

State Health Reform Assistance Network

Charting the Road to Coverage

ISSUE BRIEF
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States' Medicaid ACA Checklist for 2014

Prepared by *Alice M. Weiss, Abigail Arons, and Julien Nagarajan*

Introduction

Since the enactment of the Patient Protection and Affordable Care Act (ACA) in 2010, public attention has focused on whether states will sponsor a State-Based Exchange or expand Medicaid eligibility, while many important new Medicaid requirements have received far less discussion. With 2014 fast approaching, now is a critical time for state officials and those who support them to focus their vision on the specific requirements that states must implement to ensure their Medicaid programs are compliant with federal law by 2014. States will need to quickly understand and operationalize many of these requirements, which will likely mean enacting new laws, amending state Medicaid plans, updating policies and procedures, retraining workers and reorganizing systems.¹ The purpose of this checklist is to highlight those ACA Medicaid requirements that will take effect in the next two years, nearly all of which apply to all states regardless of whether the state chooses to expand Medicaid eligibility.² The checklist also highlights a few important optional (marked as "Optional") provisions that states may want to consider as they plan for modernizing their Medicaid programs and complying with federal requirements. Finally, this checklist provides links to relevant resources that offer additional tools and analyses to support state implementation efforts, and is accompanied by a companion [Resource List](#), which provides full citations to each resource noted in the individual resources sections below.

These new requirements are organized as a checklist because nearly everything mentioned here must be accomplished by 2014. The checklist is divided into five domains of work for states' Medicaid programs: eligibility and enrollment; operations; financing; benefits; and consumer assistance. Following a description of each requirement is a list of resources that can be useful to states working on the issue.³ All provisions discussed here are effective January 1, 2014 unless otherwise noted. Items are marked with an asterisk (*) if the requirement applies only to states that choose to expand Medicaid eligibility for adults at or below 133 percent FPL.

1. ELIGIBILITY AND ENROLLMENT:

☐ Maintenance of Effort (MOE):⁴ States must maintain their Medicaid and Children's Health Insurance Program (CHIP) eligibility standards, methodologies and procedures as they were in effect on March 23, 2010 for adult categories until January 1, 2014, or for children until September 30, 2019. States that have or anticipate a budget deficit may seek an exception from the MOE requirements for non-pregnant, non-disabled adults with incomes above 133 percent of the federal poverty level (FPL), but must revise their state Medicaid plan first.⁵ This requirement generally limits states from making major changes to eligibility and renewal rules in their Medicaid and CHIP programs before January 1, 2014.

Timeframe: States seeking an exception from the MOE requirements must first submit a state plan amendment and certification of budget shortfall to the Centers for Medicare and Medicaid Services (CMS).

Resources: CMS State Medicaid Director Letters ([February 2011](#), [August 2011](#))(N)

ABOUT STATE NETWORK

State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit www.statenetwork.org.

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For more information, please contact Alice Weiss at aweiss@nashp.org or 202.903.0101.

☐ Mandatory Coverage Expansions: The ACA includes expansions of federal Medicaid eligibility criteria for the following populations:

- *Children:*⁶ States that do not already provide Medicaid coverage to all children under 133 percent FPL are required to expand Medicaid coverage to children with family incomes up to 133 percent FPL and to maintain eligibility for newborns (children up to age one) at 185 percent FPL. States with Medicaid eligibility levels for children aged six to 18 years old (or up to age 21 in states that opted to expand child coverage) at 100 percent FPL today will need to transition children from CHIP to Medicaid coverage.⁷
- *Children Aging Out of Foster Care:*⁸ Beginning in 2014, states must expand eligibility for full Medicaid coverage to former foster care children who were enrolled in foster care and Medicaid when they turned 18 or aged out of foster care (up to age 21 in most states) and are not yet 26 years old. CMS is proposing that states enroll adults who are eligible for both the new foster care category and the new adult expansion into the foster care category and to treat as a non-modified adjusted gross income (MAGI) group since eligibility is not based on income.⁹
- *Non-elderly Adults*:*¹⁰ States are required to expand Medicaid eligibility to all non-elderly, non-pregnant adults with incomes at or below 133 percent FPL who are ineligible for Medicare or Medicaid. Due to the Supreme Court's ruling in *NFIB v. Sebelius*, states are exempt from the penalty provided in the ACA for noncompliance. As a result, experts now consider this mandatory expansion for adults to be voluntary for states.

Timeframe: States seeking to expand Medicaid eligibility for adults must submit a state plan amendment before the third quarter of 2013 to be effective by January 1, 2014.

Resources: [CMS Section-by-Section Summary of January 2013 NPRM](#) (Q); [State Network](#) (SN) [Medicaid Eligibility Transition Toolkit](#) (GG); [SN Eligibility Regulation Overview](#) (JJ); [SN Medicaid Expansion: Framing and Planning a Financial Impact Analysis](#) (II)

☐ Streamlined, Automated Enrollment Process:¹¹ States must use a single application form that an individual can submit to apply for all insurance affordability programs (IAPs), which includes Medicaid, CHIP, basic health program (if one is offered) and subsidized qualified health plans (QHPs) offered through an Exchange.¹² States and Exchanges must be able to receive this application online, by mail, by phone, or in person, through any IAP agency. States are barred from requiring in-person interviews for applicants whose eligibility is being determined on the basis of MAGI standards at application or renewal. States may request only information needed to determine eligibility or for a purpose connected to administering the Medicaid program. Non-applicants cannot be compelled to provide their Social Security numbers and states are barred from using non-applicant Social Security numbers beyond facilitating enrollment in IAPs.

Resources: [CMS Section-by-Section Summary of Eligibility Changes](#) (W); [SN Eligibility Regulation Overview](#) (JJ); [CMS Guidance on Single Streamlined Application Requirements](#) (Y)

☐ New Income Eligibility Rules: All states will have to adopt new income counting rules:

- *Income Counting Rules for MAGI-Based Groups:*¹³ States will need to use a new MAGI-based income methodology to determine eligibility for most non-elderly, non-disabled individuals applying for Medicaid. Under this new methodology, states will need to determine an applicant's projected annual income, by using tax and other data sources to verify current income, or annual budgets to determine projected annual income, and determine household income based on tax filing unit. Asset tests, income disregards and credits will no longer be allowed for the MAGI population, so states that currently use these for the MAGI-eligible Medicaid groups will need to eliminate them. States that rely on express lane agency income findings to determine Medicaid eligibility may continue to determine eligibility using express lane methods. States must maintain eligibility (through March 31, 2014 or the date of the individual's scheduled eligibility renewal, whichever is later) for individuals enrolled in Medicaid as of January 1, 2014 who would otherwise become ineligible due to the application of the MAGI methodology. CMS plans to release additional guidance in 2013 on the application of MAGI.
- *Conversion of Existing Eligibility Groups to MAGI:*¹⁴ States will need to convert existing eligibility levels for non-elderly, non-disabled eligibility groups (including children, parents and caretaker relatives, pregnant women and other adults) to new MAGI-based levels using a CMS-approved formula that accounts for prior eligibility levels and income disregards, credits, and exclusions. The CMS methodology gives states the option of using a standard methodology, applying either national Survey of Income and Program Participation (SIPP) or state data, or an alternative state methodology to determine converted income standards for each population group. States will also have to collapse their existing MAGI eligibility groups into four simplified groups: children; parents and caretaker relatives; pregnant women; and other adults.¹⁵
- *Five Percent Disregard of Income:*¹⁶ CMS is proposing to clarify that the standard five percent disregard of income established for MAGI-based eligibility groups will only apply for the highest income threshold for the MAGI-based eligibility group for which an individual might be eligible. This means that states do not have to add the five percent disregard to all of their MAGI-converted eligibility levels or use it in determining eligibility in every case, but only apply it in cases where applying a five percent disregard will make the applicant or beneficiary eligible under a MAGI-based eligibility group.¹⁷
- *Transitional Medical Assistance (TMA):*¹⁸ CMS is proposing to revise the TMA income eligibility criteria for the statutory four-month extension of eligibility, which allows parents, pregnant women or children to extend their Medicaid eligibility by four months in cases

where an increase in earnings would make the individual or family ineligible, to ensure this TMA criteria is consistent with MAGI income methodology. CMS is also proposing to eliminate the language providing TMA in cases where an individual becomes ineligible due to an increase in child support payments because such payments will not be considered income under MAGI methodology.

