# National Workgroup on Integration

**Building or Enhancing Interoperability of Human Service Programs with Medicaid Eligibility Systems and Health care Exchanges**

**<u>Frequently Asked Questions</u>**

Over the course of the initial convening of the National Workgroup on Integration (NWI) in September 2011, state and local human service leaders, industry partners, federal leaders from the U.S. Department of Health and Human Services (HHS), the U.S. Department of Agriculture (USDA) and the Office of Management and Budget (OMB), and APHSA staff worked together to outline information and current opportunities for states seeking to build or enhance interoperability between human services programs and Health Insurance Exchanges (Exchanges) and/or Medicaid eligibility systems.

These FAQs aim to provide interested state and local human service agencies with answers to questions for how to begin leveraging specific time-limited resources toward the development of these systems within the time frames and federal requirements provided through the Affordable Care Act (ACA).

**The following Frequently Asked Questions are addressed below.**

1. **Does the law allow for the interoperability of human services programs with Health Insurance Exchanges and/or Medicaid eligibility systems?**
2. **What are the critical timelines states need to keep in mind?**
3. **What are the Seven Standards and Conditions issued by CMS?**
4. **What is the cost allocation exception?**
5. **What funding is potentially available for human services agencies?**
6. **What interoperable shared services would the funding support?**
7. **What are the options available to states?**

## <u>Statutory Authority</u>

**1. Does the law allow for the interoperability of human services programs with Exchanges and/or Medicaid eligibility systems?**

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Yes. Section 1561 of the ACA requires the secretary of HHS to develop health information technology (HIT) interoperable and secure standards and protocols that facilitate enrollment of individuals in federal and state health and human services programs. The law specifically requires these standards to allow for the "ability to expand the enrollment system to integrate new programs, rules, and functionalities, to operate at increased volume, and to apply streamlined verification and eligibility processes to other federal and state programs, as appropriate." Section 1561 C (b)(5).

The HHS secretary has issued recommended standards and protocols for section 1561 that states will need to consider when planning for their Exchanges and/or Medicaid Information Technology Architecture (MITA) interoperable with human services programs. The recommendations include the utilization of core data elements, standardized verification interfaces, and shared and consistent business rules. They also include the utilization of existing HIPAA adopted transaction standards for the transmission of enrollment information and the full range of privacy and security practices and safeguards. The recommended standards and protocols are available at http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__policy_recommendations/1815.

## Key Timelines and Compliance Provisions

### 2. What are the critical timelines states need to keep in mind?

States that meet the HHS' Center for Medicare and Medicaid Services' (CMS) Seven Standards and Conditions are eligible to receive an enhanced federal financial participation (FFP) match for their Medicaid and Children's Health Insurance Program (CHIP) eligibility determination systems between now and December 31, 2015, provided they submit an Advance Planning Document (APD) describing the changes being sought and receive approval from CMS. States are able to utilize this enhanced FFP to build or enhance certain eligibility and enrollment shared services between their health and human service programs until December 31, 2015. Please refer to questions 3 and 5 for additional information on the Seven Standards and Conditions and the enhanced FFP, respectively.

Presently, states are able to apply for Establishment Grants up until June 29, 2012 ultimately providing states the opportunity to determine if they will be developing a state-based or regional Exchange or not developing one at all. For states that are undecided or for states anticipating applying for the Establishment Grants, there is still time for human service agencies to be involved in the planning for their states' Exchange and/or eligibility system efforts.

It is important to keep in mind the process-related timelines relative to the statutory deadlines. State Exchanges will need to have been developed, fully tested and operating effectively no later than December 31, 2013, in order to effectively begin enrolling Medicaid beneficiaries on January 1, 2014, per the ACA statute. Between the Fall 2012 and October 2013, CMS will be certifying state Exchanges to ensure their compliance with the standards and conditions. States will receive certification or conditional certification by January 1, 2013. If a state receives conditional certification by January 1, 2013, they will have the opportunity to move to full certification before October 2013.

