Summary of NPRM 42 CFR Parts 431, 433, 435, and 457: Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010 (Released 8/12/11)

This proposed rule makes the following changes to the Medicaid eligibility system, in accordance with the provisions of the Affordable Care Act.

1. Provides enhanced FMAP for newly eligible individuals. Newly eligibles are individuals who were not eligible for Medicaid on a benchmark or benchmark equivalent plan as of December 31st, 2009. Enhanced match rate is 100% from 2014 to 2016 and decreases annually to 90% in 2020.
2. Provides three alternative methodologies for determining the State's newly eligibles and calculating the applicable match rate: Threshold methodology, sampling methodology, proportion methodology. Each of these methodologies is presumed to be equal/have equal outcomes in terms of federal funds directed to States. States must select one methodology and use it for at least three consecutive years. If the state wishes to change the methodology for calculating newly eligibles then they must notify CMS at least 2 years in advance of the proposed change.
3. The regulation consolidates eligibility categories for parents and other caretaker relatives, pregnant woman, and infants and children under age 19. Each of these populations now has its own single eligibility category where previously there may have been multiple categories encompassing parents and caretakers or pregnant women. A new category is created for adults between 19 and 65 who are at or below 133% FPL regardless of caretaker status.
4. The Medicaid agency must adopt the Modified Adjusted Gross Income (MAGI) calculation methodology for all individuals applying for the new and consolidated Medicaid categories (Adults, Parents and Caretakers, Pregnant Woman, and Infants and Children under age 19) as of January 1, 2014. In 2014, individuals can still be eligible for Medicaid based on disability or other current Medicaid categories and would go through the current Medicaid application process; their income would not be calculated based on MAGI. This regulation contains specifics on MAGI.
5. Allows states to conduct MAGI eligibility based on current monthly income and household size or projected annual household income. A handful of additional exceptions to the MAGI rules are proposed to determination for Medicaid eligibility.
6. MAGI based eligibility determination for Medicaid, premium tax credits, and cost sharing subsidies must use a single streamlined application. HHS will develop a single streamline application for state use. A state may develop and use an alternative streamlined application or create an additional form with HHS approval.
7. MAGI based eligibility must be redetermined every 12 months. When possible the agency must make the redetermination of eligibility without requiring information from the individual. Information relevant to redetermination must be obtained through federal or other data sources before requesting the information from individuals. If an individual is determined still eligible for Medicaid the agency must notify the individual of continued Medicaid eligibility and notify the individual that they must inform the agency if any of the information on which their

eligibility was determined is inaccurate. In the case where the agency cannot redetermine eligibility on the basis of the information available individuals must be sent a renewal form containing the pre-populated data that the agency has on the individual.

8. Agency must accept self-attestation of pregnancy and the individuals that comprise the household unless the state has information that is not reasonably compatible with such attestation. Agency must verify Indian status and cannot accept self-attestation.
9. The Medicaid Agency must work to transfer applications from other insurance affordability programs (CHIP, Premium Tax Credits) to the State Medicaid Agency. Additionally, individuals that are determined not eligible for Medicaid must be screened for premium tax credits and individuals who are in the process of being determined eligible for Medicaid on a categorical basis must be screened for eligibility in insurance affordability programs (MAGI Medicaid, Premium Tax Credits) for interim coverage.

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