- *American Indians and Alaskan Natives:*¹⁹ States are barred from counting certain types of income earned by American Indians and Alaskan Natives (AI/AN) as part of their income eligibility determination.²⁰
- *Spousal Impoverishment Protections:*²¹ For a five-year period beginning on January 1, 2014, states are required to provide the same spousal impoverishment protections for spouses of Medicaid beneficiaries living in the community receiving care through home- and community-based services (HCBS) as they now provide for spouses of Medicaid beneficiaries in nursing homes.

Timeframe: States must submit a final MAGI conversion plan to CMS by April 30, 2013.

Resources: [CMS Section-by-Section Summary of January 2013 NPRM \(Q\)](#); [SN Implications of Health Reform for AI/AN \(FF\)](#); [SN Eligibility Regulation Overview \(JJ\)](#)

□ **Verification:**²² States are subject to specific new requirements governing verification of eligibility criteria, including:

- *Data-Driven, Coordinated Process:*²³ Eligibility will be verified through a data-driven process that is coordinated with other IAPs to ensure that the process serves the best interests of applicants and beneficiaries.
- *Electronic Verification as Primary:*²⁴ When verification of financial information is needed, states will access data through electronic sources, including through the federal data services hub and additional sources determined “useful” by the state.
- *Reasonable Compatibility Standard:*²⁵ States must determine eligibility and may not request additional information or documentation in cases where the information attested and the electronic verification of income are reasonably compatible. In cases where the attestation and electronic information are either above or below the eligibility level, the states must determine eligibility based on the information provided. States must also develop a “reasonable compatibility” standard for income verifications that indicates the amount of difference between the attested income and the verified income the state will allow and the process for seeking additional information and documentation.
- *Self-Attestation:*²⁶ States must allow self-attestation of pregnancy (except in cases where Medicaid claims information refutes pregnancy) and may allow self-attestation of household size, residency, and other non-financial eligibility criteria except for citizenship and immigration status.
- *Reasonable Opportunity Period:*²⁷ CMS is proposing to require states to provide a “reasonable opportunity period” of 90 days for Medicaid and CHIP applicants whose verification of citizenship and immigration status is pending. Under this requirement, applicants who meet all other verification criteria must be given benefits during this 90-day period while their status is determined, whether verification is done through the data services hub, the Social Security Administration, or other electronic data source. States have the option to extend the period beyond 90 days if the applicant is making a “good faith effort” to provide information.
- *Verification Plan:*²⁸ States are required to submit a verification plan to CMS that reports on state plans for data sources and processes for verification of eligibility, including the reasonable compatibility standard for income.

Timeframe: States have been asked to submit their draft verification plans to CMS in the first quarter of 2013.

Resources: [CMS Section-by-Section Summary of Eligibility Changes \(W\)](#); [SN Reasonable Compatibility Straw Model \(AA\)](#); [SN Eligibility Regulation Overview \(JJ\)](#); [SN Federal Requirements and State Flexibilities for Verifying Eligibility Criteria \(Z\)](#)

□ **Residency:** States will need to implement new federal standards for determining state residency for purposes of Medicaid eligibility. This includes a general rule that residency is established for an adult in the state where she is living and intends to reside (including without a fixed address) or where she has entered the state with a job commitment or seeking employment (whether or not currently employed).²⁹ These standards also include special rules for adults without capacity to state intent, children (living with family, wards of state and institutionalized), pregnant women, and institutionalized individuals.³⁰ To verify residency, states can allow self-attestation or follow the new verification procedures outlined in the final Medicaid eligibility rule.³¹ States are barred from using immigration information as evidence of non-residency.³² When states cannot agree on an individual’s residence, the state where the individual is physically located is the state of residence.³³

Resource: [SN Eligibility Regulation Overview \(JJ\)](#)

□ **Medical Support and Payments:**³⁴ Under current law, parents seeking Medicaid coverage must cooperate with states to establish paternity and obtain medical support and payments, unless the requirements are waived for good cause. CMS proposes amending current requirements to allow post-enrollment enforcement of the cooperation agreement in order to achieve greater alignment of the eligibility process among IAPs. Under this new paradigm, parents seeking coverage would have to attest on their application to future cooperation and states must enroll eligible individuals without waiting for evidence of cooperation. If an individual does not cooperate, the Medicaid agency must take steps to terminate eligibility. CMS is also proposing to exempt pregnant women from the cooperation requirements.³⁵

Resources: [CMS Section-By-Section Summary of January 2013 NPRM \(Q\)](#); [Health Reform GPS Summary Of Medicaid and Exchange Eligibility NPRM January 2013 \(DDD\)](#)

☐ **Coordination with Exchanges:**³⁶ State Medicaid and CHIP programs will have to coordinate with insurance Exchanges, whether State-Based or Federally Facilitated, on a number of key eligibility and enrollment functions, including:

- *Eligibility Criteria:*³⁷ State Medicaid agencies must certify the eligibility criteria applied in determining Medicaid eligibility used by the Exchange and other IAPs.
- *Agreements with Exchanges/other IAP Agencies:*³⁸ State Medicaid agencies must enter into agreements with Exchanges and other IAP agencies that clearly delineate responsibilities of each program to minimize burden on individuals, ensure compliance with federal requirements for coordination, and ensure compliance with timeliness standards for eligibility decisions. For states where a Federally Facilitated Exchange will be operating, the state must choose whether the federal Exchange will either assess or determine Medicaid eligibility.
- *Alignment with Exchange for Initial Open Enrollment Period:*³⁹ CMS is proposing that from October 1, 2013 to January 1, 2014, state Medicaid and CHIP agencies fulfill general coordination responsibilities with Exchanges, including accepting and transferring the single streamlined application and electronic accounts of individuals applying for coverage through Exchanges. States have the option to either accept the single streamlined application or to inform the individual on how to submit a separate application if needed to determine Medicaid eligibility before 2014.
- *Providing Medicaid for Individuals Determined Eligible by Exchange:*⁴⁰ In cases where the Medicaid agency has entered into an agreement where the Exchange or another IAP makes final eligibility decisions for Medicaid, the agency must meet certain requirements to ensure the seamlessness of the eligibility determination process and delivery of Medicaid benefits without procedural hurdles. Medicaid must establish procedures to receive secure transmissions of electronic accounts of the determinations, comply with all eligibility requirements that apply to Medicaid agencies generally including timeliness standards, and maintain oversight of the Medicaid program, including the quality of determinations, as required under the “single state agency” provisions, discussed in the Operations section below.
- *Transfer of Applications from other IAPs to Medicaid:*⁴¹ In cases where individuals are assessed for potential Medicaid eligibility but are not determined eligible, Medicaid agencies must: (1) accept a secure transmission of the electronic account; (2) not request information or documentation already provided to the IAP and received in the transmission; (3) promptly determine Medicaid eligibility in accordance with timeliness standards; (4) accept any findings of fact relating to eligibility without further verification as long as the findings are consistent with policies and procedures applied or approved by the Medicaid agency; (5) notify the IAP of receipt of the account; and (6) notify the IAP of the final determination of eligibility for individuals who enroll in another coverage program pending outcome of the Medicaid determination.
- *Evaluating Eligibility for Other IAPs:*⁴² Medicaid agencies must determine potential eligibility for individuals ineligible for Medicaid and, if appropriate, transfer the electronic account via secure electronic interface to another IAP for determination. For individuals ineligible for MAGI-based groups but for whom an eligibility determination based on non-MAGI standards is pending, the agency must promptly determine eligibility and provide notice to other IAPs of status and final decision, and may allow the Exchange to determine eligibility for premium tax credits and cost-sharing reductions, and enroll in a QHP pending the final Medicaid decision.
- *Notices and Appeals:* CMS has proposed new requirements for combined notices across Medicaid and the Exchange where feasible, and coordinated notices in other cases and for coordinated appeals, including delegation of authority to conduct Medicaid hearings. For more detail, see the sections below on Notices and Appeals.

