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Repeal of the ACA Provisions to Modernize and Streamline Medicaid Eligibility and Enrollment: What Would it Mean for States?

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Introduction

While the focus of debate regarding repeal of the Affordable Care Act (ACA) has been on Marketplaces and the Medicaid expansion, myriad other provisions of the ACA are at risk of repeal—including those that streamline Medicaid eligibility and enrollment systems and implement a national, simplified standard for income eligibility.[1] Indeed, the repeal reconciliation bill, H.R. 3762, passed by Congress and vetoed by President Obama in 2016, would have eliminated many of the ACA's eligibility and enrollment simplifications.

Prior to implementation of the ACA, Medicaid eligibility was available only to certain categories of people—such as children, pregnant women, and parents of children—and enrollment was largely determined through state specific application and eligibility rules. In determining Medicaid eligibility, states relied primarily on manual, paper-work intensive processes for collecting and verifying key eligibility information, including information that states already had on hand but could not easily access in an automated way. Most states relied on antiquated computer systems that were unwieldy and difficult to modify to support efficient and automated operations. As a result, states' pre-ACA eligibility and enrollment operations were administratively costly and slow to process applications for Medicaid-eligible, uninsured people—creating barriers to enrollment and re-enrollment and causing many eligible individuals to cycle or churn on and off coverage.

The ACA put new standards in place for modern and streamlined eligibility and enrollment processes.[2] Pursuant to these policy changes, states have vastly improved their application and enrollment processes for children, pregnant women, and non-disabled, non-elderly adults through an online, streamlined application, standard income counting rules defined in the federal tax code [modified adjusted gross income (MAGI)], and use of electronic state and federal data sources to verify eligibility and renewal information, thus minimizing paper documentation. A number of the ACA eligibility and enrollment simplifications, such as the option to apply for coverage online, over the phone, or in person, also apply to seniors and people with disabilities.

Recognizing the state systems transformation required to implement these improvements, the Centers for Medicare & Medicaid Services (CMS) extended

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enhanced federal funding for state claims payment systems to eligibility and enrollment systems improvement, providing a 90 percent federal matching rate for design, development, and implementation of modernized state eligibility and enrollment systems and a 75 percent match for the maintenance of these systems and for staff needed to operate them.[3] States have invested more than $4.5 billion (matched at the 90% enhanced federal rate) in their eligibility and enrollment systems to support modern and automated Medicaid application and renewal processes.[4] These investments have not only reduced state administrative costs related to eligibility and enrollment operations, but also have generated dramatic improvements in states' application automation and processing timeframes, including those processed in real time without state worker intervention.[5] As of January 2016, 37 states are able to complete a MAGI-based eligibility determination in real time, defined as less than 24 hours, and among these, 11 states report that at least half of their MAGI-based applicants receive an eligibility determination in real time.[6]

The future of the ACA's streamlined eligibility and enrollment-related provisions and the system improvements states have invested in to implement them are the subject of the balance of this topic brief.

Key questions for states

1. What Medicaid eligibility and enrollment simplification provisions are at risk if the ACA is repealed?

The ACA established the following changes to streamline and modernize Medicaid eligibility and enrollment policies and systems.

- **No Wrong Door to Coverage.** Children, pregnant women, and non-elderly and non-disabled adults apply for all insurance affordability programs [Medicaid, the Children's Health Insurance Program (CHIP), and Qualified Health Plans (QHPs) with premium tax credits] using a single streamlined application. Applicants are screened for eligibility and referred to the appropriate coverage program for enrollment without being required to fill out a new application or provide additional information.[7]
- **Multiple Application Modalities.** All applicants seeking Medicaid coverage are able to submit their applications for coverage online, by telephone, by mail, or in person. To facilitate online enrollment, the ACA authorizes the acceptance of an electronic signature.[8]
- **Verifying Eligibility Using Reliable Data.** Whenever possible, states use federal and state electronic data sources to verify and update eligibility at application and renewal, in lieu of paper documentation.[9] States have established electronic interfaces with the federal data services hub and other state-based and proprietary sources of data, enabling electronic verification of certain eligibility factors at application and renewal.

The ACA also established a uniform and simplified standard for determining income eligibility across Medicaid, CHIP, and federal subsidies for QHP coverage, including for most Medicaid applicants and enrollees, called MAGI.[10] Under the MAGI rules, the value of an applicant's assets (resources) is not taken into account in determining Medicaid eligibility.[11]

2. Are repeal proposals likely to eliminate the ACA eligibility and enrollment streamlining requirements?

Most prior repeal proposals have not specifically addressed the eligibility and enrollment streamlining provisions of the ACA with a notable exception: H.R. 3762, the repeal reconciliation bill passed by Congress and vetoed by President Obama in 2016, would have expressly repealed:

- No wrong door
- Single streamlined application
- Verification using electronic data sources
- Multiple application modalities
- Eligibility and enrollment integration between and among Medicaid, CHIP, and ACA Marketplaces

In the event that Congress repeals these provisions of the ACA, states could continue, but would not be obligated, to use a single streamlined application and accept applications through multiple modalities, including online. States may also continue to verify eligibility using reliable electronic data sources. Some states may opt to retain these features because of the investment to date in building this capacity and because these aspects of modernized eligibility and enrollment systems have reduced state administrative costs, while improving application processing timeframes (see Question 3, on following page).[12]

3. Did H.R. 3762 repeal MAGI? How likely is it that MAGI would be repealed?

No, H.R. 3762 did not repeal MAGI. And there is building momentum among states urging Congress to retain MAGI.

