# Final Rule: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment

**Description:** This final rule finalizes new Medicaid eligibility provisions; finalizes changes related to electronic Medicaid and the Children's Health Insurance Program (CHIP) eligibility notices and delegation of appeals; revises CHIP rules relating to the substitution of coverage to improve the coordination of CHIP coverage with other coverage; and amends requirements for benchmark and benchmark-equivalent benefit packages. This rule also implements specific provisions including those related to authorized representatives, notices, and verification of eligibility for qualifying coverage in an eligible employer-sponsored plan for Affordable Insurance Exchanges.

## Major Provisions

### Medicaid Eligibility Requirements and Coverage Options Established by Other Federal Statutes

A presumptive eligibility program allows providers, on behalf of their patients, to begin the enrollment process based on some key pieces of information at the point of service.

**Presumptive Eligibility Determined by Hospitals:** CMS proposed to implement section 1902(a)(47)(B) of the Act, added by the Affordable Care Act, to give hospitals the option to determine presumptive eligibility for Medicaid. The statute provides hospitals participating in Medicaid with this option whether or not the state has elected to permit qualified entities of the state's selection to make presumptive eligibility determinations for children, pregnant women or other specific populations under other sections of the statute. CMS is finalizing this provision as proposed.

The final rule outlines the five basic criteria that a hospital must meet to be authorized to make presumptive eligibility determinations. Specifically, a hospital must:

1. Participate as a Medicaid provider;
2. Notify the state Medicaid agency of its decision to make presumptive eligibility determinations;
3. Agree to make determinations consistent with state policies and procedures;
4. Assist individuals in completing and submitting the full application, at the state's discretion; and
5. Not be disqualified by the agency.

CMS is revising the proposed regulation to clarify that states electing to limit the presumptive eligibility determinations which hospitals can make must permit the hospitals to make presumptive eligibility determinations based on income for all of the populations included in existing regulations(that is, former foster care recipients or women with breast or cervical cancer or individuals seeking coverage of family planning services).

States may also permit hospitals to make presumptive eligibility determinations for populations for which income is not the only factor of eligibility (for example, for individuals who may be eligible under an eligibility group based on disability, or individuals eligible under a demonstration project approved under section 1115 of the Act).

If a hospital does not follow state policies and procedures, or is not successful in helping individuals to submit regular applications in accordance with standards established by the state, the proposed rule would require states to institute appropriate corrective action, including (but not requiring) termination of the hospital as a qualified hospital. CMS is revising the proposed rule by adding a provision that the agency may disqualify a hospital as a qualified hospital only after it has first provided the hospital with additional training or taken other reasonable corrective action measures.

**Presumptive Eligibility for Children:** In the proposed rule, CMS proposed to revise existing regulations to align with the adoption of MAGI-based methodologies. CMS is codifying the flexibility of states, as proposed, to direct qualified entities to use either gross income or to apply simplified methods, as prescribed by the state, to better approximate MAGI-based household income, as defined in the March 2012 final rule.

CMS clarifies that the proposed rule gave states the option to require qualified entities or qualified hospitals to request an attestation of citizenship but did not require it. CMS is retaining the language as proposed and maintains this provision as a state option.

**Presumptive Eligibility for Pregnant Women:** CMS is finalizing the regulation as proposed to provide one presumptive eligibility period for pregnant women per pregnancy.

**Essential Health Benefits in the Alternative Benefit Plan (ABP)**

The Affordable Care Act requires that the Medicaid Alternative Benefit Plan (ABP) be modified to include the new eligibility group of low-income adults, also known as the "expansion population." The ACA further requires that the ABP be modified to include the essential health benefit (EHB) requirements identified by the Department of Health and Human Services (HHS), including mental health and prescription drug coverage.

The state Medicaid agency has the responsibility to ensure that the ABP for the expansion population meets the ACA's EHB requirements. The final rule includes a two-step process that states must follow.

