State Health Reform Assistance Network
Charting the Road to Coverage

ISSUE BRIEF
September 2015

Financing Shared Administrative Functions Between State-Based Marketplaces and State Medicaid Programs: Cost Allocation Methodologies

*Prepared by **Tricia Leddy, Mark Larson,** and **Christian Heiss,** Center for Health Care Strategies*

The Affordable Care Act (ACA) advanced opportunities to expand access to health coverage for low-income Americans, including the expansion of Medicaid and the establishment of health insurance marketplaces. As pathways to public and private health coverage, state-based marketplaces (SBMs) perform many cross-program functions that support access to both marketplace Qualified Health Plans (QHPs) and Medicaid. For example, an individual cannot be found eligible for marketplace tax credits and cost-sharing reductions until they are determined ineligible for Medicaid. These shared functions represent an opportunity for achieving savings through efficiencies, but in doing so, states are required to properly attribute funding between programs through a process known as cost allocation.

In exploring cost allocation, it is to a state's advantage to take a broad view of Medicaid and SBM operations, focusing on statewide impacts rather than viewing the operations in silos. States must offer residents access to a public and private continuum of affordable health insurance coverage options, with one streamlined online application process. In addition, federal Medicaid matching funds could offset costs for services shared by Medicaid that would otherwise be paid from state general revenue funds or marketplace assessments or fees. As marketplaces have moved to become self-sustaining, it is in a state's best interest to allocate the costs of Medicaid-related operations performed by the marketplace to the Medicaid program.

This brief builds on a prior *State Health Reform Assistance Network* report from January 2013, providing an in-depth view of the mechanics of implementing cost allocation between Medicaid and marketplace programs.[1] Targeted to state policy leaders interested in financing options for state-based marketplaces, it outlines: (1) potential shared administrative services between Medicaid and SBMs that may be cost allocated; (2) cost allocation methods between Medicaid and the marketplace; and (3) available federal Medicaid match funding to support shared administrative tasks. It also provides a step-by-step process for states to develop and submit for federal approval a state-specific cost allocation methodology.

Key concepts

Any discussion of cost allocation must begin with a fundamental understanding of multiple intertwined Medicaid and marketplace financing concepts. This brief first outlines individual concepts, then provides examples to describe how they

For more information, please contact Christian Heiss at *cheiss@chcs.org* or 609-528-8400.

become intertwined. There are three separate concepts that serve as the foundation for cost allocation of administrative functions of SBMs, state Medicaid programs, and where applicable, state Children's Health Insurance Programs (CHIP):

1. **Shared administrative functions and services** between state Medicaid/CHIP programs and SBMs;
2. **Allocating (or splitting) the cost** of shared services appropriately between the two programs; and
3. **New Medicaid federal matching fund opportunities** under the ACA that are designed to promote state Medicaid Programs' ability to support and integrate administrative functions related to eligibility determination with both the federal and/or state marketplaces.

Shared administrative functions and services

Medicaid and marketplace programs must both provide a range of services to ensure efficient eligibility screening, enrollment, and management of health insurance coverage for state residents. To reduce duplication and maximize efficiency, states have explored sharing resources (or the cost of those resources) between programs. Examples of shared services between Medicaid and SBMs include:

- Technology systems and support;
- Customer service and outreach;
- Consumer education;
- Staff training;
- Health plan monitoring; and
- Data collection, analysis, and reporting.

A fundamental marketplace function is determining whether applicants for advanced premium tax credits (APTCs) or cost-sharing reductions (CSRs) are Medicaid eligible. As discussed below, the ACA provided enhanced federal matching funds that support system coordination between Medicaid and SBMs. To take advantage of the enhanced match offered for development and operations of technology systems and for eligibility workers, state Medicaid programs are required to support marketplace eligibility, for example by completing Medicaid eligibility determinations for marketplace applicants and seamlessly sharing the results with the marketplace. This enhanced match has encouraged states to implement eligibility technology systems as well as customer service functions that may be totally combined as shared services, or may be separate but integrally linked.

In addition to eligibility and enrollment, some states are using these technology systems to perform other related functions such as premium billing and sophisticated reporting for the marketplace and/or the state Medicaid program. Many states, including Colorado, Ohio, and Rhode Island, have or are planning to add other human service programs, such as Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP), to the new eligibility technology system and retire the state's legacy eligibility system.[2,3,4] Medicaid and marketplace programs may work together to conduct outreach to potential enrollees, monitor health plans, and provide education regarding health plan choice and use of health benefits, as well as other services or administrative functions that support both programs.

