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Subject: Guidance on State Alternative Applications for Health Coverage

Purpose and Scope of Guidance

Beginning on October 1, 2013, the new Health Insurance Marketplace, also known as the Affordable Insurance Exchanges (Exchanges), and State Medicaid and Children's Health Insurance Program (CHIP) agencies will use a single, streamlined application to determine eligibility for enrollment in Qualified Health Plans (QHPs) through the Marketplace, and for insurance affordability programs including advance payments of the premium tax credit (APTCs), cost-sharing reductions (CSRs), Medicaid, and CHIP.

On April 30, 2013, CMS released the model single, streamlined application for coverage through the Marketplace and insurance affordability programs. The model single, streamlined application is available for review at <http://www.cms.gov>. This application, in both its paper and online versions, will be the sole application used by the Federally-facilitated Marketplace to facilitate eligibility determinations and enrollment in health coverage. State-based Marketplaces, as well as Medicaid and CHIP agencies, may choose to use the model single, streamlined application, or may develop an alternative single, streamlined application that is approved by CMS. In States utilizing the Federally-facilitated Marketplace, the Medicaid and/or CHIP agency may develop an alternative application, but the Medicaid and/or CHIP agency must still be able to accept and process the paper version of the model single, streamlined application if an applicant for coverage submits it. This guidance is intended to provide background on the development, review and approval of alternative applications.

Designing an Alternative Application

States may submit for approval an alternative application that can be tailored to accommodate state preferences and policies, while also reflecting the general principles of the model application and complying with the applicable provision of law, as described below. This section outlines the parameters for creating an alternative application and also identifies areas where a formal approval of modifications to the model application is not needed.

General Principles

States must adhere to regulations implementing the Affordable Care Act in the area of applications, eligibility standards, verifications, determinations, and coordination in developing alternative applications. States should be guided by the model application and CMS expects State-based Marketplaces, Medicaid and CHIP agencies to collaborate in the development of alternative applications to the maximum extent possible (see specifically, 42 CFR 435.907, 435.911, 435.945-435.956 and 435.1200, 457.330-457.380, and 45 CFR 155.300-155.320 and 155.405). Some examples of the aspects of the application that are minimally required for alternative application approval include:

1. *An alternative application must request information necessary for determining eligibility for coverage in a Qualified Health Plan (QHP) and all insurance affordability programs.* The law requires that one application be used for all programs under the Affordable Care Act to ensure a proper adjudication of eligibility, minimize burden on applicants who may not know which program they are eligible for and allow households with members eligible for different programs to apply using a single application. States must include all questions that will help the relevant entity or entities determine whether an applicant is potentially eligible for coverage through a QHP and any insurance affordability program, even if the agency making available the application will not be the entity processing certain portions of the application. For example, Medicaid and CHIP agencies must include questions about access to employer-sponsored health coverage on their paper applications, though the responses may not affect eligibility for Medicaid or CHIP coverage. On an online application, system logic should trigger these questions to appear only when an applicant does not appear eligible for Medicaid and CHIP based on their attestations. It is important to note, too, that Medicaid and CHIP agencies do not need to ask questions related to QHP enrollment such as Special Enrollment Periods or tobacco use.

Likewise, because an individual cannot be eligible for APTC if he or she is eligible for Medicaid or CHIP, a State-based Marketplace must ask applicants to provide answers to questions relating to Medicaid eligibility. Additionally, states must include non-MAGI screening questions related to disability and long-term care needs, though states may seek to adjust these questions to more specifically fit the non-MAGI standards in that state.

