October 31, 2011

Centers for Medicaid and Medicare Services
Department of Health and Human Services
Attn: CMS-2349-P
P.O. Box 8016
Baltimore, MD 21244-8016

To whom it may concern:

The American Cancer Society Cancer Action Network ("ACS CAN") is the advocacy affiliate of the American Cancer Society (the "Society"). The Society is a nationwide, community-based, voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer, through research, education, advocacy, and service. The American Cancer Society, operating through its national office and 12 chartered, geographic division affiliates throughout the United States is the largest voluntary health organization in the United States.

ACS CAN appreciates the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) on the Proposed Rule for Eligibility Changes under the Affordable Care Act of 2010 in the Medicaid program published in the Federal Register on August 17, 2011. In particular, we are concerned that the new streamlined categories may make it difficult for disabled and other populations to qualify for the full Medicaid benefits that they are entitled to, such as women who would be eligible for the Breast and Cervical Cancer Treatment Option. Further, it is critical that CMS develop a process to ensure coverage and hold the consumer harmless should the Exchange and Medicaid dispute eligibility determinations differ. We recommend that while disputes are being settled between the Exchange and the Medicaid program, consumers be enrolled in an exchange qualified health plan with appropriate premium and cost-sharing subsidies. Consumers should be held harmless during this period if it is found that their actual enrollment would entail greater costs.

ACS CAN offers the attached comments for your consideration.

Sincerely,

Christopher Hansen
President
Attachment

Template Comments

Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010

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Part 431, Subpart A – Single State Agency

§431.10 Single State Agency

This provision amends the current regulatory provision requiring the designation of a single state agency with overall responsibility to operate the Medicaid program. The changes allow state Medicaid agencies to enter into agreements with government-operated Exchanges to determine eligibility for Medicaid.
One key addition to the current regulation is a specific provision regarding agreements between the single state agency and other federal and state agencies that conduct Medicaid eligibility determinations, including the requirement that merit protection principles be employed by the agency responsible for determining Medicaid eligibility. We support limiting the determination of eligibility to government-operated exchanges and would oppose allowing the eligibility determination to be conducted by non-government Exchanges

While we generally support this provision, there is a need for more specificity and clarification to protect consumers and the integrity of the eligibility determination process. Our specific recommendations follow.

Stronger Standards for "Co-Location:

While not explicitly addressed in the proposed rule itself, the preamble indicates that HHS is considering giving states the option of using "co-location" of Medicaid workers to comply with the merit protection principles outlined in §431.10(d)(5) in states with non-governmental Exchanges. If HHS retains this as an option, we strongly encourage the agency to provide far more expansive and meaningful standards for what constitutes acceptable "co-location." We are concerned that states could have just one or two eligibility workers at sites where a private contractor or other non-governmental entity is processing huge numbers of applications. In these situations, the co-located workers could simply be token representatives who can do no more than rubber stamp the determinations made by a private contractor or other non-governmental entity. Specifically, we suggest including a provision in the final rule that outlines specific standards for ensuring that co-located workers play a meaningful role in eligibility determinations and provides some guidelines for adequate staffing levels if a state elects the option to utilize a non-governmental entity as its Exchange. As an alternative, we suggest that HHS consider requiring that states with non-governmental Exchange contract with the state Medicaid agency to conduct eligibility determinations.

RECOMMENDATION: Include stronger standards for co-location in the final rule.

Ban on Fiscal Incentives to Take Actions that Discourage Enrollment

It is somewhat unclear what role, if any, HHS is envisioning private contractors may play in the eligibility determination process. As noted above, we believe that eligibility determinations for affordability programs are inherently governmental in nature. To the extent that the final rule does allow private contractors to play some role in determining eligibility, we strongly encourage you to add a provision that makes it explicit that they cannot offer fiscal incentives to their workers or any subcontractors that discourage enrollment. For example, private contractors should not provide incentives for employees to meet numerical targets for eligibility determinations or for time spent on a case or a phone call. Section 431.10(c)(3)(ii) begins to address this issue by calling for "no conflict of interest by any agency delegated the responsibility to make eligibility determinations," but it does not clearly apply to any contractors that may be playing a role in eligibility determinations. Along with expanding the scope of this provision, we encourage you to add a clause making it clear that a conflict of interest would certainly include any fiscal incentives to minimize enrollment or take other actions that would directly or indirectly discourage or prevent eligible people from securing coverage.

> **RECOMMENDATION:** The final rule should explicitly ban any fiscal incentives for contractors to take actions that discourage enrollment.

Improper Incentives/Outcomes

The proposed rule requires states to "guard" against improper incentives and outcomes. We recommend stronger language requiring that states ensure that such incentives and outcomes are not permitted, be monitored, and, if found, promptly addressed.

> **RECOMMENDATION:** The final rule should include language on the need to "guard" against improper incentives or outcomes.

State Supervision of County Offices and Other Designees for Eligibility Determinations

The proposed rule requires states to conduct oversight of local agencies and other designees that conduct Medicaid eligibility determinations. This new language is very similar to language already included in §435.903, which has never been enforced. To make the new language meaningful, it is important that CMS include review of compliance with this provision in its own oversight and audits of states. For example, compliance with this provision could be included in the performance standards that HHS has indicated it will be developing for the new eligibility systems.

RECOMMENDATION: Strengthen oversight of states' supervision of their county offices/other designees for eligibility determinations.

Part 433, Subpart E – Methodologies for Determining Federal Share of Medicaid Expenditures for Mandatory Group

All states will receive enhanced federal financial support for the coverage of those determined "newly-eligible" and enrolled under the Medicaid program expansion beginning in 2014. States are required to partner with CMS in developing a method for determining what proportion of Medicaid expenditures should be matched at the enhanced federal rate. CMS intends to evaluate proposed methods according to a strong set of principles including, that no allowable method will establish a shadow eligibility system; that no allowable method will reflect a systematic bias towards either the state or the Federal government; that all allowable methods will limit administrative burden and cost; and, that all allowable methods will be applied transparently using sufficient data. We support these principles. Our comments are intended to clarify the regulatory language to ensure that these principles are upheld.

§433.204 Definitions

The "newly-eligible" definition included in this section of the proposed regulations is different than the statutory definition used to determine eligibility under the Medicaid expansion. Certain states could receive less in federal matching payments for "newly-eligibles" than is appropriate as a result. We recommend that the definition of "newly-eligible" in this section for determining federal Medicaid matching payments conform to the statutory definition for determining Medicaid eligibility.

In §433.204, the "newly-eligible" definition excludes adults who under current state Medicaid eligibility rules qualify for a state expansion program that does not meet the benchmark benefit standard, or that operates with either an enrollment cap or waiting list. For actual eligibility determination however, the statute includes both of these populations among the "newly-eligible." Due to this disconnect, certain states could have Medicaid enrollees who are considered "newly-eligible" under the statutory definition for whom they receive only the regular Medicaid matching rate as opposed to the matching rate appropriate for "newly-eligibles" – either the enhanced matching rate in the case of a non-expansion state or the transition matching rate in the case of an expansion state. For example, Utah operates a Medicaid §1115 waiver program – the Primary Care Network (PCN) – that offers a limited benefit to low-income adults and parents. The PCN is closed and not accepting applications. Although Utahan adults enrolling in the ACA Medicaid expansion would be considered "newly-eligible" under statute because they weren't able to enroll in an existing comprehensive benefit plan, the state would not receive the enhanced federal matching payment for coverage of these adults.

Of additional concern, the "newly-eligible" definition in this section when viewed alongside the definition of an "expansion state" at §433.10(8)(iii) creates the potential for certain expansion states to receive only the regular matching rate for all those determined "newly-eligible" under statute. At §433.10(8)(iii), the criteria defined for an "expansion state" include that the state offer a benefit meeting the benchmark benefit standard. A state such

as Utah that has expanded Medicaid coverage for adults but with a lesser benefit would not qualify as an expansion state, but the adults eligible for the limited benefit program also would not be deemed "newly-eligible" for the purposes of the matching rate. Thus, the state would receive neither the transition matching rate appropriate to an expansion state nor the enhanced matching rate appropriate to "newly-eligible" coverage, but instead would receive only the regular matching rate for their expansion population.

We recommend that both the "newly-eligible" definition in §433.204 and the "expansion state" definition in §433.10(8)(iii) conform to the statutory definition of "newly-eligible" at 1905(y)(2)(A) of the Social Security Act as amended by the Patient Protection and Affordable Care Act. Namely, the definitions should take into account adult status (age over 18), should require the benefit package of an existing expansion program to meet the benchmark benefit standard, and should require that applicants are not excluded from coverage due to capped or limited enrollment.

§433.206 Choice of Methodology

The regulations envision permitting each state to choose from multiple, federally-approved methods for determining what proportion of their Medicaid expenditures is for "newly-eligibles" and thus should be matched at an enhanced rate. We are concerned this creates unnecessary complexity for both states and the federal agency. Thus, we offer the primary recommendation that a hybrid approach based on two of the methods suggested in the regulations – the "threshold method" and the "proportions method" – be used for all states. Acknowledging that there may be demand among the states for flexibility in choosing their methodology, we also will comment on each of the individual methods suggested in the regulations.

We recommend a hybrid method for the "newly-eligible" determination that would be used by each state. In the first three years of the Medicaid expansion – 2014 through 2016, states would use the "threshold method" to determine those "newly-eligible.". In these early years, states would participate in developing a simplified method for determining Medicaid eligibility under the state standards in place prior to the enactment of the ACA and which beneficiaries would be considered "newly eligible." Then, in 2017 and years thereafter, the federal government would coordinate the "proportions methods" using the data gathered from a state's unique experience in the previous three years. This hybrid model would allow each state to establish high-quality benchmark data based on its own application of former and current Medicaid eligibility standards, while then establishing an ongoing process coordinated by the federal government that would reduce the administrative burden on the state.

Regardless of which method a state uses, we are concerned states will require applicants to supply additional information for the purpose of this determination and thus complicate that application process in direct conflict with the principles articulated in the preamble. The regulations do speak to this issue at §433.206(d), but we recommend that this language be enhanced in several ways. First, we recommend that the regulations here cross-reference those at §435.907(c) where the standards of a streamlined application are

established. In addition, we recommend language clarifying that applicants should not be unduly burdened, that applicants will be informed that any additional questions related to determining “newly-eligible” status will not impact Medicaid eligibility, that applicants will receive any necessary assistance in providing supplemental information for this purpose, that electronic data matching will be used to the full extent possible in acquiring necessary information, and that CMS will establish standards for any additional application questions states will implement for the purpose of the matching rate determination. Again, these recommendations apply regardless of which method a state uses.

The regulations envision that CMS will coordinate and communicate with each state to arrive at an acceptable “newly-eligible” determination method. We are concerned that timelines for this process are undefined, or otherwise inappropriate. For example, at §433.206(b) the regulations require a state to submit for approval the “newly-eligible” determination method it will use at least two years prior to the method’s implementation. This seems reasonable and allows time for communication between CMS and the state over the details of the method, and time for the state to develop the administrative structure necessary to implement the method. However, the regulations do not establish a timeframe for CMS’ approval of the method.

We recommend an adjusted and better defined timeframe for communication between CMS and the states with regard to the “newly-eligible” determination method. If permitted a choice of methods, a state should report to CMS its method choice at least two years prior to the date it would be implemented as under the proposed regulations. Then, CMS should be responsible for approving or denying that choice within a 90-day period. If CMS requires more detailed description of the method, a state should be required to submit that information one year prior to the method’s implementation to allow for negotiation between the state and federal government. Then, CMS and the state should arrive at agreement no later than six months prior to the implementation of the method to allow time for the state to develop the administrative structure necessary for implementation.

If CMS were to establish an effective method for evaluating, negotiating, and approving a state’s “newly-eligible” determination method in a timely manner, then we support the policy in §433.206(b) that states must use an approved method for a minimum of three years. This will create stability and reduce the administrative complexity of the “newly-eligible” determination process, as well as allow adequate time for full evaluation and approval of a new approach, if a state so chooses.

§433.208 Threshold Methodology

Should the final regulations permit states to use the “threshold method”, we support several revisions to the regulatory language that describes the standards a state must meet in gathering information.

We recommend the regulations grant states the explicit option to use MAGI-equivalent standards in evaluating eligibility under the “threshold method”. The preamble language suggests this as an option, but the regulatory language does not. The MAGI-equivalent

standard appropriately will take into account disregards and deductions that states use in determining Medicaid eligibility currently. Those with MAGI between the MAGI-equivalent standard for current eligibility and the Medicaid expansion eligibility standard would be deemed "newly-eligible" assuming that they met the assets and disability status standards. States using this option would accomplish the stated goal of providing a simplified eligibility assessment using available data.

The potential for imposing additional burden on the applicant in the implementation of the "threshold method" is high. We recommend that the language in this section explicitly require states first to gather all necessary supplemental information through electronic data matching, or other processes that require no additional information from the applicant. The language in this section also should explicitly require CMS to approve any additional questions asked during the application process for the purpose of the "newly-eligible" determination with emphasis on requiring as little additional information from the applicant as possible, for instance simply checking a box to indicate that they have filed a tax return.

The preamble language indicates that states should not consider their medically needy coverage category in the "newly-eligible" determination. However, the regulations at §433.208(a)(2) are not clear in this regard instead requiring states to "incorporate state eligibility standards, including disregards and other adjustments that were in place in the State on December 1, 2009". We are concerned that without explicit direction to the contrary states may interpret this language to require that they evaluate eligibility under the medically needy coverage category for the purpose of the "newly-eligible" determination. We recommend that the regulatory language explicitly indicate this is unnecessary.

The regulations request comment on whether or not asset holdings should be considered under the "threshold method" for "newly-eligible" determination. Given uncertainty as to whether or not assets will be factored into MAGI-equivalent standards, an evaluation of assets is necessary to ensure that states receive the enhanced matching rate for those who "newly-eligible" because their assets make them ineligible for Medicaid under the current eligibility categories. However, the impact of the assets evaluation on Medicaid applicants should be minimized. Thus, we encourage that the regulations explicitly suggest the use of the Assets Verification System (AVS). By 2013, all states will have to evaluate the assets of all those in their Medicaid program determined eligible under the existent eligibility categories for the aged, blind and disabled. The AVS accesses existing assets information from financial institution databases. States could use AVS data as the basis for their assets evaluation in determining the "newly-eligibles".

The regulations request comment on whether or not disability status should be considered under the "threshold method" for "newly-eligible" determination. First, we recommend that the language explicitly require the state to inform an applicant of their right to ask for a full-eligibility determination as opposed to the standard streamlined process if they feel they might be eligible for a more comprehensive set of benefits if determined eligible under a disability category. Then, we recommend that, for the general purpose of the "newly-

eligible" determination, applicants not have to provide any additional information on disability status but rather that the state pull from existing data.

Finally, CMS would require a state choosing the "threshold method" to receive CMS approval of the detailed methodology of its plan prior to implementation. However, we are concerned that CMS does not define a timeline by which states must submit the plan, nor by which CMS must grant approval. Please see our earlier comments on §433.204 for an overall timeline recommendation.

§433.210 Statistically-Valid Sampling Methodology

The "sampling method" suggested in the regulations is unworkable. It threatens to create a scenario under which a state operates a "shadow eligibility system" thereby violating several of the core principles suggested in the preamble language. We strongly oppose the inclusion of the "sampling method" among the options available to a state for its "newly-eligible" determination method.

The "sampling method" would require states to complete, for a sample of the Medicaid enrolled population, a full-eligibility determination under both the former and current Medicaid eligibility standards in the state. We are concerned this would require the state (either during the application process or during a later "sampling period") to ask a more detailed set of questions of all those enrolled under the new adult eligibility group in order to have the information necessary to complete both eligibility determinations.

§433.212 CMS Established FMAP Proportion

The "proportions method" suggested in the regulations provides states a consistent and administratively simple means for their "newly-eligible" determination. Provided that CMS does solicit guidance from agencies and organizations with experience operating eligibility simulation models as suggested in the regulations (§433.212(c)), we believe this is a feasible method. We encourage CMS to consider the Congressional Budget Office, the Urban Institute, and the Agency for Healthcare Research and Quality at HHS as credible sources of information on effective modeling techniques. Despite its potential feasibility, we have a concern related to the implementation of this method.

