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REPORT OF THE VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Implications of Eliminating Restrictive Medicaid Eligibility Requirements through a 1634 Agreement with the Social Security Administration (Chapter 552, Item 313.KKKKKK., 2021)

TO THE GOVERNOR AND THE GENERAL ASSEMBLY OF VIRGINIA

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COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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January 6, 2022

MEMORANDUM

TO: The Honorable Ralph S. Northam
Governor of Virginia

The Honorable Janet D. Howell
Chair, Senate Finance Committee

The Honorable Luke E. Torian
Chair, House Appropriations Committee

The Honorable Mark D. Sickles
Vice Chair, House Appropriations Committee

FROM: Karen Kimsey
Director, Virginia Department of Medical Assistance Services

SUBJECT: Report on Implications of Eliminating Restrictive Medicaid Eligibility Requirements through a 1634 Agreement with the Social Security Administration

This report is submitted in compliance with the Virginia Acts of the Assembly – HB1800, Item 313.KKKKKK. which states:

> *The Department of Medical Assistance Services (DMAS) shall research the implications of eliminating restrictive Medicaid eligibility requirements through a "1634 agreement" with the Social Security Administration (SSA) which will allow for automatic enrollment of Supplemental Security Income (SSI) recipients into Virginia's Medicaid program as categorically eligible individuals. DMAS shall report on its findings, including cost and programmatic changes that would be necessary to effect such changes by October 1, 2021 to the Governor and General Assembly.*

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

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Enclosure

Pc: The Honorable Daniel Carey, M.D., Secretary of Health and Human Resources

Implications of Eliminating Restrictive Medicaid Eligibility Requirements through a 1634 Agreement with the Social Security Administration

A Report to the Virginia General Assembly — *October 1, 2021*

Report Mandate:

2021 Special Session I Budget Bill - HB1800 states:

"Item 313.KKKKKK. The Department of Medical Assistance Services (DMAS) shall research the implications of eliminating restrictive Medicaid eligibility requirements through a '1634 agreement' with the Social Security Administration (SSA) which will allow for automatic enrollment of Supplemental Security Income(SSI) recipients into Virginia's Medicaid program as categorically eligible individuals.

DMAS shall report on its findings, including cost and programmatic changes that would be necessary to effect such changes by October 1, 2021 to the Governor and General Assembly."

Background

Statutory Context

Federal regulations in 42 CFR 435.120 and 435.121 address participation requirements for states to provide medical coverage under Title XIX of the Social Security Act (the Act), known as Medicaid in most states, including Virginia. Each state requests approval of its Medicaid Plan from the Centers for Medicare & Medicaid Services (CMS). The Social Security Administration (SSA) Program Operations Manual System (POMS) contains the eligibility policy for the Supplemental Security Income (SSI) Program and the relationship between the SSI and Medicaid Programs.

The Medicaid statute requires coverage of mandatory groups and gives states the option to provide Medicaid to various other groups. Most states define the aged, blind and disabled mandatory group as SSI beneficiaries, but the states are not required to follow the SSI criteria to determine Medicaid eligibility; they may choose to use at least one criterion which is more restrictive than the SSI program. States which use more restrictive criteria are called **209(b) States**, referring to the section of the Act that pertains to these states.

Virginia is currently one of the nine (9) 209(b) states, having instituted more restrictive real property eligibility requirements than SSI criteria. States with 209(b) status make their own Medicaid eligibility determinations for SSI beneficiaries who apply for Medicaid and process annual redeterminations for SSI beneficiaries who are approved for Medicaid coverage.

About DMAS and Medicaid

DMAS's mission is to improve the health and well-being of Virginians through access to high-quality health care coverage.

DMAS administers Virginia's Medicaid and CHIP programs for more than 1.6 million Virginians. Members have access to primary and specialty health services, inpatient care, behavioral health as well as addiction and recovery treatment services. In addition, Medicaid long-term services and supports enable thousands of Virginians to remain in their homes or to access residential and nursing home care.

Medicaid members historically have included children, pregnant women, parents and caretakers, older adults, and individuals with disabilities. In 2019, Virginia expanded the Medicaid eligibility rules to make health care coverage available to more than 400,000 newly eligible, low-income adults.