1. First, a state must determine whether the ABP meets the criteria for a benchmark option for EHB, as set by HHS. If so, the standards for both the APB and EHB will be met.
2. If the benchmark option is not met, the state will proceed to the second stage – identifying one of the EHB base-benchmark options and supplementing the ABP until all EHB requirements are met.

The final rule notes that CMS will allow states a transition period beyond Jan. 1, 2014 to come into compliance with aligning the ABP with the EHB requirements, as long as a state is making reasonable progress toward compliance.

States must comply with the federal mental health parity law, as well as comply with the EHB-required habilitative benefit. According to the final rule, states will be allowed to separately define habilitative services if the benefit is not covered in the ABP subject to CMS approval.

**Premium Assistance**

The final rule clarifies that a state Medicaid program may purchase coverage in the individual market exchanges through premium assistance. States have long had the option to purchase coverage in the private market on behalf of Medicaid beneficiaries, but the final rule clarifies that premium assistance is available for the new adult coverage group.

CMS requires that the state agency furnish all benefits covered under the state plan that are not available through the individual health plan and also that the individual does not incur any cost sharing in excess of that allowed in Medicaid.

States implementing premium assistance must describe their cost-effectiveness methodology, and to the extent that such a methodology relies on annual per person costs, CMS expects states to be re-running the analysis at least annually, as new cost data is available.

States needing additional flexibility are advised to explore 1115 demonstration waivers.

**Verifying Premium Tax Credit Eligibility**

The final rule clarifies that, when an individual applies for premium tax credit through the exchanges, the individual is responsible for providing the exchange with information as to whether he or she has access to employer sponsored coverage. This clarification answers questions raised by the recent decision to delay the ACA's employer shared responsibility provisions requiring employers to offer their employees health insurance coverage and report such information to the exchange. Exchanges will rely on this self-reported information to determine an individual's eligibility for premium tax credits.

**Certified Application Counselors for Medicaid and CHIP**

The final rule recognizes that many state Medicaid and CHIP programs have established relationships with providers, such as hospitals, to assist individuals seeking health coverage. In this capacity, many hospitals have served as "application assisters," promoting health coverage enrollment for low-income populations and often providing much-needed language translation assistance. The final rule outlines a certification process to provide the training and skills needed to access confidential data and meet confidentiality requirements, as well as enable certified application counselors to track and monitor applications.

The final rule does not include provisions from the proposed rule regarding certified application counselors for exchanges nor provisions regarding accessibility for disabled or persons with limited English proficiency. CMS notes that these provisions will be addressed in future rulemaking.

**Medicaid Cost Sharing**

The final rule streamlines current Medicaid cost-sharing rules. With regard to inpatient cost-sharing, the final rule limits the maximum cost sharing for individuals at or below 100 percent of the Federal Poverty Level to $75. For those states with high maximum cost sharing amounts for inpatient services, the final rule allows states a transition period until July 1, 2017 to comply.

The final rule also clarifies language regarding a hospital's statutory responsibility to inform an individual seeking treatment through the hospital's emergency department (ED) that alternative sources of care in the community are available, and that, if the patient chooses to proceed with treatment, an ED cost-sharing amount would apply. The clarification allows hospitals to merely determine rather than ensure if the alternative source of care in the community can provide services in a timely manner.

**Continuous Medicaid Eligibility**

The proposed rule included several provisions that codified, in regulation, options for states to provide certain population groups with continuous Medicaid eligibility. Such groups included: hospitalized children that "age out" of the program during an inpatient hospital stay; pregnant women through the end of the post-partum period; newborns born to Medicaid-eligible mothers through the first 12 months of life; and children under age 19, regardless of changes in income or circumstances. *None of these provisions was included in the final rule. It is expected that some or all of these provision will be included in future rulemaking.*

**Medicaid "Institutions for Mental Diseases" (IMD) Restrictions**

The final rule clarified that, for the adult coverage group or "expansion population," the IMD restriction applies. The IMD restriction is a payment restriction where Medicaid will not pay for the cost of inpatient care incurred when treating Medicaid beneficiaries ages 21-64 if they receive treatment in IMDs such as private psychiatric hospitals. These freestanding psychiatric hospitals play a vital role in ensuring access to community-based mental health care for those with serious mental illnesses.