2. *States must only ask questions that are necessary for determining eligibility for coverage in a Qualified Health Plan (QHP) and all insurance affordability programs, or for the administration of these programs.* Questions that are not essential to these purposes or programs cannot be required. For example, in accordance with 42 CFR 435.907, states may not request citizenship and immigration information from “non-applicants,” or individuals who are identified on an application of an individual who is applying for coverage but who are themselves not applying for coverage. Requests for Social Security Numbers of non-applicants must be optional. Please see page 5 for information on multi-benefit applications.
3. *Requests for information from application filers should minimize the burden on the applying household. For State-based Marketplaces, this includes providing two paths in the application such that individuals who opt to not receive financial assistance do not need to answer financial assistance questions.* For example, online applications must be structured in a

dynamic manner, so that questions that are specific to an insurance affordability program are only asked of individuals who appear eligible for that program. These program-specific questions are outlined in sections XII and XIII of the online application questionnaire which can be found at <https://calt.cms.gov/sf/go/doc28817?nav=1>. Also, a State-based Marketplace must provide an opportunity for individuals to opt to not receive financial assistance and apply for coverage in a QHP without requesting information on income or other criteria related only to insurance affordability programs. In addition, when questions only apply to certain age groups or genders, states should ask them on online applications only when they are relevant. On paper applications, threshold questions which lead to appendices are one approach to streamline forms and minimize burden.

4. *In accordance with the regulations on the use of the Federal Data Services Hub and other electronic data sources, states must first rely on available electronic data sources and should request paper documentation only when electronic data is insufficient or inconsistent. The state may only request paper documentation when an individual's attestation conflicts with electronic data, or when there is no electronic data available to verify an individual's attestation. (See 42 CFR 435.945-435.956 and 457.330-457.380, and 45 CFR 155.315)*

Customizing the Model Application (No Approval Required)

There are a number of ways that a state may adapt the model application without need for formal approval from CMS as an alternative application. These include:

1. Adding the state Marketplace, Medicaid, and CHIP agency or program names and contact information to the application. It is important that the state's application provide the appropriate contact information for applicants to mail the paper application, contact the applicable call center, and access online help tools.
2. Changing the colors, logos, icons, and pictures on the model application to reflect branding appropriate for that state. This includes removing CMS logos from the application.
3. Eliminating questions that are not relevant to the state's eligibility rules. The model online application includes some questions that are not relevant to all states. For example, a state that does not take 40 work quarters into consideration for status as a qualified non-citizen does not need to include the associated question from the model application. This same principle applies to the paper application.
4. If the state has additional income or other verification data sources outside of those received from the Federal Data Services Hub that can be used to pre-populate the current income section of the online application, those sources may be included as part of the application process without formal approval. States may adjust the income section of the application to account for the data sources and verification criteria to be used by the state. For example, if a state Medicaid or CHIP agency will not be using or storing federal tax information (FTI), then the state would not include the "expedited" income section as it exists in the model online application. However, state Medicaid and CHIP agencies will still need to request attestations of annual income on the application in order to determine potential eligibility for APTC.

5. Adding language to the privacy statement or rights and responsibilities section of the application, if required by state law or regulation.
6. Changing the placement and order of questions regarding contact information for the household, and removal of the question about text messaging if the state does not plan to send text messages to individuals.

Modifications that Minimize Consumer Burden (No Approval Required)

States may add or change the model application questions so that their application reflects the eligibility policies in place in the state. Formal approval from CMS is not required for these changes if they do not add burden on the consumer. Examples of these types of acceptable modifications include:

1. The removal of questions when a state elects to address an issue post-eligibility. States may also tailor questions to make them more state-specific, such as including the state definition of “temporary” in the question regarding residency or the state definition of “full-time student” in the question about student status.
2. Changing the order of questions, as long as the change does not impede the online application’s dynamic nature. For example, a state could change the order of income questions within the income section, but must collect full income and household information early enough in the application so that only questions applicable to the relevant insurance affordability program or programs are asked (see item 3 in the “General Principles” section, above).
3. When needed to complete a MAGI-based eligibility determination, states may add questions relating to a state option that is not supported in the Federally-facilitated Marketplace’s eligibility assessment or determination logic. This may include questions relating to family planning, state-only funded eligibility groups, state premium assistance programs, and exceptions to waiting periods for CHIP coverage.
4. Making the application more dynamic to adapt to the state’s cascade of Medicaid eligibility categories.

