ACAP
Association for Community Affiliated Plans

1015 15th Street, N.W., Suite 950 | Washington, DC 20005
Tel. 202.204.7508 | Fax 202.204.7517 | www.communityplans.net
Bob Thompson, Chairman | Margaret A. Murray, Chief Executive Officer

May 7, 2012

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Attn: CMS-2349-F
PO Box 8016
Baltimore, Maryland 21244-8016

Re: Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010, CMS-2349-F; Interim Final Rules (March 23, 2012)

Submitted electronically via: http://www.regulations.gov

Dear Ms. Tavenner:

The Association for Community Affiliated Plans (ACAP) appreciates this opportunity to comment on the above proposed rule related to changes in Medicaid eligibility under the Affordable Care Act (ACA)[1].

ACAP is an association of 59 not-for-profit and community-based Safety Net Health Plans (SNHPs) located in 26 states.[2] ACAP member plans provide coverage to 9 million individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP) and Medicare Special Needs Plans for dual eligibles. Nationwide, ACAP members serve approximately one in three individuals enrolled in Medicaid managed care plans. ACAP's mission is to represent and strengthen its member plans as they work with providers and caregivers in their communities to improve the health and well-being of vulnerable populations in a cost-effective manner. Our plans are full partners with CMS and the states in meeting the coverage needs of our nation's low-income health care consumers – whether they are eligible for Medicaid, CHIP, the soon-to-be-developed Basic Health Program, coverage in state- or federal-based health insurance Exchanges, or other health care programs – and we are pleased to comment on these interim final regulations.

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[1] The Patient Protection and Affordable Care Act (P.L. 111-148) and the Healthcare and Education Reconciliation Act (P.L. 111-152) together are referred to in this letter as the Affordable Care Act (ACA).

[2] ACAP represents safety net health plans that are exempt from or not subject to federal income tax, or that are owned by an entity or entities exempt from or not subject to federal income tax, and for which no less than 75 percent of the enrolled population receives benefits under a Federal health care program as defined in section 1128B(f)(1) (42 USC 1320a-7b(f)(1)) or a health care plan or program which is funded, in whole or in part, by a State or locality (other than a program for government employees).

As we did in our October 31, 2011 comments on the draft regulations, ACAP again commends the Centers for Medicare & Medicaid Services (CMS) for its thoughtful and comprehensive efforts to meet the requirements of the Affordable Care Act. It is clear that CMS has approached the development and implementation of regulations with the principles of the Affordable Care Act in mind and has worked diligently to balance the potentially competing directives in the various existing and new statutes. ACAP supported the enactment of the Affordable Care Act and supports these regulations with several suggested changes.

ACAP and its members strongly support the elements of the new regulations that further the goal of ensuring that all Americans can easily enroll in and retain health coverage. A streamlined eligibility and enrollment process that minimizes administrative burdens on applicants and reviewers, and helps applicants understand their options, is clearly integral to meeting this goal. In particular, as we reviewed the interim final regulations, we were very pleased to see that the regulations clarify that, for MAGI-eligible individuals, states will be prohibited from reviewing eligibility more frequently than once every 12 months. In addition, we applaud CMS' decision to broaden the definition of the kind of entity that will be able to conduct eligibility determinations for the MAGI-eligible populations under the Exchange.

ACAP will limit its comments on the interim final rule to issues of particular importance to Safety Net Health Plans as they strive to support the implementation of the ACA, provide coordinated, continuous health care coverage to their enrollees, and support efforts to enroll all eligible individuals in the appropriate health insurance option. We are also submitting comments later this week regarding *Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers* (CMS-9989-F, Federal Register Vol. 77, No 59 (March 27, 2012) of the Patient Protection and Affordable Care Act, enacted March 23, 2010); where relevant, we have incorporated similar or comparable comments in our two submissions Our comments are summarized below:

- Modify the timeliness standards to require that states move toward a system which will conduct eligibility determinations on a "real-time" basis in the majority of cases as well as establish more aggressive maximum eligibility determination time frames than current standards (§435.912 and §457.340). Our comments specifically note the importance of incorporating the goal of a "real-time" system into the regulations, establishing a three-year timeframe to achieve this goal, as well as requiring that the shortened maximum eligibility determination time frames apply from the initial date of application.
- Reaffirm HHS' commitment to seamless, fully-integrated eligibility systems that provide all health care consumers with "no wrong door" eligibility and enrollment services. (§435.1200 and §457.348). Our comments recommend that the bifurcated system which is permitted under the interim rules be authorized for no more than three years and that states be required or encouraged to establish presumptive eligibility procedures for all applicable individuals to minimize the potential disruption caused in this interim period.

We respectfully urge you to consider our comments, which we outline in greater depth in the following pages. We believe that implementation of these comments will help to ensure that low-income health care consumers are well-served by Medicaid, CHIP and other affordable health coverage programs.

