



## **Overlapping Coverage: Medicaid & The Marketplace**

*Gian Johnson, CMS*

*Sarah Barber, CMS*

*Leslie Wagstaffe, CMS*

Sarah Barber: Thank you, Stacey.

Good morning, welcome to the Overlapping Coverage: Medicaid & the Marketplace. I'm so glad you could join us today. My name is Sarah Barber, and I work in the Consumer Support Group within CCIIO. I have a wonderful group of colleagues who are joining me today to lead this discussion about issues that arise when Marketplace and Medicaid intersect.

I would like to ask that if you have questions today during our panel discussion, please write them down on index cards. You should have a few in your participant folders, and I believe there should be a few in the back. If you need index cards, please let us know; and the CMS staff will get you one. I'd like you to write your questions down, and I have CMS staff in the auditorium who will be collecting those index cards; and then we'll be giving them to some of our subject matter experts. We will try and address as many of these questions as we can after the panel discussion. So please write your questions down on index cards; our staff will collect them and bring them over to subject matter experts so we can get to them after the discussion.

Before we begin our discussion today, I know we have a lot of very experienced assisters; but I know there are some that are a little newer. So I thought it might be helpful to go over some basic Medicaid facts. I'd like you all to get your phones out again. We're going to do a few polling

## **Overlapping Coverage: Medicaid & The Marketplace**

*Sarah Barber, CMS*

*Jessica Brill Ortiz, CMS*

*Jessica Stephens, CMS*

*Kelly Brown, CMS*

*Sarah Boehm, CMS*

questions, so use your phone or your laptop. Hopefully you were all here for the orientation this morning, and I will bring up our first Medicaid question.

Okay, so this is a True or False question: Medicaid and CHIP eligibility requirements are the same for every state; true or false? Input your answers for me.

[Pause for responses]

Too easy? I think it takes a few minutes.

[Pause]

Well, while we're waiting for that to come up, why we don't just do the old-fashioned show of hands. Oh, wait...we're getting there. Sorry, I got a little impatient. That's correct; that is false. You know that if you know one Medicaid program, you know *that* Medicaid program. So eligibility requirements definitely vary from state to state.

Next slide, please, for our next Medicaid question.

That wasn't what I was hoping for. Here we go...another True or False question: Does Medicaid eligibility depend solely on income? I'll give it just a few minutes to tally up the votes.

[Pause for responses]

Ah, you guys know your Medicaid facts. That is false. Medicaid eligibility depends on several factors, not just income but also the number of folks in the household, citizenship, immigration status, as well as the particular state the folks live in and whether they have special conditions, such as pregnancy.

## **Overlapping Coverage: Medicaid & The Marketplace**

*Sarah Barber, CMS*

*Jessica Brill Ortiz, CMS*

*Jessica Stephens, CMS*

*Kelly Brown, CMS*

*Sarah Boehm, CMS*

All right, one more question and then we'll get started on our discussion.

Okay, True or False: Medicaid covers more than 50 million low-income individuals, families, and children.

[Pause for responses]

Actually, that is true; Medicaid covers approximately 74 million low-income families, individuals, and children.

All right, so why don't we get our discussion rolling. I'm going to join our panel over here.

Can you all hear me...is this working?

Yes (response from multiple audience members).

All right, before we get started on the questions, I'd like to take a moment to introduce our panel here. To my immediate right is Jessica Brill Ortiz. She is in the Eligibility Division in CCIO. Next to her is Jessica Stephens. Jessica works in the Center for Medicaid and CHIP Services in their Eligibility Division. Next to her is Kelly Brown, who also works in Eligibility Division for CCIO. Please welcome them to the stage.

[Applause]

They are our subject matter experts on Medicaid in the marketplace. I have one other colleague...hence, the empty chair...Sarah Boehm. She will join us a little later after she's had a chance to look at some of your questions, and she will come up and she will lead that discussion.

I'm going to start with our first question. We wanted to try and touch on a couple of different topics that we know are confusing for consumers and sometimes for assisters. The first topic we wanted to work on was the Medicaid Eligibility Determination Process. This question is going to Jessica Brill Ortiz.

## **Overlapping Coverage: Medicaid & The Marketplace**

*Sarah Barber, CMS*

*Jessica Brill Ortiz, CMS*

*Jessica Stephens, CMS*

*Kelly Brown, CMS*

*Sarah Boehm, CMS*

Jessica, could you please provide us an overview of the Medicaid and CHIP Eligibility Determination Process and how that works when someone comes and applies at the Marketplace.

Jessica Brill Ortiz: Sure, so I think the first thing to set out is that FFM is one of two places that consumers in the 39 FFM states can apply for coverage. So if consumers apply for coverage with financial assistance at the Marketplace, then their eligibility for Medicaid and CHIP will be considered; and that will be using Federal as well as State-specific rules.

The specifics of what happens in that process are different depending on if it's an assessment state or a determination state. An assessment state is what most FFM states are, and it means that the FFM collects most of the information that's needed to figure out whether someone is likely eligible for MAGI-based Medicaid or CHIP. That may apply to most non-disabled children, pregnant women, and adults. So if a consumer appears to be potentially eligible for Medicaid or CHIP, then the FFM sends their application information to the state Medicaid or CHIP agency, and that's sent via a secure transaction that we call an account transfer. From there, the State collects and verifies information as necessary to make a final determination of that consumer's eligibility for Medicaid or CHIP.

For folks who aren't familiar, I mentioned MAGI; that stands for modified adjusted gross income. Those programs are mostly based on income and other eligibility criteria. So that's a quick overview of assessment states.

The other type of states, for those who aren't as aware, are determination states; for instance, Alaska is one. In those states, the FFM collects all of the information that it needs to make a determination of a consumer's eligibility for Medicaid or CHIP. If, after that the FFM decides that a consumer is eligible, then it uses that account transfer process to send the consumer's information to the State to be enrolled in that coverage.