The "proportion" determined under this method for each state should be the health care expenditures for those identified in the modeling process as "newly-eligible" enrollees in Medicaid as a proportion of total health care expenditures for all those in the new adult Medicaid eligibility group. Although the regulatory language makes clear that the proportion will be based on expenditures (§433.212(c)(2)), the language in the preamble suggests that instead the proportion would be based on enrollment. We support a proportion based on expenditures and not enrollment because it is quite possible that Medicaid expenditures for the "newly-eligible" group will be different than for those adults eligible for Medicaid under current standards.

While we support the use of MEPS, MSIS, and CPS data as the foundation for the implementation of the "proportions method," there are some serious concerns regarding sample size, especially for smaller states, in MEPS and CPS data. As a result, some of the modeling may be considered invalid by some states if based solely upon these data. So that the results are not rejected off hand on the basis of insufficient data, CMS should work with experts to continue to investigate other potential national data sources (e.g., ACS) or state-specific data (e.g., enrollment and expenditure data following several years of implementation of the ACA).

Part 435, Subpart A – General Provisions and Definitions

Part 435, Subpart B – Mandatory Coverage

<u>Consolidation of Eligibility Groups</u>

We are concerned about the consolidation of existing mandatory and optional eligibility groups into three categories starting in 2014: parents and other caretaker relatives (§435.110), pregnant women (§435.116), and infants and children under age 19 (§435.118). We understand that these categories will complement the new adult group (§435.119). Such consolidation will make enrollment less complicated, which is a laudable accomplishment. However, it is vital that consumers have a right to a full Medicaid determination, whether or not they are found eligible for the new adult group and the ability to select the eligibility category that is in the best interest of the consumer.

<u>Income Standard</u>

For each of the new eligibility categories, states are required to establish income standards in state plans using the minimum and maximum income tests set out in these regulations. Yet HHS is not requiring states to convert their minimum eligibility standards to a MAGI-equivalent standard. This means that states will not have to account for disregards that are currently employed in the state when determining the minimum income standard for MAGI-based Medicaid. As a result, individuals currently eligible under some of the mandatory categories will lose eligibility.

In the preamble discussion of these new eligibility categories, HHS indicates it considered whether or not states should convert the federal minimum income standards prescribed in statute to a MAGI-equivalent standard based on the income exclusions and disregards currently used by the state. HHS admits that doing so would maintain eligibility for individuals who may otherwise lose Medicaid due to the elimination of income exclusion and disregards under MAGI. But this would result in different minimum income eligibility standards applied across states and reduce eligibility simplification, and therefore HHS decided not to require conversion to MAGI-equivalent standards.

Yet in the preamble under Proposed Methods for Counting Income Based on MAGI, §435.603(e), HHS indicates that to

> "account for the general elimination of income disregards and to ensure continued coverage at pre-Affordable Care Act levels, per section 1902(e)(14)(A) and (E), States will convert current income standards for eligibility groups under which financial eligibility will be based on MAGI to a 'MAGI-equivalent' income standard."

Therefore the proposed rules are inconsistent and contradictory. In one section, HHS requires states to convert income standards for eligibility to a MAGI-equivalent standard, while in another section it does not.

In addition, the "net equivalency" section of the ACA clearly requires states and the Secretary of HHS to establish an income equivalent test that ensures children eligible for Medicaid do not lose coverage.[1] Despite this, HHS made a policy decision not to require states to convert their minimum eligibility standard to a MAGI-equivalent standard and does not believe the impact on eligibility will be significant. We do not agree with this and below we list the implications of HHS' decision on the different eligibility groups.

- **Parents and Other Caretaker Relatives:** For parents and other caretaker relatives, HHS says if individuals in this category lose eligibility under section 1931 (if a state reduces coverage to the minimum permitted under the statute), these individuals will still retain eligibility under the new adult group. Yet we do not know what scope of benefits individuals in the new adult group will receive, making it difficult to assess the impact of this change. Important benefits may be lost for these individuals in states that choose to provide more restrictive benchmark plans to the new adult group.

- **Pregnant Women:** HHS admits that pregnant women would be affected if a state were to decrease its income standard to the statutory minimum level because the MOE for pregnant women ends in 2014 and there is no other coverage group to which affected pregnant women can be transferred. Therefore, HHS indicates a woman in this situation would "likely become eligible for advanced payments of the premium tax credit for enrollment through the Exchange." This will most likely mean a less generous benefit package for pregnant women.

- **Infants and Children Under Age 19:** HHS states that the impact to children will not be significant because eligibility standards for children must be maintained through September 2019, in accordance with MOE provisions. HHS adds that when the MOE expires, eligibility for "only a small number of children would be affected if a State were to drop coverage to the minimum level permitted." It is unclear what data HHS relied on to make this assumption.

Plus, as mentioned above, the ACA explicitly requires the Secretary of HHS to ensure that the income eligibility thresholds established using modified gross income and household income "will not result in children who would have been eligible for medical assistance on the date of enactment of the Patient Protection and Affordable Care Act no longer being eligible for such assistance."[2] Unlike the MOE provision which expires in 2019, this provision is not time limited. Therefore children are protected beyond the MOE and this proposed regulation is in conflict with the statute.

RECOMMENDATION: For all MAGI-based Medicaid categories, we recommend that HHS require states to convert their minimum eligibility standard to a MAGI-equivalent

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[1] ACA § 2002(a), as amended by HCERA §§ 1004(b)(1)(A) and 1004(e); 42 U.S.C.A. §1396a(e)(14)(A) and (E) (West 2011).

[2] ACA § 2002(a), as amended by HCERA §§ 1004(b)(1)(A) and 1004(e); 42 U.S.C.A. § 1396a(e)(14)(E) (West 2011).

standard to account for disregards and exclusions currently used by the state. The ACA requires such a conversion for children. For uniformity purposes, and to ensure consistent results, the same should apply to all categories in this section. People who are eligible for Medicaid now, should not be made worse off upon the implementation of health reform. This conversion should not be burdensome for the states, and some states may already plan on undergoing a MAGI conversion for the purpose of determining the federal matching rate.[3]

Covered Services for Pregnant Women

States will have the option of offering some pregnant women a limited benefit package that only covers "pregnancy related services." States are only required to cover full-scope Medicaid for women with income below the AFDC income standard in effect as of May 1, 1988, which is significantly less than 133% FPL. This authorizes states to provide fewer services to pregnant women than to adults in the 133% adult expansion group who are not pregnant.

This is problematic because pregnant women will not qualify for the new adult expansion category because they are excluded by statute. And, those who are under 133% FPL cannot qualify for coverage through the Exchange. Thus, there is a segment of low-income women who may not have full-scope health insurance under any of the ACA's options. HHS should modify this regulation to prevent this from occurring since Congress did not intend to make low-income pregnant women eligible for a more limited scope of benefits than other adults with the same income.

RECOMMENDATION: HHS should eliminate the state option in §435.116(d)(1) to provide limited benefits to pregnant women. However, the option to provide enhanced pregnancy-related services as set in §440.250(p) should remain. Pregnancy-related services should be broadly defined since almost any medical condition can impact or complicate a pregnancy. Most states have recognized that all health services provided to pregnant women are pregnancy-related. Therefore HHS should accept the policy of most states as its own. Ultimately, HHS must align coverage for pregnant women with the coverage provided to all other adults.

Coverage for Individuals Age 19 or Older and Under Age 65 at or Below 133% FPL

Coverage under the new adult group may be beneficial to some Medicaid beneficiaries, but can also potentially be detrimental to those with disabilities or who would qualify for the breast and cervical cancer optional eligibility group. These individuals are eligible for traditional Medicaid, but are not being screened for this coverage and therefore may be provided a lesser benefits package under this new eligibility group.

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[3] Depending on which of the three methods the state selects. This would apply to parents and other caretakers.

States are not required to ask any screening questions to determine whether an applicant may benefit from an evaluation based on non-MAGI criteria

Under §435.911, states must promptly and without undue delay furnish Medicaid to those who are under 65 or pregnant, not entitled to Medicare Parts A or B (or title XVIII), and have household income below the MAGI standard. States are only required to collect additional information for individuals not determined eligible for Medicaid under this section. Therefore an individual, who could potentially be eligible for traditional Medicaid based on disability or breast and cervical cancer screening, will not be screened for this coverage because the state is not required to ask the questions that would determine such eligibility. Instead this applicant will get coverage through the new adult eligibility group (for those with income below 133% FPL). HHS confirms this in the preamble, by indicating that states do not need to review whether an individual who meets the applicable MAGI standard is also eligible as a disabled or medically needy individual.

Allowing people with disabilities and women with breast and cervical cancer to qualify under the new adult group is positive because these individuals will get Medicaid benefits more quickly, without having to go through the disability determination process. But at the same time, by not asking applicants if they are disabled or if someone in their household is disabled, individuals are not being screened for traditional Medicaid disability benefits and are being denied the opportunity to potentially receive a better benefits package. HHS indicates that "benefits" will be addressed in future guidance, yet these eligibility determination rules are closely intertwined with benefits, and can have significant ramifications for Medicaid beneficiaries, particularly those with disabilities or costly illnesses such as cancer.

Also, HHS' proposed framework seems inconsistent with Medicaid requirements that: 1) allow beneficiaries eligible for more than one category to have their eligibility determined under the category they select, and 2) provide eligibility will be determined in the "best interest" of the Medicaid beneficiary.[4] Moreover, states' ability to place individuals in a category in which they may only receive benchmark benefits violates 42 U.S.C. § 1396u-7(a)(2)(B) which exempts individuals who qualify for Medicaid on the basis of being disabled from benchmark benefits. Individuals who meet Medicaid's financial and disability requirements qualify for Medicaid on that basis, whether or not the state evaluates them for such coverage. Yet this regulation allows individuals who meet these requirements to receive less comprehensive benchmark coverage in the new adult group even though they qualify for full-scope Medicaid benefits by virtue of their disability and financial status.

Interaction with Application Regulations

Section 435.907 describes the application process using a single streamlined application for all insurance programs. For those who may be eligible for coverage on a basis other than MAGI, states may use either a single, streamlined application and supplemental forms

[4] 42 U.S.C. §1396a(a)(19); 42 C.F.R. §435.404.

to collect additional information needed to determine eligibility on such other basis or an alternative application approved by the Secretary.

However, in these regulations, states are not required to ask any screening questions to determine whether an applicant may benefit from an additional evaluation based on non-MAGI criteria. Nor is a state required to explain the advantages, if any, of receiving coverage under a non-MAGI group, and the need for a further determination, to obtain such coverage. The proposed rules for eligibility determinations under the new groups do not provide an explanation as to how a state is supposed to determine when an individual may be eligible for non-MAGI based eligibility, and therefore use the supplemental or alternative application forms.

As was mentioned in our comments to the proposed rules on Establishment of Exchanges and Qualified Health Plans, it is important for HHS to recognize that there are certain situations when additional information is required to determine eligibility, and therefore HHS must allow the submission of such information in order to make an accurate eligibility determination. Yet, HHS should make sure states do not make their applications overly complicated. Electronic applications should use a "decision tree" in which responses to earlier questions are processed and only-necessary subsequent questions are asked in order to minimize the number of questions each applicant has to answer based on their individual circumstances.5 Also, if additional information is required and the state has elected to use additional forms, only those forms that are needed to make the determination should be sent to the applicant.

Inconsistency with Exchange Regulations

The proposed Exchange regulation 45 C.F.R. §155.345 requires all individuals applying through the Exchange to receive a "basic screening" for non-MAGI eligibility. But the same is not required of the Medicaid agency in these regulations. This inconsistency could lead to different results based on where the individual applies for Medicaid coverage.

> **RECOMMENDATION:** Clarify in the final regulations that applicants have the right to request and receive an eligibility determination under non-MAGI based rules, and explicitly state that the applicant has the right to coverage in the best eligibility category that they qualify for.

Require all states to ask in their applications (streamlined or otherwise) whether the applicant or someone in the applicant's household is disabled.
If the answer is "yes" to the disability question, require a "duty to assist" on the part of the State Agency or other entity taking the application to make sure the individual is enrolled in the best eligibility category they qualify for (even if that is a non-MAGI category).

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[5] See NHeLP comments to the proposed rule on Patient Protection and Affordable Care Act: Establishment of Exchanges and Qualified Health Plans.

Include additional accountability measures by which HHS will monitor states' implementation of these rules to ensure beneficiaries receive the most appropriate form of coverage. Thus, HHS should review states' policies and practices to insure individuals with disabilities and "medically frail" individuals receive the coverage they are entitled to.

Part 435, Subpart C—Options for Coverage

§435.218 Coverage for Individuals Above 133% FPL

We support the creation of this new eligibility group which provides a mechanism for states to cover individuals whose income exceeds the state's income standard for mandatory coverage. HHS describes this as an alternative to income disregards which were used to expand eligibility but will no longer be available in 2014. The creation of this group does not address the issues raised in the previous section regarding MAGI-equivalency conversion because providing coverage under this new eligibility group is optional for states.

Enrollment of Medically Needy and Spend Down Recipients in 209(b) States

In the preamble, HHS indicates that to ease the administrative burden on states and to make it easier for states to enroll eligible individuals under the simplest eligibility category, it has proposed that an individual who is under 65 years old and has income above 133% FPL should be determined eligible under this group, unless based on the information available from the application, the individual can be determined eligible under another eligibility group. However, as an exception, if an individual appears to be eligible as "medically needy" based on information provided, he/she can still be enrolled in this optional group. HHS only mentions this exception in the preamble, and it should be included in the text of the rule. In addition, the regulation should also clarify that this principle applies to spend down recipients in 209(b) states.

> **RECOMMENDATION:** We recommend amending §435.218(b)(1)(iii) as follows:
>
> Are not otherwise eligible for and enrolled for optional coverage under a State's Medicaid State plan in accordance with subpart C of this part, based on information available to the State from the application filed by or on behalf of the individual, except if based on the information provided, the individual appears to be eligible as medically needy. These individuals can still be enrolled in this optional group.

Inclusion of Children in this Optional Group

We support the inclusion of children, if they are not already eligible for Medicaid, in this new optional group. HHS mentions that if a state currently covers children with incomes above 133% FPL in a separate CHIP program, but adopts coverage under this group, the state will shift the children from CHIP to Medicaid. States will still be able to claim enhanced FMAP under title XXI for such children.

This is a positive result because it will enable children to receive full Medicaid coverage, including Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits, enhanced appeal rights and potentially a better benefit package.

Impact on People with Disabilities

Coverage under the new optional group will be beneficial to some individuals, but can also potentially be detrimental to those with disabilities or costly illnesses such as breast and cervical cancer, who are eligible for traditional Medicaid, but are not being screened for this coverage and are therefore provided a lesser benefits package under this new eligibility group. Please see our comments to §435.119 above.

In addition, we recommend a change in §435.218(b)(2) to make it clear that the exception to the rule that Medicaid cannot be provided to higher income individuals before lower income individuals applies only if the state decides to cover particular categories such as pregnant women or children. This is clear in the preamble and the underlying statute but not in the language of the proposed rule, which is broader.

Part 435, Subpart E – General Eligibility Requirements

§435.403 State Residence

<u>Replacement of the Term "Reside"</u>

We strongly support HHS' decision to remove the regulatory language requiring permanency and intent to "remain[ing] permanently and for an indefinite period." Replacing this language with the term "reside" and providing that an individual is a resident if he has entered the state with a job commitment or seeking employment is a very positive step. It will help clarify and reinforce the statutory requirement that individuals must be considered state residents even if they lack a fixed address and helps ensure that migrant and temporary workers are able to establish residency. 42 USC 1396a(b)(2).

We welcome the statement in the preamble that information regarding immigration status is only one piece of evidence regarding an individual's residency and specifically stating that a temporary or time-limited status does not mean that the individual is not a state resident. The fact that an individual has an immigration status that is temporary does not necessarily indicate that he is visiting for personal pleasure or to obtain medical care. Such individuals should be given every opportunity to present evidence demonstrating that they do in fact reside in the state.

To ensure that individuals have this opportunity, we urge HHS to amend the State Medicaid Manual and delete contradictory guidance. In the Manual, HHS instructs states that certain individuals are ineligible for Medicaid because of their temporary admission status, including "foreign students [and] temporary workers including agricultural contract workers. . ." HHS, State Medicaid Manual, § 3211.10. This is inconsistent with HHS' recognition that a temporary or time-limited status does not preclude state residency and should be removed from the Manual to eliminate any possible confusion.