Timeframe: Agreements need to be in place by October 2013 when the Exchange starts making eligibility determinations.

Resources: [CMS FAQs on Program Coordination \(K\)](#); [SN Eligibility Regulation Overview \(JJ\)](#); [SN ACA Implementation Milestones \(KK\)](#)

☐ **Timeliness Standards:**⁴³ States must determine Medicaid eligibility “promptly and without undue delay,” making decisions within 45 days for non-disabled or 90 days for disabled applicants. While additional guidance is expected from CMS, states are directed to include in Medicaid state plans both timeliness and performance standards that take into account, among other things, new efficiencies gained by electronic data matching systems, which should make “real time” eligibility determinations possible “in most cases.” States must develop systems and monitoring capacity to allow them to implement and track performance on timeliness of eligibility determinations, strive for real time eligibility decisions to the greatest extent possible, and document the state’s performance in meeting the 45 day outer limit for most eligibility decisions.

Resource: [SN Eligibility Regulation Overview \(JJ\)](#)

☐ **Renewal:**⁴⁴ States must rely on already available information to support a streamlined renewal process that, to the greatest extent possible, does not burden enrollees. Agencies must ask only for information that is necessary for renewal. Where electronic information does not support a renewal, states must provide a streamlined, pre-populated form to the individual asking for needed information, but cannot require individuals to sign and return the notice if there is no change. States must be able to accept renewal information and allow enrollees to report changes online, by

phone, in person, and by mail. States may only renew eligibility once every 12 months for MAGI eligibility groups, unless information about a change in the beneficiary's circumstances requires earlier review. States must provide individuals at least 30 days to provide information requested for a renewal and individuals who fail to renew must be given a grace period of at least 90 days in which to submit needed information to re-enroll without having to re-apply.

Resource: [SN Eligibility Regulation Overview](#) (JJ)

☐ **Presumptive Eligibility:**⁴⁵ States are required to make changes to existing presumptive eligibility (PE) programs, are given the option to expand PE to new populations, and must allow “qualified” hospitals to make PE decisions:

- *Changes to Existing PE Programs:*⁴⁶ CMS is proposing to clarify that states can be reimbursed for either claims or administrative costs incurred for individuals enrolled through PE methods. For child populations, CMS also proposes to update the existing income eligibility standards to align with MAGI methodologies, to clarify that PE entities cannot delegate their authority to make PE decisions and to require states to implement oversight to ensure the integrity of PE decisions. CMS also proposes to give states the option to require PE entities to attest to the citizenship and immigration status of applicants. For pregnant women, CMS is proposing to limit states to one PE period per pregnancy. CMS also proposes to add Indian Health Service, tribal and Urban Indian Organization entities to the list of “qualified entities” who can make a PE determination.
- *Option to Expand PE to Non-Elderly Populations:*⁴⁷ States have the option under the ACA to expand PE to new non-elderly Medicaid-eligible populations, including: parents and other caretaker relatives; the new adult group; former foster care children; individuals eligible for family planning services; optional individuals needing treatment for breast or cervical cancer; and, optional individuals above 133 percent FPL.
- *Hospital-Based PE:*⁴⁸ States are required under the ACA to allow “qualified hospitals” that elect to make PE determinations to determine eligibility and temporarily enroll Medicaid-eligible individuals for a PE period. “Qualified hospitals” are hospitals that participate as a Medicaid provider, notify the agency of their election to participate, agree to make determinations consistent with policies and procedures, and have not been disqualified by the state agency from participation. States also have the option to require hospitals to assist individuals in completing and submitting the full application and understanding documentation requirements. This requirement applies to all states, even states that do not now offer PE. States also can opt to create other limits on hospital participation, including: (1) limiting hospitals’ use of PE to only those populations that are eligible for PE or allowing hospitals to determine eligibility for all Medicaid-eligible individuals under the state plan or waiver; (2) establishing standards to monitor hospital performance in enrolling those who are determined presumptively eligible; (3) disqualifying hospitals whose performance does not meet state standards; and (4) imposing other requirements.

Resources: [CMS Section-by-Section Summary of January 2013 NPRM](#) (Q); [SN Medicaid Eligibility Transition Toolkit](#) (GG)

☐ **Notices:**⁴⁹ CMS has proposed new requirements to make notices more understandable, accessible, and easier to navigate for consumers. The proposed notice requirements are in some cases very different from existing Medicaid practices.

- *Combined Notices:* CMS is proposing that state Medicaid agencies provide individuals with a single notice for a determination or denial of eligibility for all IAPs and enrollment in a QHP through the Exchange “to the maximum extent feasible,” rather than separate notices from Medicaid and/or CHIP agencies. For most applications where eligibility is based on MAGI, a combined notice will be issued by the last agency to determine eligibility.
- *Coordination:* Before combined notices are implemented, and in cases where combined notices are not feasible, CMS is proposing that state and federal agencies coordinate on the content of separate notices issued, including information regarding the transfer of the individual’s account to another IAP for determination.
- *Content:* Notices of Medicaid eligibility will have to include “clear and specific content” for both eligibility determinations and adverse actions that enable the applicant to understand the rationale for the decision. CMS, in consultation with states, consumer groups, and plain language experts, is developing model notice language that will be released in 2013.
- *Accessibility:* Notices must be written in plain language and be accessible to limited English proficient (LEP) and disabled populations.
- *Electronic Notices:* CMS is proposing that states provide notices electronically and that all individuals be given the option to select electronic notification.

Timeframe: Combined notices with the Exchange will not be required until January 1, 2015. Coordinated notices with the Exchange will be required starting January 1, 2014.