## **Overlapping Coverage: Medicaid & The Marketplace**

*Sarah Barber, CMS*

*Jessica Brill Ortiz, CMS*

*Jessica Stephens, CMS*

*Kelly Brown, CMS*

*Sarah Boehm, CMS*

A couple of quick things...the FFM doesn't apply all state-specific rules, so states can apply their own state-specific rules. And it's also important to note that in both assessment and determination states, states are responsible for resolving inconsistencies. So they may reach out to consumers to get additional documentation if there's information that the State can't verify. So after an eligibility assessment or determination is made at the FFM, the FFM provides the consumer with an eligibility determination notice. That contains the information that tells them whether they were assessed or determined eligible, for instance, for Medicaid or CHIP. It also includes next steps that the consumer may need to take.

So if you're not sure whether or not your state is an assessment state or a determination state, we have resources to help with that. Also, as an aside, I just want to mention that for other types of Medicaid...so non-MAGI, and that includes determinations that are based on disability...the FFM screens individuals as potentially eligible; but the states are the ones that make those final determinations.

Sarah Barber: Okay, thank you. I want to follow up on something you just mentioned about the account transfers. I can remember in previous years that the account transfer process was challenging. I'd like to know...how is the account transfer process working now for the Marketplace? There's a lot of information that goes back and forth between the Marketplace and the states as these determinations about eligibility are being made.

Jessica Brill Ortiz: Absolutely, and we're pleased to report that it is working very well overall. Over the past several years, we have improved a variety of different aspects related to account transfers. We've improved things like the frequency of the transfers, as well as the data that's included in those transfers and the success rate of the actual transfers themselves. As of April of this year, all of the 39 FFM states are able to receive and process the account transfers that we send them; and those account transfers are

## **Overlapping Coverage: Medicaid & The Marketplace**

*Sarah Barber, CMS*

*Jessica Brill Ortiz, CMS*

*Jessica Stephens, CMS*

*Kelly Brown, CMS*

*Sarah Boehm, CMS*

both daily and they're automated. Almost all of the account transfers that we send to states are actually successfully received by them.

Something else on that note that I think is important to mention, and hopefully helpful to you all, is that over the past year or so, we have introduced several consumer-facing improvements that relate to eligibility for Medicaid and CHIP. One that I wanted to mention is that when consumers submit an application for coverage at the FFM, when they get to their eligibility results page, on that screen there's a quick snapshot of their eligibility results; and that's in addition to a link to their full notice. That quick snapshot allows them to have at a quick glance the sort of high-level results, rather than having to immediately go right into their eligibility determination notice...which they absolutely should do, but this is an improvement, we hope, for folks.

Also, to help reduce consumer confusion and also to reduce the amount of processing time for the application, we've worked to strengthen our communication to consumers who might come back to the FFM, for instance, to report a life change and not realize that those changes should actually first be reported to the State Medicaid or CHIP agency.

So to that end, what we've done is update the content on the application screen. So when a consumer, or you helping a consumer, gets to the page where they would select that they want to update their application, the content now actually redirects consumers who are already in enrolled in Medicaid or CHIP to first report that change to the state agency. It also tells them that if, through that process, the state determines that they're no longer eligible for Medicaid or CHIP based on that change that they're reporting, then in that case they absolutely should come back to the FFM, provide the update, and move forward from there.

Jessica Stephens: I'm going to just add to that that the account transfer process is a two-way process and that states have also made a lot of significant improvements

## **Overlapping Coverage: Medicaid & The Marketplace**

*Sarah Barber, CMS*

*Jessica Brill Ortiz, CMS*

*Jessica Stephens, CMS*

*Kelly Brown, CMS*

*Sarah Boehm, CMS*

over the past few years to improve the consumer experience when processing account transfers. So in the same way that account transfers are sent more regularly, states have made improvements both in the communication that they also provide because when a state receives an account transfer, they also provide a notice to the individual that may instruct them about more information that may be needed. They've improved communication on that front...and not just for account transfers, but accounts in general. We are seeing much fewer problems than existed in earlier years in the timeliness that states are able to process accounts.

So if a consumer applies at the Marketplace and their account is sent to the State, in the majority of circumstances, states have made significant improvements in being able to process that information much more quickly and allow much faster access to coverage. Although as you are probably much more aware of, we know that there are sometimes delays in the account processing in states. To that end, we still encourage assisters and consumers to the extent that you are pretty certain that an individual might be Medicaid- or CHIP-eligible, it may be helpful to advise consumers that they should apply directly at the state level as opposed to applying at the Marketplace and having their information redirected, though we still strongly recommend not to have individuals apply in both places as once as many people did in the early years due to delays that they might have experienced.

Sarah Barber: Okay, great...sounds like we've made some real progress in getting information more smoothly transferred over both ways, both from the Marketplace to the State and from the State to the Marketplace, which I hope is making your lives a little bit easier as you go through this process.

I have another question, and I think this one is probably best for Kelly. I frequently get questions from assisters who talk about how they help consumers year after year; and each time they apply -- the consumer

## **Overlapping Coverage: Medicaid & The Marketplace**

*Sarah Barber, CMS*

*Jessica Brill Ortiz, CMS*

*Jessica Stephens, CMS*

*Kelly Brown, CMS*

*Sarah Boehm, CMS*

comes in and applies on the Marketplace – they are assessed again for their Medicaid eligibility. I sometimes get the feedback that, well, this consumer's income hasn't changed; everything is the same. Why is it that they have to go through this process each year because last year they were not found eligible for Medicaid? They just want a role in the Marketplace; why do they have to have this reassessed this year? Can you talk a little bit about that process?