<u>Residence for Children</u>

We generally support HHS' decision to consolidate the definitions of residency for children and eliminate reference to the AFDC program rules, particularly since the AFDC regulation includes the permanency requirement that has now been eliminated. We also concur with HHS' recognition and clarification that the parents' residence alone does not determine a child's residence. 72 Fed. Reg. at 51160.

We believe, however, that it is problematic that state Medicaid agencies will continue to have flexibility to establish state-specific rules governing residency for students. 76 Fed. Reg. at 51160. This is particularly true because, as HHS acknowledges, the Exchange residence definition allows the parent to choose a child's residence. 76 Fed. Reg. 51202, 51229 (to be codified at 45 C.F.R. § 155.305(a)(3)(iv)). HHS has requested input as to whether a uniform residence standard should be applied. 76 Fed. Reg. at 51207. We believe it is desirable to have one federal definition of state residence for students and that

it be the state chosen by the parent. A consistent definition will ensure that there are not conflicting rules in different states. Otherwise, there is a risk that an out-of-state student could be left with no state of residence. Moreover, a uniform rule will help generally, promote establishment of the coordinated eligibility and enrollment system established under ACA §§ 1413 and 2201.

RECOMMENDATION: We recommend adding the following language to § 435.403 as new subparagraph (i)(3):

(3) For an individual under age 21 who is not emancipated or married, is not institutionalized, is capable of indicating intent, and is a full time student living in a different state than his parent or guardian, the state of residence is either the state of residence of the parent or guardian or the state in which the student is attending school, as indicated by the parent or guardian.

Institutionalized Individuals Over Age 21 who are Incapable of Indicating Intent

HHS specifically requested input on whether to change the current state residence policy for individuals living in institutions who do not have the capacity to express intent. We believe that change is necessary. Under current regulations, the residence of an individual who is not placed by a state is usually the residence of the parent or guardian at the time of placement. This can create problems when the parent or guardian of such an individual moves to a different state and wants the institutionalized individual to move to the new state as well.

The current regulations create situations that are not only challenging and unpleasant for families, but may also violate an individual's constitutional rights. At least one court has suggested that the regulations are subject to applications that violate the right to travel. Duffy v. Meconi, 395 F. Supp. 2d 132 (D. Del. 2005). In this case, the plaintiff, Marianne Duffy, had severe disabilities and lacked the capacity to form or state intent. Her parents placed her in an ICF-MR in North Carolina before she turned 21. When Ms. Duffy was in her early 30s, her parents moved to Delaware and wanted her to move to an institution near their new home. The state Medicaid agency refused to accept an application from her or determine whether she was eligible until she actually relocated to Delaware. Unfortunately, Ms. Duffy's disabilities included severe self-injurious behavior and her parents were unable to keep her safe in their home for even a short period of time. Therefore, she could not relocate to Delaware until there was an institutional or group home placement available for her. She could not gain access to such a placement without Medicaid coverage. But, she could not qualify for Medicaid until she actually physically relocated to Delaware.

Ms. Duffy's parents filed suit on her behalf challenging Delaware's application of the residence requirement. The Court granted summary judgment to Ms. Duffy, holding that Delaware's application of the Medicaid residence regulations violated the right to travel.

Duffy v. Meconi, 508 F. Supp. 2d 399 (D. Del. 2007).[6] The state appealed this decision, but the parties reached an agreement that allowed Ms. Duffy to be found eligible for Delaware Medicaid pending her placement in a facility in that state.

To ensure that others do not find themselves in the same situation, new language needs to be added that ensures that individuals who lack the capacity to form and state intent will not be stuck in an institution in a state where their parents no longer live. In addition, though Ms. Duffy was over 21 and never had the capacity to form intent, individuals under 21 or who lost the capacity to form intent after age 21 may also experience the same problem. Therefore, we suggest a regulatory change that applies to any individual who lacks the capacity to form intent.

> **RECOMMENDATION:** We suggest amending the current regulations at § 435.403 to provide that the state of residence for all individuals who lack the capacity to form intent be chosen by the parent or guardian. The exceptions would be if the parent or guardian has abandoned the individual, if an individual has been placed by a state, or, in the case of an individual who lost the capacity to form intent after age 21, there is no legal guardian.
>
> (h) Individuals under Age 21
>
> (4). . .
>
> (i) The parent's or legal guardian's State of residence either at the time of placement or the parent's or legal guardian's current residence, at the choice of the parent or legal guardian (if a legal guardian has been appointed and parental rights are terminated, the State of residence of the guardian is used instead of the parent's); or . . .
>
> (i) Individuals Age 21 and over.
>
> (2). . .
>
> (ii) The parent's or legal guardian's State of residence either at the time of placement or the parent's or legal guardian's current residence, at the choice of the parent or legal guardian (if a legal guardian has been appointed and parental rights are terminated, the State of residence of the guardian is used instead of the parent's); or . . .
>
> (3) For any institutionalized individual who became incapable of indicating intent at or after age 21, the State of residence is the State in which the individual is physically present, except where another State makes a placement. If such an individual has a legal guardian, the State of residence is either the state of residence in which the individual is physically present or, of different and at the option of the legal guardian, the current state of residence of the legal guardian.

[6] The summary judgment decision was vacated pursuant to agreement.

Part 435, Subpart G — General Financial Eligibility Requirements and Options

§ 435.603 Application of Modified Adjusted Gross Income (MAGI)

§ 435.603(a) Basis, Scope, and Implementation

Grace Period for Application of MAGI to Current Beneficiaries

The regulation states in §435.603(a)(3) that for determining ongoing eligibility for those deemed eligible before December 31, 2013 and receiving Medicaid as of January 1, 2014, the use of the MAGI methodology will not be applied until the next regularly-scheduled redetermination or March 31, 2014, whichever is later, if that individual would lose eligibility as a result of the shift to MAGI. Allowing for such a grace period will ensure that individuals are able to maintain their coverage during the initial transition to the MAGI methodology, and is consistent with the Affordable Care Act7

It does, however, require states to review eligibility for all those currently enrolled in the program on January 1, 2014 (and subject to the new MAGI methodology). As is required under the regulation for redeterminations (§435.916), states should conduct these reviews based on information already available to the state and without any additional burden on the beneficiaries. Because states will have enormous workloads in advance of January 2014, consideration should be given to allowing states to maintain regularly scheduled redetermination schedules for their current caseloads. The grace period means that all current beneficiaries should be continued at least until their regularly scheduled redetermination date (or March 31, 2014 if later. All other beneficiaries would presumably be eligible under both current and MAGI rules, so maintaining the regular schedule (with March 31 as the earliest possible termination date) should not change the outcome in a particular case, but would help states in allocating their workloads.

The grace period in §435.603(a)(3)is not carried over to children in the Children's Health Insurance Program (CHIP). In order to consistently apply the new MAGI-based income levels across programs, as well as to ensure that children in CHIP are afforded the same protections as those in Medicaid, §457.315 should also incorporate §435.603(a)(3)

Conversion to MAGI

To account for the elimination of income disregards and ensure continued coverage at pre-ACA levels, states must convert their current income standards to a "MAGI-equivalent" standard for all groups for which eligibility will be determined using MAGI. The preamble indicates that separate guidance will be issued outlining the methodologies states may use to arrive at these equivalent standards. In addition, HHS has issued an RFP requesting

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[7] Section 1902(e)(14)(D)(v) of the Social Security Act as enacted in section 2002 of the Affordable Care Act.

assistance in developing the methodologies for arriving at the MAGI-equivalent standard. While the methodology and process for doing the MAGI conversion is not laid out in this proposed regulation, we strongly recommend that the approach taken to develop such methods and standards be a public and transparent one, both at the national and the state level, as the stakes are incredibly high for current and future Medicaid beneficiaries.

The preamble also discusses allowing states to convert to MAGI prior to 2014 using a section1115 waiver. As with the conversion process itself, the application and approval process for such waivers should be a public one. While the proposed regulations outlining the transparency requirements for section1115 waivers have not been finalized, the public notice and comment requirements in those proposed regulations were strong and should, at a minimum, be followed in such cases where a state is seeking a waiver to implement the MAGI conversion prior to 2014. Given that maintenance of eligibility requirements will remain in place for adults until 2014 and children until 2019, it is especially important that states converting to MAGI in advance of 2014 use a methodology that does not result in the loss of eligibility for current beneficiaries.

<u>Converting Minimum Eligibility Thresholds</u>

§1902(e)(14)(A) requires states to develop thresholds that are not less than the effective income levels in place at the time of enactment. In proposing a simplified approach to eligibility based on the new MAGI methodology, the intent is that eligibility will not change for any of the populations. However, the conversion to MAGI is only required for the maximum effective income levels, not the minimum standards. The preamble states that HHS considered converting the minimums to protect eligibility for those who would lose coverage if a state reduced eligibility to the minimum standards, but chose not to as it would result in different minimum eligibility standards across states and reduce simplification.

However, the minimums, at least as they apply to §1931 coverage for parents (the group most likely to be impacted by such an exclusion), are already disparate throughout the states. Additionally, it is unclear what simplification is lost as a result of such a conversion. The ACA clearly states that a conversion to MAGI is required not only for the purpose of determining income eligibility, but also for "any other purpose applicable under the plan or waiver for which a determination of income is required." As those parents who are covered under §1931 are entitled to a different benefit package than those found to be newly-eligible, it is important to maintain the minimum standards and convert them to MAGI so that these parents continue to receive the benefits they are currently afforded.

§ 435.603(b) Definitions

We support the proposed rule requiring states to count a pregnant woman as two persons in determining her household size. We agree that this method of counting pregnant women, which anticipates the change in household size that will occur after the birth, would promote continuity of coverage for the pregnant woman.

However, we recommend that states be required to always count pregnant women as two persons, whether in determining their own eligibility or in determining the eligibility of their family members. We see significant problems in the proposed rule which makes it a state option to count the pregnant woman as one or two persons when determining the household size of other family members. In such cases, if a state counts pregnant women as only one person, members of the same household could end up in different coverage programs. The problem that would result from the proposed methodology for counting pregnant women is best illustrated by the example below.

Consider a family with household income of $30,000. Members of the family include a pregnant woman, her husband, and their child. In a state that counts a pregnant woman as one person in determining the household size of other family members, the household size of the pregnant woman would be four, putting her household income at 134 percent of the poverty line and the household size of the husband and child would be three, putting them at 161 percent of the poverty line. Consequently, the pregnant woman would be eligible for Medicaid, the child would be eligible for CHIP, and the husband would be eligible for premium credits in the Exchange.

It would be difficult to explain and administer a policy that requires family members who live together and have the same income available to enroll in different coverage. Moreover, this policy would lead to disruptions in coverage for the non-pregnant members of the household. When the pregnant woman gives birth and the addition of the newborn is reported, the child and husband would become eligible for Medicaid, and would have to switch from their current source of coverage to Medicaid. If, on the other hand, the pregnant woman is always counted as two persons in determining the household size of her family members, the entire family would be covered together under Medicaid when they apply. And no changes in coverage would be necessary for any of the family members when the child is born.

We recognize that adopting the recommendation to always count a pregnant woman as two persons raises other questions related to eligibility redeterminations and continuity of coverage for women and members of her family when she becomes pregnant. For example, a woman who receives premium credits in the Exchange could become Medicaid eligible when she becomes pregnant because she would be counted by Medicaid as two persons. Thus, the question arises on whether pregnancy is eligibility factor that must be reported to the Exchange, and whether a medical claim that indicates pregnancy should automatically trigger a redetermination. We believe that it would be undesirable to require a woman to change coverage, because in some instances it would require a woman to switch coverage and plans in the middle of her pregnancy. Depending on the overlap of plans and provider networks participating in Medicaid and the Exchange in her state, she may be required to switch to a different provider which would be significantly disruptive. We recommend that in these situations, the pregnant woman and her family be allowed to keep their current coverage if they so choose, and that a redetermination not be conducted until after the child is born. To ensure an informed choice, families in this situation should receive information about their options, including comparisons of the costs and coverage options available under Medicaid.

§ 435.603(d) Household Income

<u>Not Counting Income of Non-Filers in Determining Household Income</u>

Under (d)(2), the income of an individual who is included in the household of his or her parents, but is not required to file a tax return, is not included in the household income. This is the case whether or not he or she chooses to file a return. In order to be exempt from filing a tax return, these dependents would be earning relatively little. In the 2010 tax year, for example, they could not earn more than $5,700 annually (the threshold to file taxes as a single individual under age 65 who is claimed as a dependent). As their income is minimal and would not likely be available for the purchase of health insurance coverage, excluding it from the calculation of household income in determining Medicaid eligibility is appropriate.

<u>Children Claimed as Tax Dependents by Non-Custodial Parents:</u>

Under (f)(2)(iii) and (f)(3), children who are claimed as tax dependents by their non-custodial parent would be considered in the same household as the custodial parent for the purposes of Medicaid eligibility. We strongly support HHS's decision to not require the child to obtain coverage with the non-custodial parent who claims the child as a tax dependent. It is typically the custodial parent who makes most of the health care decisions for the child. Therefore, it is oftentimes most appropriate for the child to obtain coverage with the custodial parent, and the rules should support this.

In the preamble, HHS discusses an alternative for the child to enroll through the Exchange in which the child lives and be eligible for a premium credit as a member of the non-custodial parent's household. We support making this a choice for the family. However, we note that it raises potential issues that HHS will need to address in the final regulations.

For example, consider a scenario where the custodial parent's income is below the Medicaid eligibility threshold and the non-custodial parent lives in a different state and has income that is in the range for premium credit eligibility. If the non-custodial parent wants to obtain coverage for the child in the Exchange where the child lives, how would the two state Exchanges communicate with each other to determine what the premium credit amount should be? Would the Exchange(s) require income and other information from the custodial parent to determine the child's eligibility for subsidized coverage with the non-custodial parent before determining eligibility for premium credits? Could the lack of coordination between state entities responsible for eligibility determinations result in the child having overlapping Medicaid and subsidized Exchange coverage, which would also potentially cause problems for the non-custodial parent if it is later determined that the child was not eligible for premium credits because he or she was eligible for Medicaid? While we do not have specific recommendations on how HHS can address these thorny issues, we recommend that HHS adhere to the following principles in developing guidance:

- As much as possible, HHS should develop a policy that would result in the child obtaining the most comprehensive coverage for which he or she is eligible.
- The process should ensure the protection and privacy of information of each of the parents in determining which coverage the child should get.
- The process should respect parental choice but also provide for methods to resolve disputes when parents do not agree on what type of coverage children should receive.
- The process should follow the general principles, reflected in the proposed rules, of not requiring more information than is necessary to make an eligibility determination.

<u>Counting "Actually Available Cash Support" as Income</u>

We recommend removing (d)(3) which would require the states to count actually available cash support in certain instances. In determining eligibility for individuals who are claimed as tax dependents, but are not the spouse or child of the taxpayer (e.g., children claimed by their grandparents, or a niece claimed by her aunt), the proposed rules would require states count actually available cash support provided by the taxpayer who is claiming the individual as a tax dependent. We believe this requirement is unnecessary, as well as difficult to implement and enforce.

In these instances where a taxpayer is claiming someone who is not their spouse or their natural, adopted or step child, we agree that it is appropriate to apply the rules in (f)(3) in determining the household and household income of the individuals being claimed as tax dependents. However, we also believe that it is unnecessary to require states to count actually available cash support provided by the taxpayer in determining the household income of the tax dependent. In most cases, the amount of cash support provided, such as allowances or cash gifts, is not likely to be enough to make the individual being claimed as a tax dependent ineligible for Medicaid. Moreover, it is nearly impossible to verify the amount of the cash support.

The requirement to count actually available cash support would pose additional, unnecessary burdens on people applying for Medicaid, as well as state workers who would need to collect and verify the information. We recommend dropping this requirement in the final regulations.

§ 435.603(e) MAGI-Based Income

We understand the rationale provided by HHS for retaining current Medicaid rules around lump sum income, which would count it as income in the month in which it was received and as a resource in following month. However, we believe this could lead to a gap in coverage in certain circumstances. For example, individuals who have lump sum income that would bring their monthly income at the time of application over 138 percent of the poverty line, but whose annual income is less than the Medicaid eligibility threshold, could be considered ineligible for both Medicaid and the premium credits. To prevent such gaps,

we recommend requiring states to take into account reasonably predictable decrease in future income — such as the unavailability of the lump sum income in future months — in determining eligibility. Currently, (h)(3) would allow states to do this, but we recommend making it a requirement instead.