Medicaid and CHIP (known in Virginia as Family Access to Medical Insurance Security, or FAMIS) are jointly funded by Virginia and the federal government under Title XIX and Title XXI of the Social Security Act. Virginia generally receives a dollar-for-dollar federal spending match in the Medicaid program. Medicaid expansion qualifies the Commonwealth for a federal funding match of no less than 90 percent for newly eligible adults, generating cost savings that benefit the overall state budget.

The other option for states is for their Medicaid program to accept SSA determinations for Medicaid eligibility. In this scenario, SSA completes the Medicaid determination when determining an individual's initial and ongoing eligibility for SSI. Individuals are enrolled in a state's Medicaid program without having to file a separate Medicaid application and undergo a second determination of eligibility.

When a state requests SSA to make Medicaid eligibility determinations, it completes a 1634 agreement with SSA. Named for the implementing provision in the Act, the 1634 agreement specifies the state's and SSA's responsibilities, and requires the state to provide Medicaid coverage to recipients of federally administered State Supplementary Payments (SSPs). This is the most common option for states. Currently, the District of Columbia and 34 states have 1634 agreements.

In 1643 states, the SSA also refers the records of SSI claimants who do not meet the Medicaid-only eligibility factors to the state. Examples of individuals who may not meet the requirements include those who refuse to assign their rights to third party medical payments; those who refuse to provide third party liability information; or those who appear to have a Medicaid trust. These individuals are not automatically enrolled in Medicaid; the 1634 States make their own determinations for Medicaid for these individuals.

Lastly, SSA refers individuals who are determined ineligible for SSI to the state to apply for Medicaid, since they cannot be enrolled in Medicaid without a separate Medicaid application.

Current Application and Enrollment Process

As a 209(b) State, Virginia Medicaid policy requires all individuals seeking medical coverage, including those who have been approved for SSI, to submit an application. This requirement means that SSI applicants have an additional burden to file two applications and undergo two determinations, one with SSA and one for Virginia Medicaid. Individuals are also required to complete the annual renewal and redetermination process with both agencies each year.

Currently, individuals who have been approved for SSI are instructed by SSA to apply separately for Medicaid. SSI enrollees meet the income eligibility requirement for Medicaid however, because Virginia has opted to set more restrictive real property resource eligibility requirements, applicants must provide information at the time of application about real property in which they have an ownership interest.

If the applicant has no ownership in real property or their ownership interest meets the Medicaid eligibility requirements, the individual is determined eligible for Medicaid in the SSI Medicaid covered group without any further requirement to provide resource information about personal property resources, such as automobiles or bank accounts. If the applicant indicates owning real property, all of the individual's potentially countable resources must be evaluated. All applicable exclusions and exemptions are applied during the resource evaluation.

If the individual is not eligible in the SSI Medicaid covered group, their eligibility for medical coverage must be evaluated under the "Individuals with Income $\leq$ 80% of the Federal Poverty Level (FPL)" covered group. Because the Medicaid resource policies for the 80% FPL covered group mirror the eligibility for SSI payments, these individuals could meet the resource requirement for the 80% FPL covered group.

If the individual is under 65 years old, is not entitled to Medicare, and is not eligible for Medicaid in the SSI Medicaid or 80% FPL covered groups, they would be eligible for full medical coverage in the Medicaid Expansion covered group. This coverage group does not have a resource eligibility requirement.

In summary, individuals with SSI are likely to still be eligible for Medicaid; however, instead of an efficient eligibility determination, the individual and eligibility workers are required to undergo additional administrative steps.

Burdens Associated With 209(b) Status

Rather than offering a cost efficiency, the more restrictive real property eligibility requirements result in additional labor and systems costs to the state for eligibility determinations. Requiring SSI-eligible individuals to apply separately for Medicaid and undergo an eligibility determination is a burden to these individuals who often have gaps in coverage resulting from administrative complexities.

SSA has already determined these individuals to have income below the poverty line. In 2021, the maximum federal SSI benefit is $794 per month or about 74% FPL for an individual. Countable liquid assets must be no more than $2,000 for an individual or $3,000 for a couple.

If the person proactively applies for Medicaid while their SSI application is pending, the Medicaid eligibility worker must initiate an additional disability determination process with Disability Determination Services. This means the process for two disability determinations may be initiated creating additional burdens for the individual and administrative complexities for the state.

