

State Health Reform Assistance Network

Charting the Road to Coverage

Issue Brief

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Analysis of Eligibility Changes and Implications for Selected Medicaid and CHIP Eligibility Groups in 2014

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INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) has prompted the Centers for Medicare and Medicaid Services (CMS) to promulgate Medicaid and CHIP eligibility rules designed to simplify and collapse Medicaid eligibility categories in preparation for the changes in Medicaid that will become effective under the ACA in 2014.¹ The Medicaid eligibility final rule coordinates closely with two other rulemakings on the operation of health insurance exchanges and eligibility for the Advanced Premium Tax Credit and Cost-Sharing Reductions (APTC/CSR) that will be available to subsidize private insurance through the exchanges.² The Medicaid eligibility rule requires states to reorganize their existing eligibility structures in light of the new federal structure. The changes in eligibility categories apply primarily to low-income children and adults whose eligibility is not tied to being elderly, disabled, or needing long term services and supports.

In addition to implementing changes in Medicaid categories, states will use a new income methodology, the Modified Adjusted Gross Income (MAGI) methodology, to determine Medicaid and CHIP eligibility for most low-income children and adults beginning in 2014. The MAGI methodology also applies primarily to groups whose eligibility is not tied to being elderly, disabled, or needing long term services and supports.

In the Medicaid eligibility rule, CMS consolidated most existing eligibility categories that will be affected by the shift to MAGI into four groups:

1. Children Under Age 19
2. Pregnant Women
3. Parents and Caretaker Relatives
4. Adults

To assist state agencies as they plan the transition from their current Medicaid categories to these MAGI-related categories, the National Academy for State Health Policy (NASHP) has prepared the “2014 Eligibility Transition Toolkit for States,” comprised of two matrices and this issue brief. One matrix is a blank document that administrators can fill in like a worksheet, and the other is an example of a completed matrix for a sample hypothetical state. Organized by the four new consolidated categories, the matrices compare the eligibility groups of today to their required or optional health coverage landings in 2014 in terms of income eligibility, federal financial participation, and benefits. Also organized by eligibility group, this issue brief is intended as a deeper analysis to help states think through the issues and decision points they identify using the matrices.

The bulk of the analysis and writing for this brief and toolkit were written before the recent Supreme Court decision in *National Federation of Independent Businesses, et al. v. Sebelius*, No. 11-393 (June 28, 2012), which upheld the ACA, but also held that states that do not expand Medicaid coverage with their enhanced matching funds to 133 percent of the federal poverty level may not be subject to the withholding of all their federal Medicaid funds, but rather only the funds related to the expansion. We have reviewed the content and adapted where needed to take the decision into account. At the time of this writing the brief does not benefit from CMS guidance related to the decision. For the purpose of this material, we interpret the decision as applying only to adults who would be newly eligible adults covered with 100 percent federal Medicaid funds in 2014 in the new adult group. In addition, because the Court’s decision addressed only the consequences for failing to comply with the expansion, and because the statute and regulations establish the group as a mandatory Medicaid category, this toolkit and brief treats them as a mandatory category as well.

NASHP prepared this issue brief and related toolkit as part of the State Health Reform Assistance Network (State Network), funded by the Robert Wood Johnson Foundation. NASHP initially undertook similar analyses for two individual states to assist them in systematically identifying issues and decision points they must address as they prepare for the transition to 2014. NASHP built off these state-specific products to develop a more general product that all states would find useful. The work was further informed by the recent promulgation of the final Medicaid eligibility rule.

SUMMARY

This issue brief analyzes key considerations for states as they transition their current Medicaid and CHIP eligibility structure to a new structure for 2014. The background section sets the context for the transition for states. The next section provides a

¹ Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act, P.L. 111-152; Center for Medicare & Medicaid Services (CMS), HHS, Final rule; Interim Final Rule, Medicaid Program; Eligibility Changes under the Affordable Care Act, 77 F.R. 17144 (March 23, 2012). [Hereinafter the “Medicaid eligibility rule”].

² Internal Revenue Service, Health Insurance Premium Tax Credit, Notice of Proposed Rulemaking, § 1.36B-2(c), 76 F.R. 50931 (August 17, 2011) [Hereinafter, “IRS NPRM”]; Department of Health and Human Services, Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, Final Rule, Interim Final Rule 77 F.R. 18310 (March 27, 2012) [Hereinafter, “Exchange final rule”].

synthesis of the minimum and maximum eligibility levels for the four major eligibility groups and highlights many of the decision points that arise for states in the transition process. The following section highlights a few important tools states could use to simplify the transition and assist with enrollment in 2014. The brief concludes with an enumeration of several issues not covered that states will need to consider, and recommendations on how states can use this toolkit as a framework for analysis to additional issues as they arise.

BACKGROUND

Shifting To Modified Adjusted Gross Income (MAGI) Methodology

In 2014, states will use the MAGI methodology for calculating eligibility for Medicaid and CHIP for most people under 65. The Medicaid categories exempt from the MAGI methodology are those categories covering individuals who are categorically eligible (without need for an income determination); blind; disabled; age 65 or over where age is a condition of eligibility; or seeking coverage based on the need for long term services and supports, Medicare cost-sharing assistance, or medically-needy coverage.

The MAGI methodology differs in several ways from the methodology related to the Aid to Families with Dependent Children (AFDC) program that states use today to determine Medicaid and CHIP eligibility for most children and adults under 65. The AFDC-related methodology includes significant disregards of income, whereas MAGI uses an income calculation based on modified adjusted gross income as defined in tax regulations and a flat disregard of an amount equivalent to a 5 percentage point increase of the applicable income limit expressed as a percentage of the Federal Poverty Level (FPL). MAGI also uses (with some important exceptions) a household composition definition based upon the taxpayer and his or her dependents. Forthcoming guidance from CMS and researchers will assist states with developing a method for converting current income eligibility limits to MAGI-equivalents.³

The change in the definition of household composition and the task of converting the maximum eligibility levels for various groups to their MAGI equivalents are both important topics for states that are beyond the scope of this brief. The focus here is instead on the transition issues and decision points with respect to establishing eligibility and benefits in light of federal matching dollars that states will need to consider as they envision how the people in various adult and child categories of today will be served in the new consolidated MAGI-related categories of children, pregnant women, parents and caretaker relatives, and adults of 2014.

