in-house activities – 75 percent FFP and 28F- Eligibility Determination staff – cost of private sector contractors – 75 percent FFP.
- For the Eligibility Determinations workers staffing eligible for regular administrative match, costs will be reported on the CMS-64-10 and 37-10 on line 28G – Eligibility Determination staff – cost of in-hour activities – 50 percent FFP and 28 H – cost of private sector contractors – 50 percent FFP.

As this enhanced match is implemented, CMS will closely monitor implementation and reporting, and if necessary, will revise how this data is collected on the estimate and expenditure reporting forms to ensure states and CMS have the proper break out to track these activities and their related claims.

Furthermore, CMS will continue to work with states over time to ensure that their systems continue to remain compliant with the Seven Conditions and Standards. For example, under the Reporting Condition, state systems should be able to produce accurate data that are necessary for oversight, administration, evaluation, integrity and transparency. CMS has recently provided technical specifications for the Transformed Medicaid Statistical Information System (“T-MSIS”) data file to states following more than a year of collaboration with states participating in the T-MSIS pilot. CMS envisions that the T-MSIS data file will be submitted on a monthly basis. We anticipate releasing additional guidance on this subject in the coming weeks.

As with all expenditures, federal match must be properly claimed and is subject to review and approval. Again, CMS will work closely with the each state to review and approve costs covered and will use the APD process to confirm with states specific implementation details, before states start to submit claims.

Coordination between Medicaid/CHIP and the Federally-Facilitated Marketplace

1. Will the Federally-Facilitated Marketplace apply Medicaid policies and verification procedures differently under the “assessment” and “determination” models?

In an assessment model, the Federally-Facilitated Marketplace will not make a final Medicaid determination. Instead, the Federally-Facilitated Marketplace will transmit the account to the Medicaid or CHIP agency when they have evaluated the individual and identified him or her as Medicaid or CHIP eligible, and the Medicaid or CHIP agency will make the formal determination. In a determination model, the Medicaid or CHIP agency delegate the authority to make determinations to the Federally-Facilitated Marketplace. In both an assessment and determination model, as described in more detail in 42 CFR §435.1200, the Federally-Facilitated Marketplace will utilize the same set of eligibility criteria, including selected state-specific options and standard verification procedures. If the state agency chooses the determination model, it must accept the Federally-Facilitated Marketplace determination as final. If the state chooses the assessment model, it must accept findings made by the Federally-Facilitated Marketplace relating to a criterion of eligibility, as long as the Federally-Facilitated Marketplace applies the same policies and verification procedures as those the state agency employs. In a state with a separate CHIP agency, the state Medicaid and CHIP agencies can make different choices allowing the Federally-Facilitated Marketplace to make an assessment or determination. States must choose either the assessment or determination model for all applications; they may not choose between models on a case-by-case basis. States will need to indicate their assessment or determination decision to CMS in a State Plan Amendment, as well as in the Memorandum of Agreement it signs with the Federally-Facilitated Marketplace.

2. In an assessment model, an applicant may be assessed eligible by the Federally-Facilitated Marketplace and later receive a determination as ineligible by the state Medicaid/CHIP agency. Does the state Medicaid agency need to communicate the eligibility finding to the Federally-Facilitated Marketplace?

Yes. In an assessment model, where an applicant is assessed eligible by the Federally-Facilitated Marketplace and later found to be ineligible by the state Medicaid agency, the state must transfer the account to the Federally-Facilitated Marketplace. Once received, the state Medicaid determination will be accepted and the account will be assessed by the Federally-Facilitated Marketplace for enrollment in a qualified health plan (QHP) and eligibility for Advanced Premium Tax Credits/Cost Sharing Reductions.

For the determination model, as discussed in §435.1200(c), as governed by the agreement signed between the Medicaid agency and the Federally-Facilitated Marketplace, the Federally-Facilitated Marketplace determines eligibility for individuals applying to the Federally-Facilitated Marketplace for Medicaid/CHIP based on MAGI, and the state Medicaid or CHIP agency agrees to accept eligibility findings made by the Federally-Facilitated Marketplace.

3. In an assessment model, if an applicant applied via the Federally-Facilitated Marketplace and is found eligible for Medicaid or CHIP, how will the Federally-Facilitated Marketplace coordinate with the state Medicaid or CHIP agency regarding eligibility, enrollment, redeterminations, or renewals for Medicaid/CHIP?

For individuals assessed eligible for Medicaid/CHIP by the Federally-Facilitated Marketplace, their account will be transferred to the state Medicaid/CHIP agency for a final determination. Once enrolled in Medicaid/CHIP, regardless of where the initial application was submitted, all updates, redeterminations and renewals are handled by the enrolling entity (e.g., the state Medicaid/CHIP agency). No further coordination would be needed with the Federally-Facilitated Marketplace except when an individual is found ineligible for Medicaid or CHIP during the redetermination process. In this case, the state agency would transfer the individual's account to the Federally-Facilitated Marketplace to be assessed for enrollment in a qualified health plan (QHP) and eligibility for Advanced Premium Tax Credits /Cost Sharing Reductions. The Federally-Facilitated Marketplace will not handle redeterminations or renewals for Medicaid/CHIP and will refer individuals to the appropriate site in the state as appropriate.

4. Will the Federally-Facilitated Marketplace integrate its enrollment file with the state's client registry so that data for households participating in both state programs and the Marketplace can be synchronized? Will the Federally-Facilitated Marketplace routinely check the Medicaid/CHIP enrollment files to determine any overlap between the Federally-Facilitated Marketplace and Medicaid/CHIP enrollment logs?

No. There will not be integration of the Federally-Facilitated Marketplace and states' client registries. Instead, the Federally-Facilitated Marketplace will both verify current Medicaid/CHIP enrollment as part of the Federally-Facilitated Marketplace's applicant's application, and will

also conduct quarterly checks of the Medicaid/CHIP enrollment files to determine any overlap with Federally-Facilitated Marketplace enrollment logs.

Section 1115 Demonstrations

1. Will CMS approve enrollment caps or periods of ineligibility in section 1115 demonstrations?

The Affordable Care Act provides significant federal support to ensure the availability of coverage to low-income adults. Enrollment caps limit enrollment in coverage on a first come, first serve basis. Periods of ineligibility delay or deny coverage for otherwise eligible individuals. These policies do not further the objectives of the Medicaid program, which is the statutory requirement for allowing section 1115 demonstrations. As such, we do not anticipate that we would authorize enrollment caps or similar policies through section 1115 demonstrations for the new adult group or similar populations.

2. Can states that extend eligibility for adults and propose, through a section 1115 demonstration, changes to the delivery of health care services still be eligible for the increased federal match?

Demonstrations focused on changes to how health care services are delivered, such as the use of managed care, will not generally affect the state's matching rate. Please refer to our February 2013 FAQs (available at <http://medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-ACA-Implementation/Downloads/ACA-FAQ-BHP.pdf>), which provide further clarification on the two increased federal match rates: the newly eligible rate and the expansion state rate as well as the final FMAP rule published on April 2, 2013 (available at <http://www.gpo.gov/fdsys/pkg/FR-2013-04-02/pdf/2013-07599.pdf>). Additionally, CMS issued two State Medicaid Director letters, on July 10, 2012, that provide guidance on how states can adopt integrated care models without the need for a section 1115 demonstration.