

Arkansas Medicaid Eligibility Redetermination Process



FACT SHEET

• AUGUST 2015

Arkansas's executive and legislative policymakers have faced recent scrutiny about the eligibility redetermination process for approximately 600,000 Arkansans with healthcare coverage through Medicaid. The redetermination process—that requires new information system functionality to accommodate a new method of assessing family income—has been delayed by the Arkansas Department of Human Services pursuant to a waiver granted by the federal government to deviate from the standard timelines for redetermination. Approximately two-thirds of states have been granted such waivers to address challenges related to information system development and connectivity to enable redeterminations. Roughly 220,000 individuals in private plans provided by the Health Care Independence Program (HCIP) have been a part of the state's bulk eligibility redetermination process this summer.^a The process has been marked by confusion among enrollees, advocates, and policymakers. This fact sheet describes the state's process for eligibility redetermination and seeks to provide clarity about important concepts that guide the process.

ELIGIBILITY REDETERMINATION OVERVIEW

Like other states, Arkansas has struggled with its transition to a modernized eligibility and enrollment information system along with new eligibility processes outlined by the Patient Protection and Affordable Care Act (ACA) regulations.^{1,2} The key challenge has been building and integrating functionalities to conduct eligibility redeterminations under the new modified adjusted gross income (MAGI) method (see description of MAGI in inset).³ The ACA introduced the MAGI method in an attempt to align income-eligibility rules across insurance affordability programs. States must implement eligibility system changes to accommodate MAGI methods regardless of whether or not they opted to expand Medicaid under the ACA.

Modified Adjusted Gross Income¹

Modified adjusted gross income (MAGI) is a method of calculating income and household composition to determine eligibility for insurance affordability programs, including Medicaid. It is based on Internal Revenue Service rules for determining adjusted gross income with some modification. Rather than accounting for itemized deductions from gross income, the MAGI method has a standard 5% income disregard and requires no asset test. This is why the statutory Medicaid expansion income limit of 133% of the Federal Poverty Limit (FPL) is effectively 138% FPL.

Unless a state has received information about a change in a beneficiary's circumstances in the interim, federal regulations require redeterminations of the financial eligibility of MAGI populations "...once every 12 months, and no more frequently than once every 12 months."⁴ In June 2014, Arkansas sought and ultimately received a federal waiver extending the timeframe under which the state was required to conduct eligibility redeterminations for MAGI populations, including those in the HCIP.^b Approximately two-thirds of states have been granted such waivers.⁵ The Arkansas waiver indicates that the state has until September 30, 2015, to conduct eligibility redeterminations originally scheduled during 2014. The state began eligibility redeterminations in May 2015 and is well into the process.

^a Another approximately 25,000 individuals have been determined to have exceptional healthcare needs and are in the traditional Medicaid program according to an enrollment report by the Arkansas Department of Human Services run on March 19, 2015.

^b Information in addition to income is required for some individuals who were categorically eligible for Medicaid prior to 2014, such as those who were aged, blind or disabled, or those who required long-term care services. Therefore, the MAGI method is not used for those categories.