We also support retaining current Medicaid treatment of certain scholarships and grants. We believe that continuing to exclude certain student-earned income in determining Medicaid eligibility is important to keep students from having to choose between forgoing education-related aid or Medicaid.

We also strongly support the proposal to use the most liberal combination of exemptions from both the Medicaid and 36B rules with respect to the treatment of American Indian/Alaska Native (AI/AN) income. By using these existing income exemptions, we believe the proposed rule will maximize access to Medicaid for low-income AI/AN individuals while maintaining enrollment simplification and coordination. Several forms of income are currently disregarded when determining Medicaid eligibility, including distributions from Alaska Native corporations and settlement trusts, distributions from property held in trust, and distributions resulting from certain real property ownership interests. The 36B definitions also provide broad exemptions for AI/AN individuals. By combining both the Medicaid and 36B income exclusions to AI/AN income, distributions from AI/NA trust properties and partnership interests, payments from other ownership interests or usage rights supporting subsistence or a traditional lifestyle, and financial assistance provided to students under the Bureau of Indian Affairs education programs will be included as income exemptions under the new rules.

§ 435.603(f) Household

In developing the rules around household composition for Medicaid, we recognize the tension between aligning Medicaid rules with the premium tax credit rules and ensuring that individuals now eligible for Medicaid do not lose eligibility as a result of the new rules. We believe that in attempting to strike the proper balance, the proposed rule is far too complex. Many individuals and families would have difficulty understanding the proposed household rules, and in some instances the proposed rules would split families across different coverage programs for arcane reasons.

The proposed rules would apply a different method for determining the household of an individual based whether the individual is: (1) a taxpayer; (2) a taxpayer's dependent; or (3) a non-filer or someone who is not claimed as a tax dependent. However, even though the proposed Medicaid household rules are now framed in tax terms, in many instances the rules do not align with the premium tax credit rules for determining who is in a household. Moreover, in some cases the same family will be treated differently depending on how they file their taxes.

We have identified specific situations in which we believe the outcome of the proposed rules is extremely problematic. We discuss those situations in more detail below and provide recommendations on how to address them. However, it is hard to know whether

we have accounted for all such situations. In addition to accepting our recommendations, we urge HHS to revisit the proposed rules and thoroughly examine various scenarios to identify problematic outcomes, so that they can be addressed before a final rule is issued.

In addition, based on the situations we have identified, we are particularly concerned that because of the different treatment for Medicaid and premium credits, some people might fall in a situation where they are ineligible for either program. We therefore also recommend the creation of a "safe harbor" for such individuals, which would make them eligible for Medicaid when application of the rules yields a decision of ineligibility for both Medicaid and premium credits.

Treatment of Married Couples

We support retaining current Medicaid rules that limits the inclusion of spouses in each other's household to those who are living together. We also support HHS's decision not to adopt the rule applied to eligibility for premium credits and require married couples to file a joint return in order to be eligible for Medicaid. We believe that these provisions are particularly important in protecting individuals who are victims of domestic violence. Requiring married couples to file a joint return or to include information about the spouse they do not live with, could lead individuals in domestic violence situations to forgo Medicaid.

In most cases, applying the proposed rules yields the appropriate outcome in families where the parents are married and the parents file a joint return. However, the outcome is vastly different and very complicated when the parents file separate returns. As noted previously, we support HHS's decision to not require married couples to file a joint return to be eligible for Medicaid. However, we recommend that HHS revise its methodology for determining family size for various members of the household in cases where married parents living together file separate tax returns. Under the proposed methodology, each spouse is included in the household of the other spouse despite their filing status. However, the spouse filing a separate return and not claiming the child does not get included in the household of the child.

For example, consider the situation of a married couple, Bob and Mary, who have a common child, Peter. Together, Bob and Mary make $30,000 a year. They live with and provide support for the Bob's mother, Joan. There are three potential ways this family could file their taxes:

- **Scenario 1:** Bob and Mary file a joint tax return and both claim their child, Peter, and the Bob's mother, Joan.
- **Scenario 2:** Bob and Mary file separately. Bob claims Peter and Joan. Mary does not claim anyone.
- **Scenario 3:** Bob and Mary file separately. Bob claims Joan. Mary claims Peter.

The following table illustrates the household compositions that would result when the proposed Medicaid rules are applied to the different filing situations.

	Individuals Included in Household				Household Income	Household Income as % of FPL	Program Eligibility
	Bob	Mary	Peter	Joan			
Scenario 1:							
Bob (husband)	✓	✓	✓	✓	$30,000	134%	Medicaid
Mary (wife)	✓	✓	✓	✓	$30,000	134%	Medicaid
Peter (child)	✓	✓	✓	✓	$30,000	134%	Medicaid
Joan (husband's mother)	✓				$0	0%	Medicaid
Scenario 2:							
Bob (husband)	✓	✓	✓	✓	$30,000	134%	Medicaid
Mary (wife)	✓	✓			$30,000	204%	None1
Peter (child)	✓	✓	✓	✓	$30,000	134%	Medicaid
Joan	✓				$0	0%	Medicaid
Scenario 3:							
Bob (husband)	✓	✓		✓	$30,000	162%	None1
Mary (wife)	✓	✓	✓		$30,000	162%	None1
Peter (child)	✓	✓	✓		$30,000	162%	CHIP
Joan (husband's mother)	✓				$0	0%	Medicaid

[1] Although the income level falls within the limits of premium credit eligibility, failure to meet the requirement to file a joint return when married would result in ineligibility.

In this example, the resulting household for the husband's mother, Joan, is appropriate. Regardless of how the family files its taxes, she would always be evaluated as a household consisting only of herself and considering only her income. The household — and therefore, eligibility — for Bob, Mary and Peter, however, can vary significantly based on how they file.

In this situation, it seems that the ideal outcome, regardless of how the family files its taxes, is the one reflected in Scenario 1. Thus, in the case of married couples who live together, we recommend always treating them as filing jointly — and using the rules that apply to married couples filing jointly — regardless of how that couple files taxes. We believe that this approach makes more sense since it would attribute the same income and household size to the different members of the family, ensuring that they are able to get coverage together as a family.

Unmarried Parents

In addition, we recommend that Medicaid follow the same rule as for premium credits for unmarried parents who have a child in common and who live together but cannot file a joint return. For such families, the problems with the proposed rule are illustrated in the example below.

Consider a couple, Bob and Mary, who are the unmarried parents of a child, Peter. Because they are not married, they cannot file taxes together. Bob claims Peter, while Mary files taxes separately. Bob's annual income is $16,000. Mary's annual income is $13,000. Because the income of both parents is counted in determining eligibility of the child, in this scenario the child would end up in premium credits, whereas both the parents would end up in Medicaid. Application of the proposed rules would split the child's coverage from the parents' coverage, despite the fact that they live together and have the same income available to them.

	Individuals Included in Household			**Household Income**	**Household Income as % of FPL**	**Program Eligibility**
	Bob	**Mary**	**Peter**			
Bob (father)	✓		✓	$20,000	136%	Medicaid
Mary (mother)		✓		$14,000	129%	Medicaid
Peter (child)	✓	✓	✓	$34,000	183%	CHIP or Premium Credits

Alternatively, if Medicaid follows premium credit rules for determining the household in this situation, only the income of the parent claiming the child would be considered, and the child would have the same poverty level income as the parent claiming the child. This would result in the child generally getting coverage with the parent that claims him or her on the tax return. While we understand the proposed rule is based on current Medicaid practice, the availability of premium credits and the use of a tax-based approach require a change in current rules to avoid the potential that children receive less comprehensive coverage than their parents.

§ 435.603(h) Budget Period

Section (h)(1) of the proposed rule states that financial eligibility for applicants and new enrollees is based on current monthly income. For those already enrolled, section (h)(2), allows states to elect to use monthly income or projected annual income for the current calendar year. Section (h)(3), which applies to both applicants and new enrollees and current beneficiaries allows states to choose to adopt a reasonable method to include "a prorated portion of reasonably predictable future income" when determining monthly or projected annual income. We strongly support using projected annual income and taking predictable changes in income into account, but believe this should be a requirement for both new applicants and current enrollees.

Use of Projected Annual Income

In (h)(2), HHS is proposing to allow states to use projected annual income for the current calendar year but only for current beneficiaries. Using projected annual income means a beneficiary would be able to maintain eligibility as long as annual income remains at or below the Medicaid threshold even if monthly income exceeded the threshold for certain months in the year. The rationale for such an approach is to promote the continuity of coverage by minimizing churn on and off and between sources of coverage because of relatively small changes in income or the receipt of a lump sum during the year. Additionally, while the regulation states that such a projection can be made for a calendar year, it should be adjusted to state that the projection can be made for the 12-month period following an eligibility determination to align with the proposed 12-month redetermination period in §435.916. Such an approach to projecting annual income should not be an option for states, but a requirement. It also should not be limited to those who are current beneficiaries, but should be used for those initially applying for coverage, so as not to create a disparity between groups.

In addition, HHS should clarify that this rule does not mean that states will evaluate Medicaid eligibility based on an individual's average income for the calendar year as the Exchange would do. Rather, that states should be able to take into account an individual's current situation and fluctuations in income to project his or her future average monthly income. For example, in the case of an individual with lump sum income at the time he applies for Medicaid, a state should be required to take into account that the lump sum income will not be available to the applicant in the eligibility determination process. This distinction is especially important for families whose income declines dramatically in one month, for example due to the loss of a job. If the family is screened using current monthly income, they could be determined eligible for Medicaid; however, if the state used annual income taking into account past earnings, they may be found ineligible.

Taking Into Account Predictable Changes in Income

States are currently afforded the flexibility to take into account future changes in income that can be reasonably anticipated. The proposed regulation retains this option, under (h)(3).

Taking into account a predictable change in income would not negate the requirement under §435.916(c) that beneficiaries make timely and accurate reporting of changes in circumstances. It would however, allow states to factor in, at the time of application and renewal, knowable changes in income, and therefore make a more accurate assessment of eligibility for the entire year.

Such an approach would go hand-in-hand with using projected annual income in reducing churn and maximizing continuity of coverage. For example, if an individual was employed as a landscaper, his income would fluctuate seasonally. Such an individual would be able to reasonably anticipate that his income would be higher in the summer months and lower in the winter months. Taking into account those fluctuations would ensure continuity of coverage and should be a requirement for states.

The regulation suggests the use of a "prorated portion" of this predictable future income, in determining eligibility. This would, in effect, spread out the increase or decrease in income over the entire year and by doing so eligibility determinations would be more reflective of the individual or family situation over the course of the year. However, such an approach should not alter the treatment of lump sum income, which the regulation requires be taken into account in the month it was received. As mentioned in the comments in paragraph (e) pertaining to the treatment of lump sums, states should be required to take into account the fact that such income would not be available in the future in the eligibility determination process. Treating lump sums differently makes sense, because they are one-time events.

The verification requirements for such predictable changes in income should be no more cumbersome than those required for other income as specified in §435.940. As mentioned in the preamble to section (h)(3), individuals should be able to provide verification through such means as a signed employment contract or a history of fluctuations (for example, past small-business revenue statements). In addition, self-attestation of changes should also be accepted by states, but it will be important to clearly define "reasonably compatible" so that its application is consistent both within and across states. We address this concern in our comments related to section §435.940.

Part 435, Subpart J – Eligibility in the States and District of Columbia Applications

§435.905 Availability of Program Information

In 2014 the need for information about Medicaid and other health coverage programs will be even greater than it is now due to the requirement that all individuals obtain coverage. We support many aspects of the proposed rule on availability of program information and offer recommendations to make it stronger.

The final rule should require that agencies make the following program information available to consumers: eligibility requirements; application and renewal processes and related assistance available; benefits and services provided; responsibilities of applicants, beneficiaries and agencies; and rights of applicants and beneficiaries. Consumers should be provided access to this information through multiple formats and the information should be accessible to persons with disabilities and those with limited English proficiency. Moreover, Medicaid agencies should provide information about all insurance affordability programs rather than just limiting information to Medicaid.

As proposed, the rule requires states to make program information available to "…all applicants and other individuals who request it." The final rule should retain this agency responsibility but should go further and require that program information be made publicly available so that consumers will be able to learn about the program without having to formally request information from the agency. One simple way of accomplishing this is to make it clear that the program information required under this section be made available through the internet website required under section 435.1200(d) of the proposed rule.

We support the requirement that agencies make program information available in an electronic format. Because American adults are increasingly turning to the Internet to learn about products and services, it is vital that program information be accessible electronically. Most states have already recognized the importance of using the Internet to reach consumers and have begun providing program information in this format. The final regulations should retain this requirement but should clarify that the information must be available through the state and/or agency website and that it should provide a link to the state's online application and a link to the Exchange website required by § 155.205(b).

The final rule should expand the list of program information listed in (a) to provide consumers with the following information:

- the application and renewal processes;
- the availability of assistance with applying for and renewing coverage;
- details on covered benefits, including details on benchmark benefit packages or benchmark equivalent benefit packages for newly eligible adults;;
- agency responsibilities; and
- consumer appeals (which was previously required to be available in bulletins and pamphlets was eliminated by the replacement of the current § 435.905(b)).

§ 435.905(b)

We support the requirement that program information be made accessible to persons with disabilities and those who have limited English proficiency. The final regulation should retain this requirement and should specify that program information in all modalities (ie. paper, online, oral, etc.) should be available in plain language at an appropriate reading level, should be available in multiple languages meeting the meaningful access standards for persons with limited English proficiency, and should conform to rules ensuring equal access to persons with disabilities. Specifically, the written information should be available in all languages where the lesser of 5 percent of the population or 500 LEP individuals in a service area speak a language. If there are fewer than 50 persons in a language group that reaches the 5 percent trigger, the information does not have to be translated but instead should have a tag line providing notice in the primary language of the LEP language group of the right to receive competent oral interpretation of those written materials free of charge. Oral language assistance for those seeking program information from the agency in

person or over the phone should be provided in a timely fashion; this could include using a language line contract to connect to interpreter services.

§435.907 Application

In 2014, a single, streamlined application that is a pathway to all health insurance affordability programs will be vital to ensure that eligible individuals get enrolled in the correct program without the burden and potential confusion of having to complete multiple forms to determine eligibility for subsidies. We strongly support this provision of the proposed rule, which codifies Section 1413 (b)(1)(A)(i) of the ACA and requires agencies to use a single, streamlined application to determine eligibility for Medicaid, CHIP, Basic Health (if applicable), premium credits, cost-sharing reductions.

§435.907(a)

The rule states that state Medicaid agencies must require an application for insurance affordability programs. We are concerned that the requirement could be interpreted to negate the automatic enrollment option allowed by section 203 (a)(1)(D) of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). This option allows agencies to automatically enroll children in Medicaid and CHIP without an application. To complete an eligibility determination using this option states must have sufficient information about children from express lane agencies or other data sources. The express lane option requires states to provide families with information about services provided through Medicaid (or CHIP), cost sharing responsibilities, renewal requirements, and other program requirements. Families must affirmatively consents to the enrollment of children but they are not required to complete an application. This option has allowed states such as Louisiana to increase enrollment of eligible children by using data from other state agencies like SNAP. The final rule should clarify that the automatic enrollment option is still allowable.[8]

The rule allows both authorized representative and persons acting responsibility to file an application on behalf of a consumer, but these terms are not defined. The final regulation should clarify the definition of authorized representative and person acting responsibly for the applicant and what can and cannot be done by these third parties on behalf of the applicant. Moreover, applications and other generally available information should clearly explain the powers of authorized representatives and persons acting responsibly for the applicant.. Consumers may unwillingly allow individuals or organizations to act on their behalf.

Authorized representatives should have full capacity to act on behalf of the consumer. Consumers should be aware of this and should affirmatively agree to this in writing on the application itself. It should be clarified that a person acting responsibly is not someone in the household unit; rather he/she is a person assisting applicants in the eligibility process.

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[8] While express lane eligibility is scheduled to sunset prior to the start of the required ACA Medicaid expansion, we are presuming that it will be reauthorized.