Part 435 – Eligibility in the States, District of Columbia, the Northern Mariana Islands, and American Samoa
Subpart C – Options for Coverage

- §435.912 – Timely determination of eligibility

  In our comments on the interim regulations (re: §435.911), ACAP supported the requirement that Medicaid agencies furnish benefits promptly and without undue delay for individuals determined eligible for Medicaid based on modified adjusted gross income (MAGI). However, ACAP also expressed concern that the regulations would have eliminated any specific timeframes for completing eligibility determinations. We noted that, although we recognized that the goal of the regulations was to promote streamlined, seamless and "real-time" eligibility determinations, neither the new systems to do so nor the related performance standards were in place. As such, ACAP requested that CMS consider developing contingency plans to govern the timeliness of the eligibility determination process during this transition period to new, electronic eligibility systems.

  With these interim final regulations, CMS has reinstituted the existing timeliness requirements (i.e., 90 days for individuals with disabilities and 45 days for other applicants). While the interim regulations note that these limits are maximum time periods, and that a state's State Plan must account for such factors as the availability of electronic data, there is nothing in the regulations themselves that makes it clear that states are expected to move toward on-line, real-time eligibility determinations.

  The massive investment in new eligibility systems and information data hubs which the federal government is supporting should demonstrably improve the timeliness of the eligibility process. As such, **ACAP recommends that the final regulations recognize these investments and incorporate the following components:**

  - **Regulations should clearly state that the overall goal is to move toward real-time eligibility determinations for the vast majority of applicants. Regulations should, therefore, require that State Plans outlining timeliness standards incorporate a timeline for achieving this goal. ACAP recommends that there be a three-year maximum time period for a state to achieve this goal.**
  - **Prior to attaining the above-stated goal, states should still be required to meet improved timeliness standards. ACAP recommends that the current maximum processing timeframes be reduced from 45 to 30 days for non-disabled individuals and from 90 to 60 days for individuals with disabilities.**

These time periods should also be the maximum acceptable duration for an eligibility determination for an individual whose eligibility cannot be determined on a "real-time" basis, as called for in the bullet above.

We are also concerned about the possibility of "multiple" time periods being invoked when/if an application is transferred from one entity to another (e.g., the Exchange to Medicaid to CHIP). Paragraph (c) (1) states that the timeliness and performance standards must "cover the period from the date of application or transfer from another insurance affordability program to the date the agency notifies the applicant of its decision or the date the agency transfers the individual to another insurance affordability program…" We understand the challenge of establishing a timeline which holds multiple entities responsible, in total, for a singular outcome when each entity manages only its own processes. However, applicants also deserve a degree of certainty concerning how long it will take for an eligibility determination to be made. ACAP further believes that it would be damaging to the provision of health care coverage, as well as to the overall perception of the Affordable Care Act, if the clock were able to be "reset" each time the application moved to another entity. **ACAP therefore recommends that the overall timeliness standards identified above apply from the date of application, regardless of how often an application may be transferred. Contracts among the Medicaid and CHIP programs as well as a state's Exchange will need to incorporate clear internal processing and transfer timeliness standards so that the overall eligibility determination timeliness standard can be met.**

The interim final rule also notes that the Secretary will be providing additional guidance on performance standards which states will need to meet. While our understanding, based on information provided during the webinars sponsored by CMS, is that we will have the opportunity to comment on these standards before they are final, we wanted to take the opportunity to provide some feedback on the nature of the standards which we hope will be helpful as CMS completes their development.

The interim final rule suggests that states will set their own performance standards. In the interest of ensuring appropriate data collection and oversight of the eligibility and enrollment process in a state, we recommend that CMS issue guidance to states on the key measures that should be included in the performance standards. **ACAP specifically suggests that, in addition to accuracy and consumer satisfaction, such standards also measure procedural denials of eligibility, at application and renewal; the number of determinations made exclusively using attestations and electronic verifications; the number of applications submitted with assistance from Navigators, authorized representatives, agents and brokers, or other assisters; the renewal rate; the number of enrollees who report changes during the year that result in a change in eligibility (and what the resulting change is); and the accessibility, utilization, and completion of applications and renewals for people with limited English proficiency, limited literacy, and disabilities.** The reports that

result from collecting information on these performance measures should be made available to the public on the state and/or CMS website.

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

- §435.1200 – Medicaid agency responsibilities
  This section of the interim final regulations is substantially modified from the provisions of the NPRM published in August 2011. By allowing states to decide that Exchanges will not be authorized to make Medicaid eligibility determinations, but rather will only be authorized to "screen and refer," ACAP is quite concerned that the concept of "no wrong door" for applying for health insurance coverage will be substantially damaged. A "screen and refer" process unnecessarily bifurcates the process and increases the chance that individuals will be lost in the process. Moreover, with the possibility that applicants may receive communications from organizations to which they did not apply, we are concerned that they may not recognize the nature of the communication and will fail to respond as necessary to complete the application process. Overall, establishing such a process will damage the ability of the Affordable Care Act to realize its promise of health care coverage.