Medicaid/marketplace partnerships can pose challenges in states. Different governance structures, varying degrees of administrative flexibility, and distinct organizational cultures can weigh against close organizational partnerships. Organizational priorities may not be perfectly aligned. Despite these challenges, however, the relatively new SBMs could benefit from the strengths and experiences of state Medicaid agencies. Many Medicaid programs have evolved from fee-for-service (FFS) payers to sophisticated, prudent purchasers, and are now often the largest purchaser of health insurance in many states. Many have significant experience with health plan oversight and monitoring, as well as Medicaid premium assistance programs that have established relationships with the business community. In turn, SBMs offer direct links to the commercial insurance market, the experience that comes with consumer choice, and the creation of state-of-the-art call centers.

Cost allocation: Allocating the cost of shared services

The Centers for Medicare & Medicaid Services (CMS) has clearly stated that state Medicaid programs will pay part of the cost of services shared with state-based marketplaces:

> *"**…in those cases where Exchanges share services and functionalities with Medicaid and the Children's Health Insurance Program (CHIP), those programs must also pay their share.** Using a common set of systems and services for certain*

activities has the potential to reduce all programs' administrative costs over the long run, and deliver better results for consumers...

Once Federal establishment grant funding is no longer available, Medicaid and CHIP funding (on a cost-allocated basis) will continue to be available to support operation and maintenance of shared systems benefitting the Medicaid and CHIP programs. The Medicaid program offers enhanced Federal funding in certain situations and assuming certain conditions and timeframes are met."[5]

Standards for cost allocation, which apply not only to Medicaid, but broadly to federal programs, are specified by the federal Office of Management and Budgets' (OMB) A-87 Circular, last formalized in federal regulation in 2013.[6] It establishes standards for determining costs for federal awards carried out through grants, cost reimbursement contracts, and other agreements with state and local governments and federally recognized Indian tribal governments.

The A-87 Circular specifies that, when federal funds are involved, a combined cost of a good or service should be shared (or "allocated"), if it benefits more than one program or entity. OMB states that such costs should be split or "allocated" according to the relative benefits received by each program or entity. However, the calculation of that benefit and the method by which the allocation is derived are not specified by the circular.

CMS is responsible for ensuring that state Medicaid programs follow OMB's principles when sharing services or functions with other government programs or entities. CMS does not generally specify a method or methods by which Medicaid costs must be allocated in situations where more than one program benefits from a good or service. Instead, CMS created an approval process, where states propose ways to fairly split combined costs between Medicaid and other program(s).[7,8]

It is critical that states explore a variety of methods to split costs, and carefully consider and choose a method for each shared service that will fairly split costs between the programs. Different methods of splitting costs may result in a wide range of available federal Medicaid matching funds. For example, for a particular state, splitting costs between Medicaid and the marketplace by relative number of enrollees may yield a greater Medicaid share, and therefore greater federal share, than splitting costs by number of new applicants.

CMS has approved a variety of methodologies to allocate costs between Medicaid and the marketplace, or to other programs. Medicaid eligibility-related technology and customer service costs can be allocated fully to Medicaid. Costs can be allocated as a percent to Medicaid and a percent to the marketplace if a service is provided as a mix of marketplace and Medicaid services, such as the eligibility technology system or a call center contract. Methods of calculating the cost allocation split between Medicaid and marketplaces that CMS has approved are generally in one of two categories:

- **Methods that measure level of effort**, such as:
  - Number of applications processed by the shared technology system for each program;
  - Number of phone calls to the contact center; or
  - Random moment time studies for shared state staff.
- **Methods that allocate costs by program use**, such as:
  - Number of applicants in a given period for each program; or
  - Number of enrollees in each program at a point in time.

Although CMS does not generally specify which cost allocation methodology should be used, CMS recommends use of the Random Moment Time Study (RMTS) method in situations where government program staff (such as state or municipal employees) are allocated to more than one program. For example, if the job of an employee of either the state Medicaid program or the SBM involves separate distinguishable activities for each program, the employee would periodically keep track of his or her time spent on each program throughout the day over a short period such as several days or weeks. CMS' guidance suggests that states would propose other cost allocation methods to allocate costs for contracted services.