Kelly Brown:

Sure, so each time a consumer applies at the Marketplace for coverage with financial assistance, or if they update their Marketplace application and they're still considered an applicant and also indicate that they're seeking financial assistance to help pay for their coverage, the Marketplace will evaluate or reevaluate their eligibility for Medicaid or CHIP coverage unless the consumer tells the FFM that they've been denied Medicaid or CHIP coverage within the past 90 days. So this FFM recheck occurs because factors affecting Medicaid or CHIP eligibility, things like income or household size, may change; or there could be other factors on the State side that could impact eligibility, such as the State expanding its Medicaid program or maybe there was a change in a Medicaid rule.

As you likely know, a consumer who is eligible for, or enrolled in, Medicaid or CHIP is not eligible to receive APTC -- so against payments of the premium tax credit -- or income-based cost-sharing reductions, or what I'll refer to as CSRs, to help them pay for Marketplace coverage. So this Medicaid/CHIP check also helps ensure that consumers have accurate information about the health coverage options that are available to them. It also prevents them from being enrolled in coverage that they're not eligible for and makes sure that they're accessing the most financial assistance that's available to them.

So if a consumer is found to be eligible for Medicaid or CHIP by the FFM and they are then sent to the State but the State denies their Medicaid or



## **Overlapping Coverage: Medicaid & The Marketplace**

*Sarah Barber, CMS*

*Jessica Brill Ortiz, CMS*

*Jessica Stephens, CMS*

*Kelly Brown, CMS*

*Sarah Boehm, CMS*

CHIP coverage, they can return to the FFM and attest, as applicable, to the question on the application that says that they were denied by the State within the past 90 days. So at that point, the Marketplace would evaluate them for Marketplace coverage with APTC or CSRs.

However, if it's been more than 90 days since the consumer was denied Medicaid or CHIP eligibility, they should be reconsidered for Medicaid or CHIP since factors like I just mentioned—like household size change or income change – may have changed; and it may make them potentially newly-eligible for Medicaid or CHIP. However, if they're not eligible for Medicaid or CHIP, again, the FFM will consider their eligibility for Marketplace coverage with financial assistance.

Sarah Barber: Okay, great, thanks, Kelly. That helps me understand a little bit why we continuously do the process. It's actually in the consumer's best interest to make sure circumstances haven't changed that would otherwise make them eligible for Medicaid coverage if they weren't before, and to make sure they don't get APTCs that they then might have to pay back...so that makes a lot of sense.

Okay, just trying to make sure if anybody wanted to add anything there...no?

Okay, I want to switch to a slightly different topic. We've just been talking about eligibility determination for Medicaid, but I'd also like to touch a little bit on another topic that I frequently get questions about; that is, the Medicaid/CHIP Periodic Data Matching process. This is also for Kelly, I believe.

Can you just give us sort of a high-level overview of the Periodic Data Matching process for Medicaid?

Kelly Brown: Sure, Medicaid/CHIP Period Data Matching, or what I'll be referring to as Medicaid/CHIP PDM , is the process the FFM uses to identify, notify, and

## **Overlapping Coverage: Medicaid & The Marketplace**

*Sarah Barber, CMS*

*Jessica Brill Ortiz, CMS*

*Jessica Stephens, CMS*

*Kelly Brown, CMS*

*Sarah Boehm, CMS*

reduce the number of consumers who are enrolled in both Marketplace coverage with APTC or CSRs and Medicaid or CHIP that counts as qualifying health coverage or what some of you may know as MEC, minimum essential coverage.

For consumers who are found to be dually enrolled, the FFM sends an initial warning notice to the household contact for the application and requests that they take immediate action to end Marketplace coverage with APTC or CSRs, or to update their application to tell the Marketplace that they're not enrolled in Medicaid or CHIP by the date that's listed in the notice. This date in the notice is generally 30 days from the date of the notice. Consumers who don't respond to the initial warning notice by the date listed in the notice will receive a final notice, which informs them that the Marketplace will be ending any APTC or CSRs being paid on their behalf for Marketplace coverage and that their Marketplace coverage for the impacted consumer will continue at full cost.

It notes that APTC and CSRs will also be redetermined for anyone else who is on the Marketplace plan who is still eligible for APTC or CSRs, and it will provide them the date that the changes will become effective for the household. The household contact for these consumers will also be sent an updated eligibility determination notice.

Sarah Barber: Okay, great, that's really helpful. So from the assister perspective, they have a consumer that receives one of these Periodic Data Matching notices. What can the assister do to help the consumer? How do they guide the consumer through that?

Kelly Brown: Sure, so consumers who receive the Medicaid/CHIP PDM notices may contact you for help understanding the notices, for help knowing how to respond to the notices: if they don't think they're enrolled in Medicaid or CHIP; if they want more information about Medicaid or CHIP; whether their benefits count as qualifying coverage; or if they aren't sure if they've

## Overlapping Coverage: Medicaid & The Marketplace

*Sarah Barber, CMS*

*Jessica Brill Ortiz, CMS*

*Jessica Stephens, CMS*

*Kelly Brown, CMS*

*Sarah Boehm, CMS*

been determined eligible for, or if they're enrolled in, Medicaid or CHIP. They may also want to know if they're enrolled in Medicaid or CHIP that counts as qualifying health coverage because they believe that they're actually eligible to remain enrolled in Marketplace coverage with APTC or CSRs.

So for any questions related to Medicaid or CHIP enrollment status, they really should contact the Medicaid or CHIP agency at their state. Then, once they've determined their eligibility status from the state's side, then the consumers can take action at the Marketplace based on their Medicaid or CHIP eligibility or enrollment status. However, if they disagree with the Marketplace's decision to end their APTC or CSRs, there is an appeals process. Information about how they can appeal the decision is located in the final notice.

Sarah Barber: Okay, so my take away from that was that if a consumer isn't certain about whether or not they're actually enrolled in Medicaid, they need to go to the State first and determine that; and *then* they'll go to the Marketplace, depending on what that answer is...whether they're actually enrolled or not.

Kelly Brown: Right, so if they go to the State and they find that they are actually enrolled in Medicaid or CHIP coverage, then they would come back to the Marketplace and update their application to tell the Marketplace that they are enrolled in that coverage.