Resources: [CMS Section-by-Section Summary of January 2013 NPRM](#) (Q); [SN Appeals Notices and Other E-Communications](#) (EE)

□ **Appeals:**⁵⁰ CMS is proposing new, and in some cases significantly different, requirements and options to promote coordination between the fair hearing process required under Medicaid and the right to appeals of eligibility determinations for other IAPs:

- *Methods to File Appeals:* CMS is proposing that Medicaid agencies allow individuals to file an appeal by telephone, by mail, in person, and through other commonly available electronic means, including email and possibly fax or other electronic systems. States can opt to allow filing of appeals through a website.
- *Additional Requirements for Medicaid Fair Hearings:* In cases where the Medicaid agency is conducting the Medicaid fair hearing, CMS proposes to clarify that Medicaid may not request information or documentation that has already been provided in the electronic account or to the IAP entity. Medicaid also must accept any finding of fact relating to eligibility made by another IAP appeals entity if it was made in accordance with policies applied or approved by Medicaid. In conducting fair hearings, Medicaid agencies must assess individuals for potential eligibility for other IAPs for individuals determined ineligible for Medicaid at initial application or renewal. Information about the hearing must be accessible to individuals with limited English proficiency or disabilities.
- *Expedited Appeals:* CMS proposes that state Medicaid agencies provide an expedited appeal for an individual with an urgent health need, as is now required for Medicaid managed care organizations.
- *Appeal of QHP Enrollment and PTC/CSR Automatically Triggers Medicaid Appeal:* CMS is proposing to require Medicaid agencies to treat any appeal of QHP enrollment and premium tax credit and cost-sharing reduction (PTC/CSR) amounts as automatically triggering a Medicaid fair hearing. CMS is considering a later effective date of January 1, 2015, to allow states more time to operationalize the new policy if implemented.
- *Secure Electronic Interfaces:* To ensure coordination between appeals entities, CMS directs Medicaid agencies to establish a secure electronic interface through which an Exchange appeals entity can notify the Medicaid agency regarding appeals filed and transmit or receive an individual's electronic account. This interface can be the same one used by the Medicaid agency and Exchange for electronic transfers.
- *Applicability to CHIP:* CMS is proposing conforming changes to CHIP to ensure the appeals process is consistent and coordinated with Medicaid and other IAPs.
- *Option to Delegate Medicaid Fair Hearings (Optional):* CMS is proposing to permit state Medicaid agencies to delegate authority to conduct a fair hearing of a MAGI-based Medicaid eligibility denial in cases where an individual is also appealing the amount of an advance payment of the PTC or cost-sharing reductions for enrollment in a QHP. Medicaid agencies must provide notice to the individual appealing the Medicaid decision and the right to have the fair hearing on the Medicaid denial conducted by the Medicaid agency instead. Delegation can only be made to an Exchange that is a governmental agency maintaining merit protections for its employees, including either a State-Based or Federal Exchange.⁵¹ Under this proposal, state Medicaid agencies that have delegated fair hearing authority will have to receive and accept an Exchange entity's Medicaid eligibility decision.

Timeframe: CMS is proposing to make the automatic Medicaid fair hearing trigger from any QHP enrollment and PTC/CSR appeal effective January 1, 2015.

Resources: [CMS Section-by-Section Summary of January 2013 NPRM](#) (Q); [SN Appeals Notices and Other E-Communications](#) (EE)

2. MEDICAID OPERATIONS:

□ **Single State Agency:**⁵² As discussed in the Eligibility and Enrollment section above, CMS is proposing to allow Medicaid agencies to delegate the authority to make eligibility determinations or conduct fair hearings to government agencies that maintain personnel standards on a merit basis. States must comply with safeguards and enter into agreements that will be available upon request to the public that clarify that the Medicaid agency retains responsibility to monitor the quality of decision making when eligibility determinations are delegated. All states will need to revise the single state agency provisions in their Medicaid state plans to specify whether Exchanges will be making eligibility determinations, and, if so, to describe how the Medicaid agency will continue to have final oversight of the accuracy of all eligibility determinations, including those made by other governmental entities.

Resources: [CMS Section-by-Section Summary of January 2013 NPRM](#) (Q); [SN Eligibility Regulation Overview](#) (JJ); [SN ACA Implementation Milestones](#) (KK)

□ **Safeguarding Information:**⁵³ States will need to comply with strict safeguarding rules that will apply more broadly than they currently do, especially related to information coming through the federal data hub. Income information coming from the IRS or SSA must now be protected with the safeguards of that particular federal agency. Social Security numbers now must be safeguarded, along with any other information received for verifying income eligibility. In addition, states will now need to safeguard information about both non-applicants and applicants.

Resource: [SN Eligibility Regulation Overview](#) (JJ)

☐ Increase in Primary Care Reimbursement Rates:⁵⁴ States will have to raise reimbursement rates for certain primary care providers and services in 2013 and 2014. The federal government will pay a 100 percent match on the difference between the state's July 1, 2009 rates and Medicare rates (if the state has not cut rates). States will administer the higher payments to providers, and conduct some limited verification that providers are eligible. To administer payments, states will need to choose which Medicare rates to use, since Medicare rates are geographically adjusted within a state. In cases where fee-for-service reimbursement is not used, such as managed care and waivers, CMS will be working with states to ensure the rate increase reaches providers as the ACA intended. States will need to submit two methodologies to CMS to calculate the baseline and differential payments under managed care contracts, and will need to collect documentation from managed care organizations. Finally, states will need to collect data to support evaluation of whether the increase in reimbursement improved access to care. States must obtain a SPA to reflect all of the required changes.

Timeframe: Payment increases are effective from January 1, 2013, although states may submit a SPA until March 31, 2013 and administer payments retroactively.

Resource: [Center for Health Care Strategies Primary Care Payment Redesign site](#) (QQ)

☐ State Plan Amendment (SPA) Submissions and Public Notice:⁵⁵ CMS is proposing to require states use a new automated format and template for submitting Medicaid SPAs. CMS is also proposing to require public notice two weeks before submission of proposed SPA changes for reductions in coverage or benefits or cost-sharing or alternative benefit plans (ABPs) changes. Advance notice will also be required before implementing any SPA increasing or maintaining currently provided benefits, reducing cost-sharing, or adding new benefits in the ABPs, but there is no guidance on the length of advance notice required in this circumstance.

Timeframe: CMS is proposing to allow states one year from the release of the automated template to comply with the automated submission requirement.

Resource: [CMS Section-by-Section Summary of January 2013 NPRM](#) (Q)

☐ Program Integrity:⁵⁶ States already must be in compliance with numerous Medicaid program integrity provisions of the ACA that took effect during 2010 and 2011. However, as their programs expand and modernize, states will need to continue to build up these functions. Requirements already in effect include establishing a Recovery Audit Contractor program, implementing National Correct Coding Initiative methodologies, and suspending payments to individuals and entities during fraud investigations.

Resource: [CMS Compilation of Medicaid Program Integrity provisions](#) (V)

3. MEDICAID FINANCING

☐ CHIP Match for Certain Medicaid-Eligible Children:⁵⁷ As noted in the Eligibility and Enrollment section above, the Medicaid MAGI children's category will cover children up to 133 percent FPL. In some states, children between the ages of six and 19 with family incomes between 100 and 133 percent FPL who were previously eligible for CHIP will move to Medicaid. States can still claim the enhanced CHIP federal matching assistance percentage (FMAP) for these children, instead of the lower Medicaid FMAP. To claim the higher match, states will need to implement a methodology that tracks Medicaid-eligible children who previously would have been eligible for CHIP.

Resources: [CMS FAQ on BHP and Newly Eligible and Expansion State FMAP](#) (E); [SN Eligibility Regulation Overview](#) (JJ); [SN ACA Implementation Milestones](#) (KK)

☐ Enhanced Federal Funding for Information Technology (IT) Systems (Optional):⁵⁸ Many of the new requirements for operations and eligibility mean state Medicaid IT systems will need to take on new functions and capacities, including interfacing with the federal data hub, transferring data and accounts electronically to CHIP and the Exchange, accepting online applications, and providing a secure consumer-facing account management system. In many states, IT systems are so outdated that these new functions cannot be added without building a new IT system or significantly updating an existing system. States can claim an enhanced federal match for developing their Medicaid IT systems. A 90 percent federal financial percentage (FFP) is available for design, development and implementation of IT systems, and 75 percent FFP is available for ongoing maintenance and operation. To claim the Medicaid match, states must: have an approved advance planning document (APD); comply with CMS' seven conditions and standards; and appropriately allocate costs. Two tri-agency letters from the federal government allow states to use the 90 percent development match to make upgrades to systems that support human services programs other than Medicaid, as long as the addition does not delay implementation. Other Non-Medicaid programs need to pay for (or "cost-allocate") only the additional cost of improvements specific to those programs. States also have to allocate costs to the Exchange if IT systems will support both programs.⁵⁹

Timeframe: The 90 percent FFP is available for services incurred through December 31, 2015; there is no time limit on the 75 percent FFP.