States may consider the following three key factors in testing options for cost allocation methodologies:

1) **The accessibility and availability of data.** The actual allocation percentage of costs to apply to each program for a shared service must be initially calculated for submission to CMS for approval, then periodically validated. It is important to use a methodology where the data will be accessible and available.

2) **Comparison of the financial impact of each methodology on federal revenue.** Different methodologies can yield very different results, and may be different for each service or activity being cost allocated. Therefore, states are advised to test different methodologies using the following steps: (1) calculate the allocation to each program using a variety of methodologies for each service or function; and (2) apply the appropriate federal match rate based on federal program and function.

3) **Likelihood of CMS approval of the cost allocation method.** Using methodologies, or variations of methodologies, that have been previously approved in other states can help increase the likelihood that CMS will approve a state's proposal. However, it is not necessary to use an existing methodology, as states continue to develop and submit new methodologies for approval. For a new methodology, it is important to clearly explain the method as well as why the method is a fair representation of the costs allocated to each program. Conferring with CMS prior to final submission can help a state in addressing any of CMS' concerns and refining the methodology accordingly prior to submission.

Cost allocation: States' experience

States are currently using a wide variety of approved cost allocation formulas between state Medicaid programs and SBMs. States where the Medicaid program and SBM are within the same governmental agency are able to share services more broadly and easily. They may have multiple areas of shared services, including technology and customer service, as well as other administrative functions. These states have been able to make the best use of federal funds claimed by the state through this supportive interagency arrangement.

States that share eligibility system technology have been approved for a variety of cost allocation methodologies, some simple and some quite complex, including:

- By enrolled program population (MA, MD, RI);
- By which program uses each system function (CA, MA);
- Based on the proportion of program population that will use each system function (MN); and
- By function point analysis based on lines of code to split technology development costs (RI).[9]

Resulting cost allocation percentages vary widely by state, reflecting the degree to which functions are shared and the methodology used. A few examples of how states and SBMs are allocating costs for eligibility system technology include:[10]

Approved Cost Allocation through Approved IAPDs for Integrated Eligibility System Technology Design, Development, and Implementation (DDI)		
	Medicaid/CHIP Share	**Marketplace Share**
California: DDI	18%	82%
Massachusetts: DDI	60%	40%
Rhode Island: DDI	36%	64%

New Medicaid federal matching fund opportunities

The ACA requires state Medicaid programs to coordinate with the marketplace in their state. In order to support this coordination, CMS has provided new funding sources for states. These include:

- **90 percent federal matching funds for the design, development, and implementation (DDI) of new or improved Medicaid eligibility determination systems** that states are developing to accommodate the ACA modified adjusted gross income (MAGI) rules and to coordinate coverage with the marketplaces;
- **75 percent federal matching funds for ongoing maintenance and operation (M&O)** of these eligibility determination technology systems; and

- **75 percent federal matching funds for customer service**, including call center activities and eligibility worker activities related to Medicaid application, eligibility determination, and renewal, using new or improved eligibility systems that meet CMS standards and conditions.[11,12]

Each of these new federal funding sources has in-depth guidance with strict conditions for states to meet in order to claim the matching funds.

There are two types of federal Medicaid matching funds, which can be claimed by a state Medicaid program:

1) **Federal Medical Assistance Percentage (FMAP)**
   The FMAP applies to health care payments to health plans and providers. The FMAP rate is at least 50 percent, but differs for each state according to the state's economic indicators. For example, in 2015 Mississippi can receive 73 cents for every dollar spent on Medicaid health care services from the federal government. Each state's FMAP is updated annually based on current economic indicators.

2) **Medicaid Administrative Claiming**
   This applies to state expenditures for the efficient administration of the state's Medicaid program. The standard "administrative claiming" or "administrative match" rate that states can claim is 50 percent. However, there are certain functions for which state Medicaid programs have historically been eligible for a match rate higher than 50 percent, referred to as an "enhanced match rate." In addition to integrated eligibility systems, functions eligible for enhanced match include state Medicaid management information systems (MMIS), which are federally approved information technology systems that process Medicaid provider claims.

