ACAP
Association for Community Affiliated Plans

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Bob Thompson, Chairman | Margaret A. Murray, Chief Executive Officer

October 31, 2011

Donald Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
Attn: CMS-2349-P
7500 Security Blvd
Baltimore, Maryland 21244-8016

Re: Medicaid Eligibility Changes under the Affordable Care Act of 2010, CMS-2349-P; 76 Fed. Reg. 51148 (Aug. 17, 2011)

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

Dear Dr. Berwick:

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 28 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 regulations.

[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).

First, ACAP 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.

ACAP will limit its comments 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 also have attached, incorporate and (where, we believe, particularly relevant to our comments herein) reiterate the comments we submitted to the Department of Health and Human Services (HHS) today regarding *Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers* (CMS-9974-P; 76 Fed. Reg. 51202 (Aug. 17, 2011)). We have also attached comments submitted today to the Department of Treasury, Internal Revenue Service regarding *Health Insurance Premium Tax Credit*, REG-131491-10; 76 Fed. Reg. 50931 (Aug. 17, 2011).Our comments are summarized below:

- Allow states to implement twelve-month continuous eligibility for adults without being required to receive CMS approval of a waiver of their State Plan
- Clarify that establishment of a twelve-month eligibility period is required rather than optional
- Broaden conditions under which states can delegate Medicaid eligibility determination responsibilities to Exchanges so that "quasi-governmental" entities can conduct Medicaid eligibility determinations on behalf of a state
- Continue to include state Medicaid eligibility determination performance standards and/or develop contingency plans and standards in instances where a state has not implemented required eligibility systems changes
- Maintain coverage and minimize gaps in coverage by adopting three major components:
  - Extend Medicaid eligibility and plan enrollment while eligibility under another affordable health coverage program is being completed
  - Allow individuals to retain their Medicaid plan enrollment when transitioning out of Medicaid without requiring plans to meet Exchange requirements

- Require, rather than permit, states to prorate income over an annual eligible 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 431 -- State Organization and General Administration
Subpart A – Single State Agency

- §431.10(c)(iii) – Single State Agency
  This section of the draft regulations allows state agencies to delegate Medicaid eligibility determination responsibilities to Exchanges only when they are "government-operated." ACAP is pleased that the draft regulations expand the opportunities for states to delegate their eligibility determination responsibilities beyond the current limitations (another state or local agency; under appropriate supervision), **but is concerned that the definition of "government-operated" may be construed narrowly**. Under a narrow interpretation, Exchanges established (or in the process of being established) in several states might not be considered "government-operated" due to the legal establishment of their governing bodies. For example, we are concerned that an Exchange which is a public entity with board members appointed by various elected state officials, but not a state agency or authority, would not be able to make final Medicaid eligibility determinations. If that were the case, individuals in those states would be unable to have their Medicaid and CHIP eligibility determinations processed on-line and in real time because the state Medicaid agency would not be authorized to delegate this responsibility to the Exchange. Coordination with separate CHIP eligibility determination processes could also become more, rather than less, fragmented. Possible state efforts to find a "work-around" (such as having an eligibility worker approve the final Exchange determination) would significantly slow the determination process and impede the goal of streamlined, simplified enrollment.

  ACAP urges CMS to reconsider this restriction or to clarify the definition so that the kinds of "quasi-governmental" entities which are being considered by many states would also be enabled to make final Medicaid eligibility determinations. Alternatively, we urge CMS, in the preamble to its final regulations, to identify the kinds of relationships between Exchanges and state Medicaid agencies that would enable the real-time, on-line eligibility determinations called for in the ACA. For example, state certification of an Exchange's on-line application and determination process as being comparable to an electronic or in-person Medicaid agency determination could be deemed sufficient to

permit a state to delegate some of its eligibility determination responsibilities to a "non-government-operated" Exchange.

Part 435 – Eligibility in the States, District of Columbia, the Northern Mariana Islands, and American Samoa
Subpart G – General Financial Eligibility Requirements and Options

- §435.603 (e)(2) – Application of modified adjusted gross income/MAGI-based Income
- §435.603(h) – Application of modified adjusted gross income/Budget Period

ACAP commends CMS for its overall efforts to align the Medicaid and premium tax subsidy time periods and requirements. ACAP concurs that it is very important to align these requirements as much as possible to avoid inadvertent gaps in coverage are avoided.