Below is a timeline highlighting the general dates and time periods states will need to consider when planning, designing and implementing their Exchanges. As seen below, Exchanges are anticipated to be operational on a base level by January 1, 2013 and are required to be fully operational for consumers by January 1, 2014. While Exchanges have to be operational by 2014, interoperable system planning and development may continue beyond that date and up to the end of 2015. Planning can ensure for both as long as it does not jeopardize completion of the Exchanges.


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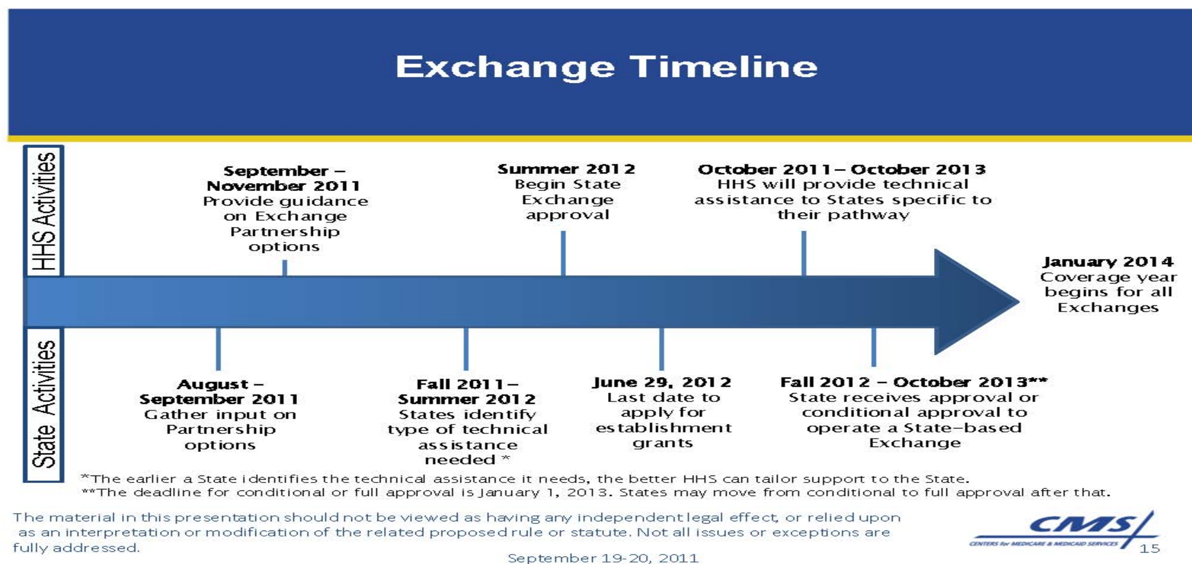


**3. What are the Seven Standards and Conditions issued by CMS?**

Upon the issuance of the secretary's standards and protocols, CMS released their IT Guidance 2.0 outlining the standards and conditions required of states to include in the design of their Exchanges and/or MITA as a condition of receipt of enhanced federal funding. They include: *use of modularity; alignment to MITA; incorporation of industry standards; promotion of leverage and sharing of technologies within and among states; utilization of business results and desired outcomes; ability to produce reporting data/reports/information;* ***and allowing for the interoperability with Exchanges and/or MITA of human services programs.*** Please see CMS' website at [http://www.cms.gov/Medicaid-Information-Technology-MIT/](http://www.cms.gov/Medicaid-Information-Technology-MIT/) for specific information regarding the Seven Conditions and Standards.