Sarah Barber: And they would want to end their APTC or CSR if they're dually enrolled, correct?

Kelly Brown: Correct.

Sarah Brown: Okay, let me follow that up with a question that I get fairly frequently, where a consumer may have come in and talked to an assister and was not aware or just didn't understand that they couldn't have both Medicaid

## Overlapping Coverage: Medicaid & The Marketplace

*Sarah Barber, CMS*

*Jessica Brill Ortiz, CMS*

*Jessica Stephens, CMS*

*Kelly Brown, CMS*

*Sarah Boehm, CMS*

coverage *and* be enrolled in the Marketplace with APTC/CSRs. I think that's a fairly common scenario. One of the questions I've gotten several times is if that happens and I have a consumer that comes in and is dually enrolled, are they going to have to pay back the APTC/CSRs that they received while they were dually enrolled both in the Medicaid and Marketplace?

Sarah Barber: As you know, again, consumers who are enrolled in, or eligible for, Medicaid or CHIP are not eligible to receive APTC or CSRs for help paying for a Marketplace plan premium and covered services. So as I mentioned before, through the Medicaid/CHIP PDM process, if we find that the consumer is dually enrolled, we'll notify them through an initial warning notice asking them to take action within a set period of time. If they don't respond, then we will send a final notice letting them know that we're ending that APTC or CSRs.

But at this time, according to recent IRS guidance, if the Marketplace makes a determination or an assessment that an individual is ineligible for Medicaid or CHIP and eligible for APTC when the individual enrolls in Marketplace coverage, the individual is treated as not eligible for Medicaid or CHIP for the purposes of receiving the premium tax credit when they're enrolled in Marketplace coverage for that year. So a consumer who is dually enrolled in Medicaid or CHIP coverage, that counts as qualifying coverage; and Marketplace coverage with APTC or CSRs would not be liable to pay back APTC or CSRs for the months in which they are dually enrolled.

However, we do want to note that a consumer who is eligible for, or enrolls in, Medicaid coverage that *doesn't* count as qualifying coverage may be eligible for APTC or CSRs. So if they have non-MEC Medicaid, then they could potentially get APTC or CSRs. So basically, the bottom line is that if they're dually enrolled in Marketplace coverage with APTC or

## Overlapping Coverage: Medicaid & The Marketplace

*Sarah Barber, CMS*

*Jessica Brill Ortiz, CMS*

*Jessica Stephens, CMS*

*Kelly Brown, CMS*

*Sarah Boehm, CMS*

CSRs *and* Medicaid or CHIP that counts as qualifying coverage based on IRS guidance, there should be no tax liability.

Sarah Barber: Great, that's wonderful...now I *finally* have the answer to that question I don't know how many of you have asked. But you heard it here first; and I will remember that, I promise.

I want to move on to another topic that I'd like to touch on as far as Medicaid goes. I want to talk for a minute about the Special Enrollment Periods and also the Special Enrollment Verification process which just recently started and how that impacts consumers that are eligible for Medicaid.

I'm back to Jessica now.

Jessica, as you know, there have been some changes to the Special Enrollment process. Can you please talk a little bit about how those changes may affect consumers that enrolled in Medicaid or found eligible?

Jessica Brill Ortiz: Sure, I'm happy to give an overview of that; but I also want to flag that if this is an area they're interested in, there are two sessions that are happening here this afternoon. One is on Special Enrollment Periods; one is on Special Enrollment Period Verification processes. So I would encourage you to attend one or both of those sessions for more details, but I can certainly give a high-level overview. I'll be referring to Special Enrollment Periods as SEPs, just to shorten things up a little bit.

In terms of what's happening, starting this summer consumers may have to verify their eligibility for certain SEPs, including SEPs for individuals who recently lost or were denied minimum essential coverage, including Medicaid or CHIP. Currently, when consumers attest to a loss of qualifying coverage, they need to submit documents to confirm their eligibility for an SEP on the basis of that loss of coverage. This would

## **Overlapping Coverage: Medicaid & The Marketplace**

*Sarah Barber, CMS*

*Jessica Brill Ortiz, CMS*

*Jessica Stephens, CMS*

*Kelly Brown, CMS*

*Sarah Boehm, CMS*

include consumers who were enrolled in Medicaid or CHIP, lost it, and are now eligible for Marketplace coverage. So that's what's happening right now.

Starting a little bit later this summer, in August, the Marketplace will start trying to automatically verify consumers' eligibility, both for the loss of qualifying coverage SEP and for the Medicaid/CHIP denial SEP. The way that the Marketplace will try to do that will be using a variety of information, including that which comes from states to the FFM via the account transfer when a consumer is denied Medicaid or CHIP eligibility by the State, as well as other information that the FFM has in its data sources.

So we expect that a good number of consumers will be able to be automatically verified by the Marketplace. What that means is that they will not have to provide documentation on their own to prove their eligibility for either of those SEPs that I mentioned. However, if the Marketplace cannot automatically verify those consumers, then it will request that they send in documentation...again, proving their eligibility for the SEP that they're trying to access. They will have 30 days to send in those documents to access the SEP.

So in terms of those documents that they can provide – again, they're trying to prove that they either lost Medicaid or CHIP or were denied it within the past 60 days. Examples of those documents that they could send in could be a denial or a termination letter from the State Medicaid or CHIP agency. It could also be a screenshot of their eligibility results if they were using the State's online application. But we do have a full list of acceptable documents, and that's online at [www.Marketplace.CMS.gov](http://www.Marketplace.CMS.gov).