**Coordination of Appeals of Eligibility Determinations**

To simplify the process for consumers and states, the final rule provides options for a coordinated appeals process between the Marketplace, Medicaid and CHIP, and establishes that state Medicaid agencies may delegate the authority to conduct Medicaid fair hearings to the Marketplace, provided that certain standards that protect Medicaid applicants and beneficiaries are met.

The option is similar to the option states have to delegate Medicaid eligibility determinations to an Exchange. States are not required to delegate such authority, but may continue to have the Medicaid agency conduct all Medicaid fair hearings.

- In a state that has established a state-based Exchange, the state Medicaid agency may delegate authority to conduct fair hearings of MAGI-based determinations to the state-based Exchange by requesting a waiver under the Intergovernmental Cooperation Act of 1968 (ICA), as long as the state-based Exchange is a state agency and the state can assure sufficient oversight of the delegated fair hearing process.

- In states where the FFE is operating, a state Medicaid agency that allows the FFE to make a Medicaid eligibility determination has appeal delegation options not available to a State that proceeds with the assessment model.
    - If the Medicaid agency authorizes the FFE to make MAGI-based eligibility determinations, the agency may also delegate authority to the HHS appeals entity to conduct fair hearings related to determinations of Medicaid ineligibility made by the FFE, establishing an integrated appeals process with simultaneous appeals related to a determination of advance payments of the premium tax credits or cost-sharing reductions.
- In states in which the Exchange will make an assessment of Medicaid eligibility, and will not make final Medicaid eligibility determinations or denials, an assessment of ineligibility for Medicaid based on MAGI will not trigger Medicaid appeal rights. This is because an assessment is not a final Medicaid eligibility determination.

**Notices**

To ensure consumers have clear information and to modernize program operations, the rule specifies that notices to applicants, enrollees and beneficiaries must include clear and accurate information about eligibility for all insurance affordability programs (including Medicaid, CHIP, and premium tax credits and cost-sharing reductions to help pay for health insurance coverage through the Marketplace) and establishes that electronic notices will be available from the Marketplace starting on October 1, 2013, and from state Medicaid and CHIP agencies no later than January 1, 2015.

**Medicaid Cost Sharing**

The final rule updates and simplifies policies around Medicaid premium and cost-sharing requirements designed to promote the most effective use of services and to assist states in identifying cost-sharing flexibilities. Specifically, the final rule permits states to establish higher cost sharing for prescription drugs, for non-emergency use of the emergency department and updates the maximum allowable cost-sharing levels to consolidate provisions. The final rule also creates one streamlined set of rules for all Medicaid premiums and cost sharing while clarifying that the limit on out of pocket costs will continue to ensure that coverage remains affordable for the lowest income Americans.

**Open Enrollment**

Consistent with the proposed rule, the final rule establishes that Medicaid and CHIP agencies will begin accepting the single streamlined application during the initial open enrollment period to help facilitate a coordinated transition to new coverage that will become available in Medicaid and through the Marketplace in 2014. Between October 1, 2013 and January 1, 2014, state Medicaid and CHIP agencies will determine eligibility for coverage that will begin in 2014 and accept electronic account transfers from the Marketplace. During this three month period, states will also be expected to make timely Medicaid and CHIP eligibility determinations with respect to eligibility under the current (2013) rules, but have flexibility in how they will manage these responsibilities.

**Changes to Modified Adjusted Gross Income and MAGI Screen**

The proposed rule applied the 5 percent disregard established by the Act for purposes of determining the income eligibility of an individual for medical assistance whose eligibility is determined based on MAGI, provided the determination was for the eligibility group with the highest income standard under which the individual could be determined eligible using MAGI-based methodologies. This rule finalizes that proposal.