States have invested significant time and money in developing IT systems to determine eligibility based on MAGI and to implement the streamlined and modernized eligibility and enrollment processes described above. Reversing these system and process changes would be onerous and costly for all states, especially for those states that built new and integrated eligibility and enrollment systems across their Medicaid programs and state-based marketplaces (SBMs) (see Question 4, below).

For this reason, many state leaders are urging retention of the MAGI standard and the other streamlining provisions of the law. For example, the National Association of Medicaid Directors (NAMD) notes: "States dedicated significant resources to implement this new [MAGI] standard by making significant IT systems and policy changes, including standing up new eligibility and enrollment systems. Revising this income eligibility standard would come at a significant cost to states and the federal government, and possibly cause states to re-procure new eligibility systems once again."[13] Governor Brian Sandoval (R-NV) in his letter to congressional leaders providing input on health care reform said:

> "In addition to the policy decision made to ensure health care coverage to all Nevadans, my administration has made substantial technology investments to implement ACA reforms. The Nevada Department of Health and Human Services invested approximately $95 million dollars to upgrade eligibility determination systems, and the state's Medicaid Management Information System. These costs, while the result of federal mandates under the ACA, have resulted in administrative efficiencies and enhanced data sharing cap abilities for our state agencies. To adopt another system that disregards these investments will have an adverse effect on our healthcare system, waste millions of dollars and cost hundreds of Nevadans their jobs."[14]

4. What would it mean for states if MAGI rules are repealed?

If Congress repeals the MAGI rules in their entirety, states will need to make sweeping changes to their eligibility and enrollment systems and related procedures to reverse the move to MAGI. MAGI rules vary in myriad ways from pre-ACA rules, and if Congress simply strikes the MAGI provisions, states must revert to the pre-ACA rules. These provisions require states to evaluate Medicaid eligibility using the same income exemptions and disregards applicable to the cash assistance category to which the person is most closely linked (i.e., Aid to Families with Dependent Children for children and families and Supplemental Security Income for seniors and people with disabilities).[15] States had some flexibility to modify these disregards and exemptions, but in the absence of a legislative "fix," this flexibility is not broad enough to allow them to fully maintain MAGI rules. For example, the pre-ACA rules for children and families require states to consider only persons who are legally responsible for each other—spouses, parents, and children—when determining someone's household. In contrast, MAGI rules typically require states to look at who files taxes together (with some exceptions), but there is nothing in pre-ACA law that allows them to do so for children and families if MAGI is eliminated.

While a good number of the differences between MAGI and pre-ACA rules are relatively minor, they are truly voluminous. It took years for states to figure out how to modify their systems and train eligibility workers to use MAGI rules. Elimination of MAGI requirements, at least without an option to retain them, would again necessitate sweeping changes to eligibility system rules, related application and renewal forms, verification requirements, and staff training programs.

5. What are the unique ACA repeal considerations for Medicaid eligibility and enrollment operations in states that have SBMs?

ACA repeal has unique and significant implications for Medicaid eligibility and enrollment systems and operations in states with SBMs. States that have implemented eligibility and enrollment systems for Medicaid, CHIP, and QHPs with tax subsidies through their SBMs generally have fully-integrated functionality across these three programs. This means that their systems are designed to seamlessly take applications and determine eligibility for any individual in the state who seeks financial assistance for health insurance, regardless of the program for which they are eligible. In these states, the online application and eligibility rules engines are designed to respond dynamically to determine eligibility across all subsidy programs using the MAGI income standard. If MAGI is repealed as the standard for all or some of these programs (or if ACA tax credits are repealed altogether), the state will face substantial system redesign work and expense to disentangle program eligibility and implement unique standards for each program. Additionally, in a scenario where ACA repeal results in elimination of SBMs, state Medicaid agencies will be faced with another major landscape shift for their programs—in which the agencies will have to take on and modify eligibility and enrollment systems formerly managed by their SBMs, build new systems, or revert to their antiquated legacy systems.

6. What are the unique ACA repeal considerations for Medicaid eligibility and enrollment operations in states that rely on the federally-facilitated marketplaces (FFM) eligibility and enrollment platform (FFM, state-based marketplace-federal platform state)?

States that rely on the FFM eligibility and enrollment platform receive applications for their Medicaid programs directly and also through applications to HealthCare.gov that are electronically transferred to the Medicaid agency. These states have invested significant time and resources in building the system functionality to communicate with the FFM through the "account transfer" service. If MAGI is repealed as the income standard for tax credits (or if ACA tax credits or HealthCare.gov are eliminated altogether), states would face increases in direct application volume as well as system design work to "turn off" account transfer functionality.

