

Appendix: Questions

1. If a state assumes the responsibility of overseeing plan management and consumer enrollment assistance in the Partnership Exchange, to what degree will the Federal government revert a portion of the user fees back to that state?
2. What type of flexibility do states have when building and deploying IT infrastructure to support seamless information exchange between their Medicaid programs and Exchanges?
3. How can states find information on approved RFPs or bids from states that have completed steps toward building a State Exchange?
4. Will HHS/CMS be able to extend deadlines to accommodate additional time states are seeking to complete the IT procurement process?
5. To what degree should there be alignment between qualified health plans (QHPs) operating in the Exchange and those operating outside of the Exchange (e.g. network adequacy, coverage effective days, performance standards etc.)?
6. What would the governance structures for the Federally-facilitated Exchange and Partnership Exchange look like? To what extent will states have representation on the governance board?
7. What does the required MOU agreement look like and what is the timeline for creating that agreement with states that will be participating in a Federal Exchange?
8. What are the potential costs to states who participate in the Federal Exchange and how are they calculated?
9. Is there a list of services that HHS would be willing to subcontract to states (i.e. patient navigators) that participate in the Federal Exchange?
10. Will states that expand Medicaid coverage up to a level below 133 percent of the federal poverty limit (FPL), for example up to 100 percent FPL, still receive the enhanced federal medical assistance percentage (FMAP) available for “newly covered” populations?
11. Can states phase in expansion of newly covered populations over several years? If states do expand Medicaid coverage, can they scale back the expansion in the future as fiscal conditions change?
12. When will HHS issue the regulations and methodology for reductions in Disproportionate Share allotments? Two, for a state that does not see a decrease in its uninsured population, will the remaining state absorb the full reduction? In addition, can a state implement a new DSH Diversion program as part of the optional expansion? Can a state implement new DSH Diversion programs for services to the uninsured/uncompensated care services?
13. What are the effects of continuing uncompensated care if Medicaid not expanded
14. What will the increase in demand for health care do to prices for everyone?

15. What are the macro-economic effects on state economies by, for example, expanding employment?
16. What additional health care workers will be needed to create adequate access?
17. What incentives will employers have to move workers into expanded Medicaid
18. What incentives will states have to move beneficiaries into the exchanges?
19. Will states be able to pay exchange premiums for beneficiaries if they do not expand Medicaid?
20. What is the cost to the state of programs/services that would be paid under expanded Medicaid; e.g., community mental health?
21. Will states that previously expanded coverage to the childless adult group be eligible for enhanced FFP even if they decide not to proceed with further expansion to the optional adult group?
22. What is the formal process for exercising the option to expand? Is it a submission for approval to expand or a submission to opt of the expansion?