The duties of these individuals should be limited to functions that are meant to help a consumer complete the eligibility process and can include function such as being able to determine the disposition of the application and receive notice when the application requires additional documentation or other information. The final rule should require that consumers be clearly informed about the powers they are giving to authorized representatives and persons acting responsibly. Consumers should also be able to terminate the authority of these individuals at any time.

§435.907(b)

As required by section 1413 (b)(1) of the ACA, the rule allows states to use the application developed by HHS or an alternative application developed by the state and approved by the Secretary. We strongly support this rule and believe that the use of the HHS application and the approval process for alternative applications will ensure that applications are not unnecessarily burdensome for consumers. The final regulation should clarify that after HHS has approved the initial application, states should be required to get approval before making any substantive changes such as adding questions.

While we strongly support the single, streamlined application envisioned in the proposed rule, we are concerned that some states may misunderstand the regulation to mean that multi-benefit applications are no longer allowed. If states stop using multi-benefit applications, consumers who wish to apply for multiple assistance programs will have to complete separate applications that require many of the same data elements, to obtain health coverage, Supplement Nutrition Assistance Program or Child Care Subsidies, and/or other benefits. The final regulation should clarify that nothing in the rule should be interpreted to prevent states from having multi-benefit applications in addition to their single, streamlined application for insurance affordability programs. The regulation should clarify that multi-benefit applications which request information that is not needed for eligibility for insurance affordability programs, should provide consumers the opportunity to select which programs they would like to apply to receive. In online, telephone and in-person applications, consumers only need to be asked questions that are relevant to the benefits that they have selected to apply for. In paper applications, questions can be sequenced, marked and/or provided in sections so that consumers can easily choose to only complete the health insurance affordability program related questions.

There are also states that currently use the Medicaid application as an application for health coverage that is offered in the state such as health safety-net programs. The final rule should clarify that states will be able to create alternative applications that allow consumers to choose to apply for other health coverage programs.

§435.907(c)

The ACA provides the States with an opportunity to create new eligibility and enrollment systems in the agency and the newly designed Exchanges. These improvements including streamlined applications, coordination between the Exchange and the Medicaid program and data sharing between the Federal and State governments hold tremendous promise for

health care consumers. To the extent practicable and possible the regulations should extend these improvements to the non-MAGI populations as well.

We support the provision allowing states to elect whether to use the single, streamlined application with supplemental forms or an alternative application to collect information needed for those eligible for coverage that does not use MAGI. Although the regulation requires the alternative application form to be approved by the Secretary, it is unclear if the Secretary must also approve the supplemental forms. Additionally, the rule does not specify that the supplemental forms and alternative applications must be held to the same standards as the single, streamlined application in (b) of this section. If left unchanged, individuals who are aged, blind, disabled, etc. could be required to complete applications that are unnecessarily burdensome. The final rule should require that the supplemental forms and alterative applications be approved by the Secretary when first developed and when substantive changes are made. The rule should also require that these forms only require minimum additional information necessary to determine eligibility and be structured to maximize applicants' ability to complete the forms as required by section 1413 (b)(1)(A). The final rule should also ensure that when supplemental forms are used, they should be provided with the initial application. Sending forms after the initial single, streamlined application is submitted risks creating delay in the eligibility determination and, if determined eligible, the receipt of the benefit. When supplemental forms are used, the application should prompt consumers to complete the supplemental if consumer meets specific criteria such as higher income, possible disability and/or the consumer is over 65 years old.

Alternative Application for Non-MAGI Applicants

We understand that some non-MAGI populations, such as the long term care population may need to submit information beyond what must be submitted by the MAGI population and therefore alternative applications may need to be developed.

For non-MAGI populations that will need to submit information beyond what must be submitted by the MAGI population, CMS has outlined two pathways: create a separate streamlined non-MAGI application or require supplemental forms be submitted along with the MAGI application. We request that if an alternative form is created by a State Medicaid agency that the Secretary must approve the application using similar criteria for approving the MAGI application. If a State Medicaid agency decides to require additional forms be submitted along with the streamlined MAGI application, we ask that those forms be reviewed and approved by the Secretary to ensure that the forms are not duplicative or unduly burdensome. Any additional forms should be provided with the initial MAGI application. Sending additional forms to the applicant after the initial application risks creating delay in the eligibility determination and, if determined eligible, receipt of the benefit. Moreover, for populations that can be easily identified as non-MAGIs, the MAGI application should instruct the applicant to go to the appropriate additional forms. The applicant should not be required to fill in information that is unnecessary.

Non-MAGI applicants should have a variety of submission pathways including paper submission. However, all non-MAGI applications should be provided online and allow for

online submission in a manner similar to the MAGI application. Additionally, the regulations must emphasize that regardless of the application pathway, translation and interpretation services are available through the State Medicaid agency.

§435.907(d)

We support the requirement that Medicaid agencies establish procedures to allow consumers to submit applications via the internet, telephone, mail, in person and fax. This provision should be retained to allow consumers the choice of applying in the manner that best meets their need.

§435.907(e)

We strongly support this provision of the proposed rule, which codifies agency obligations when requesting social security numbers (SSN) and citizenship information, based on the Privacy Act of 1974 and Title VI of the Civil Rights Act of 1964. As the preamble points out, this rule reinforces longstanding requirements set forth in the Tri-Agency Guidance Regarding Inquiries into Citizenship, Immigration Status and Social Security Numbers in State Applications for Medicaid, CHIP and other programs that was written and provided to state in 2000. It is extremely important to codify the rules prohibiting states from requiring SSNs from individuals who are not seeking coverage for themselves (non-applicants).. Agencies are still able to request SSNs from non-applicants as long as it is voluntary; it is used only for purposes related to Medicaid eligibility or for administration of the state Medicaid plan and that consumers are notified as such when the number is requested. The rule allows agencies to seek out the number but allows beneficiaries to make informed decisions about providing it. The final rule should retain these requirements to protect civil and privacy rights.

We also commend HHS for pointing out in the preamble, that the Medicaid program's longstanding rules and confidentiality provisions enacted in the Affordable Care Act, limit the use and disclosure of information about Medicaid applicants and recipients. 42 USC §1396a(a)(7). The preamble also clarifies that information from non-applicants that is used to determine an applicant's eligibility must be safeguarded pursuant to Medicaid's existing laws. These clarifications should be incorporated in the final rule.

Recommendations for Information Not Addressed in the Proposed Regulation

While this rule is silent on combining the single, streamlined application with the enrollment form for qualified health plans, the proposed Exchange rule at §155.405 combines these two documents. Since the single, streamlined application is supposed to be the same for all insurance affordability programs, we are concerned that this would be the same for the single, streamlined application that the Medicaid agency is required to use. As we stated in our comment on proposed regulation §155.405, the Medicaid regulation should clarify that eligibility applications are separate from enrollment forms.

Consumers who want to enroll in insurance affordability programs will generally have to complete three separate but related tasks: 1) go through an eligibility process 2) use the eligibility determination to understand his/her choices 3) make a selection and enroll in a health plan (for those found eligible for QHP and/or Medicaid/CHIP in the case the state requires a managed care selection). Assuming eligibility can be determined in "real time" it is possible that these steps can be completed in one sitting when a consumer uses an online, phone or in-person application process. However, even in these cases, consumers may want some time to think about their options, and to consult with others before selecting and enrolling in a plan. It is unlikely that the three steps can occur when a consumer completes a paper application. In that case, consumers will not know the outcome of their eligibility determinations and thus will not know what choices they have in selecting a plan. To allow consumers to know the result of the eligibility determination, allow them time to make a decision and complete the enrollment process at their own pace without potentially affecting their application date and date of eligibility, the final regulation should clarify that the application for eligibility should be separate from the enrollment form. The regulation can further clarify that to the extent information collected in the eligibility application is relevant, needed and useable in the enrollment form, that information can be extracted for the purpose of completing the enrollment form. In online, telephone and in-person environments this can be done by simply not asking for information that has already been collected. In a paper process, the enrollment form can be pre-populated with information from the eligibility application. Only information absolutely needed by the qualified health plans (QHP) should be provided to those entities. Keeping beneficiary information confidential is another reason to keep the single, streamlined application and enrollment form separate. There is a lot of confidential consumer information on the application that should never be transmitted to the QHP or Medicaid managed care providers.

The preamble of this rule indicates that accessibility and readability will be addressed in further guidance. Persons who are disabled and/or have limited English proficiency should have equal access to the application process. The final rule should clarify state obligations to provide equal access and should ensure that the form(s) in all modalities (ie. paper, online, telephone, etc.) are written in plain language at an appropriate reading level and available in multiple languages. Applications should meet the meaningful access standards for persons with limited English proficiency and should conform to rules ensuring equal access to persons with disabilities.

Specifically, the written application should be translated in all languages where the lesser of 5 percent of the population or 500 LEP individuals in a service area speak a language. If there are fewer than 50 persons in a language group that reaches the 5 percent trigger, the application does not have to be translated but instead should have a tag line providing notice in the primary language of the LEP language group of the right to receive competent oral interpretation of those written materials free of charge. The standard for applications via the telephone and in-person, oral language assistance should be provided in an adequate and timely fashion to everyone requesting assistance; this could include using a language line.

§435.908 Assistance with Application and Redetermination

§435.908(a)

We support the continued requirement that Medicaid agencies allow applicants and beneficiaries to obtain assistance from their choice of individuals through the application and redetermination process. The final rule should retain this requirement and also retain the language in the current regulation that requires Medicaid agencies to allow applicants and beneficiaries the choice to have individuals accompany them or represent them through the application and redetermination process.

§435.908(b)

We commend HHS for including an explicit requirement that Medicaid agencies provide assistance to individuals seeking help with the application or redetermination process. In 2014, many individuals and families will need assistance to understand the coverage available to them and how to access and maintain the coverage. Ensuring that Medicaid agencies provide assistance to individuals will be critical to the effort to maintain high coverage levels envisioned in the ACA. The final regulations should retain this provision.

We strongly support the provision requiring Medicaid agencies to make such assistance available to individuals in person, over the phone, and online. We support giving consumers options for obtaining assistance to ensure individuals have choices that meet their schedules, capacity and need. This provision should be retained. However, this provision needs to further specify standards for Medicaid agencies to ensure that assistance is truly accessible. These standards should include providing assistance both during and outside normal business hours. According to research, parents seeking to enroll their children in Medicaid or CHIP often feel the process is too burdensome, for reasons such as being put on hold for too long when trying to get questions answered and not being able to obtain assistance outside normal business hours (during which most parents work and are unable to take time off to go to an eligibility office or access a computer).9 As HHS develops standards and metrics referenced in several parts of the preamble of this NPRM, HHS should add standards that will ensure adequate access to assistance by measuring agency performance looking at: call abandonment, call wait times, number of days to wait for an in-person assistance appointment, waiting time for online assistance, and other measures.

We strongly support the provision of the rule requiring agencies to ensure that assistance is accessible for people with disabilities and people with limited English proficiency. The final rule should also clarify state obligations to provide equal access and should ensure that assistance in all forms (ie. in person, online, and telephone) meet the meaningful

[9] "Consumer Voices: What Motivates Families to Enroll in Coverage?" (Washington: Robert Wood Johnson Foundation, GMMB, and Lake Research Partners, September 14, 2010), available online at http://www.insurekidsnow.gov/professionals/outreach/webinars/challenging_times_motivate_families_slides.pdf.

access standards for persons with limited English proficiency and should conform to rules ensuring equal access to persons with disabilities.

Specific to persons with LEP, all oral language assistance should be provided in appropriate languages as requested. These services should be provided in an adequate and timely fashion and agencies can use language lines or other services to meet this standard.

Recommendation for Information Not Addressed in this Regulation

The rule does not address the outreach requirements specified in Section 1943(b)(1)(F) of the Social Security Act (added by the Affordable Care Act). The preamble mentions these requirements, but the final regulation should also codify states' responsibility to conduct outreach to vulnerable and underserved populations eligible for Medicaid. HHS should also add measurements and/or standards that will ensure states are conducting sufficient outreach to reach the specific groups identified in the statute.

§435.911 Determination of Eligibility

§435.911(c)(1) Eligibility for Mandatory Coverage on the Basis of Modified Adjusted Gross Income

We are pleased that this provision will allow an applicant who may be Medicaid eligible as disabled or medically needy to immediately enroll into the newly created adult group so long as the applicant meets the non-financial and financial MAGI eligibility criteria. We are, however, concerned that as currently written the regulation does not require further screening of these individuals for non-MAGI programs for which they may qualify unless the individual affirmatively asks for further screening. If these individuals are not also screened for non-MAGI categories of Medicaid eligibility they may end up with a less generous Medicaid benefit. Given that the proposed guidance on benefits has not been released, we ask that unless the benefit is equal to the benefits under non-MAGI Medicaid these individuals must be screened for and enrolled into the non-MAGI programs for which they might qualify. The individual, who is unlikely to be aware of the various categories of eligibility, should not bear the burden of asking for such screening.

§435.911(c)(2) Eligibility on Basis Other than Applicable Modified Adjusted Gross Income Standard

We are pleased that the guidance instructs State Medicaid agencies to collect additional information needed to make an eligibility determination for non-MAGI applicants. The regulations should encourage States to work to extend the enrollment and data sharing benefits for the MAGI applicants to the non-MAGI applicants. State Medicaid agencies could, for example, utilize State income tax data or asset verification systems to verify information submitted by non-MAGI applicants, rather than requesting additional proof from applicants. This is particularly useful for non-MAGI benefits such as the Medicare Savings Programs (MSPs), which in many States already require only minimal proof of income and assets. Such benefits could easily be folded into the data sharing eligibility and enrollment

improvements extended to MAGI applicants. Additionally, the regulations should encourage States to explore other alternatives such as self-attestation of income and/or assets.

CMS has already clarified that States may use the increased 90%/10% Federal Medical Assistance Percentage (FMAP) to improve eligibility and enrollment systems for the non-MAGIs. CMS should encourage States to carve in the non-MAGI populations before 2015 when these funds will no longer be available. CMS should encourage States, to the extent practical, to guard against bifurcating Medicaid eligibility and enrollment systems. This comment should not be read to suggest that contracting out both MAGI and non-MAGI Medicaid eligibility and enrollment to 3rd parties would guard against such bifurcation. Instead, it should be read to encourage State Medicaid agencies to develop a single enrollment and eligibility process for the MAGI and non-MAGI populations.

The preamble makes clear that the term 'as needed' refers to collecting information that is needed to make an eligibility determination, however, that is not immediately clear in the text of the regulation. We ask that CMS clarify that the term 'as needed' refers to the information needed to make an eligibility determination and not that the State may simply elect not to collect information.

As mentioned we ask that State Medicaid agencies utilize data available from other State agencies such as tax returns and that States utilize electronic asset verification systems. However, we recognize that additional information and documentation may be required from the applicant. If a State has elected to use a single non-MAGI application with additional forms, we ask that only those forms that are needed to make an eligibility determination be sent to the applicant. The regulations should make clear that the request should be tailored to that particular applicant. Similarly, if the State has elected to use a modified application for the non-MAGI population, the applicant should be sent a modified application with the already submitted information pre-populated into the application.

The Low Income Subsidy, or Extra Help, is the program that helps eligible Medicare beneficiaries pay for Medicare Part D prescriptions. Although it is not currently defined as an insurance affordability program, we ask that CMS include the Low Income Subsidy in the insurance affordability program definition and that State Medicaid agencies be required to screen for this benefit.

§435.916 – Periodic Redeterminations of Medicaid Eligibility

We strongly support the overall approach of this section. We believe these rules will reduce administrative burden on states and improve retention among eligible beneficiaries. The proposed changes build on state practices that have had documented success in reducing staff time, decreasing churn and improving program integrity. These rules additionally come close to aligning Medicaid rules with those proposed for the premium tax credit.

§435.916(a)(1)

We commend HHS for requiring that redetermination be completed once every 12 months unless the state has information about changes in circumstances. Although states currently have the flexibility to require redeterminations more frequently, few have chosen to do so for children and parents in Medicaid. This regulation only applies to beneficiaries found eligible for Medicaid based on MAGI, the final rule should retain this requirement and it should be extended to apply to Medicaid beneficiaries that are found eligible for Medicaid on a non-MAGI basis.