In order for state Medicaid programs to secure enhanced federal matching rates for eligibility systems, the state must be compliant with certain conditions, including: (a) accepting the new single streamlined application to make MAGI-based eligibility determinations; and (b) coordinating with the SBM or the federally facilitated marketplace (FFM). Coordination includes sharing administrative services that will support both the marketplace and Medicaid, such as building integrated eligibility systems, or modifying current systems to provide seamless communication between the marketplace and Medicaid technology to transmit referrals, eligibility determinations, renewals, etc.[13]

State Medicaid programs in FFM states may communicate with the FFM and the federal data hub, for the purpose of determining eligibility and enrolling Medicaid eligible individuals and families. The majority of FFM states receive enhanced federal match for new or improved eligibility systems that provide this federal communication link and meet all other conditions.

Initially, federal regulations specified that the 90 percent match for DDI of integrated eligibility system technology would expire on December 31, 2015; the 75 percent enhanced match for M&O of these systems did not have an expiration date.[14] CMS has subsequently announced its intention to remove the time limit on enhanced match for DDI.[15,16]

Current marketplace efforts to further stabilize integrated eligibility systems are considered DDI costs, as CMS has defined such costs as eligible to be paid for with either 1311 funds (which are restricted to eligible DDI expenditures after January 1, 2015),[17,18] or with other marketplace revenue. The Medicaid portion of this system stabilization work, considered DDI, is eligible for 90 percent federal match, provided the expenditures meet the other conditions for 90 percent match.

Customer service centers that support integrated eligibility systems are often shared between Medicaid and marketplaces. Although traditional Medicaid customer service activities are eligible for 50 percent federal match, the Medicaid share of contact center and other customer service costs that are related to Medicaid application, renewal, or eligibility determination using integrated technology are eligible for 75 percent federal match. Medicaid eligibility workers who support work related to application, eligibility, and renewal under income-based rules, using systems integrated with the marketplace are also eligible for 75 percent federal match.[19]

In addition to technology and customer service, state marketplaces and Medicaid programs can partner in other related administrative functions, and allocate the costs across Medicaid and marketplace as appropriate.[20] Outreach and customer education on choosing a health plan and other shared administrative staffing are examples of potential additional shared services and costs.

These activities are eligible for the regular Medicaid administrative federal matching rate of 50 percent. Table 1 outlines activities related to eligibility determination, customer service, and outreach that are eligible for 75 percent FMAP and those that can be matched at 50 percent.

Table 1: Medicaid Administrative Match Rates for Eligibility-Related Functions[21]

Eligible for 75/25 Match Application, Ongoing Case Maintenance, and Renewal Functions*	Eligible for 50/50 Match Policy, Outreach, and Post-Eligibility Functions
■ **Intake** – Application/data receipt (i) ■ **Acceptance** – Edits, verification, and resolution of inconsistencies (ii) ■ **Eligibility determination** (iii) ■ **Outputs** – Issuance of eligibility notices to customer, file updates, and transactions to partners (iv) ■ **On-going case maintenance** activities, including intake activities related to renewals (v) ■ **Customer service**, including call center activities (vi) and out-stationed eligibility worker activities (vii) related to eligibility determination ■ **Maintenance and routine updates**, including routine system maintenance, security updates, and other routine maintenance activities related to the Eligibility Determination System	■ **Outreach and Marketing** – General public outreach, beneficiary education and outreach, including explanation of eligibility policies, program, and benefits ■ **Policy development and research** even if related to eligibility determination standards and methodologies ■ **Staff development and training** even if related to eligibility determination, except for operational readiness training ■ **Community-based application assistance** ■ **Program integrity**, including auditing efforts ■ **Appeals** of final eligibility system determinations ■ **On-going case maintenance activities**, including plan choice/ counseling and enrollment ■ **Customer service**, including call center activities and out-stationed eligibility worker activities, related to beneficiary education, benefits, plan choice/enrollment, and civil rights complaints

*Includes line staff, supervisory staff, and support staff for the activities listed.

i. Activities related to receipt of the application or data related applications.

ii. Manual and automated edits and verification of data.

iii. Activities related to assisting the automated eligibility determination system in the evaluation of the edited, verified data to make an eligibility determination.

iv. Includes the issuance of the eligibility notice to the beneficiary, file updates, and all activities related to notification to partners of the decision (e.g., FFM, SBMs, MCOs, POS, etc.).

v. Includes receipt of data related to the ongoing eligibility and maintenance of a beneficiary's eligibility, such as annual renewals, address changes, income changes, household composition changes, etc., and the related steps as described in notes i, ii, iii & iv above.

vi. Costs of call center staff should be allocated based on the portion of staff time spent performing functions eligible at the 75 percent versus 50 percent federal financial participation (FFP) levels. Those call center functions related to benefits, general beneficiary education, plan choice, and enrollment would only be eligible at the 50 percent FFP level.

vii. Costs of out-stationed eligibility workers entering eligibility application data also would be eligible for 75 percent FFP. Costs of workers conducting consumer assistance would only be eligible for 50 percent FFP.

