MACPAC

Medicaid Enrollment and Renewal Process

Medicaid and CHIP Payment and Access Commission
Kirstin Blom and Martha Heberlein

Program Efficiency

- Both states and the federal government have an interest in improving the efficiency of the program
- MACPAC is undertaking work across a range of issues in this area, including improving program integrity efforts

ACA Changes to Medicaid Enrollment and Renewal Process

- Intended to simplify and streamline process for all eligible individuals
- Expectation that states automate the application process, integrate with other programs, and retire outdated legacy systems
- Anticipated that more eligible individuals would enroll and retain coverage, errors would decrease, determinations would occur more quickly and cost less

Implementation of Changes

- Initial implementation period was rocky as states modernized legacy eligibility systems and transitioned to new income counting rules
- May be time to assess whether the processes are functioning properly:
  - Are they meeting the intended goals?
  - Could additional changes further improve program efficiency?

Current Policy

Comparison of Current and Pre-ACA Policy

- Income counting
- Asset tests
- Applications
- Face-to-face interviews
- Eligibility verification
- Redeterminations
- Eligibility processing and coordination
- State options

Income Counting

- Pre-ACA, was based on financial methodology of the cash assistance program most closely related to the individual's status; included deductions and disregards
- ACA aligned Medicaid income eligibility with eligibility for subsidized exchange coverage for many populations using modified adjusted gross income (MAGI)

MAGI and Non-MAGI Populations

MAGI population	Non-MAGI population
• Children under age 19 • Individuals with income above 138 percent FPL • New adult group • Parents and caretaker relatives • Pregnant women	• Foster care children • Individuals age 65 and older with incomes at or below 100 percent FPL • Individuals eligible for home and community-based services waiver • Individuals eligible for Medicare Savings Programs • Individuals eligible for Supplemental Security Income program • Institutionalized individuals • Medically needy • Working disabled

Asset Test

- States have had the option to eliminate the asset test for some populations and flexibility in counting assets
- Pre-ACA, most states had eliminated asset tests for pregnant women and children, while about half still required asset tests for parents
- ACA eliminated the asset test for all MAGI populations

Applications

- Prior to enactment of the ACA, many states used eligibility-group specific applications
- The ACA required individuals be able to use one application for Medicaid, CHIP, and subsidized coverage on the health insurance exchanges
  - States have the option of using a separate application or supplemental forms for non-MAGI populations

Face-to-Face Interviews

- Pre-ACA, states had option to require face-to-face interviews for new applicants and for people renewing their coverage, but very few did
- ACA ended the option for the MAGI population at both application and renewal
- States can still require the interview for the non-MAGI population at application, but not renewal

Eligibility Verification

- For those who are not automatically eligible for Medicaid, states are required to verify individuals' eligibility for coverage
- Historically, obligation to demonstrate eligibility was placed on applicant
- ACA shifted much of this burden to states, which must rely on electronic data sources to the greatest extent possible

Redeterminations

- Redeterminations account for changes in eligibility criteria and may catch errors in eligibility determinations
- Following the ACA:
  - States must renew eligibility no more than once every 12 months for MAGI populations
  - States can conduct regular renewals of eligibility more frequently for non-MAGI populations
  - States must conduct ex parte renewals
  - States must use pre-populated renewal form for MAGI populations

State Options

- States have a number of options available to streamline enrollment and renewal:
  - Presumptive eligibility
  - Express lane eligibility
  - 12-month continuous eligibility

Eligibility Processing and Coordination

- States must meet timeliness and performance standards
  - Must complete eligibility determinations within 90 days for those applying on the basis of disability and within 45 days for all others
- States must provide three months of retroactive coverage if an individual received covered services and would have been eligible at the time the service was provided

Different Procedures: MAGI and Non-MAGI

Procedure	MAGI	Non-MAGI
Income counting	Federal tax rules for counting income and household size	Financial methodologies and requirements of the cash assistance program most closely related to the individual's status
Asset test	No asset test	Asset test
Single, streamlined application	Required	States may use with supplemental forms or a separate non-MAGI application
Face-to-face interviews	States cannot require	States can require at application
Redeterminations	Once every 12 months; no more frequently	At least once every 12 months
Prepopulated forms	If state cannot confirm ongoing eligibility using available data, must send a prepopulated renewal form to the beneficiary	If state cannot confirm ongoing eligibility using available data, may send a prepopulated renewal form to the beneficiary

Potential Areas for Future Work

Reducing the Burden on States and Beneficiaries

- The ACA set out to reduce the administrative burden on Medicaid programs and on individuals
- Possible areas to examine:
  - How is no wrong door working?
  - How are administrative renewals working?
  - Are there outstanding concerns regarding MAGI determinations?

Churn

- Shifts in coverage may not all be detrimental, but frequent changes may negatively affect health and increase administrative burden and costs
- New sources of coverage created potential new sources of churn
- Twelve-month renewal periods and the reliance on electronic data might decrease administrative burdens and lessen churn

Understanding Churn

- MACPAC funded two studies to examine the extent of churn, characteristics of churners, and the reasons for churn using national survey data from:
  - Preliminary restricted-use research files from the 2014 and 2015 Current Population Survey Annual Social and Economic Supplement (CPS-ASEC) (2013 and 2014 data)
  - Wave 1 of 2014 Survey of Income and Program Participation (SIPP) (2013 data)
- Most prior research used income eligibility as a proxy for Medicaid enrollment or administrative data limited to Medicaid enrollees
- These new studies used a more direct measure (reported coverage changes) to assess the validity of prior estimates

Similar Results Using CPS and SIPP

- In 2013, churn rates among adults ranged from 5 percent (SIPP) to 8 percent (preliminary CPS-ASEC)
- Magnitude of churn is lower than prior studies, but other findings are consistent
- Most individuals who became disenrolled from Medicaid churned to uninsured
- Most individuals that churned to coverage churned to employer-sponsored coverage
- Very few individuals churned back to Medicaid

Barriers for Non-MAGI Populations

- Complicated enrollment and renewal procedures have been cited as reasons for low participation among non-MAGI populations
- Are there simplification measures that can be extended to the non-MAGI population?
  - Eliminate state option for face-to-face interview
  - Requiring states use a pre-populated renewal form

Other Changes

- Congress, CMS, and states have revisited some of the changes made in the ACA and other Medicaid procedures
- Commissioners may want to weigh in on proposals, such as:
  - Reintroduction of asset tests
  - Increased frequency of renewals
  - Elimination of retroactive eligibility

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