Sarah Barber: Okay, great, thank you very much. If you didn't catch her shameless plug for this afternoon's session, I'm going to do it one more time. We very much want folks to come because we know that this is a complicated

## **Overlapping Coverage: Medicaid & The Marketplace**

*Sarah Barber, CMS*

*Jessica Brill Ortiz, CMS*

*Jessica Stephens, CMS*

*Kelly Brown, CMS*

*Sarah Boehm, CMS*

process, and we know that you all are going to be on the frontline helping consumers with the new SEP verification process. Again, it will be in the Grand Auditorium this afternoon; and we really hope everyone will come. We have a lot of great material, and we have a lot of great subject matter experts who are going to spend some time going over that.

Jessica Stephens: I might add one piece to that as it relates to Medicaid and CHIP, which may be relevant for this discussion...may not go into as much in the afternoon session...which is that for those who are seeking a special enrollment period based on a loss of Medicaid or CHIP, while many of them are likely to be verified through the account transfer process and don't have to provide documentation, for individuals who *do* have to provide documentation, it will represent a bit of a change from the experience that many individuals have today because I think we have historically said that for most consumers who are seeking a special enrollment period after a denial or loss of Medicaid or CHIP don't necessarily need the notice. They go in, and it's essentially an attestation process where they basically claim that they either lost or were denied Medicaid or CHIP.

Now, even though the notice is not the only piece of documentation that could be used to verify a special enrollment period if you're unable to be verified electronically, it's probably the one that consumers are most likely to use. So it may be helpful for consumers who are found eligible for Medicaid or CHIP now in the states to select the option to have their notices available to them electronically, to the extent that those options exist in states today. To make it easier, in the event that they are denied or lose their Medicaid or CHIP coverage when they go over to the Marketplace, to make it easier to access whatever documentation they may need in order to prove their eligibility for a special enrollment period. And states, I think, will be changing their processes or making it easier to contact appropriate individuals in the state to get that additional

## Overlapping Coverage: Medicaid & The Marketplace

*Sarah Barber, CMS*

*Jessica Brill Ortiz, CMS*

*Jessica Stephens, CMS*

*Kelly Brown, CMS*

*Sarah Boehm, CMS*

documentation that individuals may need in order to prove their eligibility within the time frame needed.

Sarah Barber: That is a great tip because 30 days is not a long time to make sure that you have your documentation and that you can send it in to the Marketplace and get your SEP verified. Great, it sounds like we're going to have some more help from the states getting this material.

While I've got you, the next question is for you. We've been talking a little bit about minimum essential coverage, or MEC as we like to call it. I know not all Medicaid qualifies as minimum essential coverage. Can you talk about that a little bit because I think sometimes that's a hard distinction for people to understand?

Jessica Stephens: Right, and the term "minimum essential coverage" is such a technical term. It is true that most of the coverage that most people are familiar with is considered minimum essential coverage; or, as Kelly referred to it earlier, it's qualifying coverage in the context in which we talk about it for the Periodic Data Matching process.

Some specific types of coverage that are *not* considered as minimum essential coverage are things like family planning only services or coverage for tuberculosis-related services. There are some scenarios where it is a state-specific designation about whether a specific type of coverage is minimum essential coverage. For example, states that provide pregnancy only services...in some circumstances they may be considered as minimum essential coverage. That is a designation that is made by us based on the types of services that are provided in the coverage. In other cases, they are not.

Medically needy coverage may also vary state by state, in terms of whether it's considered minimum essential coverage. To find the state-specific designations we have, there is a table online on



## Overlapping Coverage: Medicaid & The Marketplace

*Sarah Barber, CMS*

*Jessica Brill Ortiz, CMS*

*Jessica Stephens, CMS*

*Kelly Brown, CMS*

*Sarah Boehm, CMS*

[www.Medicaid.gov](http://www.Medicaid.gov) that talks specifically about whether a certain coverage in each state is considered minimum essential coverage.

I'll note that for some specific groups, such as medically needy and pregnancy-related coverage, even if those are *not* considered as MEC or minimum essential coverage, if you lose access to those services, you may still be eligible for a Special Enrollment Period based on loss of coverage. Whereas typically, when we think of the loss of coverage Special Enrollment Period, it refers to the loss of minimum essential coverage. Does that help?

Sarah Barber: That was helpful, thank you. It's a complicated topic, but I'm glad that we have some resources available for folks to help determine that.

I want to talk a little bit about another place where I think sometimes people get – or consumers especially get a little bit hung up. I want to talk about the transition from Marketplace to Medicaid or from Medicaid to Marketplace, and how to best make sure that transition goes smoothly for a consumer. I'm specifically thinking about gaps in coverage and making sure that consumers get seamless coverage when they're moving from one to the other.

Jessica Brill Ortiz: For a consumer who is losing Medicaid coverage, and we're talking about how they might avoid a gap in coverage, it's important that that consumer update or create their Marketplace application as soon as they find out that their Medicaid or CHIP coverage is ending. So on the application they'll then want to attest, as appropriate, to the loss of coverage. As we mentioned earlier, consumers have 60 days from the date that they lose that coverage to utilize the Special Enrollment Period that corresponds to it. So if they're trying to use this SEP, then the verification process I mentioned earlier will apply if the Marketplace is unable to internally and automatically verify them for them for the loss of qualifying coverage

## **Overlapping Coverage: Medicaid & The Marketplace**

*Sarah Barber, CMS*

*Jessica Brill Ortiz, CMS*

*Jessica Stephens, CMS*

*Kelly Brown, CMS*

*Sarah Boehm, CMS*

Special Enrollment Period. Then they will be asked to submit documents, and the process goes on from there.

To further avoid a gap in coverage then, in addition to coming to the FFM and submitting an application as soon as they learn that they'll be losing their Medicaid coverage, a consumer should also select a plan at the Marketplace as soon as possible and send in any of those required documents as soon as possible. Just a reminder that for more information and for specific questions about any of the Special Enrollment Period verification process, the sessions this afternoon should be really helpful in that regard.

Sarah Barber: Okay, can we talk about the reverse? So if a consumer is newly-eligible for Medicaid and they need help ending their Marketplace coverage, what's the best way to approach that to make sure that they don't have a gap in coverage?