Resources: [CMS FAQ on Medicaid Eligibility and Enrollment Systems](#) (J); [HHS and USDA Tri-agency Letter on Cost Allocation](#) (M); [CMS Guidance for IT systems](#) (O); [CMS Compilation of Medicaid IT Provisions](#) (U); [CMS Enhanced Funding Requirements: Seven Conditions and Standards](#) (P); [SN Financial Sustainability of Medicaid and Exchange Integrated Eligibility Systems](#) (LL)

☐ Enhanced Federal Funding for Newly Eligible Adults*:⁶⁰ If a state chooses to expand eligibility to adults at or below 133 percent FPL, the state will receive 100 percent FMAP for these individuals from 2014 to 2016. This enhanced FMAP will gradually decrease to 90 percent in 2020. The

state must implement a methodology to account for expenses to which the enhanced FMAP applies. This methodology must statistically separate out the expenses of “newly eligible” enrollees—those not eligible under previous categories—without maintaining the old eligibility system to check for previous eligibility. The state must select among several methodological options for claiming the 100 percent FMAP, to be released by CMS in future guidance.

Resources: [SN ACA Implementation Milestones](#) (KK); [SHADAC and RAND FMAP Methodology Webinar](#) (EEE)

4. MEDICAID BENEFITS

Alternative Benefit Plans:⁶¹ States will have to provide an “Alternative Benefit Plan” (ABP) benefit package to two types of groups: (1) the new adult group in states that choose to expand eligibility to adults at or below 133 percent FPL and (2) current optional or waiver adult groups that receive a benchmark or benchmark-equivalent benefit under Section 1937 of the Social Security Act. ABPs must be benchmarked to particular plans in the state and include the ten categories of essential health benefits (EHBs) required under the ACA, including mental health parity, prescription drug and family planning benefits which may not be covered by a state’s existing 1937 benefit packages. States can choose a different ABP for different groups, or the same plan for multiple groups. Further, the state does not need to use the same EHB benchmark as offered on the Exchange or in the general commercial insurance market. States will need to consider the pros and cons of having the same package for different categories and programs. States will need to update their Medicaid state plans to reflect the new benefit package(s). CMS is proposing several clarifications to states’ requirements for ABPs, such as guidelines for specific benefits (e.g. preventive benefits, habilitative services), the option to provide a targeted ABP to populations with specific needs, and rules on how states may define and make updates and modifications to ABPs. CMS is also proposing to update the definition of medically frail populations and to add former foster care children to the list of groups that will be exempt from required participation in ABPs.

Resources: [CMS State Medicaid Director Letter](#) (I); Working documents from [Oregon](#) (CCC) and [Illinois](#) (ZZ)

Prescription drug exclusions:⁶² In addition to other ACA prescription drug requirements that took effect in 2010, beginning in 2014 states will be barred from excluding three types of drugs from Medicaid coverage: tobacco cessation drugs; barbiturates; and benzodiazepines.

New Preventive Benefit Standards Coverage (Optional):⁶³ States that choose to cover a list of preventive benefits (U.S. Preventive Services Task Force services rated A or B) with no cost-sharing will get a one percentage point increase in their FMAP for those services. Effective September 2011, the ACA also requires states to provide coverage of comprehensive tobacco cessation services for pregnant women in Medicaid.

Timeframe: States can start receiving the one percentage point FMAP increase on January 1, 2013.

Resources: [SMD Letter on Preventive Services](#) (F) [Kaiser Family Foundation Coverage of Preventive Services](#) (WW)

5. CONSUMER ASSISTANCE

Consumer Assistance Requirements:⁶⁴ States will be required to provide consumer assistance to individuals as they apply for or renew Medicaid benefits.

- *Multiple Options to Access Assistance:* Consumers must be able to access assistance in person, by telephone, and online. This is the first time consumer assistance has been required in Medicaid. Many states already use telephone consumer assistance hotlines, and/or in-person application assisters or enrollment brokers to help consumers at various points in the Medicaid coverage process. However, most states will need to add online consumer assistance for the first time, and states may need to update existing programs so that they provide broad consumer assistance at all stages in the coverage process, comply with ACA accessibility requirements, and provide up-to-date information about IAPs.
- *Application Counselors (Optional):* As an option for in-person assistance, CMS is proposing that Medicaid programs may certify application counselors. Certified application counselors will be allowed to access beneficiaries’ personal information, if they meet the certification requirements CMS is proposing. States should be aware that Exchanges are required have a certified application counselor program. If states choose to certify application counselors in Medicaid, they will need to provide counselors with specific tools and training to effectively assist consumers, such as a web portal that meets privacy and security standards.

Timeframe: Must be functional by January 1, 2014, although states may want to implement sooner to coordinate with Exchange consumer assistance that begins on October 1, 2013.

Resources: [SN Designing Consumer Assistance Programs: Resources from the Field](#) (BB); [SN Leveraging Current Programs in Navigator Development](#) (DD); [NASHP Consumer Assistance in the Digital Age](#) (XX); [Enroll America In-person Assistance](#) (AAA)

Authorized Representatives:⁶⁵ CMS is proposing to clarify a requirement that states must allow individuals to designate an authorized representative, either an individual or an organization, who acts on the individual’s behalf in communications with the Medicaid agency (e.g., during application or renewal). CMS is proposing that states must accept a designation of authority at any time, through various specific means. For authorized representatives that are organizations, states must enact agreements that ensure the representatives are trained in conflict of interest, confidentiality, and meet other minimum requirements.

Resources: [CMS Section-by-Section Summary of January 2013 NPRM](#) (Q)

❑ Consumer-Facing Website:⁶⁶ States will need to provide a website that is accessible to consumers, provides information on IAPs, and allows consumers to apply for, enroll in, and renew their Medicaid benefits. The website can operate in conjunction with, link to, or be the Exchange website, as long as it provides the required functionalities for Medicaid. Certain information must be available to consumers on the website, such as eligibility levels, Medicaid benefits, and consumer rights and responsibilities. Although most states have already chosen to operate Medicaid websites, the application, enrollment, and renewal functions will be new to most, as will the robust standards for information to be available on the site.

Resources: [Office of Disease Prevention and Health Promotion Online Health Literacy](#) (X); [NASHP Enrollment Superhighway](#) (GGG)

❑ Accessibility Requirements:⁶⁷ The information on the website and the assistance provided in person, by phone, and online will need to be accessible to consumers. This means states will have to provide language services to limited English proficient consumers, and aids and services to consumers with disabilities (at no cost to the consumer). The information and assistance will need to be in plain language and timely. States may also want to consider cultural competency as they develop accessible consumer assistance; although this is not a requirement for Medicaid, it is a requirement for Exchanges and health plans. Many states will need to update their materials and consumer assistance programs to meet these new accessibility guidelines. CMS is proposing additional details on accessibility requirements.

Resources: [Center for Plain Language](#) (RR); [Enroll America Communicating with Plain Language](#) (TT); [Enroll America Translations](#) (UU)

Conclusion

To modernize their Medicaid programs in the way the ACA envisions, states face many tasks across these critical Medicaid domains: eligibility and enrollment; operations; financing; benefits; and consumer assistance. This checklist is a comprehensive tool that states can use to prioritize tasks and identify remaining areas of work as they prepare for January 1, 2014 and beyond. The resources noted here and in the accompanying [Resource List](#) will help states as they undertake these tasks. States can leverage the excellent analyses, tools, and experience from federal agencies, outside experts, and states to make meaningful progress on reforming their Medicaid program towards ACA compliance by 2014.