Development and Approval of Alternative Applications – Modifications that Require CMS Approval

If your state’s application differs from the model application in ways other than those described in the previous sections (which do not require CMS approval), CMS will review these changes to ensure that the state’s application is consistent with the applicable statute and regulations, and maintains the principle of minimizing burden on the consumer. Some examples of changes that would require approval include:

1. A different implementation of the option to consider reasonably predictable future changes in income.

2. A different mechanism to determine whether dependents and children have federal income tax filing requirements.
3. Different “reasonable explanation” questions for addressing inconsistencies between income or household size information provided on the application and information from with electronic data sources used for verification.
4. A different approach to the timing of checking electronic data sources, e.g., at the end of the application after all questions have been asked, rather than verifying with electronic data sources as questions are asked at earlier points in the application process. In this situation, a state may be considering eliminating questions that CMS has included based on data matching, including the questions soliciting reasonable explanations for discrepancies with income data and the “expedited” income section.
5. The addition of questions related to eligibility for Medicaid on a basis other than MAGI. Please see information further below on the use of a supplemental form for non-MAGI Medicaid questions.

Special Considerations for Multi-benefit Applications

Many states have expressed interest in using a multi-benefit human services application as the base for their alternative application. This approach is acceptable if the application collects sufficient information to determine MAGI-based eligibility for all insurance affordability programs. These applications include questions related to other benefit programs, such as the Supplemental Nutrition Assistance Program (SNAP). These types of questions may be included on a single streamlined application, as long as the state clearly indicates the additional questions are optional, or not required for submission, and therefore do not serve as a barrier to the MAGI determination. States may not deny or delay eligibility for an insurance affordability program due to missing or unverified information pertaining only to a non-health program. States that elect to make available a multi-benefit application must also ensure the opportunity for an applicant to file a health coverage-only application.

Non-MAGI Based Medicaid Applications

For individuals seeking Medicaid eligibility on a basis other than MAGI, states may use a combination of the model single, streamlined application (or a CMS-approved single, streamlined application) and supplemental forms to collect the information needed to determine eligibility, or states may use a completely separate application designed specifically for this population. If a state chooses to ask non-MAGI questions through a separate supplemental form, or through a completely separate application, these materials should be submitted to CMS in accordance with 42 CFR 435.907, but do not require CMS approval prior to use.

Medicaid agencies seeking to incorporate non-MAGI related questions in their alternative application must ensure that these questions do not add burden on the consumer completing the application. In an online application, these questions should only be asked of individuals who are potentially eligible for Medicaid on a basis other than MAGI, such as when the applicant answers affirmatively to one of the non-MAGI screening questions. On a paper application, the

state must clearly indicate that these questions are optional and are posed to the applicant only if relevant. Under both formats, the MAGI-based eligibility determination must not be delayed while information is collected to make the non-MAGI eligibility determination.

Process for Submission and Approval of Alternative Applications

Starting this year, for State-based Marketplaces, the state's submission of its Marketplace Blueprint application will indicate the state's intent to use either the model single, streamlined application or a CMS-approved alternative application. As part of the Blueprint application, the State-based Marketplace should submit the material described below for CMS review and approval. For State-based Marketplace states that develop an alternative application, decisions pertaining to the approval of the state's application will be conferred by the Center for Consumer Information and Insurance Oversight (CCIIO). CMS is committed to providing states with a coordinated, streamlined review process and CCIIO will conduct its review of State-based Marketplace alternative applications in close consultation with the Center for Medicaid and CHIP Services.