Consideration of Uninsured in 2014

Even as the ACA provides for expanded Medicaid eligibility levels and the new APTC/CSR to make private insurance more affordable through the exchange, many households will remain uninsured after 2014. Although the ACA is projected to reduce the number of uninsured by assisting over 30 million people, an estimated 26 million people will still be uninsured because they will remain unable to afford coverage or access the assistance of the ACA.⁴

Many of the uninsured will be exempt from the requirement to purchase coverage. Individuals will be exempt if:

- The cost exceeds 8 percent of their income;
- They are exempt from filing taxes due to low income;
- They are Native Americans;
- They are incarcerated individuals; or
- They are undocumented immigrants.⁵

In addition, an individual who qualifies for “minimum essential coverage” without help from the APTC/CSR is disqualified from receiving the APTC/CSR through the exchange. Minimum essential coverage includes many public sources of coverage, and also employer-sponsored insurance (ESI) that provides a certain minimum value and is “affordable.”⁶ The IRS’s proposed interpretation of affordability could cause more people to be excluded from the APTC/CSR than first expected. The IRS had proposed that ESI be considered affordable if the contribution for the taxpayer’s *self-only* coverage is less than 9.5 percent of household income.⁷ If finally adopted, this would have effectively excluded family members from the APTC/CSR even when the taxpayer’s contribution toward ESI for *family* (e.g., self and spouse, self and child(ren), or self,

³ See, Center for Medicare and Medicaid Services, *Conversion of Net Income Standards to Equivalent Modified Adjusted Gross Income Standards and Solicitation of Public Input*. Retrieved June 29, 2012, <http://www.medicaid.gov/State-Resource-Center/Events-and-Announcements/Downloads/MAGI-income-conversion.pdf>.

⁴ Congressional Budget Office, *Updated Estimates for Insurance Coverage Provisions of the Affordable Care Act*, 3 (March 2012). Retrieved March 23, 2012 from <http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf>.

⁵ ACA § 1501.

⁶ IRS NPRM § 1.36B-2(c), 76 F.R. 50940 – 50941.

⁷ IRS NPRM, 76 F.R. at 50935.

spouse and child(ren)) coverage is, in reality, unaffordable. In the final rule, the IRS left the issue open, indicating it would determine the definition of “affordability” for family members at a later time.⁸

Both lawfully residing and undocumented immigrants are groups that will remain largely uninsured. Undocumented immigrants, in addition to being ineligible for CHIP and Medicaid (except for emergency Medicaid), will not be eligible for the APTC/CSR. Undocumented immigrants will also not be able to purchase coverage at full price through the exchange. Lawfully residing immigrants will continue to be ineligible for Medicaid in situations where their citizen counterparts are not. Lawfully residing immigrants are eligible to purchase coverage through the exchange and benefit from the APTC/CSR. However, the ACA did not change the requirements in Medicaid or CHIP with respect to legal immigrants. Most lawfully residing low-income immigrant adults will remain subject to a 5-year waiting period for Medicaid. States will continue to have the option to provide coverage to lawfully-residing pregnant women and children regardless of their date of entry into the United States. States may also use CHIP funding to provide prenatal care to pregnant women, regardless of their immigration status. Because of the denial of federally-funded Medicaid for most lawful immigrants, many states provide state-funded health coverage assistance to specified immigrant populations. At least 16 states provide some form of completely state-funded health care to immigrants who are unable to access Medicaid, with both the population covered and the benefits provided being broad or quite narrow, depending on the state.⁹

In short, whether citizen or immigrant, not everyone will have access to affordable coverage through the ACA. This reality will influence state decisions on whether to retain or add optional non-MAGI Medicaid or state-funded programs that might continue to be a critical safety net for needy individuals still unable to afford coverage in 2014.

MEDICAID ELIGIBILITY ISSUES BY POPULATION CATEGORY

CHILDREN, AGES 0 – 19

Under current law, states are required to provide Medicaid coverage to children ages 0 through 5 with family income at or below 133 percent FPL, and to children ages 6 through 18 with family income no greater than 100 percent FPL. At their option, 28 states provide Medicaid to infants ages 0 to 1 at income levels of 185 percent FPL or higher.¹⁰ In addition, the option under section 1902(r)(2) of Title XIX of the Social Security Act (SSA) to disregard blocks of income has effectively allowed states to increase Medicaid eligibility limits for children (as well as adults) of any age up to any state-defined limit. This option will no longer be available after December 31, 2013. All states provide coverage for children above the Medicaid eligibility limits using CHIP, with its enhanced federal matching dollars. CHIP is available to children under 19 in households with incomes up to a maximum standard of 200 percent FPL or 50 percentage points above the Medicaid limit, whichever is higher.

Under the ACA’s maintenance of effort provision, states are not permitted to use standards, procedures, or methodologies that reduce eligibility for children in either CHIP or Medicaid until after September 30, 2019.¹¹ Thereafter, children must be covered if their household income is at or below at least the minimum eligibility level described in the box below. When states shift to the MAGI methodology, children eligible for Medicaid or CHIP must retain eligibility, and states must take into account existing disregards when converting current income eligibility levels into a MAGI-equivalent income standard. The minimum and maximum income standards set out below reflect the new final Medicaid and CHIP eligibility rules. The standards maintain current federal minimum eligibility standards, while also maintaining until December 31, 2013 the flexibility under current authority for states to increase eligibility by disregarding income or resources. States are expected to convert the maximum eligibility levels to a MAGI-equivalent eligibility limit.

⁸ 77 F.R. 30377, 30380 (May 23, 2012).

⁹ National Immigration Law Center, Table: Medical Assistance Programs for Immigrants in Various States (Update to Guide to Immigrant Eligibility for Federal Programs, July 2011. Retrieved April 20, 2012, <http://www.nilc.org/guideupdate.html>. See also National Immigration Law Center, How are Immigrants Included in Health Care Reform? (April 2010). Retrieved April 20, 2012, <http://www.nilc.org/immigrantschr.html>.

¹⁰ Statehealthfacts.org, Income Eligibility Limits for Children’s Regular Medicaid and Children’s CHIP-funded Medicaid Expansions as a Percent of Federal Poverty Level (FPL), January 2012 (Kaiser Family Foundation). Retrieved April 14, 2012, <http://www.statehealthfacts.org/comparereport.jsp?rep=76&cat=4>. [Hereinafter, State Health Facts, Children’s Medicaid and CHIP Income Limits]

¹¹ The maintenance of effort provisions from the ACA are found in the SSA §§ 1902(gg) and 2105(d). The Supreme Court did not discuss maintenance of effort in *National Federation of Independent Businesses v. Sebelius*. The Court expressly limited the holding to noncompliance with the Medicaid expansion and stated, “Today’s holding does not affect the continued application of §1396c [of Title 42 of the U.S. Code, authorizing the Secretary to withhold funding for noncompliance with Medicaid law] to the existing Medicaid program.” (slip opinion, at 56).