ELIGIBILITY REDETERMINATION PROCESS

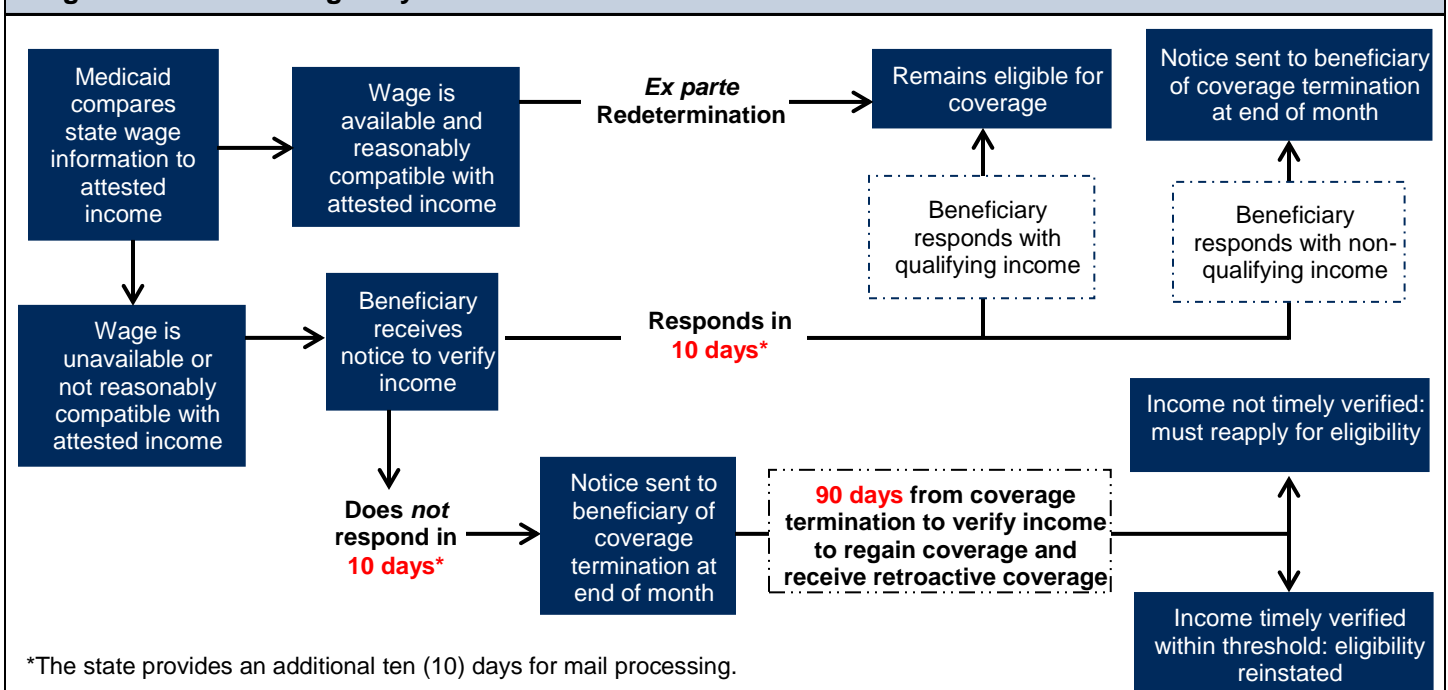
Redeterminations begin with the most recent quarter year's wage information available to the state through the Arkansas Department of Workforce Services. If available, a family's quarterly wages are compared to family income at the time of the previous eligibility determination. If the wages are "reasonably compatible" (see "Reasonable Compatibility" text box) with previously provided information, then the state renews the beneficiary's eligibility *ex parte*—without action by the beneficiary. If wage information is unavailable or is not "reasonably compatible" with previously provided information, beneficiaries must verify financial eligibility to continue coverage. Financial eligibility income threshold requirements for individuals covered through the HCIP are 0-138 percent of the federal poverty level (FPL) for childless adults and 17-138 percent FPL for parent/caretaker adults. Figure 1 below depicts the eligibility redetermination process, including timeframes for beneficiary verification of financial eligibility.

Reasonable Compatibility⁶

Data accessed by the state upon redetermination is "reasonably compatible" to attested income if "both are either above, at, or below" the applicable income threshold. This generally means that the discrepancy does not impact eligibility. Arkansas's federally-required verification plan allows a discrepancy between attested income and data accessed by the state, so long as the data accessed does not show a 10% change in the family's 100% of FPL income and the crossing of an eligibility threshold. For example, if a beneficiary reported an income of 50% of FPL and data show an income of 30% of FPL, the data are reasonably compatible and the beneficiary remains eligible. If a beneficiary reports an income at 50% of FPL and data show an income of 150%, the beneficiary must verify that the difference is within 10% of the family's 100% of FPL income.