## Available Funding

### 4. What is the cost allocation exception?

On August 10, 2011, HHS' CMS and the Administration for Children and Families (ACF), and the USDA's Nutrition and Consumer Services (FNS) announced the cost allocation exception to OMB's Circular A-87* for states to considering when planning for the design of their Exchanges and Medicaid eligibility systems. As part of the Administration's commitment to promote flexibility for states and to ensure effective and efficient use of state and federal resources, CMS is providing a time-limited, specific exception to the cost allocation requirements set forth in A-87 Circular (Section C.3) to allow, at the option of the state, federally funded human services programs to benefit from investments in state eligibility systems being made by state-operated Exchanges, Medicaid and CHIP. This exception, discussed below, allows states the opportunity to thoughtfully consider the benefits of integrating the eligibility determination functions across health and human services programs and the timing of any such integration.

The exception allows human services programs to utilize systems designed specifically for determining a person's eligibility for affordable insurance programs without sharing in the common system development costs, so long as those costs would have been incurred anyway to develop systems for the Exchanges, Medicaid, and CHIP. Any human service program-specific add-ons do not qualify under the A-87

exception and must be paid for by the designated program. The tri-agency letter is available at *http://www.aphsa.org/Home/Doc/Tri-Agency_Letter_08-10-11.pdf*.

> ** Through statutory authority under the Budget and Accounting Act of 1921 and administered through the OMB, the A-87 Circular establishes principles and standards for determining allowable costs incurred by state, local, and federally recognized Indian tribal governments under grants, cost reimbursement contracts, and other agreements with the federal government. A-87 also provides policy guidance to these entities for cost allocation plans and when conditional exemptions are permitted. In general, the basic cost allocation principle of A-87 is that programs that benefit from an information technology system should pay their fair share of the common costs in proportion to the benefit derived. While there are several ways to calculate the shares allocated to the various benefitting programs, the most common is the number of program beneficiaries likely to make use of the service. In other words, if 100 clients were to benefit from a program and, for example, 43 of them were Medicaid beneficiaries, then the Medicaid program would be assigned 43% of the common costs with the other programs contributing their respective shares. Please note that in calculating who pays for what there are actually two steps involved. The first, cost allocation is the process by which each program's "share" (proportion of costs to be assigned to it based on usage). Having determined the "share", then the relevant "matching rate" for each program is applied. When discussing "A-87" the issue revolves around the former, cost allocation and determining the "share", rather than the latter.*

**5. What funding is potentially available for human services agencies?**
CMS has made available to states enhanced FFP rates to apply to eligibility systems built to serve the needs of the Medicaid program. ***To the extent these same services can benefit human services programs, the A-87 exception permits states to make use of them at no additional charge or need to cost allocate those costs back to human services as would be applicable under the traditional A-87 requirement.***

Medicaid eligibility determination systems are potentially eligible for enhanced 90 and 75 percent FFP. States wishing to receive enhanced FFP should be aware of the following opportunities:

(1) States may receive enhanced 90 percent FFP for expenditures **for design, development, installation, or enhancement** of eligibility determination systems only through calendar year 2015. Please note that this is true even if work on approved APDs continues after 2015. The state's APD must state that all development, design, installation and enhancement will be completed by the end of calendar year 2015.

Enhanced FFP at the 75 percent rate to **maintain and operate** systems that previously qualified for 90 percent FFP will be available after 2015.

States should note that to receive the enhanced 90 percent FFP for the design, development, installation or enhancement of an eligibility determination system through calendar year 2015, states must incur costs for goods and services furnished no later than December 31, 2015. For example, if an amount has been obligated by December 31, 2015, but the good or service has not yet been furnished by that date, then such expenditure would not be eligible for enhanced FFP.

(2) For states that have already invested in improvements that will allow systems to qualify without the need for additional enhanced development, design, installation or enhancement funding, they

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can receive enhanced 75 percent FFP funding prior to December 31, 2015 to maintain and operate their eligibility determination systems.