ACAP particularly commends CMS, however, for establishing certain exceptions to their alignment policy, most specifically the exception contained in §435.603(e)(2), which exempts scholarships or fellowship grants used for education purposes from the determination of MAGI-based income. ACAP and its plans fully support this exemption in recognition of the importance for all individuals, including those eligible for Medicaid, to have access to grants that will enable them to further their education. Moreover, ACAP itself supports an annual scholarship contest, the proceeds of which are to be used for educational purposes. Initial participation in the contest was impeded because of uncertainty over this issue, and having this exemption clearly outlined in regulations will remove that concern going forward.

ACAP also supports the draft regulations at §435.603(h), which allow states to adopt a State Plan Amendment to prorate projected annual income when making an eligibility determination. ACAP supports this change because it should give states more flexibility in maintaining Medicaid eligibility in the face of income fluctuations. For example, states would be able to maintain eligibility if annual income based on MAGI methods for the calendar year remains below the Medicaid income standard even if income for a given month were to be higher. Thus, small fluctuations in income would not result in individuals losing coverage. We are concerned however, as CMS also notes in the preamble to the draft regulations that, if a state does not adopt this policy in its State Plan, there may be situations in which an individual or a family is determined ineligible for both Medicaid and the premium tax subsidy. Such an outcome would be contrary to the clear intent of the Affordable Care Act. In addition, given that the proposed Health Exchange rules indicate that the Health Exchange will use annual income for eligibility determination, aligning the income determination portion of the eligibility process between the two programs is necessary to streamline the process and

rationalize the outcome. **ACAP therefore recommends that CMS strengthen this provision by requiring states to prorate projected annual income when making an eligibility determination.** We believe that it is within the authority established by Section 1321 of the ACA, which gives the Secretary authority to issue "such other requirements as . . . appropriate" to meet the requirements of Title 1 of the ACA, for the Secretary to require states to adopt such a State Plan Amendment.

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

- §435.907 – Applications
  ACAP strongly supports the creation of a single, streamlined application for all insurance affordability programs and the requirement that any state alternative applications be no more burdensome than the model the Secretary develops. In the majority of cases, this determination should be possible using a single application that can be completed online, over the phone, in person, or via fax or mail. The "front end" process should be the same for all applicants, and they should not have to determine for which program to apply: one application should unlock the door to any coverage the applicant or their family members are eligible to receive. This front end process should also allow potential applicants to explore their options with minimal provision of personal information required. ACAP strongly supports the requirement that states accept electronic signatures as part of this process as well; this is central to ensuring that the entire application process can be completed in all of the ways listed in paragraph (d). Finally, the streamlining incorporated into the ACA for those eligible on a MAGI basis should be incorporated, to the extent possible, for those who are eligible due to age, blindness or disability. **ACAP therefore supports the provisions of paragraph (c) which would allow states to use the single, streamlined application and supplemental forms, or an alternative form, for these applicants.**

- §435.911 – Determination of Eligibility

  ACAP supports 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). ACAP also supports the requirement that Medicaid agencies must similarly collect additional information as needed and promptly furnish benefits for those individuals who are eligible for Medicaid under non-MAGI methodologies.

  However, ACAP is concerned that the regulations, as proposed to be amended, would eliminate the specific timeframes in the existing regulations (i.e., 90 days for individuals with disabilities and 45 days for other applicants). While CMS is to be commended for noting that they will develop performance standards and metrics for streamlined and coordinated eligibility and enrollment systems, ACAP would like to express its concern with repeal of a needed protection when the replacement requirements are unknown. Moreover, ACAP does not believe that all states will be

able to implement the system changes before 2014. Without these new systems in place, states facing financial pressures may be challenged to maintain their current systems while new systems are being developed; as a result, eligibility determination timeframes may lengthen inappropriately. Such a situation will jeopardize gains in the areas of eligibility determination and continuity of coverage that so many have striven to adopt over the years. Therefore, **ACAP respectfully requests that CMS consider developing contingency plans for such situations, including the possible approach of maintaining the current requirements until the new systems and performance standards are implemented.**

- §435.915(b) – Effective Date (redesignated from 435.914(b))

  The agency has specifically asked for comments on how gaps in coverage can be avoided. At a minimum, ACAP supports the CMS suggestion that this paragraph be modified to permit states to extend Medicaid eligibility until the end of the month in which a determination of ineligibility has been made.

