Coordinating Human Services Programs with Health Reform Implementation

A Toolkit for State Agencies
The Center on Budget and Policy Priorities, located in Washington, D.C., is a non-profit research and policy institute that conducts research and analysis of government policies and the programs and public policy issues that affect low and middle-income households. The Center is supported by foundations and individual contributors.

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<th>Future MAGI Medicaid Requirements</th>
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|                       | State must re-determine eligibility at least every 12 months. States have a lot of flexibility in designing their periodic review processes and procedures. For example:  
• Some states use rolling renewal where at any time the Medicaid agency has sufficient information to process eligibility; the state uses that information to push forward the next scheduled renewal date.  
• For children, Medicaid agencies can implement continuous eligibility. | States cannot conduct redeterminations more often than once every 12 months unless there is information about a change in circumstance that would affect eligibility.  
• States can use rolling renewal if the Medicaid agency has sufficient information to process eligibility without requiring additional information from the beneficiary they can push forward the next scheduled renewal for another 12 months. | States can choose certification periods of up to 12 months for most households. Elderly or disabled households with no earnings may be certified for up to 24 months.  
Most states choose simplified reporting with six-month certification periods or 12-month certification periods and a six-month interim report (see below).  
States have the flexibility to align certification periods with health programs. (The Food and Nutrition Service has approved waivers to allow states to start a new certification period when the state is conducting a renewal for another program.) |
<table>
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<tr>
<th>Reporting Requirements</th>
<th>Current Medicaid Requirements</th>
<th>Future MAGI Medicaid Requirements</th>
<th>SNAP Requirements</th>
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|                        | Beneficiaries must make timely and accurate reports of any change in circumstances that may affect their eligibility and states must act on such changes. | Beneficiaries must make timely and accurate reports of any change in circumstances that may affect their eligibility and states must act on such changes. | Almost every state uses “simplified reporting.”
|                        | Some states have begun giving consumers the option to complete reviews through a variety of formats, including telephone and online. Interviews can be required at the state option. | Beneficiaries must be allowed to complete renewals online, in person, by telephone, or by mail. Interviews cannot be required. | • Changes in household composition, income, and residence must be reported every six months on a report form or through the recertification process and states must act on these changes.
<p>|                        |                                    |                                  | • Otherwise, over the six-month period only increases in income above 130 percent of poverty must be reported. States may act on other reported changes that increase or decrease benefits, or may choose to act only on changes that increase benefits. A recertification application with a signature (can be electronic or telephonic) must be submitted — in person, by mail, or online. An interview is required at least every 12 months, but can be done by telephone. The household has a right to an in-person interview. |</p>
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<th>Process for Conducting Redeterminations</th>
<th>Current Medicaid Requirements</th>
<th>Future MAGI Medicaid Requirements</th>
<th>SNAP Requirements</th>
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<td>States are required to conduct ex parte reviews of ongoing eligibility to the extent possible.</td>
<td>Agencies must use information available to them, including looking to see if they have information from other benefit programs, wage reporting, SSA, etc.</td>
<td>New rules establish a Medicaid administrative renewal process requiring states to use available databases for eligibility verification.</td>
<td>The state must notify the household and provide a recertification application and a list of required verifications.</td>
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<td>Some Medicaid agencies use pre-populated forms that include all information the state has about the beneficiary. States sometimes require beneficiaries to return the form only if a change has occurred in their circumstances; other states always require beneficiaries to return the form.</td>
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<td>States have the flexibility to:</td>
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<td>New rules establish a Medicaid administrative renewal process requiring states to use available databases for eligibility verification.</td>
<td>• Align certification periods with health programs (The Food and Nutrition Service has approved waivers to allow states to start a new certification period when the state is conducting a renewal for another program.)</td>
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<td>Every 12 months, states must conduct back-end verification using existing information available to the agency. The state will then notify the individual that they have been found eligible for Medicaid and the basis of their determination.</td>
<td>• Combine renewal with other programs.</td>
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<td>The individual must notify the agency (online, by phone, by mail, in person, or by fax) if any information is inaccurate but is not otherwise required to take action (no signature or return of the notice if the information is accurate).</td>
<td>• Allow renewals by telephone or online (the required signature can be submitted this way).</td>
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<td>If the state cannot determine Medicaid eligibility through administrative renewal, it must send a pre-populated recertification form. The beneficiary has 30 days to recertify.</td>
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Appendix 4.2: PowerPoint Slides on ACA Renewal and Change Reporting Requirements