Choosing a cost allocation formula

The following tables provide a sample calculation of four cost allocation methodologies for call center services provided by the marketplace for Medicaid applicants/eligibles, assuming use of the 75/25 enhanced match for ongoing M&O and customer service. The different methodologies result in different percentages to split costs. Applying the federal match percent of 75 percent to the Medicaid share provides the resulting federal funding to the state. Each methodology results in a different federal revenue scenario. These sample calculations do not take into account activities financed at a 50 percent match rate (see Table 1).

Table 2: Sample Methodologies for Sharing Call Center Services

	Method 1	Method 2	Method 3
Methodology description	**Call center calls**	**Population enrolled who could access the call center**	**Number of FTEs taking calls by program**
Medicaid*	25%	60%	45%
Marketplace*	75%	40%	55%

* Percentages calculated from state program reports

Table 3: Resulting Cost by Program and Funding Source for Each Methodology

	Marketplace (total cost X percent above by method)	**Method 2** (total cost X percentage above by method X 75% federal match)	**Method 3** (total cost X percentage above by method X 25% state match)	**Total Cost**
Method 1	$ 750,000	$ 187,500	$ 62,500	$ 1,000,000
Method 2	$ 400,000	$ 450,000	$ 150,000	$ 1,000,000
Method 3	$ 550,000	$ 337,500	$ 112,500	$ 1,000,000

Options to finance Medicaid state share

Once a state has established an approved cost allocation methodology, the state will have to determine the source of state matching funds to draw down federal funds for shared services. As Medicaid programs work with SBMs that have developed their own sustainability plans, this decision may require analysis and consideration of several possible sources of state funds. Recognized sources of funding for the state share of Medicaid payments include:

- Legislative appropriations to the single state agency;
- Inter-governmental transfers (IGTs);
- Certified public expenditures (CPEs);
- Permissible provider donations; and/or
- Permissible taxes (or "assessments").[22,23]

Permissible taxes and assessments include broad-based taxes such as SBM assessments of commercial payers. Therefore, there is no prohibition on the use and transfer of broad-based premium assessment funds from an SBM to a state Medicaid program to support the Medicaid state share of shared administrative functions.

Implementing cost allocation for shared Medicaid/marketplace services

States that decide to finance shared services between Medicaid and the SBM can follow this process to develop a cost allocation strategy:

1) **Identify marketplace/Medicaid work teams.**
   Assign focused interagency teams to work on the below steps. Assign a deadline for each step, and schedule regular check-ins to discuss progress and potential barriers.

2) **Develop a list of shared services to be cost allocated.**
   Review the SBM budget, including staff, operational expenses, and contracts, to determine where there may be expenditures for functions that benefit Medicaid. In addition, meet with lead operational marketplace staff to clarify marketplace functions that benefit Medicaid enrollees. Develop a final list of shared services, documenting whether expenditures are for: (a) application and eligibility technology development; (b) application and eligibility system operations and maintenance; (c) call center application/eligibility-related calls or tasks; or (d) other administrative functions or services.

3) **Identify potential cost allocation methodologies.**
   Review current cost allocation methodologies used in the state as well as methodologies from other states. Review program reports to look for program measures that could be used to split costs for each shared service. Create several potential cost allocation methodologies for each shared service and identify data sources for each.

4) **Test the methodologies.**
   Perform rough calculations using program statistics and appropriate federal match rate (e.g., 75 percent for call center activities related to application); narrow choice of methodologies for each shared service based on availability of data for validation, comparison of the financial impact of each methodology on federal revenue, and likelihood of CMS approval.

5) **Review and describe exchange financing sources.**
   Identify acceptable state matching fund source(s) available by state fiscal year to finance the plan based on federal Medicaid rules.

6) **Decide on a method for allocating costs between Medicaid and the marketplace.**
   Identify how Medicaid federal claiming will be used to provide funding for SBM expenditures that benefit Medicaid applicants and enrollees, such as call center contracts. Potential options include transfer of dollars to the SBM account or adding Medicaid accounts to SBM contract purchase orders.