Jessica Brill Ortiz: For a consumer who is newly-eligible for Medicaid, they should come to the Marketplace and end their coverage immediately. Do you want to speak more to that?

Kelly Brown: Sure, it's also helpful to know that in most states, Medicaid coverage is effective back to the date of application or the first day of the month in which the individual applied. So termination effective dates depend on who is on the Marketplace plan. If ending Marketplace coverage for everyone on the application, termination can take effect as soon as 14 days from the date that they terminate coverage. If they're ending FFM coverage for just some people on the application, in most cases their coverage will end immediately once they continue through plan compare in the application. If the consumer is the only person on the Marketplace plan, they can select a termination date that's 14 days or more in advance of when they'd like their coverage to end.

## **Overlapping Coverage: Medicaid & The Marketplace**

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*Kelly Brown, CMS*

*Sarah Boehm, CMS*

So for consumers who are assessed by the FFM as potentially eligible for Medicaid or CHIP and they're waiting on a final eligibility determination from the State agency, they may want to avoid a potential gap in coverage by waiting to end their Marketplace coverage until they've heard back from the State regarding their final determination Medicaid or CHIP eligibility. However, if the consumer doesn't want to wait for the State's final determination and goes ahead and ends their Marketplace coverage and then receives a denial of Medicaid or CHIP eligibility from the State, if they originally applied for coverage during the Marketplace open enrollment period, they can request the Medicaid or CHIP denial Special Enrollment Period that we talked about earlier in order to close that gap in coverage.

We also wanted to note that if a consumer who has been determined eligible for Medicaid or CHIP that counts as qualifying coverage also wants Marketplace coverage, they will have to pay the full cost for the Marketplace plan premium and covered services.

Sarah Barber: Okay, great, well, I hope this has been helpful. We have about 20 minutes left, and I wanted to save some time for questions from the audience. If you have questions, I'm going to ask you again to write them down on the index cards and pass them over here.

I'd like to invite Sarah Boehm to come up. Sarah is the Deputy Director for our Eligibility Division at CCIIO. She's going to come up and try and address as many of your questions as she can. Hopefully we can get through as many as possible. I'm going to hand the mic over and turn it over to Sarah Boehm.

Sarah Boehm: Thank you.

Hi, everyone. We got a lot of good questions. Thank you, guys; you're obviously way ahead of us because some of these things we got questions on we were going to cover and did cover kind of later in the

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discussion but are worth kind of clarifying or repeating. I'm going to ask a couple of questions, and forgive me if I'm going to paraphrase a few questions because sometimes we got duplicates and things like that; so I'm rephrasing some of the questions that we got.

One question we got is: "How long should the account transfer take to happen?"

Maybe we could talk a little bit, and this goes to either Jessica...just a question about – talk about from the State to the FFM how long that takes, and then we can maybe we can talk about the reverse a little bit.

Jessica Stephens: So we talked a lot in the beginning – Jessica talked about the account transfer process, when an individual starts at the Marketplace and goes to the FFM. There is also the account transfer process when somebody starts an application at the state level, and it's bound to be ineligible for Medicaid or CHIP. So the State then transfers their account from the State to the FFM.

There is a little bit of variation in the processes that states use and the frequency with which states transfer accounts from the state to the Marketplace, although we know that the frequency has significantly improved over the past several years and that many states still transfer that account on a nightly basis...or daily or nightly or every week day. And in the same way that when the FFM that has an account that transfers to the State and then a notice is sent, the same process works in the reverse where an individual will be notified that their information is being transferred over to the Marketplace; and then the Marketplace also sends a notice to the consumer letting them know that they need to come back in and update their account so that they can receive an eligibility determination for Medicaid or CHIP.

Anything you want to add, Jessica?

## Overlapping Coverage: Medicaid & The Marketplace

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Jessica Brill Ortiz: No.

Sarah Boehm: Thank you.

So this question is about the fact that we are coming up on a shorter open enrollment period. You touched on this already, but it's about basically when someone maybe is assessed eligible for Medicaid by the FFM during that open enrollment period but they still are later denied by the State, will they be able to still enroll in FFM after December 15th. So this gets to the kind of SEP questions.

Jessica Brill Ortiz: So if I'm following, if somebody applies at the Marketplace for coverage during open enrollment and is assessed by the Marketplace as potentially eligible for Medicaid or CHIP, their information gets sent to the State via the account transfer. If at that point the State determines that the individual is not eligible for Medicaid or CHIP, the consumer can come back to the Marketplace and see if they're eligible for Marketplace coverage with financial assistance.

If they're coming back to the Marketplace outside of open enrollment, they may still be able to enroll in coverage using the Medicaid/Chip denial Special Enrollment Period. So they need to come back within 60 days of the State telling them that they were not eligible for Medicaid or CHIP. From there, they will proceed with the Special Enrollment Period process.

Sarah Boehm: Great, thank you.

(Inaudible question from and member)

I think she's asking about when eligibility starts for that person.

Are you saying back to the date that they applied...so are you talking about retroactive coverage for that person?

(Inaudible comment from audience member)

## Overlapping Coverage: Medicaid & The Marketplace

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Jessica Brill Ortiz: I believe the way that works is that it would be a prospective date. But if they wanted it retroactive to the date that it would have been, I believe they can request that specially.

Sarah Boehm: So I think there was a question – just to touch on this because someone did ask about is there kind of an easier way to get that retroactive date. At the moment, it's still a casework process; so there's no kind of other work or automated way that they get that retroactive date.

Let's go to...we have a couple questions about being dually enrolled. Basically, this question is asking if a family is both eligible for Medicaid and the Marketplace because of a mixed family eligibility -- for example, kids are on CHIP and the parents are on Marketplace coverage -- can the family have both?