7. Will states be able to continue to access 90/10 matching funds for modifications or upgrades to their Medicaid eligibility and enrollment systems?

It is unclear. The statutory and regulatory authority for enhanced federal funding at the 90/10 match rate to support the design, development, or installation of modernized Medicaid eligibility and enrollment systems exists "outside" of the ACA and is not automatically at risk in a potential repeal scenario.[16] On the other hand, Congress is considering a number of changes that would directly implicate federal financial support for IT systems and other administrative expenses.

The most significant risk to the enhanced administrative match for eligibility and enrollment and Maintenance Management Information Systems (MMIS) are proposals to cap federal funding to states for their Medicaid programs. As discussed in State Network's recent topic brief, *Capping Federal Medicaid Funding: Key Financing Issues for States*,[17] typically, proposals to cap federal Medicaid funding to states base each state's capped funding on historical Medicaid spending. A key question for states, then, is what funding is considered when setting the cap, including whether historical administrative spending is included in the cap or excluded and paid separately to states, and if paid outside the cap, at what matching rate?

The Healthcare Accessibility, Empowerment and Liberty Act of 2016, a per capita cap bill sponsored by Representative Pete Sessions and Senator Bill Cassidy, for example, explicitly **excludes** 90/10 funding from the per capita cap, meaning the funds are not in the base for the per capita cap and can continue to be paid outside of the cap.[18] Representative Paul Ryan's *A Better Way* proposal, which includes both a per capita cap and a block grant option for states, would **include** average, historical non-benefit spending in the cap for a 2016 base year, but offers no additional specificity with regard to how administrative expenditures will be calculated or adjusted over time.[19]

Endnotes

[1] For the purposes of this issue brief, eligibility and enrollment provisions that apply to Medicaid also apply to CHIP.

[2] Patient Protection and Affordable Care Act, P.L. 111-148.

[3] "Medicaid Program; Federal Funding for Medicaid Eligibility Determination and Enrollment Activities; Final Rule," Fed. Re. Vol. 76, No. 75 (April 19, 2011) (setting expiration date of 90/10 matching funds to December 2015); "Medicaid Program; Mechanized Claims Processing and Information Retrieval Systems (90/10)," Fed. Reg. Vol. 80, No. 233 (December 4, 2015)(permanently extending the 90/10 matching funds).

[4] $4.7 billion in Medicaid 90/10 funding. Source: HHS, FY 16 Budget-in-Brief, p. 93 Cumulative, through December 2014 (last public data reported).

[5] Medicaid and CHIP Learning Collaborative. 2013."Simplified, Real Time Verification Issue Brief."; CMS All-State SOTA Call. 2015. "Achieving Real Time Eligibility Determinations."

[6] Brooks, Tricia, Sean Miskell, Samantha Artiga, and Elizabeth Cornachione. 2016. "Medicaid and CHIP Eligibility, Enrollment, Renewal and Cost Sharing Policies as of January 2016: Findings From a 50 State Survey," The Kaiser Commission on Medicaid and the Uninsured. *http://files.kff.org/attachment/report-medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2016-findings-from-a-50-state-survey*.

[7] Supra note 2 at §§ 1413(a) & (b), 2201.

[8] Supra note 2 at §§ 1413(b), 2201.

[9] Supra note 2 at §§ 1413(c), 1561.

[10] Supra note 2 at §§ 2002, § 2101(d).

[11] Supra note 2 at § 2002(a).

[12] Centers for Medicare and Medicaid Services. 2015. "Achieving Real Time Eligibility Determinations," CMS All-State SOTA Call. *https://www.medicaid.gov/state-resource-center/mac-learning-collaboratives/downloads/real-time-eligibility-determinations.pdf*.

[13] National Association of Medicaid Directors. 2016. "Key Considerations in Affordable Care Act Repeal & Replace Initiatives." *http://medicaiddirectors.org/wp-content/uploads/2016/12/Key-Considerations-in-Affordable-Care-Act-Repeal-and-Replace-Initiatives.pdf*.

[14] Governor Sandoval letter to Congress. January 5, 2017. *http://www.adea.org/WorkArea/DownloadAsset.aspx?id=35946*

[15] Centers for Medicare & Medicaid Services. Medicaid Eligibility. *https://www.medicaid.gov/medicaid/eligibility/index.html*

[16] Social Security Act Section 1903(a)(3)A)(i).

[17] Mann, Cindy, Deborah Bachrach, Patricia Boozang, Jocelyn Guyer, and Anne Karl. 2016."Capping Federal Medicaid Funding: Key Financing Issues for States," Robert Wood Johnson State Health Reform Assistance Network. *http://statenetwork.org/resource/capping-federal-medicaid-funding-key-financing-issues-for-states/*.

[18] 114th Congress, Healthcare Accessibility, Empowerment, and Liberty Act of 2016 (HAELA). 2016. *http://www.goodmaninstitute.org/wp-content/uploads/2016/05/SESSIO_007_xml.pdf*.

[19] Paul Ryan's A Better Way plan, *http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf*.