7) **Finalize financing and any funds transfer decisions.**
   Meet with anyone, including legal and budget office contacts, who needs to approve decisions about identifying additional state match, transfer of funds between Medicaid and the marketplace, and determining the mechanism for Medicaid to pay a portion of certain marketplace staff, operational expenses, or contracts.

8) **Discuss the state's shared services and cost allocation methodology with CMS.**
Have informal conversations with CMS to verify that the planned cost allocation methodology, services, functions to be cost allocated, and proposed verification data are acceptable and will likely receive approval.

9) **Write an Interagency Agreement.**
The Interagency Agreement should document the agreed-upon responsibilities of Medicaid and the SBM to provide functions/services and clearly specify documentation to be provided, funds to be transferred, and expenditures to be paid/reimbursed. The agreement should be signed by both Medicaid and marketplace directors, and will become final upon CMS approval of the request.

Once a state has followed these steps, the state is ready to submit its Medicaid administrative cost allocation proposal to CMS for approval, using one of the following two processes:

1) **Cost Allocation Plan**
A Cost Allocation Plan should be used when a state is proposing to share ongoing program costs, usually involving other government agency functions that benefit Medicaid. These interagency program costs will usually be claimed by Medicaid at the regular Medicaid federal administrative match of 50 percent. A Cost Allocation Plan requires each of the government programs or entities that are sharing costs to enter into and maintain an up-to-date Interagency Agreement. Cost Allocation Plans may be reviewed by the state's Regional Medicaid Office. Typically, such Interagency Agreements exist between state Medicaid programs and other areas of state and local government such as: mental health and substance abuse authorities; agencies with responsibility for populations with long-term care needs; agencies with responsibility for the aging population; state and local departments of health; and/or special education programs within municipal school systems.

2) **Implementation Advanced Planning Document**
An Implementation Advanced Planning Document (IAPD) is submitted to CMS for approval for Medicaid to claim an enhanced federal match rate for administrative costs (75%, 90%) for a large development project. An IAPD, developed using the CMS template,[24] must be submitted for the state Medicaid program to receive enhanced federal match for an integrated eligibility system, whether integrated with an SBM or the FFM. If a state proposes to share costs between the state Medicaid program and a state-based marketplace, the cost allocation plan is included in the IAPD to request enhanced federal matching funds.

   If there is a proposal to share costs associated with the integrated eligibility technology system, such as with the SBM and/or with human service programs, the IAPD must specify exactly how the shared costs will be split and what documentation will be collected to "validate the methodology" to assure that the shared cost percentages reflect reality. Furthermore, the IAPD requires each of the government programs or entities that are sharing costs to enter into and maintain an up-to-date Interagency Agreement with the state Medicaid program, and to periodically update the cost percentages to reflect current program numbers.

CMS advises states to work closely with CMS during the IAPD process.[25] For example, in drafting the IAPD, the state may wish to consult with the state Medicaid program's CMS liaison to ensure that the state has adequate documentation. Working closely with CMS prior to submission increases the likelihood that, once the state formally submits the IAPD, it can be approved without delay. IAPDs are submitted to the Central Medicaid Office, the Center for Medicaid and CHIP Services (CMCS) within CMS. CMCS will coordinate review by other CMS centers, such as the Center for Consumer Information and Insurance Oversight (CCIIO), and other federal agencies if needed, such as the U.S. Department of Agriculture (USDA) if any SNAP funding is included.

Conclusion

Implementation of the ACA, in particular the establishment of health insurance marketplaces, has been plagued by twists and turns, from Supreme Court rulings to technology failures at both the federal and state marketplaces. As marketplace establishment grants end and states enter their third open enrollment period later in 2015, many states are only starting to fully consider the impact that cost allocation could have on reducing the impact of marketplace administrative costs on state residents. Other states, responding to perennial budget pressures, may want to review and update existing cost allocation methodologies to achieve additional savings. This brief can provide background for stakeholders not familiar with the general principles of cost allocation, and help state teams assign tasks and establish deadlines to rapidly arrive at necessary agreements and achieve necessary state and federal approvals.

References

[1] V. Guerra, C. Ingram, and S. McMahon. "Financial Sustainability of Medicaid and Exchange Integrated Eligibility Systems: State Cost Allocation Methodologies." *State Health Reform Assistance Network* brief, Robert Wood Johnson Foundation, January 2013.

[2] Guidance to States on the OMB Circular A-87 Cost Allocation Exception. Centers for Medicare & Medicaid Services, August 10, 2011. Available at: *http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/Cost-Allocation-IT-Systems.pdf*.