  ACAP strongly believes that CMS should reaffirm its commitment to a seamless, fully-integrated eligibility determination system for all consumers. We do recognize, however, that not all states will have operable Exchanges by January 1, 2014, and that the use of the "screen and refer" process may make it easier to stand up a state's Exchange more quickly. ACAP, therefore, recommends that states be permitted to establish the "screen and refer" process outlined in paragraph (d) of this section only on an interim basis. As we noted in our comments on §435.912, we believe that this interim time period can be no longer than three years and that there must be demonstrable progress toward full implementation during that time period.

  In the event that CMS decides to retain the bifurcated eligibility process currently outlined in the interim final regulation, or allows it only on an interim basis as we have recommended, ACAP further recommends that CMS require states to demonstrate the ability to effectively manage such a situation. For example, states would need to demonstrate that their Medicaid agency either has the capacity to conduct eligibility determinations in compliance with the final Medicaid eligibility rule or is moving in that direction and will be able to meet this requirement by the end of the interim time period. Moreover, states should be required to demonstrate that they are able to process eligibility determinations without any re-verification of existing data. Similarly, to minimize the possibility that the Exchange and the state agency will arrive at differing eligibility determinations and/or that the state will re-do the eligibility

assessment using different standards, the Exchange should be required to use the same rules engine definitions and criteria as the state does.

ACAP also recommends that CMS clarify that the agreements referenced in paragraph (b)(3) on the delineation of eligibility determination responsibilities between Medicaid agencies and other insurance affordability programs must be approved by CMS and must be readily available to the public on the state Medicaid agency's as well as CMS's website, not simply available to the Secretary of HHS upon request. The public should also be given opportunities to provide input on these agreements and any major changes to such agreements in the future.

Section 2001(a)(4)(B) of the ACA allows states that use presumptive eligibility for children or pregnant women to also use presumptive eligibility for parents and other adults who appear to be eligible for Medicaid. Therefore, **ACAP further recommends that, if a state elects, for however long permitted by regulations, to have its Exchange merely conduct a preliminary "assessment" of potential Medicaid eligibility and then relinquish the final eligibility determination to the Medicaid agency, CMS should encourage or require the Exchange to determine applicable individuals to be presumptively eligible for coverage in Medicaid and/or CHIP. These individuals should be immediately enrolled in the program and, as appropriate, in a managed care plan, for the duration of the determination process.** While such a requirement would not eliminate the problems created by fragmented eligibility systems, it could go a long way toward mitigating the negative effect of this bifurcated system.

Part 457 – Allotments and Grants to States (CHIP Program)

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

- §457.340(d) – Application for and enrollment in CHIP; Timely determination of eligibility

ACAP's comments on this section are consistent with those made above with respect to §435.912. As we noted in those comments, ACAP is concerned that the timeliness standards for eligibility determinations do not reflect the investments in improved processes nor the need for demonstrably prompt determinations. ACAP makes comparable recommendations to shorten the maximum allowable eligibility determination time frames while continuing to promote attainment, over no more than a three-year period, of the previously-stated goal of determining eligibility on a real-time basis for the vast majority of applicants.

We also note that subparagraph (d) (2) calls for states to define a "date of application" and that such a requirement does not exist in the Medicaid or the Exchange programs.

We are unclear why such a date should be established only in the CHIP program, but also note that its establishment could cause confusion between and among the various programs.

- §457.348 – Determination of Children's Health Insurance Program eligibility by other Insurance affordability programs

  ACAP's comments on this section are consistent with those made above with respect to §435.1200, based on our assessment that the separate "screen and refer" process authorized by this section damages the concept of "no wrong door" for applying for health insurance coverage. ACAP makes comparable recommendations that this type of system should be authorized on only an interim basis, that states should be required to demonstrate certain competencies to avail themselves of this option, that agreements among the various parties should be publicly available and that presumptive eligibility determination authority should be incorporated into any separate "screen and refer" process .

Conclusion

Once again, ACAP would like to commend CMS for its efforts to develop regulations to further the goal of ensuring that all Americans can easily enroll in and retain health coverage while improving the efficiency and reducing administrative burdens associated with Medicaid eligibility determinations. We believe that incorporation of the modifications which we have recommended in these comments will strengthen the eligibility process and promote health care coverage while recognizing the challenges that face entities as they work to implement this ground-breaking legislation.

Please do not hesitate to contact me (202-204-7509 or mmurray@communityplans.net) or Kathy Kuhmerker (202-204-7510 or kkuhmerker@communityplans.net) if you have any questions concerning our comments.

Sincerely,

Margaret A. Murray
Chief Executive Officer