§435.916(a)(2)

Consistent with section 1413(c)(3) of the ACA, this regulation requires states to rely on data available from other programs to the maximum extent possible for completing redeterminations of eligibility. We strongly support that the rule requires agencies to first evaluate information available to it from the client file and other reliable third party data sources and make determinations using this information when these sources provide sufficient information to make an eligibility determination.

Section 435.945 gives states flexibility in choosing when to use information that is available from other agencies, stating that the Medicaid agency must use that information "to the extent the agency determines such information is useful to verifying the financial eligibility of an individual. We recommend that states be required to use data that are available, timely, and accurate. Specifically, to the extent a beneficiary is a current participant in SNAP, the agency should be required to use income information verified for determining eligibility for SNAP to determine Medicaid income eligibility. States already spend considerable effort rigorously evaluating income for SNAP participants at least every six months and participants are required to report changes that would make them ineligible so this information should always be considered timely and accurate. SNAP information should also always be considered to be available to the Medicaid program because Section 1561 of the ACA and related standards approved by HHS, require that states develop their systems to meet interoperability standards that will facilitate data exchange needed to support this data sharing and states have access to 90 percent federal match to develop their systems to support the implementation of the ACA. The final regulation should). We believe that requiring states to use data that is available, timely and accurate (including SNAP data) for the completion of the redetermination process outlined in 435.916(a)(2) will reduce administrative burdens and costs for agencies, be far less burdensome for applicants and beneficiaries, will significantly increase the number of eligible individuals who retain coverage.

We also support the process in the proposed rule. Under this process, when states find beneficiaries are still eligible based on available information, beneficiaries are notified that they remain eligible, and they are not required to sign and return the notice. Beneficiaries only have to respond if any information on the notification is not accurate. This too will significantly increase the number of eligible individuals who remain eligible.

§435.916(a)(3)

Further, we strongly support process required by 435.916(a)(3) for cases when the agency is not able to redetermine eligibility based on available data. This provision requires agencies to provide consumers with forms that the agency pre-populates with available information it has and provides 30 days to respond and provide further information if necessary. We commend HHS for requiring states to use available data sources to verify information but recognizing that those data sources should have been exhausted in implementing the process outlined in 435.916(a)(2), it is likely that the data checks will not yield all the information that is needed to determine eligibility. The final regulation should require that beneficiaries be able to provide reasonable alternative documentation to verify their statements and when such documentation is not available or readily accessible, allow for self attestation.

We support allowing beneficiaries to complete the renewal processes via the Internet, telephone, mail, in-person and fax. This will give consumers the choice of renewing coverage in the manner that best meets their needs and that is most accessible to them.

We strongly support that if a beneficiary is terminated because they fail to complete the renewal processes in 30 days, there is an opportunity to be "reconsidered" if the individual responds to the agency within a reasonable period without the need for the individual to file a new application. The final regulation should retain this rule and set a standard for what is considered to be "timely." As suggested in the preamble, we agree that a 90-day period is appropriate given that coverage can be retroactive for 90 days.

§435.916(a)(4)

We also strongly support the provision requiring the Medicaid agency to assess eligibility for other insurance affordability programs when an individual is determined to be no longer eligible for Medicaid, and to send the pertinent data to the appropriate program for a determination of eligibility. This rule will help promote continuous coverage and should be retained in the final rule.

§435.916(b)

In the preamble HHS seeks comment on whether to extend the MAGI renewal rules and processes to non-MAGI beneficiaries. We strongly support the principles set out in §435.916(a) and would support extending them to all beneficiaries.

In addition, the redetermination process is an opportunity for State Medicaid agencies to determine if there has been a change in the beneficiary's health status, for example if the beneficiary has become disabled or medically needy. However, the onus must not be placed on the beneficiary to proactively identify the potential change in status or eligibility. We believe that the State, rather than the beneficiary, is in the best place to gather needed information and assess any potential change in status. Therefore, the Medicaid agency should do outreach to consumers, requesting that they voluntarily provide health status

updates and, in the course of periodic redeterminations, should be required to screen for eligibility for non-MAGI programs.

§435.916(c) and (d)

The rule requires agencies to have procedures in place to "…ensure that beneficiaries make timely and accurate reports of any change in circumstances that may affect their eligibility." It also requires agencies to redetermine eligibility "when it receives information about changes in a beneficiary's circumstances that may affect his or her eligibility." While we believe the final rule should require beneficiaries to report changes such as loss or gain of household members, loss or gain of employment or change in state residency, we do not believe that the final rule should require beneficiaries to report income fluctuations throughout a 12 month eligibility period. Nor do we believe that the final rule should require agencies to act on fluctuations in income during 12 month eligibility periods. The variability of income is high among persons with low income and we believe that it will be administratively burdensome and costly to require agencies to act on fluctuations that may temporarily make individuals become eligible for premium credits instead of Medicaid. At the very least the final rule should limit the burden on beneficiaries and agencies by only requiring that changes that are likely to change eligibility be reported and acted on. This alternative would still require beneficiaries to report changes in household size, loss or gain of employment and change of state residency and agencies would be required to act on those changes. However, beneficiaries would only be required to report income changes that would have the effect of putting them over the Medicaid income threshold and agencies would only be required to act on such changes. This alternative approach would require that enrollment agencies notify beneficiaries of a monthly dollar amount that would put them over the income threshold are require that beneficiaries report if their income goes above that threshold and is reasonably expected to stay above that threshold on an annual basis.

Additionally, it is important to consider, as individuals transition from MAGI beneficiaries to non-MAGI beneficiaries, such as those about to turn 65, agencies must conduct beneficiary outreach and education regarding the need to enroll into other insurance affordability programs. These individuals may continue to qualify for Medicaid under another category once they become a non-MAGI beneficiary. Like the redetermination process this transition process provides the agency with an opportunity to identify a change in Medicaid status and facilitate enrollment into the new eligibility category. The regulations should require agencies to provide this outreach and to facilitate these eligibility screenings and transitions. Moreover, for MAGI-eligible enrollees who have a Medicaid application for a non-MAGI Medicaid benefit, agencies should provide conditional Medicaid enrollment. This will help to ensure continuous insurance coverage and avoid unnecessary gaps in insurance due to application processing delay.

§435.945 General Requirements

The ability of states to verify eligibility by accessing relevant data electronically will revolutionize the application process. It will ease administration for states and simplify

enrollment for consumers. Data sharing systems will only improve, and at some point in the near future states may be able to access significant amounts of relevant eligibility data in real time often leading to instantaneous eligibility determinations.

Data matching for verification should occur upon application, redetermination, and at other appropriate eligibility review junctures, but it should not be an affirmative on-going and real time responsibility for states with regard to Medicaid. Requiring states to conduct behind-the-scene verification on a continual basis places too much burden on states. This problem may be exacerbated by the fact that some databases (such as wage databases) may not be as current as other data sources (such as SNAP) the state has. It also will lead to enrollees having to answer inquiries about new data, missing data, or data "mismatches" with a frequency that could become a major enrollment nuisance and eventually lead to disenrollments for lack of response.

> **RECOMMENDATION:** We recommend that the regulation should be clear in requiring the use of data sharing for the purposes of appropriate verifications at application and redetermination, and as individuals report changes, but not as an on-going real time Medicaid responsibility.

§435.945(a)

Under subpart (a), the proposed rule sets program integrity out as a top priority. Program integrity is a critical programmatic component. However, restating the objective of program integrity in such broad terms serves little practical purpose in the regulation, and instead weakens the regulation by allowing a broad vague exception to all provisions of the regulation if any program integrity interest can be identified. Almost any eligibility decision or verification policy would have some impact on program integrity, and thus the entire force of the regulation is eviscerated. For example, a state could use subpart (a) to justify creating impossibly burdensome barriers in enrollment procedures to ensure that no one ineligible enrolls. The net effect could be simply to prevent eligible individuals from enrolling.

> **RECOMMENDATION:** Program integrity is clearly dealt with under part 455 and is best addressed through those specific regulations, thus the removal of subpart (a) is recommended.

> **ALTERNATIVE RECOMMENDATION:** To the extent subpart (a) is preserved, the language should be altered to protect the integrity of these regulations as a whole; as written, the language in the current proposed regulation provides a state with full authority to violate any other provision of the regulation if it can create any plausible connection to program integrity.

§435.945(b)

We commend the authority for states to accept attestations for most verification purposes. However, we recommend that the regulation be strengthened to require states to accept

attestation for these purposes unless there is a clear reason not to use attestation under specific circumstances. The benefits of the administrative simplicity for states and the reduced barriers for clients far outweigh any potential problems from making attestation the default position. The numerous state programs that use attestation to great success supports this fact. We note, in particular, that the extremely poor population that this regulation addresses is a population that will frequently need to rely heavily on attestations no matter what the regulation says, since they will not be able to otherwise document informal arrangements regarding employment, residence, etc. The harm in requiring attestation is minimal, and the efficiency gained is significant.

> **RECOMMENDATION:** To the extent that the regulation truly seeks to enable use of acceptance of attestation, the regulation should narrow the broad language ("subject to the verification requirements set forth in this subpart") and preamble references to strict § 1137 compliance. While we agree that sometimes (or perhaps, usually) verification flexibility should be secondary to other considerations, we believe that attestation should not necessarily be allowed only subject to all of the other verification requirements in this regulation. State interests in promoting attestation may not be secondary to every other provision of the regulation.

§435.945(c)

We commend the firm requirement on states to request and use eligibility information referred to in § 435.948 through § 435.956, most notably the requirement to use information made available through the federal information hub at § 435.948. We consider it one of the most important functions of this regulation to require states to ask for info from a consumer only if necessary information is unavailable through some other source, like the centralized federal database. This is a critical requirement that will reduce the administrative burden on states and assist consumers who will otherwise have difficulties producing documentation.

§ 435.945(d)

We commend the requirement that states must share information, as specified in subpart (d), in a timely manner.

§ 435.945(e)

We commend the requirement under subpart (e) that states provide other agencies with reimbursement for furnishing relevant information.

§ 435.945(f)

We commend the requirement under subpart (f) to inform individuals that requests will be made to obtain information from other agencies or programs.

To strengthen this provision, we recommend making the following revisions to the final rule:

- States should be required to inform individuals as to the specific data sources that will or may be used to access information.
- Notices should be provided in writing, either electronically or on paper based on the client's preference.
- This notice should be appropriately designed to be accessible to consumers. One way to ensure this is for the regulation to require consumer input on the notice design process.
- The notice should include an explanation of the alternatives (if any) and consequences should the consumer choose not to have one of the data sources contacted.
- Any confidential or especially sensitive information sought, such as information relating to specific illnesses or disability, should have an protections built in and an exceptions process for the individual to avoid having that information accessed and potentially subject to wider data sharing.

§ 435.945(g)

We commend the requirement under subpart (g) that the agency report information about compliance with verification requirements.

RECOMMENDATION: The regulation should require that these data be reported publicly and that the Secretary assess compliance and issue a report of findings. We also recommend that the report include a consumer and consumer advocate survey component as to the effectiveness of the verification process.

§ 435.945(h)

We commend the requirement under subpart (h) that information be exchanged securely and confidentially.

RECOMMENDATION: We recommend that the regulation specify that information can only be requested, shared or used for purposes strictly relevant to eligibility verifications.

§ 435.945(i)

We commend the requirement under subpart (i) that states establish formal agreements to protect information.

RECOMMENDATION: We recommend that these formal agreements require that information can only be used for narrow and relevant verification purposes.

§435.948 Verifying Financial Information

In a teleconference hosted by CMS on October 17, 2011, CMS staff described the verification procedures required in accordance with the proposed rules, including the application of a "reasonable compatibility" standard. We support a definition provided in this teleconference, in which reasonable compatibility between an individual's attestation and the available electronic data are relatively consistent and do not vary in a way that is meaningful for eligibility. For example, if an individual's attestation of income and the income information available through IRS or other databases differ, but both are below the Medicaid eligibility threshold, the individual should be considered eligible and enrolled without delay; the two sources of data need not match one another if both lead to the same eligibility determination. However, this crucial definition is absent from the regulations.

> **RECOMMENDATION:** CMS should define reasonable compatibility as information that is relatively consistent and does not vary in a way that is meaningful for eligibility.

§435.948(a)

Paragraph (a) states that the agency must request information from state, federal, and other databases to the extent that the information is "useful" to verify financial information. This is quite subjective, and could result in some states defining useful in such a way that all available databases are not tapped. Replacing this subjective term with more specific language—available, accurate, and timely—will ensure that states are not required to tap databases that are out of date or not know to provide pertinent information, but that they are required to make full use of the data sources available to them, rather than relying on the application to provide paper verification. The language may help to effectuate the significant culture change that will be required in some states in order to truly modernize eligibility and enrollment.

> **RECOMMENDATION:** Replace the word "useful" in paragraph (a) with "available, accurate, and timely."

§435.948(b)

We commend the requirement that the agency "must" obtain data available from the federal electronic data services established in §435.949.

§435.948(c)(1)

States should be propelled to develop state data hub services that provide the Medicaid and other state agencies access to relevant, useful data to verify eligibility. With the availability of enhanced federal financial support for systems development, state costs will be minimum and quickly offset by administrative savings.

RECOMMENDATION: Change the proposed rule to reflect that the agency "must" obtain the information directly from the appropriate agency or program consistent with the requirements in §435.945 of this subpart.

§435.948(c)(2)

The requirement in (c)(2) to use SSNs as the point of entry into electronic verification of financial information is problematic for mixed status families, in which the applicant may not have an SSN.

RECOMMENDATION: Include references to the requirements that Medicaid and CHIP agencies assist individuals in obtaining an SSN (435.908 and 457.340(a)).

§435.948(d) Flexibility in Information Collection and Verification.

Paragraph (d) allows agencies to obtain the Secretary's approval to use alternative data sources, as long as such alternatives reduce administrative costs and burdens on individuals and states. It is unclear whether agencies would be approved to use such alternatives on a blanket basis (for all applicants at any point in the application process), only when other data sources required by paragraph (a) do not yield useable results, or on an individual basis.

RECOMMENDATION: The regulation should provide more detail as to how alternative sources would be used. This paragraph could explicitly allow the agency to contact the individual's employer to obtain financial information when such information is not available through the federal data hub or through the sources mentioned in paragraph (a). This would still be less burdensome on the applicant than requiring them to supply paper documentation, and could also be faster and more efficient.

Additional Recommendations

Generally speaking, this section does not contain any timeliness requirements. Specific requirements for agencies to verify financial data in a timely manner would strengthen the section.

RECOMMENDATION: Provide specific requirements in terms of timeliness of verifying financial data.

Finally, the regulation text does not appear to suggest the same process for presenting the individual with known financial information and allowing them to affirm or deny it, as is the suggested procedure for exchanges making Medicaid determinations in 155.320(c). The regulation should more explicitly require Medicaid agencies to follow this process, to ensure individuals experience the same eligibility process whether they apply through the Medicaid/CHIP agency or the exchange.

RECOMMENDATION: Require the Medicaid agency to provide individuals with the known financial information and allow them to affirm or deny it.

§ 435.949 Verification of Information through an Electronic Service

§435.949(a)

We commend the creation of the federal electronic service through which States must use to verify eligibility-related information available through the "hub". We recommend that HHS consider expanding the scope of information provided by establishing linkages to state or other databases that contain reliable, relevant eligibility data. In particular, it is a priority for HHS to develop an electronic source that will assist states in determining whether an individual has access to minimum essential coverage.

RECOMMENDATION: HHS should seek to provide as robust a data service hub as possible and to continually improve and expand the sources of information available through it to aid states in verifying eligibility electronically, in real-time.

§435.949(b)

We support the requirement that states must use the information available through the federal data services hub.

§435.952 Use of Information and Requests of Additional Information from Individuals

§435.952 (a)

The rule should clarify the Medicaid agency responsibility to "promptly evaluate information received or obtained by it in accordance with regulations under §435.940 through §435.960 of this subpart to determine whether such information may affect the eligibility…" The final rule should specify timeliness standards for Medicaid agencies to act on information during the initial application and beneficiary redetermination, which will occur once every 12 months. We propose that Medicaid agencies be required to complete such determinations as quickly as possible but under no circumstances should it take more than 30 days.