According to federal regulations, Medicaid beneficiaries for whom the state cannot verify eligibility must respond within 30 days^c to a "pre-populated renewal form" with sufficient information to determine eligibility before termination of coverage.⁷ Arkansas, however, requires a beneficiary response within 10 days of a notice from the state indicating insufficient information is available to determine financial eligibility. Arkansas officials have indicated that the state is not engaging in a full eligibility redetermination as referenced by the federal regulations, including sending pre-populated renewal forms. Instead, the state is verifying income and applying a 10-day response timeframe pursuant to a state-based Medicaid policy.⁸ Beneficiaries who do not respond with sufficient information in a timely manner are determined to be no longer eligible for coverage.

Figure 1: Medicaid Eligibility Redetermination Process



^c The regulation sets a 30-day minimum, which may be extended by states.

Importantly, due to Arkansas's use of premium assistance to purchase private coverage for HCIP beneficiaries, the eligibility termination date is not the same as the coverage termination date. A beneficiary will have at least 30 days from the notice to verify income until coverage ceases at the end of the month, and some beneficiaries may have up to 50 days before coverage ceases. As shown in Figure 1, all beneficiaries have up to 90 days from coverage termination to verify financial eligibility. If a beneficiary provides the state with sufficient information during the 90 days from the coverage termination, the beneficiary will have access to services retroactively to the coverage termination date. The beneficiary will be reinstated into the private plan from which he or she was previously receiving services in the following months.^d If a beneficiary does not respond during the 90-day timeframe with sufficient information, he or she will be considered a new applicant, requiring completion of the entire eligibility and enrollment process again. Beneficiaries who have been terminated from the program and are above the 138 percent of FPL family income threshold but below 400 percent of the FPL will be eligible for tax credits through the health insurance marketplace and qualify for a special enrollment period.

CONCLUSION

Eligibility redeterminations required by federal rules and implemented by state Medicaid programs have a long history of generating gaps in coverage and care through disenrollment. These disenrollments may be appropriate, for example, when beneficiaries are found to have family income that exceeds eligibility limits. Alternatively, disenrollments may be erroneous—or at a minimum disruptive—when there is a lack of information available through data sources or supplied by the beneficiary. These disenrollments may result in interrupted therapeutic treatments and avoidable admissions for beneficiaries who are, in fact, financially eligible. A balanced approach to redeterminations will mitigate such adverse consequences to beneficiaries while ensuring fiscal integrity of the Medicaid program inclusive of the Health Care Independence Program (HCIP). The HCIP's use of private insurers through the marketplace adds a complexity through pre-payment of coverage month-to-month, increasing the need for accurate and timely determinations of eligibility. The reliance of the state on private insurers for plan administration also brings an additional communication relationship with beneficiaries other than the state Medicaid agency, increasing the need and opportunity for coordinated messaging.

REFERENCES

- ¹ "Featured Editorial: Ohio's Medicaid Mess." Toledo, OH: *The Blade*, March 13, 2015, <http://www.toledoblade.com/Featured-Editorial-Home/2015/03/13/Ohio-s-Medicaid-mess.html>.
- ² "Thousands ruled ineligible for Mass. Medicaid." *The Boston Herald and Herald Media*, July 21, 2015, http://www.bostonherald.com/news_opinion/local_coverage/2015/07/thousands_ruled_ineligible_for_mass_medicaid.
- ³ 42 CFR 435.603
- ⁴ 42 CFR 435.916(a)(1)
- ⁵ "Status of State Action on the Medicaid Expansion Decision." *The Henry J. Kaiser Family Foundation*, July 20, 2015, <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>.
- ⁶ 42 CFR 435.952
- ⁷ 42 CFR 435.916(a)(3)
- ⁸ "Verification must first occur through electronic sources. If unable to obtain verification through electronic sources, verification will be required from the client and a 10 day notice will be sent requesting the required verification. Additional time to provide the verification will be allowed if requested. Information that is not necessary to determine eligibility will not be requested." *Medical Services Policy Manual G-114*, Arkansas Department of Human Services, Division of Medical Services, January 1, 2014.

^d Similar to an original eligibility application, if a reinstatement occurs on or before the 15th of a month, the beneficiary will have private plan coverage in the next month. If a reinstatement occurs after the 15th of the month, the beneficiary will have private plan coverage in the month following the next month. Recent arrangements between the state and two of the insurers offering coverage to HCIP beneficiaries may result in more immediate reinstatement of coverage.