ELIGIBILITY FOR MEDICAID AND CHIP CHILDREN GROUP IN 2014

Medicaid (Final Medicaid eligibility rule, § 435.118)

- **Minimum income level:** 133% FPL *or, for children 0 – 1*, a higher amount that was less than 185% FPL and effective on December 19, 1989, or had authorizing legislation as of July 1, 1989.
- **Maximum income level:** The highest income level that was in effect on March 23, 2010 or December 31, 2013, *or, for children 0 – 1*, 185% FPL, if higher (converted to MAGI equivalent).

CHIP (Final Medicaid eligibility rule, § 457.310)

- **Minimum income level:** Above Medicaid.
- **Maximum income level:** The higher of: (1) 200% FPL, (2) 50 percentage points above the Medicaid applicable income level (converted to MAGI equivalent) as of March 31, 1997, **or** (3) the effective income standard (converted to MAGI equivalent) in effect as of December 31, 2013.

Notes

- Maintenance of effort applies to this group through September 30, 2019.
- Medicaid for individuals at higher income levels (including children) may also be provided in 2014 through the new optional Medicaid group described in § 435.218 of the regulations.
- No asset or resource test applies in 2014.

Considerations for Transitioning Children to 2014:

Maintenance of effort

Under the ACA's maintenance of effort provision, states must maintain eligibility standards for children under Medicaid and CHIP until September 30, 2019. Any child who loses Medicaid eligibility due to the loss of income disregards in the shift to a MAGI-equivalent income standard must be eligible in a separate CHIP plan at least through the date of the child's next renewal.¹² CMS considers premiums to be a condition of eligibility and therefore the state may not raise premiums beyond an inflation-adjustment unless it had been specifically authorized to do so under its state plan.¹³

Required enrollment

Under the ACA, states may not enroll parents and caretaker relatives in Medicaid unless the children under 19 (or, at state option taken as of March 23, 2010, under 20 or 21) that live with them are enrolled in Medicaid, CHIP or other minimum essential coverage.¹⁴

Increased mandatory income limit for children age 6 to 19 in Medicaid

The Medicaid rule increases the mandatory eligibility limit for children ages 6 to 19 to 133 percent FPL. Currently, 42 states cover children ages 6 to 19 with incomes above 100 percent FPL with enhanced CHIP matching dollars, either through CHIP-financed expanded Medicaid programs, separate CHIP programs, or a combination of the two.¹⁵ Under the final rule, children with incomes between 100 percent and 133 percent FPL in separate CHIP programs must be shifted to the Medicaid program. The enhanced CHIP match will remain available for these children.

19 and 20 year-old young adults

Under current law states must provide Medicaid coverage to children until they turn 19, but have the option to provide coverage to young adults up to ages 20 or 21. This existing option does not change in 2014. However, under the maintenance of effort provisions discussed above, states that elected to cover 19 and 20 year-old young adults will be required to continue to cover them in the children's category until September 30, 2019.¹⁶ In states that did not elect to cover 19 and 20 year-olds, these young people would be covered as part of the new adult group and be counted toward the enhanced Federal Medical Assistance Percentage (FMAP) for the newly eligible.

Former foster children covered

States are currently required to provide Medicaid to children in foster care or to those receiving adoption assistance under Title IV-E of the SSA until they turn age 18. At least 18 states have opted for a Foster Care Transition Medicaid Program to

¹² Final Medicaid eligibility rule, § 457.310(d).

¹³ Details on the restriction on premium increases because of maintenance of effort are set out in CMS's State Medicaid Director Letter, SMDL # 11-001, Questions 13 – 14 (February 25, 2011). Retrieved April 12, 2012, <http://www.cms.gov/smdl/downloads/SMD11001.pdf>.

¹⁴ 42 CFR § 435.119(c); SSA, § 1902(k)(3)).

¹⁵ State Health Facts, Children's Medicaid and CHIP Income Limits.

¹⁶ SSA § 1902(gg)(2).

continue eligibility for children who have aged out of foster care until they turn 19, 20 or 21.¹⁷ Under the ACA, after 2014 states will be required to provide full Medicaid, including Early Periodic Screening, Diagnosis and Treatment (EPSDT) to former foster children who were receiving Medicaid at the time they aged out of foster care, until they are 26 years old.¹⁸ They will be treated as non-MAGI because they will not need an income determination.

Categorical and Section 1931 eligibility

Children who are categorically eligible for Medicaid and not subject to a financial eligibility determination, for example because they receive Supplemental Security Income (SSI), are in foster care, or receive adoption assistance, will not shift to a MAGI determination. They will continue to be categorically eligible and not be subject to a separate income determination.

Children eligible under § 1931 of Title XIX (children in families who would have met the state's July 1996 AFDC-related eligibility criteria) and their parents will shift to a MAGI determination.

PREGNANT WOMEN

Under current law, states are required to provide Medicaid benefits to pregnant women (including 60 days postpartum) with family incomes at or below 133 percent FPL. However, 36 states provide, at their option, Medicaid to pregnant women with incomes up to 185 percent FPL or higher.¹⁹ Currently, states are required to provide full Medicaid benefits only to those women with family incomes up to historic AFDC eligibility levels. For women with incomes between that level and 133 percent FPL or the optional higher income standard the state adopts, states are only required to cover pregnancy-related services. Further, pregnant women are excluded from the new adult group under the ACA and therefore unable to access those benchmark benefits. As a result, there is concern that Medicaid-eligible pregnant women could be left with less generous benefits than those in the new adult group. In the preamble to the final rule, CMS responded to this concern by clarifying that pregnancy-related services as defined in § 440.210(a)(2) must include services for conditions that might complicate a pregnancy. The ACA statute preserves states' flexibility to provide either full Medicaid or pregnancy-related services under 42 CFR §§ 440.210(a)(2) and 440.250(p).²⁰ However, if a state chooses to deny coverage for a service to pregnant women that the state covers for other adults, CMS will require an explanation of the basis of that decision when reviewing a state plan amendment submitted for the Secretary's approval.²¹

ELIGIBILITY FOR MEDICAID PREGNANT WOMEN GROUP IN 2014

For Full Medicaid (Final Medicaid eligibility rule, § 435.116(d)(4))

- **Minimum income level:** The AFDC income standard in effect as of May 1, 1988.
- **Maximum income level:** The highest income level that was in effect for pregnant women on March 23, 2010 or December 31, 2013, if higher, converted to MAGI-equivalent.