ACA Renewals
Periodic Renewals

- Renewal frequency
  - every 12 months
  - MAGI-based no more frequent than once every 12 months
- Change reporting
  - limit inquiries to what is material to the change
- Option to push forward renewals
- Transition steps, when no longer eligible for MAGI-based Medicaid:
  - other categories
  - assess eligibility and make transfers to other insurance affordability programs

Eligibility must be renewed once every 12 months:
- For both MAGI and non-MAGI groups.
- For those whose eligibility is based on MAGI, the scheduled renewal can be no more frequent than once every 12 months.

States must have processes and procedures in place to ensure that beneficiaries report any changes in their circumstances that may affect eligibility:
- For those whose eligibility is based on MAGI, when a change occurs within a renewal period, states must limit information requests of the beneficiary to what is material to the change.
- However, if the agency has enough information to complete a full renewal, it can do so and push forward the next renewal date. For example, if the agency gets all of the information it needs from information provided to make an eligibility determination this allows for synchronization of renewals with other benefit programs.

When beneficiaries are no longer eligible:
- If the agency determines that the individual is no longer eligible for Medicaid, the agency must assess if he/she is eligible for other insurance affordability program (CHIP, premium credits, etc.) and electronically transmit all relevant information to other programs as applicable.
The new rules for renewals focus on simplifying the renewal process for consumers and maximizing the use of third party data sources. Data-driven renewals are required for both MAGI and Non-MAGI:

- At the time of renewal if the state has enough information in the case file and/or data sources, then the state must use this information to complete the renewal for beneficiaries.
- The state sends the beneficiaries a notice with the decision and information used to make the determination.
- If the information used to make the determination is accurate, the beneficiary does not have to sign or return the form.
- If the information used is not accurate, then the beneficiary must inform the agency and must be able to do so online, telephone, in-person or other electronic means.
The use of pre-populated renewals is required for Medicaid based on MAGI and is at the state’s option for non-MAGI:

- Agencies must send beneficiaries pre-populated renewal forms containing information available to the agency that is needed to renew eligibility. HHS will specify what information will be needed.
- Beneficiaries must be able to respond online, via phone, mail, in-person and sign the form using electronic and telephonic formats as well as handwritten.
- Beneficiaries must be given at least 30 days to respond and provide any necessary documentation.
- If the beneficiary fails to respond in this timeframe, but responds within 90 days (90 days is a minimum, states can choose a longer period) of the termination the state must “reconsider” them without requiring an application.
- Agencies must notify the beneficiary of the decision.
Pushing forward Medicaid renewals:

- Although MAGI-Based Medicaid only allows for renewals to occur no more frequently than once every 12 months, if the state has information about a change and has everything it needs to re-determine the case, then it can push forward eligibility another 12 months.
- That means if SNAP collects everything needed for Medicaid during a SNAP 6 month report, Medicaid eligibility can be determined and pushed forward.

Using data from other benefit programs:

- States are required to use data from SNAP to the greatest extent possible to make determinations. This is very important because most people enrolled in SNAP are very likely to meet the applicable income standard for MAGI-Based Medicaid.
- However, differences in how income is counted and household units might make using this data a little challenging. Key things to note are that:
  - For the most part SNAP will count more income sources than MAGI-Based Medicaid
  - SNAP households are related to who lives and eats together along with some relationship factors and MAGI based Medicaid will calculate households by relationship of people living together and tax filing.
- States can explore which groups enrolled in SNAP and TANF are always going to meet the applicable Medicaid income standard and find a way to simply determinations for these groups, for example:
  - If the income total income for the family is less than 138% of the FPL for a family size of one, then no need to reconfigure the households, everyone meets the MAGI-Based Medicaid income standard.