  A more effective way to minimize disruptions in coverage, and allow greater degrees of alignment among affordable health insurance programs, would be to allow Medicaid enrollees found at the time of redetermination to no longer be eligible, to retain their Medicaid eligibility and their health plan enrollment pending a determination by the exchange as to eligibility for subsidies for the purchase of a QHP. Proposed regulations at 42 C.F.R. §435.1200 would require that when an individual is determined to be ineligible for Medicaid, that the state agency must assess the individual for potential eligibility for "other insurance affordability programs and promptly and without undue delay transfer such individuals' electronic accounts to any other program(s) for which they may be eligible." Such assessment should also take place for existing Medicaid enrollees who are determined to no longer be eligible; while that assessment is taking place, Medicaid eligibility should be retained and the beneficiary continue to be enrolled in their Medicaid plan. This would ensure that an individual was not dropped from Medicaid before he or she could be enrolled in other insurance affordability programs. As discussed above, even small disruptions in coverage can have significant health consequences, especially for individuals with chronic conditions.

  ACAP further recommends that CMS consider adopting regulations which would allow individuals determined ineligible for Medicaid, but eligible for a premium subsidy, to retain membership in their Medicaid health plan on an opt-out basis. As noted in analytic work done on the issue of "churning," the population with the greatest propensity to experience coverage changes is that with a household income between 100% and 150% of the Federal Poverty Level; such

populations go in and out of the Medicaid program with the greatest frequency.[3] As we note in our comments on the draft regulations pertaining to the *Establishment of Exchanges and Qualified Health Plans,* **ACAP recommends that HHS allow Exchanges to certify as licensed those Medicaid (and CHIP) health plans with enrollees who move into the Exchange and which cover families with split eligibility for the purpose of continuing to cover those individuals and families only.** (If the plan wishes to seek certification as a qualified health plan to serve "all-comers" in the Exchange, the plan can do so by meeting the requirements of that Exchange.) Allowing individuals--even after a determination of ineligibility for Medicaid--to continue their enrollment in their Medicaid plan, without requiring the plan to meet Exchange requirements, and allowing families to remain in the same plan, would significantly minimize disruptions in coverage. Moreover, this policy would allow Medicaid health plans to continue to bring their population-specific experience and expertise to the needs of these individuals.

Adoption of such policies would be a reasonable exercise of the Secretary's general rulemaking authority under §1102 of the Act and §1321 of the ACA pertaining to the meeting the requirements of Title 1 of the ACA. It would also further the ACA's goal of expanding coverage and reducing gaps in coverage.

- §435.916 – Periodic Redeterminations of Medicaid Eligibility
- §435.953 – Identifying items of Information to Use (recommended to be deleted)

ACAP shares CMS' concern with reducing interruptions in coverage (widely known as "churn") within the Medicaid population and commends CMS for its efforts to reduce detrimental gaps in coverage through changes to the Medicaid eligibility determination and redetermination processes as well as the methodological changes for assessing eligibility. ACAP also supports the passive renewal provisions incorporated in §435.916(a) (2) and recommends that similar procedures be considered for the non-MAGI population. However, these steps do not go far enough in addressing the problem of churn. As described in more detail below, the negative consequences of frequent loss and regaining of Medicaid eligibility could be substantially avoided if state Medicaid agencies were permitted to guarantee eligibility during the twelve-month benefit period.

- **Overview of Medicaid Eligibility Problem**

Income fluctuation and resultant loss and regaining of Medicaid eligibility carries with it a number of negative consequences. It is well-established that gaps in

[3] Sommers B. Rosenbaum S., Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges. Health Affairs 30, No. 2 (2011) ("Sommers and Rosenbaum").

coverage have a negative impact on quality and continuity of care and result in increased hospitalizations and costly emergency department visits. [4] Retention of coverage permits Medicaid enrollees to establish long-term relationships with their primary care providers. Frequent loss of coverage interrupts these relationships. Unfortunately, data show that 43 percent of newly enrolled adults in Medicaid experience a disruption in coverage within twelve months. [5] Studies also show that the longer an individual remains enrolled in Medicaid, the lower their average monthly medical costs.[6]

Frequent interruptions in coverage also result in substantial increases in administrative costs which are typically borne by state and local eligibility agencies as well as Medicaid health plans and primary care providers--all of whom may spend time helping individuals navigate the enrollment and re-enrollment process.