Acknowledgements

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¹ For more details on the full list of Medicaid reforms tracked to state plan amendment requirements, please see Center for Health Care Strategies, Inc., *Medicaid State Plan Amendment Requirements for the Affordable Care Act*, (Princeton, NJ: State Health Reform Assistance Network, August 2012) <http://www.statenetwork.org/resource/medicaid-state-plan-amendment-requirements-of-the-affordable-care-act/>

² The proposed rule that CMS issued on January 22, 2013 affected many of these requirements, as detailed in the sections below. As this guidance is proposed and not final, states will need to continue to track developments in the coming months. In addition, the guidance included several provisions that do not directly stem from the ACA, but impose additional new requirements on Medicaid agencies that are not discussed here.

³ Each resource in this document includes a hyperlink for easy access. We have also named each resource with a letter code to ease identification in the accompanying Resource List. The companion Resource List lists the letter code along with the full citation for each resource. "SN" appearing next to the resource indicates that the resource was created by the State Health Reform Assistance Network.

⁴ Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act, P.L. 111-152, [hereinafter "ACA"] § 2001(b)

⁵ For more details on the MOE provisions and guidance, see CMS State Medicaid Director Letters dated February 25, 2011 (SMDL 11-001) and August 5, 2011 (SMDL 11-009). For an analysis of the impact of the Supreme Court's opinion in *NFIB v. Sebelius*, see Kathleen S. Swendiman, Evelyne P. Baumrucker, *Selected Issues Related to the Effect of NFIB v. Sebelius on the Medicaid Expansion Requirements in Section 2001 of the Affordable Care Act*, CRS, July 16, 2012.

⁶ ACA § 2001(a)

⁷ As discussed in the Financing section below, states will be eligible for an enhanced federal matching rate for children previously covered under CHIP who are newly eligible for Medicaid. Centers for Medicare and Medicaid Services, *Questions and Answers: Medicaid and the Affordable Care Act*, (U.S. Department of Health and Human Services, February 6, 2013) <http://medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/Downloads/ACA-FAQ-BHP.pdf>

⁸ ACA § 2004(a); Centers for Medicare and Medicaid Services; *Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing; Proposed Rule*, CMS-2334-P, Vol. 78 No. 14 (22 January 2013) pp. 4593 - 4724. [Hereinafter, January 22, 2013 NPRM] <http://www.gpo.gov/fdsys/pkg/FR-2013-01-22/pdf/2013-00659.pdf>; CFR § 435.150

- ⁹ Under the January 22, 2013 NPRM, CMS clarified that states will still have the option to cover independent foster care adolescents as an optional eligibility group subject to different rules. CMS also clarified that individuals eligible or enrolled in a mandatory Medicaid eligibility group under section 1902(a)(10)(A)(i)(I) through (VII) do not have to be enrolled in the mandatory foster care group, but that mandatory foster care group eligibility makes an individual ineligible for the optional new adult group under 1902(a)(1)(A)(i)(VIII). CMS is considering only requiring states to provide this mandatory coverage for individuals who received foster care in the state in which they are applying for Medicaid and allowing states the option of covering out-of-state foster care youths, but is seeking comment on this point. January 22, 2013 NPRM, Pages 40-42 of Preamble
- ¹⁰ ACA § 2001(a)
- ¹¹ 42 CFR § 435.907
- ¹² Note that this application must either follow the federal model application or be approved by the Secretary as an alternative state application.
- ¹³ ACA § 2002(a); 42 CFR §§ 435.119, 435.603; The exemption from MAGI eligibility determination for eligibility groups determined eligible based on income determinations from an Express Lane Eligibility agency can be found at 42 CFR 435.603(j)(1).
- ¹⁴ ACA § 2002(a); Centers for Medicare and Medicaid Services, State Health Official Letter, *Conversion of Net Income Standards to MAGI Equivalent Income Standards* (U.S. Department of Health and Human Services, December 28, 2012) <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO12003.pdf>
- ¹⁵ Children whose eligibility changes from Medicaid to CHIP due to the application of the MAGI income eligibility methodology will need to be placed in a separate CHIP program by states for the first year. Center for Medicaid and CHIP Services, *Medicaid and CHIP Affordable Care Act Implementation, Answers to Frequently Asked Questions, Coordination Across Insurance Affordability Programs* (U.S. Department of Health and Human Services, May 22, 2012) <http://www.medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/Downloads/Coordination-FAQs.pdf>
- ¹⁶ 42 CFR § 435.603(d)(4)
- ¹⁷ For additional discussion of the rationale for this proposal, see January 22, 2013 NPRM, Preamble
- ¹⁸ 42 CFR §§ 435.112, 435.115
- ¹⁹ 42 CFR § 435.603(e)(3)
- ²⁰ These sources include: financial assistance to students through the Bureau of Indian Affairs education programs; income from Alaska Native corporations and settlement trusts; earnings from property under the Secretary of Interior's supervision, on or near reservations or sites formerly housing reservations; and payments from ownership interests and usage rights that support a traditional or subsistence lifestyle. 42 CFR § 435.603(e)(3)
- ²¹ ACA § 2404; for more information, see National Association of State Units On Aging, *Long-Term Care in Brief: Explaining the HCBS Spousal Impoverishment Protections* (Washington, DC: National Association of State Units on Aging, March 11, 2011) http://www.nasud.org/documentation/aca/NASUAD_materials/ltcb_protectionforHCBSrecipients.pdf
- ²² 42 CFR §§ 435.948, 435.949, 435.952
- ²³ 42 CFR §§ 435.940, 435.945
- ²⁴ 42 CFR § 435.948
- ²⁵ 42 CFR § 435.952
- ²⁶ 42 CFR § 435.956
- ²⁷ 42 CFR § 435.956
- ²⁸ 42 CFR § 435.945(j)
- ²⁹ 42 CFR § 435.403(h). This differs from the prior standard that the individual reside "permanently or for an indefinite period." Manatt Health Solutions, *Overview of Final Medicaid Eligibility Regulation*, (Princeton, NJ: State Health Reform Assistance Network, April 2012) <http://www.statenetwork.org/resource/overview-of-final-medicaid-eligibility-regulation>
- ³⁰ 42 CFR § 435.403(i); 42 CFR § 457.320
- ³¹ 42 CFR § 435.956(c). Note that reasonable verification procedures can be found at 42 CFR § 435.952
- ³² 42 CFR § 435.956(c)(2)
- ³³ 42 CFR § 435.403(m)
- ³⁴ 42 CFR §§ 433.148, 433.610
- ³⁵ 42 CFR § 435.145(a)
- ³⁶ ACA § 2201; 42 CFR §§ 431.10, 431.11, 435.1200
- ³⁷ 42 CFR § 435.1200(b)(2)
- ³⁸ 42 CFR § 435.1200(b)(3)
- ³⁹ 42 CFR § 435.1205
- ⁴⁰ 42 CFR § 435.1200(c)
- ⁴¹ 42 CFR § 435.1200(d)
- ⁴² 42 CFR § 435.1200(e)
- ⁴³ 42 CFR § 435.912. Note that the new timeliness standards were proposed as interim final in the Final Medicaid Eligibility Rule.
- ⁴⁴ 42 CFR § 435.916
- ⁴⁵ ACA §§ 2001(a)(4)(B), 20012202(a)(4); 42 CFR § § 435.1001, 435.1002, 435.1100, 435.1101, 435.1102, 435.1103, and 435.11110.
- ⁴⁶ 42 CFR §§ 435.1001, 435.1100, 435.1002, 435.1101, 435.1102, 435.1103

⁴⁷ 42 CFR §§ 435.1100, 435.1103

⁴⁸ 42 CFR § 1110

⁴⁹ ACA § 1413 requires states to streamline procedures for enrollment through Exchange, state Medicaid, CHIP and health subsidy programs.