[3] Additional Guidance to States on the OMB Circular A-87 Cost Allocation Exception. Centers for Medicare & Medicaid Services, January 23, 2012. Available at: *http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-01-23-12.pdf*.

[4] Guidance to States on Extension of A87 Waiver Authority. Centers for Medicare & Medicaid Services, October 28, 2014. Available at: *http://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/downloads/medicaid-90/10-funding-extension.pdf*.

[5] Supplemental Guidance on Cost Allocation for Exchange and Medicaid Information Technology (IT) Systems Questions and Answers. Centers for Medicare & Medicaid Services, October 5, 2012. Available at: *http://medicaid.gov/AffordableCareAct/Provisions/Downloads/Key-Cost-Allocation-QAs-10-05-12.pdf*.

[6] 2 CFR part 200, "Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards" (78 FR 78589; December 26, 2013). Available at: https://federalregister.gov/a/2013-30465.

[7] Affordable Care Act: State Resources FAQ. Centers for Medicaid & Medicare Services, April 25, 2013. Available at: *http://www.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/Affordable-Care-Act-FAQ-enhanced-funding-for-medicaid.pdf*.

[8] Medicaid Eligibility and Enrollment Implementation Advanced Planning Document Template. Centers for Medicare & Medicaid Services, December 19, 2014. Available at: *http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10536.html*.

[9] V. Guerra, C. Ingram, and S. McMahon, op. cit.

[10] Ibid.

[11] Affordable Care Act: State Resources FAQ. Centers for Medicare & Medicaid Services, April 25, 2013. Available at: *http://www.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/Affordable-Care-Act-FAQ-enhanced-funding-for-medicaid.pdf*.

[12] Enhanced Funding Requirements: Seven Conditions and Standards: Medicaid IT Supplement. Department of Health and Human Services, Centers for Medicare & Medicaid Services, April 2011. Available at: *http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/EFR-Seven-Conditions-and-Standards.pdf*.

[13] Ibid.

[14] Centers for Medicare & Medicaid Services, "Medicaid Program: Federal Funding for Eligibility Determination and Enrollment Activities." (76 FR 21949) Federal Register, April 19, 2011. Available at: *https://federalregister.gov/a/2011-9340*.

[15] Fact Sheet: Mechanized Claims Processing and Information Retrieval Systems Proposed Rule (CMS 2392-P), Centers for Medicare & Medicaid Services, April 14, 2015. Available at: *http://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/downloads/90-10-fact-sheet-4-14-15.pdf*.

[16] Centers for Medicare & Medicaid Services. "Medicaid Program; Mechanized Claims Processing and Information Retrieval Systems (90/10)." (80 FR 20455) Federal Register, April 16, 2015. Available at: *https://federalregister.gov/a/2015-08754*.

[17] FAQs on the Use of 1311 Funds and No Cost Extensions. Centers for Medicare & Medicaid Services, March 14, 2014. Available at: *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/no-cost-extension-faqs-3-14-14.pdf*.

[18] FAQs on the Clarification of the Use of 1311 Funds for Establishment Activities. Centers for Medicare & Medicaid Services, June 8, 2015. Available at: *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FINAL-1311-FAQ-06-08-15.pdf*.

[19] Affordable Care Act: State Resources FAQ. Centers for Medicare & Medicaid Services, April 25, 2013. Available at: *http://www.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/Affordable-Care-Act-FAQ-enhanced-funding-for-medicaid.pdf*.

[20] Medicaid Administrative Claiming. Centers for Medicare & Medicaid Services, July 13, 2015. Available at: *http://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/medicaid-administrative-claiming.html*.

[21] Affordable Care Act: State Resources FAQ. Centers for Medicare & Medicaid Services, April 25, 2013. Available at: *http://www.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/Affordable-Care-Act-FAQ-enhanced-funding-for-medicaid.pdf*.

[22] For more information on Medicaid financing and reimbursement, visit: *http://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/financing-and-reimbursement.html*.

[23] State Health Official Letter # 14-001. Health Care-Related Taxes. Center for Medicare & Medicaid Services, July 25, 2014. Available at: *http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SHO-14-001.pdf*

[24] Medicaid Eligibility and Enrollment Implementation Advanced Planning Document Template, op. cit.

[25] Affordable Care Act: State Resources FAQ, op. cit.