***States should also note that any State receiving enhanced FFP at 90 percent or 75 percent prior to December 31, 2015, must continue to operate eligibility determination systems that meet the requirements, standards and conditions in order to continue receiving 75 percent enhanced funding after December 31, 2015.**

(3) Lastly, states that do not wish to receive enhanced funding through calendar year 2015 can receive 50 percent FFP for systems developed, installed, or enhanced after calendar year 2015 and will continue to receive 50 percent FFP for any maintenance and operations conducted on these eligibility determination systems.

In 2010, CMS also initiated the first round of grants to states for Exchange planning and design. The Planning Grants were the first to be awarded to states to begin the process of planning and designing their IT upgrades as well as for states to conduct assessments of their capacity to develop and operate Exchanges. The second round of grants awarded in early 2011 were the Early Innovator Grants, which were awarded to states willing to lead the way in systems development and able to demonstrate a variety of approaches whose core functionalities are replicable and could be adopted and tailored by other states. Lastly, CMS announced the Establishment Grants in May 2011 and again in August totaling $219.4 million to facilitate the process of building the Exchanges states previously planned. These grants will continue to be used to facilitate the process of building the Exchanges previously planned for by the states. For additional information on federal Exchange grants and awardees, visit http://cciio.cms.gov/.

**6. What interoperable shared services would the funding support?**

Listed below are possible examples of shared services * between Exchanges and/or Medicaid eligibility systems and human services that may be available for funding under the A-87 exception. Only to the extent these shared services apply to the Medicaid program are they eligible to also be utilized by other programs at no additional cost to the benefitting program. For example, if the number of client portals needed for a state's Medicaid purposes were 50, but the state needed an additional 25 for the SNAP or other human services programs, those additional 25 would need to be cost-allocated to the appropriate benefitting program beyond Medicaid. Hence, it is not the function, alone, that determines what program is charged for the activity but also the volume of transactions attributed to the various programs such that any amount above that required by Medicaid should be cost-allocated to the appropriate program.

*Client Portals*
*Data Warehouse*
*Interoperability of Eligibility Screening*
*Enterprise Framework*
*Client Index (Identifier)*
*System Integration*
*Document Generation*
*Governance*
*Digitization of Case Record*
*Case Management*
*Real time Medicaid Eligibility Determination*
*Modular or Federated Rules Engine*
*Development Team & Architects*
*Workflow Management Tools*
*Appeals Processes*
*Framework & Infrastructure Support*
*Interfaces to Community Organizations and Partners*
*Exchange Infrastructure (Interfaces & Centralized Interconnections)*

*These shared services have yet to be defined by CMS. More guidance will be provided over the next couple of months.

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## Options

### 7. What are the options available to states?

**As to Exchanges.**States have several options of how to build and operate their Exchanges. A state may decide to develop and operate a state-based Exchange where they would be required to establish the governance, business processes, technology, consumer assistance, and additional functions that are yet to be determined. States may also opt to form a regional collaborative comprised of a consortium of states working together to develop one Exchange. It is important to note that this type of model does not necessitate states to be contiguous [to one another] or even in the same geographical region. Lastly, if states opt not to develop their own Exchange, the federally-facilitated Exchange is required to operate in a state.

**As to Interoperability with Human Services.** While each state has the availability to utilize the A-87 exception for enhancing the interoperability of its health and human services systems, it is critical to keep in mind that both the Exchanges and the cost allocation exception for the interoperability of human services programs are at state option. It is unclear at this stage whether the federally-facilitated Exchanges will include the option for interoperability with human services programs. It is also important to recognize that while a state may choose to not operate a state-based Exchange or participate in a regional collaborative Exchange and thereby enter into the federally-facilitated Exchange by default, the opportunity to utilize the enhanced FFP for the Medicaid eligibility systems is still present [provided states are in compliance with the conditions described in the A-87 exception.]

*CMS is still in the process of drafting regulations on the different models states may want to utilize if opting to enter into a partnership with the federally-facilitated Exchanges and on the definition of core functions.

*******The contents of this FAQ do necessarily reflect the views of CMS nor have they been cleared by CMS.*

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