For Pregnancy-Related Services (Final Medicaid eligibility rule, § 435.116(c))

- **Minimum income level:** 133% FPL or "such higher income standard up to 185 percent FPL, if any, as the State had established as of December 19, 1989 . . . or, as of July 1, 1989, had authorizing legislation to do so." § 435.116(c)(1)
- **Maximum income level:** The higher of: 185% FPL or the highest income level that was in effect for pregnant women on March 23, 2010 or December 31, 2013, if higher, converted to MAGI-equivalent.

Notes

- Pregnancy-related services include those services and services for other conditions that might complicate the pregnancy, 42 CFR § 440.210(2). In the preamble to the final rule, CMS stated that given how intertwined the health of the mother is with her expected child, "[i]f a State proposes not to cover certain services or items for pregnant women that it covers for other adults, the State must describe in a State plan amendment . . . its basis for determining that such services are not pregnancy-related." (77 F.R. at 17149)
- Maintenance of effort applies to pregnant women through December 31, 2013. However, in the case of pregnant women covered by CHIP through eligibility for their unborn child, it is likely that the maintenance of effort provision for children would apply through September 30, 2019.

¹⁷ Sonya Schwartz and Melanie Glascock, *Improving Access to Health Coverage for Transitional Youth* (Portland, ME: National Academy for State Healthy Policy, 2008), 9. Retrieved April 12, 2012, http://www.nashp.org/sites/default/files/transitional_youth.pdf.

¹⁸ SSA § 1902(a)(10)(A)(i)(IX).

¹⁹ Statehealthfacts.org, *Income Eligibility Limits for Pregnant Women as Percent of Federal Poverty Level (FPL)*, January 2012, (Kaiser Family Foundation). Retrieved April 13, 2012, <http://www.statehealthfacts.org/comparereport.jsp?rep=77&cat=4>.

²⁰ 42 CFR § 440.250(p) permits states to provide services for pregnant women that are greater in amount, duration or scope than for the rest of those on Medicaid population.

²¹ 77 F.R. at 17148-49.

Transitional Considerations for Pregnant Women:

Flexibility to increase eligibility income limit

States may establish higher Medicaid eligibility levels for pregnant women for either full Medicaid services or for pregnancy-related services by obtaining a state plan amendment (SPA) before December 31, 2013 that increases disregards for the household. This expansion would be financed at the state's regular FMAP rate.

Coverage for pregnant women under CHIP

States that provided coverage on March 23, 2010 for some pregnant women through the CHIP program's "unborn child" option would likely be required to continue that option until September 30, 2019 under the maintenance of effort requirement. States that do not provide CHIP coverage for pregnant women will continue to have that option for the future.²²

Impact on other eligibility groups

The income standard a state chooses for pregnant women will affect other eligibility groups. The highest income level for the pregnant women group also sets the income eligibility standard for the family planning services option. In addition, the level established for the pregnant women group will also affect the number of newborns that will be covered for their first 12 months, although most infants born to eligible pregnant women would likely be covered under the state's Medicaid or CHIP programs in any event.

Decision Points:

Determine how to count pregnant women in household composition

When determining eligibility for a pregnant woman, a state must count the pregnant woman plus her expected child(ren) in determining the household size. By contrast, when determining eligibility for a person in the pregnant woman's household, a state has the option to count the pregnant woman as either one person, two people, or herself plus the number of children she is expected to deliver. This was clarified in the final rule at § 435.603(b).

Determine new eligibility standards and benefit packages for pregnant women

While states are required to establish eligibility for full Medicaid benefits for pregnant women below the historic AFDC level, states will want to consider coverage and benefit options for pregnant women with incomes above that limit. In considering the seven options below, note that Essential Health Benefits have been defined to include maternity and newborn care, and thus these benefits would be included in all of the options.²³

These options would likely be used in some combination based on a state's circumstances and policy decisions.

1. **Full Medicaid benefits.** States have the option to provide full Medicaid benefits to pregnant women up to any state-defined limit by disregarding blocks of income. If a state wishes to increase the income standard for full Medicaid benefits for pregnant women, it may have to do so with a state plan amendment before December 31, 2013, after which it will no longer be able to implement disregards of income.
2. **Pregnancy-related benefits.** States may offer pregnancy-related services to pregnant women in the pregnant women group with incomes up to a level higher than the full Medicaid income limit. In this case, the state would need to specify the income limits for both levels of benefits. As with increasing the income limit for full Medicaid benefits, if a state wishes to increase the income standard for pregnancy-related Medicaid benefits, it would likely have to do so with a state plan amendment before December 31, 2013.
3. **Optional Medicaid group.** States may include pregnant women in the new optional Medicaid group for those with incomes above 133 percent FPL.
4. **Basic Health Program.** States may include pregnant women in the state's Basic Health Program (BHP), if any, for those with incomes up to 200 percent FPL.
5. **Subsidized exchange coverage.** Pregnant women with incomes above Medicaid (or BHP) levels could be left to access the exchange to purchase private coverage subsidized by the appropriate APTC/CSR.
6. **Medically needy program.** States may maintain a Medicaid medically needy program for pregnant women who are ineligible for Medicaid and unable to afford other coverage; this program would use non-MAGI income methodology.
7. **CHIP coverage option for pregnant women.** States may cover through CHIP the unborn child of pregnant women who are not eligible for Medicaid due to non-financial criteria.

²² For more information on this option, see, J. Garner, State Health Official Letter, SHO # 09-006 (Center for Medicaid and State Operations, May 11, 2009). Retrieved April 9, 2012 from <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO051109.pdf>.