That is correct. They can have both; as long as the children are on CHIP and the parents are on Marketplace coverage with APTC, that's fine. The issue of dual enrollment comes with – the concern is when an individual, one of the people, is both enrolled in Medicaid and CHIP and enrolled in Marketplace coverage. So that's what we've been talking about.

Just to flesh out that topic a little bit more, this one says that many consumers are not aware that they're dually enrolled; and it's asking whether they should contact their local Medicaid office to see if they're still eligible for Medicaid. Oh, I see...I think actually the question is more directed towards whether the State can assist by reaching out to consumers to let them know that they're still eligible for Medicaid instead of auto enrolling them, the consumers...but I don't know if there are any mechanisms or—

Jessica Stephens: Auto enrolling? I'm not sure I understand.

Sarah Boehm: I think the question is basically like if someone -- instead of the default, which is that we automatically enroll people once they go to the State,

## Overlapping Coverage: Medicaid & The Marketplace

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that the State kind of alerts people...somehow lets them know, hey, we think you might be dually enrolled or something like that and confirms -- let's them know that they're -- I'm not sure. I think that's what the gist of it is...instead of automatically enrolling them, you kind of reach out to them.

Yeah, at the moment, that is not -- at the moment it is an automatic enrollment. Maybe you guys can talk a little bit more about that.

Jessica Stephens: Right, at the moment it is an automatic enrollment. But on the Medicaid or CHIP side, when an individual is sent over to the Medicaid or CHIP agency and is determined eligible for Medicaid or CHIP, there are multiple notices that go out to the individual letting them know that they are, in fact, enrolled and that you received the eligibility card. They may be enrolled in a managed care organization, so all that process still goes.

I don't know, Kelly, if there's anything you want to add on the process?

Kelly Brown: Well, on the Marketplace side, when the consumer applies at the Marketplace for coverage with financial assistance, we do a data check in real time to see if that consumer is, in fact, enrolled in Medicaid or CHIP at their state. If they are found to be enrolled in Medicaid or CHIP at their state, then a data matching issue would be set; and then they would have to send in further documentation if they believe that they're not enrolled in that coverage so that we could give them Marketplace coverage with APTC as applicable.

Sarah Boehm: I think the answer is we do a lot of noticing; and sometimes, it's still confusing for consumers understandably.

This one is, I think, again, is more of the same. I think we've covered it. It has to do with getting the retroactive coverage back to the date, and we have talked about that happening through the coverage effective date if they're denied for coverage by the State. We talked about that happening through casework.

## Overlapping Coverage: Medicaid & The Marketplace

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Let's see...this one is related to Medicaid, so I'm going to direct this to Jessica. It says: "Consumers seem worried that their children will lose Medicaid if parents apply to the Marketplace. What messages from the Marketplace are helpful to make parents feel safe to apply to the Marketplace?"

Jessica Stephens: I think for this question we're talking about a scenario where a family has children who may already be enrolled in Medicaid or CHIP; and the parents perhaps might not be eligible for Medicaid or CHIP in the State, and so they're sent over to the Marketplace. So I think it started with a good question that there are many mixed-coverage status families, where there are children who may be enrolled in Medicaid or CHIP and adults who are ineligible for Medicaid and CHIP, largely because eligibility levels for Medicaid and CHIP for children are much higher than eligibility levels for adults.

So if a family has children who are enrolled and they go over to the Marketplace and the parents apply for coverage and they are determined eligible for Marketplace coverage with ATPC, that will not affect eligibility for the children unless of course the household income of the family has increased such that the children are no longer eligible for Medicaid or CHIP. In that case, they may be eligible for Marketplace coverage with ATPC and CSRs as well so that the family would then have coverage together at the Marketplace. But there should be no worry about children losing Medicaid or CHIP coverage if they're still eligible, even if the parents are not found eligible for Medicaid or CHIP.

Sarah Boehm: Great, thank you.

We have some more about if someone thinks they're ineligible for Medicaid, for example...they just think or possibly just for a variety of reasons they think they're ineligible for Medicaid, do they have to receive a denial notice in order to attest to being denied...that they were denied



## Overlapping Coverage: Medicaid & The Marketplace

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Medicaid on Marketplace -- and I'll give this to either Kelly or Jessica -- in order to get ATPC?

So even if they just think they are, for whatever reason, not eligible for Medicaid?

Kelly Brown: Well, I wouldn't -- even if they just think that they're potentially not eligible for Medicaid or CHIP, I wouldn't recommend checking that box saying that they've been denied if they haven't actually received notice from the State that they have been denied within the past 90 days because there are different rules for Medicaid or CHIP eligibility, depending on the state in which they're applying. It could turn out that they actually are eligible without knowing.

Jessica Brill Ortiz: Right, and that's part of the application process when they come to the Marketplace. If they apply, as we mentioned, if they say that they want to be considered for financial assistance, we'll first look at whether or not they may or are eligible for Medicaid or CHIP. So maybe they are and they don't know, and then that could be a really great option for them cost and coverage wise. So we absolutely would recommend that they come in and apply and see what coverage they can get that would best fit their needs.

Sarah Boehm: Great, thank you.

I think this is having to do with maybe some confusion. It's asking: "Is there any post-enrollment assistance for Medicaid coverage? For example, if a person comes in and is found eligible through the Marketplace, there's no way to update their documents on [www.Healthcare.gov](http://www.Healthcare.gov).

I think this gets to the question of when someone has a data matching issue for Medicaid and CHIP -- and I believe that Jessica Stephens covered this or someone did -- when someone has a data matching issue

## Overlapping Coverage: Medicaid & The Marketplace

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*Jessica Brill Ortiz, CMS*

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*Sarah Boehm, CMS*

on the Marketplace related to Medicaid or CHIP, they are sent to the State; and the State actually resolves any inconsistencies. So the State would follow up to collect appropriate documentation. That's why there's not a place on [www.Healthcare.gov](http://www.Healthcare.gov) for you to upload documents for Medicaid and CHIP; it's just for Marketplace purposes.