⁵⁰ January 22, 2013 NPRM <http://www.gpo.gov/fdsys/pkg/FR-2013-01-22/pdf/2013-00659.pdf>

⁵¹ States cannot delegate to sister agencies but can seek a waiver under the Intergovernmental Cooperation Act of 1968 by submitting a State Plan Amendment (SPA). January 22, 2013 NPRM, Preamble, p. 17.

⁵² 42 CFR §§ 431.10, 431.11, 435.1200

⁵³ 42 CFR §§ 431.300 through 305. Note that these provisions were proposed as interim final in the Final Medicaid Eligibility Rule.

⁵⁴ ACA (HCERA) § 1202; 42 CFR §§ 438, 441, 447 (Final Rule on Primary Care Payments)

⁵⁵ 42 CFR §§ 430.12, 440.386

⁵⁶ ACA § 6411; ACA § 6507; ACA § 6402(h)(2)

⁵⁷ ACA § 2101; Centers for Medicare & Medicaid Services (CMS), HHS, "Preamble", Final rule; Interim Final Rule, Medicaid Program; Eligibility Changes under the Affordable Care Act, 77 F.R. 17144 (March 23, 2012) [Hereinafter "Medicaid Eligibility Final Rule Preamble"].

⁵⁸ *Medicaid Program; Federal Funding for Medicaid Eligibility Determination and Enrollment Activities; Final Rule*, CMS-2346-F, Vol. 76 No. 75 (19 April 2011) pp. 21949 – 21975. <http://www.gpo.gov/fdsys/pkg/FR-2011-04-19/pdf/2011-9340.pdf>

⁵⁹ States also have access to additional funds to support IT systems development for Exchanges through Exchange planning and establishment grants.

⁶⁰ ACA § 2001

⁶¹ January 22, 2013 NPRM; 42 CFR § 440; ACA §§ 2001, 2303(c); Centers for Medicare and Medicaid Services, *Frequently Asked Questions on Essential Health Benefits Bulletin*, (U.S. Department of Health and Human Services, February 17, 2012) <http://ccio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf>; Centers for Medicare and Medicaid Services, Federal Policy Guidance: *Essential Health Benefits in the Medicaid Program*. (U.S. Department of Health and Human Services November 20, 2012) <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf>

⁶² ACA § 2502(a)

⁶³ ACA § 4106

⁶⁴ 42 CFR § 435.908; Medicaid Eligibility Final Rule Preamble III(E)

⁶⁵ January 22, 2013 NPRM; 42 CFR § 435.923

⁶⁶ 42 CFR §§ 435.1200, 435.905; Medicaid Eligibility Final Rule Preamble III(E)

⁶⁷ 42 CFR § 435.905(b); Medicaid Eligibility Final Rule Preamble III(E)

States' Medicaid ACA Checklist Resource List

This document is a companion to the State Health Reform Assistance Network brief States' Medicaid ACA Checklist and provides a list of all the resources cited in the document with links to each document in the electronic version. Each resource is given a code which is used in the Checklist for quick citation and is also noted here for content corresponding to one of the five topic areas addressed in the Checklist as follows: **1.** Eligibility and Enrollment, **2.** Medicaid Operations, **3.** Medicaid Financing, **4.** Medicaid Benefits, and **5.** Consumer Assistance. Documents are also organized by source, including, in descending order, Federal Resources, State Health Reform Assistance Network Resources and other resources.

Federal Resources

Regulations

- (A) Centers for Medicare and Medicaid Services; Medicaid, *Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing; Proposed Rule*, CMS-2334-P, Vol. 78 No. 14 (22 January 2013) pp. 4593 – 4724. <http://www.gpo.gov/fdsys/pkg/FR-2013-01-22/pdf/2013-00659.pdf> **TOPICS: 1,2,3,4,5**
- (B) Centers for Medicare and Medicaid Services; *Payments for Services Furnished by Certain Primary Care Physicians and Charges for Vaccine Administration Under the Vaccines for Children Program; Final Rule*, CMS-2370-F, Vol. 77 No. 215 (6 November 2012) pp. 66669 – 66701. <https://www.federalregister.gov/articles/2012/11/06/2012-26507/rin-0938-aq63> **TOPIC: 3**
- (C) Centers for Medicare and Medicaid Services; *Eligibility Changes Under the Affordable Care Act of 2010; Final Rule*, CMS-2349-F, Vol. 77 No. 57 (23 March 2012) pp. 17143–17217. <https://www.federalregister.gov/articles/2012/03/23/2012-6560/medicaid-program-eligibility-changes-under-the-affordable-care-act-of-2010> **TOPIC: 1**
- (D) Centers for Medicare and Medicaid Services; *Federal Funding for Medicaid Eligibility Determination and Enrollment Activities; Final Rule*, CMS-2346-F, Vol. 76 No. 75 (19 April 2011) pp. 21949 – 21975. <https://www.federalregister.gov/articles/2011/04/19/2011-9340/medicaid-program-federal-funding-for-medicaid-eligibility-determination-and-enrollment-activities> **TOPIC: 1**

Subregulatory Guidance

- (E) Centers for Medicare and Medicaid Services, *Questions and Answers: Medicaid and the Affordable Care Act*, (U.S. Department of Health and Human Services, February 6, 2013). <http://medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/Downloads/ACA-FAQ-BHP.pdf> **TOPICS: 1,3**
- (F) Centers for Medicare and Medicaid Services, State Medicaid Director Letter: *Affordable Care Act Section 4106 (Preventive Services)*, (U.S. Department of Health and Human Services, February 1, 2013). <http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-002.pdf> **TOPIC: 4**
- (G) Centers for Medicare and Medicaid Services, State Health Official Letter, *Conversion of Net Income Standards to MAGI Equivalent Income Standards*, (U.S. Department of Health and Human Services, December 28, 2012). <http://www.medicare.gov/Federal-Policy-Guidance/downloads/SHO12003.pdf> **TOPIC: 1**
- (H) Centers for Medicare and Medicaid Services, Affordable Care Act, Federal Policy Guidance: *Frequently Asked Questions on Exchanges, Market Reforms and Medicaid*, (U.S. Department of Health and Human Services December 10, 2012). <http://medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/Downloads/Governor-FAQs-12-10-12.pdf> **TOPICS: 1, 3**
- (I) Centers for Medicare and Medicaid Services, State Medicaid Director Letter: *Essential Health Benefits in the Medicaid Program*, (U.S. Department of Health and Human Services November 20, 2012). <http://www.medicare.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf> **TOPIC: 4**
- (J) Center for Medicaid and CHIP Services, *Medicaid and CHIP Affordable Care Act Implementation, Answers to Frequently Asked Questions, Eligibility and Enrollment Systems*, (U.S. Department of Health and Human Services, November 19, 2012). <http://www.medicare.gov/State-Resource-Center/Frequently-Asked-Questions/Downloads/Eligibility-and-Enrollment-Systems-FAQs.pdf> **TOPICS: 1, 3**
- (K) Center for Medicaid and CHIP Services, *Medicaid and CHIP Affordable Care Act Implementation, Answers to Frequently Asked Questions, Coordination Across Insurance Affordability Programs*, (U.S. Department of Health and Human Services, May 22, 2012). <http://www.medicare.gov/State-Resource-Center/Frequently-Asked-Questions/Downloads/Coordination-FAQs.pdf> **TOPIC: 3**
- (L) Centers for Medicare and Medicaid Services, *Frequently Asked Questions on Essential Health Benefits Bulletin*, (U.S. Department of Health and Human Services, February 17, 2012). <http://ccio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf> **TOPIC: 4**