²³ Center for Consumer Information and Insurance Oversight, *Essential Health Benefits Bulletin*, (December 16, 2011). Retrieved March 22, 2012 from http://ccio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

The above options would combine for pregnant women. For example, a state might provide full Medicaid for pregnant women up to 200 percent FPL, then provide pregnancy-related coverage through the pregnant women group for those who have incomes up to a higher state-defined level. Alternatively, a state that adopts the BHP, might provide full Medicaid for pregnant women with incomes at or below 133 percent FPL and the BHP for those with incomes up to 200 percent FPL. In this scenario, the APTC/CSR would be available to eligible women above 200 percent. While there are many options in structuring benefits for pregnant women, in any scenario a medically needy program could be available for women who are unable to afford employer-sponsored insurance or insurance through the exchange. Likewise, the CHIP option could be available for those pregnant women who do not meet the non-financial criteria for Medicaid.

PARENTS AND CARETAKER RELATIVES

The new parent and caretaker relative group will serve individuals that states currently cover as § 1931 parents and caretaker relatives (parents and caretaker relatives in families who would have met the state's July 1996 AFDC-related eligibility criteria). Other parents and caretaker relatives with incomes above current § 1931 limits but below 133 percent FPL will go into the adult group. In addition, the ACA retains the existing law on the Transitional Medical Assistance (TMA) and medically needy programs which are discussed at greater length below.

Currently, states must provide full Medicaid to parents and caretaker relatives with household incomes up to the 1996 AFDC income eligibility levels; the ACA does not change this requirement. States also have had the option to disregard blocks of income under both § 1931 and § 1902(r)(2) of Title XIX in order to provide Medicaid to parents and caretakers at higher income levels. Presently, states vary widely on the extent to which Medicaid covers parents and caretaker relatives. Although 12 states currently provide Medicaid coverage to parents and caretaker relatives in households with incomes above 133 percent FPL, 15 states limit eligibility to below 100 percent FPL, and seven of these have limits below 50 percent FPL.²⁴

Although the ACA will result in many parents and caretaker relatives with incomes under 133 percent FPL receiving Medicaid coverage for the first time, these individuals will be covered in the adult group, and states will have the option to provide a benchmark benefit package rather than full Medicaid. Other parent and caretaker relatives that states currently cover, such as those covered under an § 1115 waiver program, will also go into the adult group. The adult group is discussed in detail in the next section.

Current federal law requires states to provide TMA to parents, caretakers and their children for at least 6 months after eligibility for Medicaid under § 1931 is lost due to an increase in earnings or loss of disregards. States have the option of extending TMA for an additional 6 months for those with incomes below 185 percent FPL. The current authorization for this six or 12 month extension expires December 31, 2012, and its future is unclear. Even if allowed to expire, a permanent transitional Medicaid provision would remain, providing four months of transitional Medicaid for those who lose eligibility due to increased child or spousal support or due to increased earnings.²⁵ Further considerations regarding TMA are discussed below.

Finally, the ACA left intact current law that parents and caretaker relatives who are over-income for Medicaid may still become eligible under the optional medically needy program if they have high medical bills and "spend down" to a protected income level. The final rule made it clear that participation in the medically needy program does not disqualify an individual from enrolling in an optional Medicaid program, should the state create one.²⁶ States should also note that medically needy groups will continue to use a non-MAGI income methodology.

²⁴ Statehealthfacts.org, Income Eligibility Limits for Working Adults at Application as a Percent of the Federal Poverty Level (FPL) by scope of Benefit Package, January 2012 (Kaiser Family Foundation). Retrieved March 19, 2012, <http://www.statehealthfacts.org/comparereport.jsp?rep=54&cat=4>.

²⁵ SSA § 1902(e) provides for the four months of transitional Medicaid; whereas § 1925, the authorization for which is set to expire, provides for the 6 to 12 months of TMA.

²⁶ See preamble to final Medicaid eligibility rule, 77 F.R. at 17147.

ELIGIBILITY FOR MEDICAID PARENT AND CARETAKER RELATIVES GROUP IN 2014

(Final Medicaid eligibility rule, § 435.110(c))

- **Minimum income level:** The AFDC income standard in effect as of May 1, 1988.
- **Maximum income level:** The highest of:
 - The income level (taking into account disregards) that was in effect for § 1931 families on March 23, 2010 or December 31, 2013, if higher, converted to a MAGI equivalent standard, or
 - The state’s July 16, 1996 AFDC income standard increased by no more than the percentage increase in the Consumer Price Index for all urban consumers between July 16, 1996 and the effective date of such increase.

Notes

- Parents or caretaker relatives above the income level established in the state according to the rules above but at or below 133% FPL will qualify for the new adult group and count toward the state’s enhanced FMAP if they are newly eligible. States may also provide Medicaid to those above 133% FPL (or above the state standard, if higher than 133% FPL) by including them in the Optional Medicaid group described in the Medicaid eligibility rule at § 435.218.

Transitional Considerations for Parents and Caretaker Relatives:

Medicaid eligibility for adults at or below 133 Percent FPL

Parents and caretaker relatives with incomes below 133 percent FPL but above the maximum limit of the parent and caretaker relative group will be eligible for Medicaid in the new adult group. Those that are “newly eligible” would be part of the calculation in determining the enhanced FMAP the state will receive for those who are newly eligible.

Transitional Medical Assistance (TMA)

CMS has indicated it will address TMA in future guidance. Current reauthorization for TMA (which was included in the recent payroll tax cut bill) is scheduled to sunset December 31, 2012. The distinction between TMA and other coverage in 2014 could affect the benefits families receive, because states must offer full Medicaid benefits under TMA but may opt for lesser benchmark benefits under other categories, such as the adult group.

States should also consider that fewer people may be eligible for TMA after 2014, because the ACA’s new MAGI income calculation excludes child support payments from being counted as income and disallows the use of earned income disregards. As a result, no TMA would be associated with these factors after January 1, 2014. Given these circumstances and the fact that TMA has not yet been addressed by CMS, it remains unclear how TMA eligibility will play out in a post-2014 eligibility environment.

Caretaker relatives age 65 and over

The final rule clarified that the exemption from MAGI for those age 65 and over applies only when age is a condition of eligibility. This means that states must use MAGI in determining eligibility for caretaker relatives age 65 and over if they are eligible as a caretaker relative. This avoids having to use the old AFDC methodology for this small subset of people. If the person later becomes ineligible as a caretaker, eligibility would then be reconsidered under age-based eligibility methodology.²⁷

Decision Points:

Determine the definition of caretaker relative

The final Medicaid rule at § 435.4 specifies the degree of relation to the child that defines the caretaker relative, and provides states the option of including additional relatives, the domestic partner of the parent or caretaker relative, or other adults taking primary responsibility for the child. States may want to consider revisiting current definitions of caretaker relatives for Medicaid to promote consistency with other laws relating to private insurance coverage or to promote other policies, including supporting extended family members who raise children, marriage equity, or other goals.