Anything you guys want to add on that?

Jessica Stephens: No.

Sarah Boehm: Okay, so some more questions...this one had to do with whether there is availability of training on Medicaid enrollment and post Medicaid assistance. And it's asking about – it's mentioning that one of the main obstacles is with the State...that they could use more support, and how could they get more help or possibly a liaison to help with this. So this basically is just the recommendation, and folks can add on anything here. But it's just to contact the State, Medicaid, and CHIP. If they need contact information for the State, we can help with that; but basically the State should be able to provide you with that kind of assistance.

Does anyone want to add anything on that?

Jessica Stephens: I don't think so.

Sarah Boehm: This one has to do with some errors in the account transfer process. It says: "We're finding that apartment numbers and phone numbers are not transferred from the Marketplace to the Medicaid office. There's very high denial rate for these consumers. The State has been notified of the issue, and DHS has been notified. Is there anything that the Marketplace can do to resolve this?"

So, basically, thank you for alerting us to this if we're not already aware of it. I don't know if you guys are aware of that from your account transfer things, but some things we continually work on trying to improve the account transfers and the quality of the data that gets sent over.

## Overlapping Coverage: Medicaid & The Marketplace

*Sarah Barber, CMS*

*Jessica Brill Ortiz, CMS*

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Jessica Stephens: I mean, I think—

Go ahead.

Jessica Brill Ortiz: Just sort of adding on to what Sarah had said, I think it's also important to note that first of all, we are working on troubleshooting and fixing what is essentially a low-volume level at this point for the causes for errors that still exist. But also, if there's an actual problem with an account making it to the State, if it can't make it, it is sent to the State; it's just sent in a different way. So we send it in a different file format, and it sends on a monthly basis. So it will get there, if a little bit slower. But, yes, in the meantime, we are continuing to troubleshoot those low-level volume errors.

Sarah Boehm: All right, this is the last one I have from when I walked up here. We have a couple more; if we have time, we're happy to address them. This is a question about if a consumer is eligible for Medicaid but they don't want to be on Medicaid, what are their options? This is people and they just want to opt out of Medicaid.

Do you want to talk to that one?

Kelly Brown: Sure, if a consumer is eligible for Medicaid but they don't want to be in that coverage, because they're eligible for Medicaid they will not be eligible for financial assistance at the Marketplace for a Marketplace plan. So essentially, they would be eligible for a Marketplace plan without financial assistance.

Sarah Boehm: We have a couple more. How much time do we have?

Sarah Barber: We have four-and-a-half minutes left.

Sarah Boehm: Four-and-a-half minutes...a couple more...okay.

Yeah, go ahead...here.

## Overlapping Coverage: Medicaid & The Marketplace

*Sarah Barber, CMS*

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Audience member: Hi, guys. So this question was specific to family planning benefits in a particular state. And if someone qualifies for family planning coverage, which is not MEC or minimal essential coverage Medicaid, can they get QHP coverage or Marketplace coverage with ATPC; and, if so, how?

Jessica Stephens: Maybe I can start and then others can jump in. So the short answer is, yes, they can get coverage; and they can get coverage by applying at the Marketplace. As I mentioned earlier, family planning coverage is one of the types of Medicaid coverage that is generally not considered minimum essential coverage, which means that it's unlike the types of coverage we've been talking about, where if you are enrolled you are ineligible for Marketplace coverage with ATPC. In this case, because it's not considered minimum essential coverage, you may still be eligible for marketplace coverage with ATPCs and CSRs.

So an individual could apply, let's say, at the Marketplace; and they would fill out an application in the same way that anybody else would. They would not indicate that they have minimum essential coverage, and they would not be flagged as having minimum essential coverage through the process that Kelly described where the Marketplace checks prior to enrolling you and finding you eligible for advanced premium tax credit.

Anything else to add?

Jessica Brill Ortiz: No.

Jessica Stephens: Great, thank you.

Audience member: This one may for you as well, Jessica: "Can a consumer choose Marketplace..." and we may have touched on this, so it might be repetitive. "Can a consumer choose Marketplace coverage even if their children are eligible for CHIP?"

Jessica Stephens: Yes, CHIP eligibility levels in all states are higher than those for Medicaid; but there may still be – actually more frequently than in Medicaid – cases

## **Overlapping Coverage: Medicaid & The Marketplace**

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where children may be eligible for CHIP but parents are not eligible for Medicare in the state because the Medicaid eligibility levels are generally lower. So as we talked about before, there are many instances where you have mixed coverage status families, where children are eligible and enrolled in either Medicaid or CHIP; and the parents or others in the household are enrolled Marketplace coverage. So the short answer is, yes; you can have families with CHIP-enrolled kids and Marketplace-enrolled parents, or any combination of those two.

Sarah Barber: Thank you, Anna.

I'd like to take a moment and just thank the panel here. All of your tough questions that I get and I have no idea how to answer them go to all of them. They are a great resource. So I want to thank them very much for taking time out of the day to come up and participate.

[Applause]

I also want to thank all of you for your great questions. Any questions that we were not able to address, we will take back with us. We're trying to gather all the questions that you all are giving us and make sure that we can address them in the newsletter or on webinars. You give us great ideas for topics that we need to cover or topics that we need to cover in greater depth.

So thank you again. I hope you enjoy the rest of the Summit.

[Applause]

Stacey Plizga: Okay, we are going to be taking a lunch break at this time. I have kind of an important announcement that if you would like to participate in one of the four optional networking sessions, please return to that session at 12:25 p.m., either at the Grand Auditorium or one of the three breakout rooms. And then for our webcast participants, or those who do *not* want to participate in a networking session, you can return at 1:05 p.m.

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The cafeteria is downstairs. There's a Farmer's Market outside the cafeteria. Or, if you preordered your lunch, please pick it up at the Jazzman Café, which is right outside the cafeteria...enjoy.