We do not believe that states should be required to act on fluctuations in income during the 12-month eligibility period. HHS has articulated in the preamble to this NPRM and in sub-regulatory guidance that it expects states will have access to "real time" information about applicants and beneficiaries. Arguably, the state could be said to have access to information of beneficiaries at any time, and thus would continuously be responsible to act when there are fluctuations in income. The variability of income is high among persons with low income and it is unreasonable to expect states to continuously act on fluctuations throughout the 12-month eligibility period. If states are required to do so, many individuals will likely move back and forth between Medicaid and coverage through the

Exchange with premium tax credits throughout the year. This movement between programs would be burdensome to consumers and costly to Medicaid agencies, Exchanges, health plans and medical providers. The final rule should only require Medicaid agencies to act on changes in household size, state residency and loss or gain of employment and should only permit Medicaid agencies to act on fluctuations in income during the initial application and redetermination that occurs once every 12-months.

At the very least the final rule should limit the burden on Medicaid agencies by only requiring that they act on information that is likely to change the eligibility of beneficiaries. This alternative would still require that Medicaid agencies act on changes in household size, loss or gain of employment and change of state residency. However, agencies would only be required to act on income fluctuations that would likely have the affect of putting beneficiaries over the Medicaid income threshold. This alternative would still be labor intensive for Medicaid agencies and should still be limited by only permitting states query data for beneficiaries once every three months.

§435.952(b)

We believe HHS intended to codify section 1413(c) of the Affordable Care Act with this provision. Section 1413(c) requires eligibility for insurance affordability programs to be determined using data matching to the maximum extent practicable. Section 435.952(b) requires Medicaid agencies to make eligibility determinations based on information obtained through data matching when the data are reasonably compatible with information provided on applications or renewals. However, the provision indicates that this should be completed in accordance with the proposed rules §435.948, §435.949 or §435.956. We are concerned that each of these rules is largely optional for states.

Proposed rule §435.945(a) indicates that nothing in the subpart, which includes §435.948, §435.949 or §435.956, should be considered to limit state program integrity efforts. We are concerned that if states wish to continue relying on processes that heavily depend on the collection of paper documentation, they can do so if they believe this will help to ensure program integrity. We believe that the final rule in §435.945(a) should require that if states choose to not implement provisions in this subpart in order to maintain program integrity, they should be required to document how the alternative process will improve program integrity and get approval from the Secretary.

With the exception of the Public Assistance Reporting Information System, the proposed rule §435.948 only requires states to use information in the data sources listed when the state determines that they are useful. The final regulation should provide stronger parameters for states in determining when to use data sources to process eligibility, by replacing the word "useful" in paragraph §435.948 (a) with "available, accurate, and timely."

Additionally, this provision should set parameters in defining what is "reasonably compatible." In cases where there is a difference between the consumer statement and the data match, but in either case the individual would meet the standard for eligibility, the

information should be considered reasonably compatible. HHS should additionally set specific thresholds for states to use so that this standard is applied uniformly across the country. At minimum states should be required to set thresholds and policies that are applied uniformly throughout all entities determining eligibility for any insurance affordability program within a state.

In a teleconference hosted by CMS on October 17, 2011, CMS staff described the verification procedures required in accordance with the proposed rules, including the application of a "reasonable compatible" standard. We support the definition provided in this teleconference, in which reasonable compatibility means an individual's attestation and the available electronic data are relatively consistent and do not vary in a way that is meaningful for eligibility. For example, if an individual's attestation of income and the income information available through IRS or other databases differ, but both are below the Medicaid eligibility threshold, the individual should be considered eligible and enrolled without delay; the two sources of data need not match one another if both lead to the same eligibility determination. However, this crucial definition is absent from the regulations.

§435.952(c)

We strongly support allowing applicant or beneficiary statements to submit statements to explain discrepancies. This provision should be retained in the final rule. We also support agencies must providing consumers with a reasonable period to provide proof. The final provision should define a "reasonable period." We recommend a period of 30 days.

The regulation eliminates the 45 day standard that currently exists in 435.952(c). The preamble says that HHS expects that verification will happen in "real time wherever possible" and they will work with stakeholders to define standards and metrics, which will be defined in further guidance. As we mentioned in our comment to §435.952(a), we believe a timeliness standards should be incorporated into this rule and it should require Medicaid agencies to complete such determinations as quickly as possible but under no circumstances should it take more than 30 days.

§435.952(d)

We strongly support the provision prohibiting the agency from terminating or reducing benefits based on information received through data matching unless the agency has sought additional information from the individual. The final rule should retain this provision, and should also retain "suspend" which is in the current rule. Consistent with rules on application and renewal, the final rule should provide reasonable and multiple methods for consumers to provide documentation such as in-person, by mail, by telephone contact, by fax, and online. Consumers should also have access to assistance they may need to obtain documentation. Finally, the rule should list types of acceptable documentation such as paper documentation provided by applicant/beneficiary, letters from employers, and telephone contact with reliable third party sources (if approved by applicant/beneficiary). The final rule should also clarify that Medicaid agencies may not

require consumers to produce a specific document, for example, the agency cannot say "the alternative must be a pay stub."

§435.956 Verification of Other Non-Financial Information

§435.956(c) State Residency

We strongly support that the Medicaid agency may accept an applicant's attestation of residency to determine eligibility unless the state has information that is not reasonably compatible. Allowing for self-attestation instead of requiring paper documentation will greatly reduce the burden of applying for coverage for applicants and states. We prefer that states be required to accept self-attestation to support consistency of verification among all Insurance Affordability programs.

> **RECOMMENDATION:** To support consistency among all insurance affordability programs, we recommend that states be required to accept self-attestation of residency.

§435.956(e) Pregnancy and Household Size

We strongly support that the Medicaid agency must accept attestation of pregnancy and household members, unless the state has information that is not reasonably compatible. Allowing for self-attestation instead of requiring paper documentation will greatly reduce the burden of applying for coverage for applicants and states.

§435.956(f) Age and Date of Birth

We support that the Medicaid agency may accept an applicant's attestation of age and date of birth to determine eligibility. However, we urge CMS to require that Medicaid agencies "must" accept self-attestation of age and date of birth, unless there is a clear reason to not use self-attestation in a particular circumstance. This will further streamline and simplify the application process for consumers and states.

> **RECOMMENDATION:** The final rule should require that Medicaid agencies must accept an applicant's attestation of age and date of birth to determine eligibility unless there is a clear reason to not accept self-attestation in a particular circumstance.

Part 435, Subpart M – Coordination of Eligibility and Enrollment Between Medicaid, CHIP, Exchanges and Other Insurance Affordability Programs

§435.1200 Medicaid Agency Responsibilities

We support the overall approach of this section, which provides for coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other programs. However, we believe there is a need for more specific standards regarding the timeliness of applications, how consumers will be informed and notified, and how issues that will arise between the various coverage programs will be resolved.

§435.1200(c) General Requirements

We support requirement the Medicaid agency to enter into agreements with the Exchange and other agencies administering insurance affordability programs to ensure coordination. This must be retained in the final rule, and we suggest that HHS provide model agreements for this purpose.

§435.1200(d)—Internet Website

We support the requirement to maintain a Web site that provides information on the various insurance affordability programs, as well a mechanism through which people can apply for and renew coverage. We also support the specific requirement that the website be accessible to people with disabilities and people with limited English proficiency.

While we understand that the agency's intention is to address accessibility in other regulations, we wish to emphasize the importance of making translated materials available on state websites so that limited English proficient individuals can fully participate in these programs and the requirements of Title VI of the Civil Rights Act can be met. Similarly, access for persons with disabilities is critical. We urge HHS to develop specific and thorough regulations governing accessibility. We also recommend that HHS work with states to develop model forms, uniform vocabulary and other materials so that states can avoid expensive duplicative efforts.

We understand the preamble to permit State websites to be either: a single website for information about and enrollment into all insurance affordability programs or a broad health care website that includes information about health insurance coverage and health services. We encourage any State Medicaid website to include information about all coverage and services. However, we ask that the regulations do not permit States to create sites that are merely health care information clearinghouse portals. Instead applicants should be able to fill out and submit applications for all insurance affordability programs from a single site. A webpage that does not allow for online application submission should not satisfy the text of the regulation.

Online applications (as well as telephone screenings and paper applications) should be designed with questions at the start that seek to immediately identify non-MAGI applicants, for example individuals over the age of 65. By identifying these populations early in the application process, the applicant can be directed only to provide information needed for these non-MAGI categories and will not have to provide unnecessary or duplicative information to the State.

§435.1200(e) Provision of Medicaid for Individuals Found Eligible for Medicaid by the Exchange

We support the requirement that the Medicaid agency furnish Medicaid "promptly and without undue delay" to applicants found eligible by the Exchange to the same extent as if they were found eligible by the Medicaid agency. (However, as noted below, we are concerned that current timeliness standards for processing of applications that set an outside limit of 45 days (90 days for a determination of disability) have been repealed.)

§435.1200(f) Transfer of Applications from Other Insurance Affordability Programs to the State Medicaid Agency

We are pleased that the proposed regulations prohibit the State Medicaid agency to request information or documentation from the applicant that is already contained in the transferred application. Similarly, and echoing our comments regarding §435.911(c)2, we ask that State Medicaid agencies consider verifying information already known to other State entities or utilizing data sharing technologies such as asset verification systems before requesting additional information from the applicant.

We also support the requirement that the Medicaid agency electronically transfer applications of individuals determined not eligible for Medicaid to other insurance affordability programs.

§435.1200(g) Evaluation of Eligibility for the Exchanges and Other Insurance Affordability Programs

We applaud CMS for allowing individuals who are eligible for other insurance affordability program to immediately enroll into these programs while a Medicaid determination regarding eligibility on the basis of being blind or disabled is pending.

Additional Recommendations

The challenge of ensuring effective coordination among the various insurance affordability programs is compounded by a number of factors including the lack of alignment of eligibility rules on household composition, timing of income, different treatment of employer coverage, as well as different income standards based on age and disability. Added to this is the fact that exchanges can determine eligibility for Medicaid and CHIP, but unless a state chooses to allow it, Medicaid agencies cannot determine eligibility for premium credits.

These factors heighten the need for clear standards regarding timeliness, dispute resolution, notices, and how hand-offs should be conducted. Moreover, there is an enormous need for consumer assistance, monitoring and oversight and measurable performance standards. While we understand that these areas will be addressed in future guidance, there is a need for further specificity on timeliness standards and "safe harbors" in the rule. Moreover, as mentioned elsewhere in our comments, we are concerned that the rule does not discuss the process for assuring that individuals receive the appropriate benefit package. While, in general, we support a streamlined process that assesses financial eligibility first without determining disability, we cannot fully address the merits of the approach without further information on the benefits issue.

We make the following specific suggestions for the regulation and future guidance:

- **Timeliness standards:** As noted, the 45-day application processing standard (90 days for disability determinations) has been removed from the regulation. In its place are numerous requirements for conducting various activities in a prompt manner without "undue delay." We recommend including specific timeliness standards for electronic transfers, which should take no longer than 24 hours once the need for a transfer is identified, in the final rule. As noted in our comments in §435.952(a), HHS should specify a maximum time period for processing an application, which should be no more than 30 days for applications that do not require a disability determination. There is also a need for timeliness standards for action by the Medicaid agency on an approved application transferred from the Exchange when coverage depends on enrollment in a plan. In these cases, the Medicaid agency should send notices within one business day.

- **Monitoring and enforcement:** To ensure effective coordination of the application process, there should be ongoing oversight by HHS based on meaningful performance measures. HHS should ensure that consumers have adequate means to have their complaints addressed in addition to a formal appeal process.

- **Consumer assistance and notices:** Throughout our comments we note problems that are likely to occur because of the lack of alignment described above. In some instances we recommend ways to mitigate that impact of the lack of alignment. However, in many situations, even with these recommended changes, some families will be split between different forms of coverage and families will often have to change coverage in the middle of the year. Consumers will need help navigating what will still be a complex system. Notices will have to be sent at numerous points in the process, and they should be clear and easily understandable.

- **Need for clear standards on dispute resolution and "safe harbors:"** Despite efforts to clearly delineate eligibility for the different programs, it is very likely that disputes will arise as to which program should cover an individual or family. In some instances, an individual or family may be found ineligible for all coverage

programs even though their income is below 400 percent of the poverty line. HHS should outline clear standards for resolving these cases without delaying benefits and without disadvantage to beneficiaries. The need for these standards will be especially acute in states with a federal exchange in which the state is opposed to health reform. Coverage through qualified health plans participating in the Exchange with appropriate cost-sharing and premium subsidies should be provided as interim coverage if a final determination cannot be made within 30 days.

Part 457, Subpart A – Introduction; State Plans for Child Health Insurance Programs and Outreach Strategies

§457.10 Definitions and Use of Terms
§457.80 Current State Child Health Insurance Coverage and Coordination

Part 457, Subpart C – State Plan Requirements: Eligibility, Screening, Applications, and Enrollment

§457.315 Application of Modified Adjusted Gross Income and Household Definition

The proposed rule adopts the new Medicaid financial methodologies outlined in §455.603 for CHIP. While we support the alignment of financial methodologies between Medicaid and CHIP, in our comments to §455.603, we raise significant concerns about the complexity of proposed rule. Those comments also pertain to CHIP.

We note that HHS makes an exception to the application of MAGI for individuals for whom the state relies on a finding of income made by an Express Lane agency. We support this exception, and believe that it is important to maintain this simplification that has already been adopted in some states.

§457.320 Other Eligibility Standards

We generally support this provision and believe it is desirable for the Medicaid and CHIP residency provisions to be as consistent as possible.

§457.330 Application

The rule states that the state shall use the single, streamlined application required by proposed rule § 435.907(b) and should also comply with most provisions in §435.907 except for those related to non-MAGI applicants. We commend HHS for applying the relevant requirements equally to CHIP and Medicaid. Comments we have made for §435.907 that are applicable to CHIP are as follows:

In 2014, a single, streamlined application that is a pathway to all health insurance affordability programs will be vital to ensure that eligible individuals get enrolled in the correct program without the burden and potential confusion of having to complete multiple forms to determine eligibility for subsidies. We strongly support this provision of the proposed rule, which codifies Section 1413 (b)(1)(A)(i) of the ACA and requires agencies to use a single, streamlined application to determine eligibility for Medicaid, CHIP, Basic Health (if applicable), premium credits, cost-sharing reductions.

<u>§ 435.907(a) as it relates to CHIP</u>

The state must require an application for insurance affordability programs. We are concerned that the requirement could be interpreted to negate the automatic enrollment option allowed by section 203 (a)(1)(D) of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). This option allows states to automatically enroll children in Medicaid and CHIP without an application. To complete an eligibility determination using this option states must have sufficient information about children from express lane agencies or other data sources. The express lane option requires states to provide families with information about services provided through Medicaid (or CHIP), cost sharing responsibilities, renewal requirements, and other program requirements. Families must affirmatively consents to the enrollment of children but they are not required to complete an application. This option has allowed states such as Louisiana to increase enrollment of eligible children by using data from other state agencies like SNAP. The final rule should clarify that the automatic enrollment option is still allowable.10

The rule allows both authorized representative and persons acting responsibility to file an application on behalf of a consumer, but these terms are not defined. The final regulation should clarify the definition of authorized representative and person acting responsibly for the applicant and what can and cannot be done by these third parties on behalf of the applicant. Moreover, applications and other generally available information should clearly explain the powers of authorized representatives and persons acting responsibly for the applicant. Consumers may unwillingly allow individuals or organizations to act on their behalf.

Authorized representatives should have full capacity to act on behalf of the consumer. Consumers should be aware of this and should affirmatively agree to this in writing on the application itself. It should be clarified that a person acting responsibly is not someone in the household unit; rather he/she is a person assisting applicants in the eligibility process. The duties of these individuals should be limited to functions that are meant to help a consumer complete the eligibility process and can include function such as being able to determine the disposition of the application and receive notice when the application requires additional documentation or other information. The final rule should require that consumers be clearly informed about the powers they are giving to authorized representatives and persons acting responsibly. Consumers should also be able to terminate the authority of these individuals at any time.

<u>§ 435.907(b) as it relates to CHIP</u>

As required by section 1413 (b)(1) of the ACA, the rule allows states to use the application developed by HHS or an alternative application developed by the state and approved by the Secretary. We strongly support this rule and believe that the use of the HHS application and the approval process for alternative applications will ensure that applications are not unnecessarily burdensome for consumers. The final regulation should clarify that after

[10] While express lane eligibility is scheduled to sunset prior to the start of the required ACA Medicaid expansion, we are presuming that it will be reauthorized.