Decide whether to eliminate “deprivation” standard in the definition of dependent child

Any state that has not already eliminated the requirement that eligible parents be taking care of children deprived of parental support or care due to unemployment, incapacity, death or continued absence, may wish to consider doing so. Under current law, state Medicaid programs may require that children meet this deprivation standard if their parents are to be determined

²⁷ Final Medicaid eligibility rule, § 435.603(j); see also the preamble to the final Medicaid eligibility rule, 77 F.R. at 17157-58.

eligible for coverage. In those states, a determination that a child is not deprived of parental support or care may prevent a parent from being eligible for Medicaid entirely. Under the ACA in 2014, whether or not a parent meets the deprivation standard may only impact whether the parent falls in the parent group or the adult group. This raises the question whether the administrative burden to states of determining deprivation outweighs the benefit. Both CMS and states will want to consider the FMAP consequences of eliminating the deprivation requirement, where the parents could be newly eligible, but technically fall in the parent's group. States will also want to account for the potentially different benefit package in the parent group compared to the adult group.

Determine coverage options for parents and caretaker relatives above 133 Percent FPL

Parents and caretaker relatives will be required to enroll their children and themselves into some form of minimum essential coverage, unless they are otherwise exempt from that requirement. States could consider the same options for this group as for other adults above 133 percent FPL, as discussed in the next section.

OTHER ADULTS

Under current law, other adults under 65 might receive Medicaid benefits through various pathways: under a § 1115 waiver, a family planning waiver or option, the breast and cervical cancer program, or the option to provide limited benefits to people with tuberculosis.

In 2011, using § 1115 waivers, eight states provided full Medicaid benefits to childless adults, and 17 states provided more limited benefits to childless adults. However, in six of the latter states, enrollment was closed.²⁸

As of March 1, 2012, 22 states provide family planning services under a § 1115 waiver and seven states provide family planning services through a state plan amendment using the new option under § 2303 of the ACA. Nineteen states cover family planning services for individuals under age 19, and 13 states provide family planning services to men as well as women.²⁹ Family planning services and supplies are covered at a 90 percent FMAP rate.³⁰

All 50 states provide Medicaid under the Breast and Cervical Cancer program.³¹ Under this program, people without insurance who are screened for breast and cervical cancer through a CDC-funded program and who require treatment are eligible for Medicaid. CDC-funded screening is limited to women at or below 250 percent FPL. CDC screens women ages 18 to 64 for cervical cancer and ages 40 to 64 for breast cancer.

States also have the option to enroll people infected with tuberculosis in Medicaid using the same income and resource standards as for people with disabilities. CMS recently issued a bulletin encouraging states to adopt this option.³²

MEDICAID ELIGIBILITY FOR ADULT GROUP IN 2014

- **Minimum income level:** 133% FPL. (Final Medicaid eligibility rule, § 435.119)
- **Maximum income level (Optional Medicaid group):** Established by state. (Final Medicaid eligibility rule, § 435.218(b)(iv))
- **Maximum income level (Family Planning option):** No higher than for pregnant women. (SSA § 1902(ii))
- **Maximum income level (Breast and Cervical Cancer Program):** 250% FPL set by CDC for screening; no income determination needed by Medicaid. (SSA § 1902(aa))

Note

- Maintenance of effort applies through December 31, 2013. There is an exception to maintenance of effort if the state certifies a budget deficit for non-pregnant, non-disabled adults with incomes above 133% FPL.

²⁸ M. Heberlain, T. Brooks, J. Guyer, S. Artiga, and J. Stephens, Performing Under Pressure: Annual Findings of a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 12 (Kaiser Commission on Medicaid and the Uninsured, January 2012).

²⁹ Guttmacher Institute, *Medicaid Family Planning Eligibility Expansions*, (as of March 1, 2012). Retrieved March 20, 2012 from http://www.guttmacher.org/statecenter/spibs/spib_SMFPE.pdf.

³⁰ See C. Mann, "Family Planning Services Option and New Benefit Rules for Benchmark Plans," *State Health Official Letter*, July 2, 2010.

³¹ Statehealthfacts.org, *Medicaid Breast and Cervical Cancer Treatment Coverage Expansions, 2002*, (Kaiser Family Foundation). Retrieved April 30, 2012, <http://www.statehealthfacts.org/comparabletable.jsp?ind=457&cat=10&sub=109>.

³² C. Mann, "State Option to Enroll Tuberculosis (TB) Infected Individuals into the Medicaid Program," *CMCS Informational Bulletin* (June 16, 2011).

Transitional Considerations for Adults:

Adult eligibility and enhanced FMAP

Adults under 65 who are not pregnant, not eligible under another mandatory eligibility group, not eligible for Medicare, and have household incomes at or below 133 percent FPL will be eligible for at least benchmark coverage in Medicaid in the new adult group.³³ Under the ACA, states will receive an enhanced FMAP of 100 percent through 2016, then phasing down to 90 percent in 2020, for newly eligible individuals in the adult group. “Newly eligible” refers to those individuals who would not have been eligible for at least benchmark Medicaid under state standards in effect on December 1, 2009. The adult group will include childless adults, parents not eligible in the parent group, and, in some instances, people with disabilities. People with disabilities who have indicated on an application or otherwise requested inclusion in a non-MAGI category must be enrolled promptly and may be placed in the adult group until they have been evaluated for the non-MAGI category and shifted to that group if eligible.³⁴

The standard for “newly eligible” and enhanced FMAP

CMS has deferred issuing a final rule on how it will calculate FMAP for the “newly eligible” in 2014 as it awaits the results of a study on converting to MAGI involving researchers and 10 participating states. Some have been uncertain because of language (now withdrawn) from the proposed rule about whether the calculation will include an enhanced FMAP for adult populations who are currently eligible for a limited Medicaid benefit in their states, but will be eligible in the new adult group in 2014. In general, the ACA is clear that states should consider as newly eligible in 2014 those in the adult group who would not have been eligible for at least benchmark or “benchmark equivalent” coverage in Medicaid using state eligibility standards in effect on December 1, 2009.³⁵ Benchmark benefits must include at least the 10 benefit categories listed as Essential Health Benefits under 1302(b)(1) of the ACA, including (1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services, including behavioral health treatment, (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventative and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care.³⁶ Thus, adults who would have been eligible for only family planning services or for a limited benefit under a waiver that does not include essential health benefits should be included in enhanced FMAP calculations.