- (M) U.S. Department of Health and Human Services and U.S. Department of Agriculture: *Tri-Agency Letter, Cost Allocation of Information Technology Systems*, (U.S. Department of Health and Human Services, January 23, 2012). <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-01-23-12.pdf> **TOPIC: 3**
- (N) Centers for Medicare and Medicaid Services, State Medicaid Director Letter: *Frequently Asked Questions on Maintenance of Effort Provisions*, (U.S. Department of Health and Human Services, February 25, 2011 and August 5, 2011). <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD11001.pdf>; <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD11-009.pdf> **TOPIC: 1**
- (O) Centers for Medicare and Medicaid Services, *Guidance for Exchange and Medicaid Information Technology Systems*, (U.S. Department of Health and Human Services, May 2011) Version 2.0. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/exchangemedicaiditguidance.pdf> **TOPIC: 2**
- (P) Centers for Medicare and Medicaid Services, *Enhanced Funding Requirements: Seven Conditions and Standards*, (U.S. Department of Health and Human Services, April 2011). <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/EFR-Seven-Conditions-and-Standards.pdf> **TOPIC: 3**

Other Federal Resources

- (Q) Centers for Medicare and Medicaid Services, *Section-by-Section Summary – Exchange/Medicaid/CHIP Eligibility, Notices and Appeals, and Alternative Benefit Plans Proposed Rule*, (U.S. Department of Health and Human Services, February 2013). <http://www.medicaid.gov/AffordableCareAct/Provisions/Downloads/Section-by-Section-Summary-%E2%80%93-Exchange-Medicaid-CHIP-Eligibility-Notices-and-Appeals-and-Alternative-Benefit-Plans-Proposed-Rule.pdf> **TOPICS: 1,2,3,4,5**
- (R) Centers for Medicare and Medicaid Services, *Affordable Care Act, Provisions: Medicaid*, (U.S. Department of Health and Human Services). <http://www.medicaid.gov/AffordableCareAct/Provisions/Provisions.html> **TOPICS: 1, 2, 3, 4**
- (S) Centers for Medicare and Medicaid Services, *Affordable Care Act, Provisions: Medicaid Benefits*, (U.S. Department of Health and Human Services). <http://www.medicaid.gov/AffordableCareAct/Provisions/Benefits.html> **TOPIC: 4**
- (T) Centers for Medicare and Medicaid Services, *Affordable Care Act, Provisions: Medicaid Eligibility*, (U.S. Department of Health and Human Services). <http://www.medicaid.gov/AffordableCareAct/Provisions/Eligibility.html> **TOPIC: 1**
- (U) Centers for Medicare and Medicaid Services, *Affordable Care Act, Provisions: Medicaid Information Technology Systems & Data*, (U.S. Department of Health and Human Services). <http://www.medicaid.gov/AffordableCareAct/Provisions/Information-Technology-Systems-and-Data.html> **TOPIC: 2**
- (V) Centers for Medicare and Medicaid Services, *Affordable Care Act, Provisions: Medicaid Program Integrity*, (U.S. Department of Health and Human Services). <http://www.medicaid.gov/AffordableCareAct/Provisions/Program-Integrity.html> **TOPIC: 2**
- (W) Centers for Medicare and Medicaid Services, *Medicaid and CHIP Eligibility Changes Under the Affordable Care Act Section-by-Section Summary*, (U.S. Department of Health and Human Services, March 23, 2012). <http://www.medicaid.gov/AffordableCareAct/Provisions/Downloads/Medicaid-Eligibility-and-Enrollment-Final-Rule-Section-by-Section-Summary.pdf> **TOPICS: 1, 2, 3, 5**
- (X) Office of Disease Prevention and Health Promotion, *Health literacy online: A guide to writing and designing easy-to-use health web sites*, (U.S. Department of Health and Human Services, 2010). <http://www.health.gov/healthliteracyonline/> **TOPIC: 5**
- (Y) Centers for Medicare and Medicaid Services, *Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Affordable Insurance Exchanges, Medicaid, and Children's Health Insurance Program Agencies*, (U.S. Department of Health and Human Services). <http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10440.html> **TOPIC: 1**

State Health Reform Assistance Network Resources

- (Z) Deborah Bachrach and Kinda Serafi, *Federal Requirements and State Flexibilities for Verifying Eligibility Criteria*, (Princeton, NJ: State Health Reform Assistance Network, May 2012). <http://www.statenetwork.org/resource/federal-requirements-and-state-flexibilities-for-verifying-eligibility-criteria/> **TOPIC: 1**
- (AA) Deborah Bachrach and Kinda Serafi, *“Reasonable Compatibility” Straw Models: Federal Requirements and State Options for Constructing a State’s Financial Reasonable Compatibility Standard*, (Princeton, NJ: State Health Reform Assistance Network, August, 2012). <http://www.statenetwork.org/resource/reasonable-compatibility-straw-models/> **TOPIC: 1**
- (BB) Katie Baudouin, Rachel Dolan and Christina Miller, *Designing Consumer Assistance Programs: Resources from the Field*, (Princeton, NJ: State Health Reform Assistance Network, February 2013). <http://www.statenetwork.org/resource/designing-consumer-assistance-programs-resources-from-the-field/> **TOPIC: 5**

- (CC) Center for Health Care Strategies, Inc., *Medicaid State Plan Amendment Requirements of the Affordable Care Act*, (Princeton, NJ: State Health Reform Assistance Network, August 2012). <http://www.statenetwork.org/resource/medicaid-state-plan-amendment-requirements-of-the-affordable-care-act/> **TOPIC: 1**
- (DD) Rachel Dolan, et al. *Building on a Solid Foundation: Leveraging Current Programs and Infrastructure in Navigator Program Development*, (Princeton, NJ: State Health Reform Assistance Network, August 2012). <http://www.statenetwork.org/resource/building-on-a-solid-foundation-leveraging-current-programs-and-infrastructure-in-navigator-program-development/> **TOPIC: 5**
- (EE) Melinda Dutton, *Appeals, Notices and Other E-Communications*, Meeting Presentation, Small Group Convening, (Princeton, NJ: State Health Reform Assistance Network, October 2012). <http://www.statenetwork.org/wp-content/uploads/2012/11/State-Network-Consumer-Assistance-SGC-Notices-and-Appeals.pdf> **TOPIC: 1**
- (FF) Carolyn Ingram, Veronica Guerra, Shannon McMahon and Alice Weiss, *Implications of Health Reform for American Indian and Alaska Native Populations*, (Princeton, NJ: State Health Reform Assistance Network, February 2012). <http://www.statenetwork.org/resource/implications-of-health-reform-for-american-indian-and-alaska-native-populations/> **TOPIC: 1**
- (GG) Mary Henderson, Abby Arons and Alice Weiss, *2014 Medicaid Eligibility Transition Toolkit for States*, (Princeton, NJ: State Health Reform Assistance Network, July 2012). <http://www.statenetwork.org/resource/2014-medicaid-eligibility-transition-toolkit-for-states/> **TOPIC: 1**
- (HH) Manatt Health Solutions, *Assessment of Current Coverage Programs and Future Options*, (Princeton, NJ: State Health Reform Assistance Network, October 2012). <http://www.statenetwork.org/resource/assessment-of-current-coverage-programs-and-future-options/> **TOPICS: 1, 3**
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