



NATIONAL ASSOCIATION OF MEDICAID DIRECTORS

May 6, 2011

Ms. Cindy Mann
Deputy Administrator and Director
Center for Medicaid, CHIP and Survey & Certification
Centers for Medicare and Medicaid Services
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Ms. Mann:

Medicaid Directors are facing the most difficult budgetary challenge in recent memory. We are committed to maintaining the strength and integrity of our programs in the context of more than \$175 billion in budget shortfalls over the next biennium. While we have also written to you on the need for flexibility in the area of provider payment rates, it is critical for us to also discuss eligibility and how to make changes to the congressionally-mandated maintenance of effort (MOE).

The MOE on Medicaid eligibility originally passed in the Stimulus Act (ARRA) and froze eligibility at 2008 levels. It bars states from making eligibility more restrictive, including changes to determination “policies or procedures”. Although the enhanced FMAP funding under which the MOE was imposed ends on June 30th, 2011, the Affordable Care Act (ACA) continues the Medicaid MOE requirements to 2014, extends the MOE to the Children’s Health Insurance Program (CHIP), and carries the MOE forward to 2019 for children. Without further guidance from HHS on what is considered to be a change to a more restrictive “policy and procedure,” the Department’s previous interpretations of the MOE will also carry forward, including limits on changes to documentation requirements, the frequency and method for redeterminations, and application of the restrictions to changes in premiums.

As we examine opportunities to improve the Medicaid program’s efficiency and reduce costs for both the state and federal governments, there are a number of common sense solutions that could improve the management of Medicaid during this critical period. Regardless of what happens in the broader political discussion of the ACA, we urge you to work with us to find more workable interpretations of the MOE, including, but not limited to:

Confirm that CMS policy allows states to maintain program integrity. In the August 19, 2009 letter to State Medicaid Directors (SMD #09-005), CMS confirmed that states may change eligibility standards, methodologies, and procedures when necessary to avoid an inconsistency with other federal requirements, explaining that “it is not plausible to require States to choose between [strict adherence to the MOE] and potential disallowances for expenditures that were inconsistent with applicable Medicaid authorities.” As you know, new loopholes often emerge that subvert Medicaid eligibility rules, expand enrollment, and reduce the accuracy of state eligibility decisions. We are writing to confirm that, consistent with the approach taken in SMD #09-005, states may change certain eligibility methods and standards to protect Medicaid program integrity when new eligibility loopholes are exploited in areas such as the transferring

or hiding of assets, or when information cannot adequately be verified in a determination or redetermination.

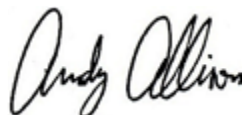
Create a CMS approved template for an MOE waiver. States would like clarity around the requirements for requesting a waiver of the MOE, which is clearly within the purview of the Secretary. CMS could develop a pre-print/template for such requests.

Allow states to change eligibility determination for services within Medicaid, specifically long-term care. Presently, HHS considers level-of-care (LOC) as an eligibility issue and therefore subject to the MOE. Many states are interested in increasing flexibility to either adjust levels of care or decouple LOC from eligibility requirements. States should be allowed to provide for different and more restrictive eligibility criteria for nursing facility benefits and less restrictive criteria for waivers in order to move individuals from nursing homes to home and community based waiver programs.

Exempt reasonable changes in premiums from the MOE. CMS has rejected state requests for increases in premiums in many instances because these changes might have an impact on either the decision of an eligible person to apply for Medicaid or CHIP, or their ability to afford the increased cost once enrolled. Reasonable increases in premiums, however, are clearly addressed in the affordability provisions of both the Social Security Act and the ACA, and states should therefore be allowed to implement such changes that are consistent with these statutory guidelines.

We thank you for your consideration of our views on this crucially important issue and look forward to working with you to find a workable solution for the situations raised in this letter and for other situations that may arise.

Sincerely,



Andy Allison
Executive Director
Kansas Health Policy Authority
President, NAMD



Darin J. Gordon
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Administration
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