Because Virginia's more restrictive real property requirements for individuals with SSI do not apply to other Medicaid covered groups, these individuals may be eligible for Medicaid in another covered group.

Enrolling SSI-eligibility individuals directly into Medicaid will reduce labor and systems costs and promote continuity of coverage for eligible members.

Transition from 209(b) to 1634 Status Impact on Medicaid Enrollment and Participation

As of July 2021, there were 153,417 Virginians receiving SSI benefit. Of these individuals, Medicaid covers 152,133 in the SSI covered group. Medicaid covers an additional number of individuals and couples with SSI in other covered groups.

If Virginia transitions to a 1634 status, the coverage gap of Virginians with SSI benefits who do not currently have full Medicaid, coverage would be filled upon their automatic enrollment into Medicaid.

With the conversion to 1634 status, annual renewals for members currently enrolled in the SSI Medicaid covered group, as well as those enrolled in the future, will be automatically completed via a data match with SSA to verify the continued receipt of SSI payments

Data Sharing Agreement

DMAS currently has in place data sharing agreements with SSA that are renewed annually. The conversion from 209(b) to 1634 status will involve DMAS signing a new agreement with SSA to initiate the implementation of the 1634 process.

The completion of the agreement process takes approximately eight weeks. Once the agreement is signed, an SSA representative will schedule meetings with SSA systems staff and other SSA stakeholders to setup the 1634 network transmission between DMAS and SSA.

State Plan Amendment Process

DMAS will need to revise or amend several sections of the State Plan with CMS to reflect the change from a 209(b) to a 1634 state. State plan amendments are reviewed by CMS, and approval is typically received within 90 days of submission.

In conjunction with a State Plan amendment, DMAS will coordinate with the General Assembly as necessary to facilitate any necessary amendments to the Virginia Administrative Code or Code of Virginia. It may be possible to enact Emergency Regulations, which will allow the 1634 status change to be implemented during the regulatory process.

Eligibility and Enrollment Systems Changes

The Medicaid eligibility and enrollment process involves separate and distinct eligibility and enrollment systems. The Virginia Department of Social Services (VDSS) maintains the eligibility system, Virginia Case Management System (VaCMS). The enrollment system, the Virginia Medicaid Management Information System (VAMMIS) is maintained by DMAS. The VaCMS system is the only system that is expected to require modifications. This update would be scheduled with VDSS through the normal change request process.

Overall Cost Estimate

If the change to 1634 status is implemented, 1,284 individuals will be enrolled in Virginia. Approximately 50% of these individuals are dually eligible for Medicare and Medicaid. They will receive Medicaid coverage under the Commonwealth Coordinated Care (CCC) Plus Managed Care Program as "dual eligibles. The remaining 50% of these individuals will be "non-dual" members under CCC Plus. The monthly capitation rate paid to the managed care plans for Dual CCC plus members is about $504.34, while the rate for non-Long Term Care CCC Plus members is $1,683.

The above figures were considered in order to develop the potential costs of implementing this change. The administrative cost includes a one-time cost in Fiscal FY23 (Fiscal Year) for $500,000 ($85,225 general fund) for changes to the Department of Social Services' VaCMS system and ongoing costs totaling $269,772 ($31,121 general fund) annually. The estimated total cost in FY23 is $16,202,976 ($1,896,750 general fund, $14,306,226 non-general fund). The estimated cost in FY24 is $17,130,520 ($1,976,209 general fund, $15,154,311 non-general fund). In addition, indirect costs have also been included to support administrative functions.

A carry over impact of Virginia transitioning to 1634 status would be a reduction in administrative burden to advocacy organizations that have assisted members eligible for SSI in the Medicaid application process.

Summary

The SSA has determined that SSI beneficiaries have income below the maximum income limit for Medicaid eligibility and few liquid assets. Transitioning Virginia from 209(b) status to 1634 status will allow Virginia's Medicaid policy to align with the policy used for the SSI Program. Moreover, individuals approved for SSI benefits will automatically be enrolled in health

coverage, reducing unnecessary member churn, gaps in care, and administrative burden. Local DSS agencies will be able to better allocate staff resources to focus on enrolling and maintaining health coverage for other Virginians.

1634 Status Report Workgroup

DMAS would like to acknowledge the members of the 1634 Status Report Workgroup. We thank you for contributing your time and expertise to this project.

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