Implications for the breast and cervical cancer program

People without insurance screened for breast and cervical cancer through a CDC-funded program and who require treatment are eligible for Medicaid at state option. As of 2002, 50 states had opted to provide a Breast and Cervical Cancer Program (BCCP), and 23 states allowed screening by both CDC and non-CDC providers.³⁷ Applicants for coverage with incomes at or below 133 percent FPL who might otherwise fall in this category will be eligible for the adult group. The availability of new adult Medicaid and other insurance options for higher-income adults will likely reduce the enrollment in the BCCP. Those who are eligible for both the adult group and the BCCP because they need treatment should be informed of the differences in benefits (if any) between the 2 eligibility categories so that they are able to access the treatment needed.³⁸ In addition, the BCCP would remain important for those who are found to need treatment after a screening but who, even after 2014, remain uninsured.

Decision Points:

Determine future of adults now covered at or below 133 Percent FPL

States that currently have a § 1115 waiver or a fully state-funded program to cover adults not otherwise eligible for Medicaid with incomes at or below 133 percent FPL will need to make decisions about the transition of these adults in 2014 to the adult group. As indicated above, if individuals were eligible for at least benchmark coverage on December 1, 2009 in Medicaid, they will not count as newly eligible for the purpose of calculating the enhanced FMAP.³⁹ However, if the state’s

³³ SSA § 1902(a)(10)(A)(i)(VIII).

³⁴ The process of determining eligibility category for an individual who is eligible under MAGI and may also be eligible under another non-MAGI category is set out in the final Medicaid rule at § 435.911 and discussed in the preamble at 77 F.R. at 17166 – 17170.

³⁵ SSA §§ 1902(a)(10)(A)(i)(VIII), 1905(y).

³⁶ ACA § 1302. See generally, Center for Consumer Information and Insurance Oversight, *Essential Health Benefits Bulletin*, (December 16, 2011).

³⁷ Statehealthfacts.org, *Medicaid Breast and Cervical Cancer Treatment Coverage Expansions, 2002* (Kaiser Family Foundation). Retrieved April 27, 2012, <http://statehealthfacts.org/comparabletable.jsp?ind=457&cat=10>.

³⁸ Final Medicaid Rule, §435.905. See also, the preamble to the Final Medicaid Rule, 77 F.R. at 17167, indicating that information provided must be sufficient to allow applicants and beneficiaries to make an informed decision.

³⁹ If the state has been providing coverage to all adults, statewide, with incomes up to 100% of the poverty level, the state may be considered an “expansion state” and subject to a different FMAP scenario that transitions them to enhanced FMAP for childless adults. Expansion states include Arizona, Delaware, Hawaii, Maine, Massachusetts, New York, and Vermont. R.R. Bovbjerg, B.A. Ormond, and V. Chen, *State Budgets under Federal Health Reform: The Extent and Causes of Variations in Estimated Impacts*, ii (Kaiser Commission on Medicaid and the Uninsured, February 2011) (Maine’s status may be unclear due to the state’s limited benefit package.)

waiver program offered a more limited benefit to adults under 133 percent FPL, or if these adults were covered by a wholly state-funded program, they would count as eligible for the 100 percent match in 2014.

States with state-funded programs covering particular groups will need to carefully compare the eligibility requirements of the new adult group to that of their state program and determine who will remain ineligible for Medicaid coverage in 2014. These states may want to restructure the state program to maximize Medicaid coverage in the adult group (thereby maximizing the federal matching funds received) while not inadvertently causing people in the state-funded program who are ineligible for Medicaid to lose coverage.

States covering adults with a § 1115 waiver may want to consider amending or renewing their waiver in a manner that would allow the state to shift this group of enrollees to the adult group using the MAGI methodology before 2014. This could allow the state to test systems on a smaller, identified group that is already known to the state. In addition, having this population properly in place in advance of 2014 will allow the state to focus on transitioning other groups and serving new applicants. CMS has indicated it would look favorably upon § 1115 waivers that would convert the methodology to MAGI before 2014.⁴⁰

Determine options for covering adults above 133 percent FPL

States have a number of options for covering adults with incomes greater than 133 percent FPL, including:

1. **Optional expansion coverage group.** States may provide optional Medicaid coverage under SSA § 1902(a)(10)(A)(ii)(XX) for those with income greater than 133 percent FPL. The income eligibility limit would be established by the state, because there is no upper limit imposed by law.⁴¹ The FMAP for this coverage would be the state's regular FMAP.
2. **Basic Health Program.** States may create and operate a BHP to provide at least essential health benefits to those with incomes between 133 percent and 200 percent FPL. Federal funding would be approximately 95 percent of the value of premium tax credits and reduced cost sharing that would have been available to those individuals in the exchange.
3. **No formal coverage option.** Rather than establishing a state alternative, states may leave adults to purchase health insurance through their employer or through the exchange if they are able.

Determine structure of family planning waiver or option

States covering family planning services through either a waiver or state plan amendment may want to consider restructuring eligibility. Individuals now receiving these services with incomes at or below 133 percent FPL will be eligible under the new adult group in 2014. This may allow states to consider increasing the income eligibility standard or expanding the benefits available under a family planning waiver or option for those who remain uninsured after 2014. States will also want to decide whether to continue or renew their waiver or convert to the family planning option under the ACA. The option permits states to use the same income methodology for the family planning option as it uses for pregnant women, including counting the woman as two people in determining household size. Eligibility for the family planning option may not exceed the income level the state has established for pregnant women. Under the option, states may not restrict eligibility based on age or gender, although in practice some services may be limited based on medical necessity. Presumptive eligibility is also available for this group. If a state chooses to continue its family planning waiver, CMS has indicated that cost neutrality may need amendment and renegotiation.⁴²

ADDITIONAL CONSIDERATIONS

In addition to the issues discussed in this brief, states will consider many other factors in preparing for the transition to 2014. This memo does not purport to consider them all, and most notably, does not address the changes in FMAP methodology or changes in income and household composition rules that apply under MAGI. However a few additional matters that policy makers and administrators might consider in transitioning MAGI-related eligibility groups to 2014 are highlighted below.