For Medicaid and CHIP agencies, the review and approval of alternative applications will be through the State Plan Amendment (SPA) process. CMS will soon be releasing SPA pages to assist states in indicating their decision to use the model single, streamlined application or an alternative application. The approval of alternative applications will occur within the timeframes required by the SPA process, but CMS will make every effort to expedite technical assistance and requests for additional information so that states have time to implement changes and reach resolution. For Medicaid/CHIP agencies that develop an alternative application, decisions pertaining to the approval of the state's application will be conferred by the Center for Medicaid and CHIP Services (CMCS). Likewise, CMCS will conduct its review of Medicaid and/or CHIP-developed alternative applications in close consultation with CCIIO.

For the paper application, states should submit a full copy of the proposed alternative form and any accompanying supplements and instructions which relate to a MAGI-based determination. For the online application, the state may submit 1) a questionnaire document in a format similar to the model application online questionnaire; 2) a packet of screenshots depicting the screens a family completing the alternative application would see, and/or 3) a flow chart demonstrating the logic that takes applicants between sections and questions on the online application. CMS may also request an interactive demonstration of the proposed online application.

States should also provide an analysis document that identifies and describes key differences between the model application and the state's alternative application, in terms of the modifications that require CMS approval. Differences that do not require CMS approval do not need to be included in this document, but would be helpful to note and may expedite the review process. States using a common IT vendor to develop their core application can submit one analysis document for the vendor-developed core application, along with a state-specific analysis describing only the state-specific modifications made, or proposed, to the core application that represents differences from the model application. Upon receipt of a submission, CMS will contact the state to confirm receipt, and conduct its review.

Approval of Alternative Applications for Coverage Year 2014

CMS recognizes that a unique set of circumstances exist for State-based Marketplaces, as well as Medicaid and CHIP agencies, who are implementing applications for coverage beginning on January 1, 2014. Specifically, we are aware of the challenges posed by the amount of development work that states had completed on their applications and eligibility systems prior to the release of the model application and the release of this guidance. CMS may offer an expedited approval process, as necessary, for states and CMS will allow for conditional approval of an alternative application for 2014.

In order to receive conditional approval of an alternative application, a state must: 1) attest that the application meets, or will meet by a certain date, all applicable regulatory requirements described in the “General Principles” section of this document; 2) attest that the design of the state’s application took into consideration, or aligns with, the proposed model single, streamlined application released on January 29, 2013; and 3) provide the material described in the section above, “Process for Submissions of Alternative Applications,” for CMS review. A state must also submit a proposed timeline towards addressing any recommendations identified through CMS’ review.

In order to receive full approval from CMS, a state must demonstrate that all applicable regulatory requirements are met by doing the following: 1) modifying its application based on recommendations identified by CMS’ review, or modifying its application to align with the model application. This includes modifications to core application functionality that is shared across multiple states, through the use of a common IT vendor. CMS will evaluate the State’s proposed timeline for such modifications and will arrive at an agreed-upon timeline between CMS and the state; 2) subsequently submitting evidence of the modifications, or submitting evidence indicating alignment with the model application, for CMS review. This evidence can be submitted as part of regular or ad-hoc reviews conducted by CMS (e.g., Exchange Life Cycle Reviews, Gate Reviews, Design Reviews, and/or Implementation Reviews).

States intending to implement alternative applications for coverage year 2014 may begin requesting CMS approval upon the release of this guidance, and will need to receive full approval of their applications in 2014. CMS will make every effort to work with states in achieving conditional or full approval to states in as timely a manner as possible.

Technical Assistance

CMS is committed to providing states with a coordinated technical assistance process to states in their development of alternative applications. CMS remains available to provide technical assistance to states to facilitate adoption of the model application, in their development of alternative applications. CMS staff is available to review draft materials, participate in discussions and to join interactive demonstrations with states. Questions from Medicaid and CHIP agencies regarding this guidance can be directed to Anne Marie Costello, Director of the Division of Eligibility, Enrollment and Outreach at CMCS at 410-786-5175. Questions from State-based Marketplaces regarding this guidance can be directed to Hilary Dalin, Director of the State Technical Assistance Division, State Exchange Group at CCIIO at 301-492-4343, or Jenny Chen in the State Exchange Group at CCIIO at 301-492-5156.