Medicaid Eligibility Extension Related to MAGI

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Legislative Drafting
February 11, 2014
HHS Oversight

Presentation Outline

- Affordable Care Act and “MAGI”
- Redetermination of Medicaid Eligibility
- Waiver Option Presented by CMS
- Impact of Delaying Redetermination
- Problems with Obtaining the Waiver
- Outstanding Questions for DHHS
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Affordable Care Act and "MAGI"

- Affordable Care Act (ACA) standardizes the calculation of financial eligibility for certain Medicaid groups:
  - Families, children, pregnant women, former foster care children, individuals with breast or cervical cancer, family planning services
  - Optional adult expansion group (not applicable in North Carolina)
- New nationwide eligibility standard is modified adjusted gross income (MAGI), as defined in the Internal Revenue Code
- Switch to the new standard not *intended* to impact which individuals are eligible, but will impact some individuals
- Text of the ACA grandfathers children and families for the first three months of 2014, which necessitates two standards:
  - New applicants use MAGI
  - Until March 31, 2014, applicants who had been enrolled on December 31, 2013, use the old North Carolina income and asset test

NOTE: For more background on MAGI from CMS, see: http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Modified-Adjusted-Gross-Income-and-Medicaid-CHIP.pdf

Redetermination of Medicaid Eligibility

- After an individual qualifies for Medicaid, their eligibility is periodically redetermined
- Federal requirements (after Jan 1, 2014):
  - For non-MAGI individuals, redeterminations must occur at least once every 12 months
  - For MAGI individuals, redeterminations must occur "once every 12 months, and no more frequently than once every 12 months"
- State requirements:
  - For categorically needy aged, blind, and disabled individuals, redeterminations must occur at least once every 12 months
  - For categorically needy individuals under family and children-related categories, redeterminations must occur at least once every 6 months
  - For medically needy individuals, redeterminations must occur at least once every 6 months

NOTE: See 42 CFR 435.916 for federal requirements and 10A NCAC 23G .0301 for state requirements.

Waiver Option Presented by CMS

- Centers for Medicare & Medicaid Services (CMS) presented states several enrollment strategies related to ACA
  - "Strategy 2" from CMS letter:
    - Obtain waiver to delay by three months Medicaid redeterminations scheduled to occur during first three months of 2014
    - Avoids having to use two financial eligibility standards during first three months of 2014
- Division of Medical Assistance (DMA) applied for and was approved to delay redeterminations

NOTE: Waiver authority under Section 1902(e)(14)(A) of Social Security Act. Letter from CMS presenting option to states available at: http://www.medicaid.gov/federal-policy-guidance/downloads/sho-13-003.pdf

Impact of Delaying Redetermination

- A delay keeps some recipients enrolled in Medicaid longer than they otherwise would have been
- Specifically, delaying redetermination does both of the following:
  - Recipients that would have not requalified for Medicaid during January, February, or March will receive three extra months of coverage
  - Recipients redetermined after March 31st are redetermined using MAGI, which means they get 12 months of eligibility rather than 6 months before their next redetermination

Problems with Obtaining the Waiver

- Legal
  - G.S. 108A-54.1A requires public and legislative notice of all state plan amendments and waivers, *but no notice of the waiver was given*
- Fiscal
  - No notice of the potential fiscal impact of the choice was given to Fiscal Research or OSBM
  - Impact of the choice on FY 2013-14 and FY 2014-15 remain uncertain

Outstanding Questions for DHHS

- How many people are expected to receive Medicaid coverage due to the redetermination extension who would not otherwise have received Medicaid coverage?
  - What methodology was used to calculate this number of people?
- What procedures have been implemented to ensure better public and legislative notification of state plan amendments and waivers, as required by law?
- What is the net cost of the decision to delay recertification?
  - How much is saved by not using two financial eligibility standards (one for new applicants, one for redeterminations) at the same time?
  - How much will it cost to cover the individuals who no longer qualify for Medicaid, but had delayed redeterminations and will receive extra months of coverage?
- How will the surge in the number of redeterminations during April, May, and June be handled?
- Will this be the only redetermination extension or will there be others?

Appendix: Timeline of Events

Date	Event
May 17, 2013	CMS letter to State Health Officials offering waiver options
July 26, 2013	FY 2013-15 budget passed (S.L. 2013-360); included new G.S. 108A-54.1A, which requires notification of state plan amendments (SPAs) and waivers
August 8, 2013	Carol Steckel, then Medicaid Director, sent a letter to CMS requesting a waiver to implement "Strategy 2"
September 30, 2013	CMS sent a letter to DHHS granting the waiver but requiring the DHHS to send a letter approving and accepting the waiver authority
October 18, 2013	Sandra Terrell, Acting Medicaid Director, sent the acceptance letter to CMS
October 22, 2013	DHHS sent a notice to enrolled families and children whose redetermination date fell between January 1, 2014 and March 31, 2014 regarding the 3-month extension
November 15, 2013	Sandra Terrell sent a letter to County Directors of Social Services informing them that the extension had been entered into the Eligibility Information System (EIS), and indicating that no additional action needed to be taken
January 2014	DHHS first informed legislative staff of the extension of eligibility related to MAGI