HHS has approved the initial application, states should be required to get approval before making any substantive changes such as adding questions.

While we strongly support the single, streamlined application envisioned in the proposed rule, we are concerned that some states may misunderstand the regulation to mean that multi-benefit applications are no longer allowed. If states stop using multi-benefit applications, consumers who wish to apply for multiple assistance programs will have to complete separate applications that require many of the same data elements, to obtain health coverage, Supplement Nutrition Assistance Program or Child Care Subsidies, and/or other benefits. The final regulation should clarify that nothing in the rule should be interpreted to prevent states from having multi-benefit applications in addition to their single, streamlined application for insurance affordability programs. The regulation should clarify that multi-benefit applications which request information that is not needed for eligibility for insurance affordability programs, should provide consumers the opportunity to select which programs they would like to apply to receive. In online, telephone and in-person applications, consumers only need to be asked questions that are relevant to the benefits that they have selected to apply for. In paper applications, questions can be sequenced, marked and/or provided in sections so that consumers can easily choose to only complete the health insurance affordability program related questions.

There are also states that currently use the Medicaid or CHIP application as an application for health coverage that is offered in the state such as health safety-net programs. The final rule should clarify that states will be able to create alternative applications that allow consumers to choose to apply for other health programs.

§ 435.907(d) as it relates to CHIP

We support the requirement that states establish procedures to allow consumers to submit applications via the internet, telephone, mail, in person and fax. This provision should be retained to allow consumers the choice of applying in the manner that best meets their need.

§ 435.907(e) as it relates to CHIP

We strongly support this provision of the proposed rule, which codifies state obligations when requesting social security numbers (SSN) and citizenship information, based on the Privacy Act of 1974 and Title VI of the Civil Rights Act of 1964. As the preamble points out, this rule reinforces longstanding requirements set forth in the Tri-Agency Guidance Regarding Inquiries into Citizenship, Immigration Status and Social Security Numbers in State Applications for Medicaid, CHIP and other programs that was written and provided to state in 2000. It is extremely important to codify the rules prohibiting states from requiring SSNs from individuals who are not seeking coverage for themselves (non-applicants). States are still able to request SSNs from non-applicants as long as it is voluntary; it is used only for purposes related to CHIP eligibility or for administration of the state Medicaid plan and that consumers are notified as such when the number is requested. The rule allows states to seek out the number but allows beneficiaries to make informed decisions about

providing it. The final rule should retain these requirements to protect civil and privacy rights.

We also commend HHS for pointing out in the preamble, that the Medicaid program's longstanding rules and confidentiality provisions enacted in the Affordable Care Act, limit the use and disclosure of information about Medicaid applicants and recipients. 42 USC §1396a(a)(7). The preamble also clarifies that information from non-applicants that is used to determine an applicant's eligibility must be safeguarded pursuant to Medicaid's existing laws. These protections should be extended for CHIP and codified in the final rule.

Recommendations for Information Not Addressed in this Regulation

While this rule is silent on combining the single, streamlined application with the enrollment form for qualified health plans, the proposed Exchange rule at §155.405 combines these two documents. Since the single, streamlined application is supposed to be the same for all insurance affordability programs, we are concerned that this would be the same for the single, streamlined application that the state is required to use for CHIP. As we stated in our comment on proposed regulation §155.405, the CHIP regulation should clarify that eligibility applications are separate from enrollment forms.

Consumers who want to enroll in insurance affordability programs will generally have to complete three separate but related tasks: 1) go through an eligibility process 2) use the eligibility determination to understand his/her choices 3) make a selection and enroll in a health plan (for those found eligible for QHP and/or Medicaid/CHIP in the case the state requires a managed care selection). Assuming eligibility can be determined in "real time" it is possible that these steps can be completed in one sitting when a consumer uses an online, phone or in-person application process. However, even in these cases, consumers may want some time to think about their options, and to consult with others before selecting and enrolling in a plan. It is unlikely that the three steps can occur when a consumer completes a paper application. In that case, consumers will not know the outcome of their eligibility determinations and thus will not know what choices they have in selecting a plan. To allow consumers to know the result of the eligibility determination, allow them time to make a decision and complete the enrollment process at their own pace without potentially affecting their application date and date of eligibility, the final regulation should clarify that the application for eligibility should be separate from the enrollment form. The regulation can further clarify that to the extent information collected in the eligibility application is relevant, needed and useable in the enrollment form, that information can be extracted for the purpose of completing the enrollment form. In online, telephone and in-person environments this can be done by simply not asking for information that has already been collected. In a paper process, the enrollment form can be pre-populated with information from the eligibility application. Only information absolutely needed by the qualified health plans (QHP) or CHIP managed care plans should be provided to those entities. Keeping beneficiary information confidential is another reason to keep the single, streamlined application and enrollment form separate. There is a lot of confidential consumer information on the application that should never be transmitted to the QHP or CHIP managed care providers.

The preamble of this rule indicates that accessibility and readability will be addressed in further guidance. Persons who are disabled and/or have limited English proficiency should have equal access to the application process. The final rule should clarify state obligations to provide equal access and should ensure that the form(s) in all modalities (ie. paper, online, telephone, etc.) are written in plain language at an appropriate reading level and available in multiple languages. Applications should meet the meaningful access standards for persons with limited English proficiency and should conform to rules ensuring equal access to persons with disabilities.

Specifically, the written application should be translated in all languages where the lesser of 5 percent of the population or 500 LEP individuals in a service area speak a language. If there are fewer than 50 persons in a language group that reaches the 5 percent trigger, the application does not have to be translated but instead should have a tag line providing notice in the primary language of the LEP language group of the right to receive competent oral interpretation of those written materials free of charge. The standard for applications via the telephone and in-person, oral language assistance should be provided in an adequate and timely fashion to everyone requesting assistance; this could include using a language line.

§457.335 Availability of Program Information and Internet Website

The rule states that the provisions in §435.905 and §435.1200(d) apply to states that administer CHIP separate from Medicaid. We commend HHS for applying these requirements equally to CHIP and Medicaid. Comments we have made for §435.905 and §435.1200(d) that are applicable to CHIP are as follows:

In 2014 the need for information about CHIP and other health coverage programs will be even greater than it is now due to the requirement that all individuals obtain coverage. We support many aspects of the proposed rule on availability of program information and offer recommendations to make it stronger.

The final rule should require that states make the following program information available to consumers: eligibility requirements; application and renewal processes and related assistance available; benefits and services provided; responsibilities of applicants, beneficiaries and agencies; and rights of applicants and beneficiaries. Consumers should be provided access to this information through multiple formats and the information should be accessible to persons with disabilities and those with limited English proficiency. Moreover, states should provide information about all insurance affordability programs rather than just limiting information to CHIP.

As proposed, the rule requires states to make program information available to "…all applicants and other individuals who request it." The final rule should retain this state responsibility but should go further and require that program information be made publicly available so that consumers will be able to learn about the program without having to formally request information from the state. One simple way of accomplishing this is to

make it clear that the program information required under this section be made available through the internet website required under section 435.1200(d) of the proposed rule.

We support the requirement that states make program information available in an electronic format. Because American adults are increasingly turning to the Internet to learn about products and services, it is vital that program information be accessible electronically. Most states have already recognized the importance of using the Internet to reach consumers and have begun providing program information in this format. The final regulations should retain this requirement but should clarify that the information must be available through the state and/or agency website and that it should provide a link to the state's online application and a link to the Exchange website required by § 155.205(b).

The final rule should expand the list of program information listed in (a) to provide consumers with the following information:

- the application and renewal processes;
- the availability of assistance with applying for and renewing coverage;
- details on covered benefits, including details on benchmark benefit packages or benchmark equivalent benefit packages for newly eligible adults;
- agency responsibilities; and
- consumer appeals.

§435.905(b) as Applied to CHIP

We support the requirement that program information be made accessible to persons with disabilities and those who have limited English proficiency. The final regulation should retain this requirement and should specify that program information in all modalities (ie. paper, online, oral, etc.) should be available in plain language at an appropriate reading level, should be available in multiple languages meeting the meaningful access standards for persons with limited English proficiency, and should conform to rules ensuring equal access to persons with disabilities.

Specifically, the written information should be available in all languages where the lesser of 5 percent of the population or 500 LEP individuals in a service area speak a language. If there are fewer than 50 persons in a language group that reaches the 5 percent trigger, the information does not have to be translated but instead should have a tag line providing notice in the primary language of the LEP language group of the right to receive competent oral interpretation of those written materials free of charge. Oral language assistance for those seeking program information from the agency in person or over the phone should be provided in a timely fashion; this could include using a language line contract to connect to interpreter services.

§435.1200 (d) as Applied to CHIP

We support that the proposed rule requires states to maintain a web site that provides information on the various insurance affordability programs along with an opportunity to apply for and renew coverage and the specific requirement that the website be accessible to people with disabilities and people with limited English proficiency.

§457.380 Eligibility Verification

§457.380(a) General Requirements

We support the ability of CHIP agencies to continue to accept attestation of all information needed to determine eligibility.

§457.380(c) State Residents

We support that if the CHIP agency does not accept self-attestation of residency, that it must follow rules consistent with those proposed for Medicaid at §435.956(c), amended by any recommendations we have proposed for that section. We prefer that states be required to accept self-attestation to support consistency of verification among all Insurance Affordability programs.

> **RECOMMENDATION:** To support consistency among all insurance affordability programs, we recommend that states be required to accept self-attestation of residency.

§457.380(d) Income

We support that if the CHIP agency does not accept self-attestation of income, that it must follow rules consistent with those proposed for Medicaid at §435.945(b), §435.948 and §435.952, amended by any recommendations we have proposed for those sections.

457.380(e) Other Factors of Eligibility

We support that if the CHIP agency does not accept self-attestation for other factors of eligibility, that it must follow rules consistent with those proposed for Medicaid at §435.945(b), §435.952 and §435.956(c), amended by any recommendations we have proposed for these sections.

457.380(f) Requesting Information

We support requiring states to use electronic sources of data before requesting paper documentation from individuals. We also support allowing states to accept a statement which reasonably explains any discrepancy in data and that states much provide the individual a reasonable period to furnish such information.

457.380(g) Electronic Service

We support requiring CHIP agencies to accept the federal data services hub as established by §435.949.

457.380(h) Interaction with Program Integrity Requirements

Program integrity is a critical programmatic component that is addressed in current regulations relating to the Children's Health Insurance Program. Restating the objective of program integrity in such broad terms serves little practical purpose in the regulation, and instead weakens the regulation by allowing a broad vague exception to all provisions of the regulation if any program integrity interest can be identified. Almost any eligibility decision or verification policy would have some impact on program integrity, and thus the entire force of the regulation is eviscerated. For example, a state could use subpart (h) to justify creating impossibly burdensome barriers in enrollment procedures to ensure that no one ineligible enrolls. The net effect could be simply to prevent eligible individuals from enrolling.

> **RECOMMENDATION:** Program integrity is clearly dealt with under part 455 and is best addressed through those specific regulations, thus the removal of subpart (h) is recommended.

> **ALTERNATIVE RECOMMENDATION:** To the extent subpart (h) is preserved, the language should be altered to protect the integrity of these regulations as a whole; as written, the language in the current proposed regulation provides a state with full authority to violate any other provision of the regulation if it can create any plausible connection to program integrity.

457.380(i) Flexibility in Information Collection and Verification

Paragraph (i) allows agencies to obtain the Secretary's approval to use alternative data sources, as long as such alternatives reduce administrative costs and burdens on individuals and states. It is unclear whether agencies would be approved to use such alternatives on a blanket basis (for all applicants at any point in the application process), only when other data sources required by paragraph (a) do not yield useable results, or on an individual basis.

> **RECOMMENDATION:** The regulation should provide more detail as to how alternative sources would be used. This paragraph could explicitly allow the agency to contact the individual's employer to obtain financial information when such information is not available through the federal data hub or through the sources mentioned in paragraph (a). This would still be less burdensome on the applicant than requiring them to supply paper documentation, and could also be faster and more efficient.

Outstanding CHIP Issues in Need of Future Rulemaking

The Children's Health Insurance Program (CHIP) has been a resounding success since its enactment in 1997. CHIP introduced a myriad of innovations in outreach, simplification of

the enrollment and renewal processes, use of technology, coordination between programs, and perhaps most importantly, the welcome mat effect it has had on Medicaid enrollment.

There are several significant reasons why a strong CHIP program must remain as an option among the Insurance Affordability programs:

- **Access to "affordable" minimum essential coverage:** The Treasury proposed rule defines that coverage is affordable to families if the cost of self-only coverage is less than 9.5% of household income. This definition does not consider that actual cost of family coverage. Simply waiving the individual mandate penalty for dependents in these families does not address the significant concern that many of these children could go uninsured.

- **Essential benefits are yet undefined.** If the essential benefit package does not provide adequate provisions for children or grants significant flexibility to the states as other proposed rules have, CHIP will remain a critical source of child-friendly health benefits essential for the health and development of low-income children.

- **Untested coverage in the Exchange.** The Affordable Care Act implements sweeping changes in how low-income families access coverage. Despite the best planning and attention to implementation, it will take some time to identify and work kinks out of the system. During this time of refinement, and until we know positively that children will be served at least as well, if not better, in the Exchange, CHIP must be remain a viable option for children in low-income families.

- **Maintenance of Effort Provisions:** The stability provisions in the ACA have protected children's coverage during these difficult budget times, enabling our country to continue to fill the gap created by a decline of private coverage and achieve record-high coverage for more than 90% of American children. Without these protections going forward, states will be tempted to save money by dismantling their CHIP programs particularly once families can seek coverage through the Exchange. By preserving the MOE, we can assure there is sufficient time to assess how well Exchanges are likely to serve the specific needs of children. Additionally, HHS should prohibit any state from implementing a cap or freeze on CHIP enrollment that was not "in effect" on March 23, 2009.

- **Bump-Up in CHIP FMAP:** At the beginning of FFY 2016, states are slated to receive a bump-up of 23 percentage points in their CHIP match. This higher financial support would create an incentive for states to maintain their highly-effective CHIP programs. Efforts to address the nation's budget issues should not trump the importance of high-quality comprehensive coverage for children.

- **Crowd-Out Provisions:** To comply with federal requirements that states protect against erosion of private coverage, many states have implemented waiting periods in CHIP. Families with children eligible for CHIP will not qualify for premium tax

credits for their children but will face potential penalties if they allow their children to be uninsured. Given this situation, waiting periods represent an even larger barrier to coverage and should be addressed in future rulemaking. For example, federal guidance could provide an explicit exception to waiting periods for families who qualify for premium tax credits.

- **FMAP Above 300 Percent of the Poverty Line:** States will be required to determine "effective MAGI equivalence" eligibility that for a number of states will result in eligibility above the current maximum level in CHIP of 300%. Future rulemaking should explicitly confirm that the enhanced CHIP match will apply to eligibility levels above 300% (New York and New Jersey were grandfathered with higher CHIP coverage levels) resulting from the MAGI-conversion so that states are not penalized.

- **Double Hit on Premiums.** Estimates from the Urban Institute indicate that three out of four (75%) parents who are eligible for the subsidized coverage in the Exchange will have one or more children eligible for CHIP or Medicaid. There are no provisions in the ACA to include the cost of other insurance, including CHIP, in the calculation of a family's share of premium costs in the exchange. Future rulemaking could provide flexibility to states to waive CHIP premiums for children whose parents qualify for premium tax credits.

- **Future Expansion of Coverage:** State's ability to establish eligibility for CHIP above 200% FPL (or beyond 50 percentage points above their Medicaid level in place on March 31, 1997) was possible by disregarding a block of income. To promote simplification of eligibility, disregards and deductions will not only be allowed under the ACA and proposed rules. This means states will no longer be able to expand CHIP coverage after December 31, 2013, even if their eligibility is below the maximum eligibility level of 300% explicitly stated in CHIPRA.

  Furthermore, any future expansions of coverage for children must be through the new Medicaid coverage group for individuals above 133% FPL established in §435.218. Should a state chose this option to expand coverage in the future, it will be required to move all CHIP children into Medicaid, although the regulations allow the state to continue to draw the enhanced CHIP match for those already eligible. These provisions are disincentives to states to provide more comprehensive and affordable coverage for children in the future that could be addressed in future legislation.