Express Lane Eligibility as a Tool for Simplifying the Transition

Express Lane Eligibility (ELE) permits states to borrow the eligibility determination of another designated "Express Lane" agency to determine eligibility for Medicaid and CHIP for children.⁴³ Under the ACA, states are exempt from using the

⁴⁰ See, e.g., CMS's comment in the Medicaid NPRM, 76 F.R. at 51155.

⁴¹ See the final Medicaid rule, § 435.218.

⁴² CMS, State Health Official Letter, SMDL 10-013, 5. (July 2, 2010). Retrieved April 20, 2012, <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMDL10013.pdf>. This letter also provides a good description of which services are eligible for the 90% match for family planning services.

⁴³ SSA § 1902(e)(13) provides the authority for ELE. SSA § 1902(e)(14)(D)(ii) exempts those found eligible through ELE from the MAGI-related eligibility determination. State Health Official Letter # 10-003 (February 4, 2010) provides states guidance on implementation of ELE. Many resources on ELE and "e-

MAGI methodology for individuals determined eligible through the ELE methodology. Thus states may use a trusted determination, such as SNAP eligibility, as a proxy for a Medicaid determination to quickly and simply enroll people in 2014. Although authorization for ELE appears to expire on September 30, 2013, there are indications it may continue to be an option for states into the future for children and adults. First, the statutory reference to ELE as an exception to MAGI implies an intent that ELE programs will remain in effect in 2014 and beyond. Second, CMS indicated in the preamble to the final Medicaid eligibility rule openness to receiving § 1115 waivers to permit ELE for adults. CMS has recently granted one such waiver to Massachusetts to use ELE for renewing eligibility of parents as well as children.⁴⁴

Some states, like Alabama and South Carolina, are currently implementing ELE for renewals. Louisiana has had positive experiences with automated enrollment of children using ELE. Other states, like New York, are proposing to allow Medicaid and CHIP agencies to be considered ELE agencies and plan to borrow income determination findings from either program to smooth transitions in coverage from one program to another when eligibility status changes. When considering ELE, states will want to think through a full range of policy options to determine the best choice given the state's unique policy goals and circumstances. A review of available enrollment data, identifying those in the potential Express Lane program who, although likely eligible, are not enrolled in Medicaid, should be a part of states' cost-benefit analysis in assessing ELE as an option. Even if applied to children only, ELE promises to make the application, eligibility, renewal and enrollment process easier for families with children and reduce the ongoing workload of eligibility workers.

Relationship to Other Programs

Aside from ELE, states are discussing using SNAP and other human service program information to expeditiously enroll many people into Medicaid. Many states today use multi-benefit applications so that a person who initially approached the agency for SNAP could apply for TANF and Medicaid with the same application. The preamble to the final Medicaid eligibility regulations makes it clear that multi-benefit applications remain permissible in 2014, and would have to be approved by the Secretary of HHS pursuant to § 435.907(b)(2) of the Medicaid Eligibility Rule as a state-developed alternative application. CMS stated it would look forward to working with states in developing such applications.⁴⁵ Assuring that SNAP and TANF application and renewal forms can also be treated as Medicaid applications may allow for a streamlined process for many newly eligible adults even in states where ELE is not an option. This would reduce the state or exchange's workload associated with enrolling newly eligible adults for January 1, 2014 benefits.

In addition to shared applications, the state's SNAP or other program data will also be an important resource for identifying, informing, and verifying eligibility information for individuals who are likely eligible for Medicaid.

Presumptive Eligibility

Under current law, a state may allow qualified entities, as defined by the state, to determine presumptive eligibility for children, pregnant women, people needing treatment for breast or cervical cancer and for the family planning waiver program. Presumptive eligibility provides temporary coverage until the person has applied and had his or her eligibility fully determined. Under the ACA, if a state has opted to provide presumptive eligibility for pregnant women or children, it may also choose to provide presumptive eligibility for the new adult group and for families who receive Medicaid under § 1931 of the SSA (the families who would have been eligible under the old AFDC rules).⁴⁶ In addition, in 2014 hospitals will be able to elect to determine presumptive eligibility for Medicaid in the same manner presumptive eligibility is implemented today, regardless of whether the state elects presumptive eligibility for any particular population.⁴⁷ Presumptive eligibility will be the subject of future CMS guidance. However, it is reasonable to expect that every state will need to have a system for presumptive eligibility in place at least for hospitals. States with presumptive eligibility in place will need to decide how to modify its system and what procedures will be needed to ensure it results in streamlined enrollment of those eligible. States with no presumptive eligibility system in place will need to begin considering how to put it in place for hospitals and watch for future CMS guidance.

enrollment" are available on the website of the Children's Partnership:

http://www.childrepartnership.org/AM/Template.cfm?Section=Express_Lane_Eligibility1&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=148&ContentID=12069. A case study of Louisiana's experience with automatic enrollment and ELE is also available, S. Dorn, I. Hill, and F. Adams, *Louisiana Breaks New Ground: The Nation's First Use of Automatic Enrollment through Express Lane Eligibility*, (Urban Institute, February 2012).

⁴⁴ See the suggestion to use an § 1115 waiver for ELE in the preamble to the final Medicaid eligibility rule, 77 F.R. at 17171.

⁴⁵ 77 F.R. at 17163.

⁴⁶ ACA § 2001(a)(4).

⁴⁷ ACA § 2202.

CONCLUSION

This issue brief and toolkit put forth an array of transitional considerations and decision points that states must weigh as they transition long-standing Medicaid structures to the simplified MAGI structure of 2014. By mapping current categories to the four new MAGI categories, many changes in income limits, benefit options, and federal match become apparent. As the issue brief and toolkit highlight, such mapping is an efficient and systematic way for states to spot issues moving forward.

The considerations laid out in this brief only scratch the surface of the many issues that states must analyze. States still await key guidance that will direct further analysis. Chief among the outstanding issues is the final rule regarding the calculation of the enhanced FMAP for newly eligible individuals in the adult group. This guidance will be issued after CMS receives the findings of researchers and the 10 states that are studying potential conversion methods and policies. Final guidance has already been issued on other notable financial eligibility issues such as household composition, budgeting periods, and verification. While beyond the scope of this toolkit, states must think through these issues in planning for their transitions to 2014. In addition, states should consider eligibility tools such as Express Lane Eligibility and Presumptive Eligibility that could make a smoother transition for both beneficiaries and state agencies.

As states plan their transitions, they will undoubtedly spot additional issues specific to their own circumstances that may affect other states as well. As these issues arise, states could communicate to each other and to CMS their concerns and ideas for ways to make the transition easier.