The existing problems associated with maintaining Medicaid coverage promise to take on a new form once the state health insurance exchanges become operational in 2014. Because state exchanges are required, under the ACA, to evaluate individuals for eligibility for subsidized coverage through the exchanges, it can be expected that there will be a number of individuals and families who will cross the Medicaid-exchange divide. In fact, Sommers and Rosenbaum estimate that the population with the greatest propensity to experience coverage changes is that with a household income between 100% and 150% of the Federal Poverty Level.[7] This may result in a shift between plans and provider networks, with inevitable disruptions in continuity of care. Insurance coverage disruptions have been shown to have adverse effects on access and administrative costs, and even if there is no gap in coverage, problems can arise simply from a change in plans or providers.[8]

- **ACA Provisions to Enhance Continuity of Coverage/Redetermination Periods**

The ACA includes a number of ACAP-supported provisions designed to promote retention of Medicaid coverage. One is the use of the modified adjusted gross income (MAGI) standard for determining eligibility of most of the Medicaid

[4] Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, CMS 2349-P, Preliminary Regulatory Impact Analysis, August 12, 2011 (p.5) available at http://www.cms.gov/MedicaidEligibility/downloads/CMS-2349-P-PreliminaryRegulatoryImpactAnalysis.pdf
[5] Sommers and Rosenbaum. Op Cit
[6] Ku L., MacTaggart, P., Pervez F., Rosenbaum S., Improving Medicaid's Continuity of Coverage and Quality of Care. George Washington University Department of Health Policy. July 2009. Prepared for Association for Community Affiliated Plans. (Copy available at: http://communityplans.net/ResourceCenter/BibliographyMedicaidManagedCare/tabid/208/Default.aspx)
[7] Sommers and Rosenbaum. Op cit
[8] Sommers and Rosenbaum. Op cit

population. As noted earlier in comments on §435.603(h), ACAP supports this change because it should give states more flexibility in maintaining Medicaid eligibility in the face of income fluctuations.

It also appears that CMS proposes to require states to conduct redeterminations of Medicaid eligibility no more frequently than every twelve months. Currently, states have the option to conduct redeterminations more often, which results in more individuals losing Medicaid eligibility and an increase in disruptions in coverage. Under proposed 42 C.F.R. § 435.916(a) redeterminations would be required "once every 12 months" for individuals whose eligibility is determined based on MAGI rather than "at least every 12 months." ACAP interprets this as limiting redeterminations to one per year. **But it is not clear that CMS intends to limit redetermination time periods to every twelve months and, as such, it would be helpful if CMS clarified this in the final rule to avoid possible confusion.** This could be done by revising the proposed regulation to state "no more frequently than every 12 months" or the agency could clarify in the preamble to the final rule that this is its intent. Although most states have already implemented a twelve-month eligibility period, making this mandatory would clearly support the agency's goals of reducing disruptions in coverage. **ACAP also recommends that states be permitted to vary from the twelve-month redetermination requirement for purposes of aligning eligibility periods between and among family members** since it will be less disruptive and more supportive of maintenance of eligibility if a family does not need to address eligibility issues numerous times during the course of a year.

However, ACAP is concerned that interruptions in coverage and the concomitant adverse consequences will continue to be a problem despite these efforts. Currently, state Medicaid agencies are required under the income verification and eligibility rules set forth at 42 C.F.R. §§ 435.916 and 435.940 *et seq*. to obtain enrollee financial information from state and federal sources and engage in ongoing review and data-matches of this information for the purpose of assessing whether the individual remains eligible. To the extent that the state receives information indicating an individual has become ineligible, it is expected to act on that information even before redetermination. This frequent eligibility verification increases mid-enrollment shifts and contributes significantly to the churn problem.

Optional Guaranteed Twelve-Month Eligibility

The detrimental effects of disruptions in Medicaid coverage could be reduced even further were state agencies permitted to guarantee eligibility for the entire twelve-month benefit period.[9] Historically, states have had to apply for and receive a federal

[9] Although ACAP believes that ideally 12-month guaranteed eligibility should be a required element of the Medicaid program, we understand that such a requirement would be outside the scope of this proposed rule.

waiver in order to allow twelve-month guaranteed eligibility. ACAP strongly believes that even in the absence of a waiver, CMS has the legal authority as part of this rulemaking to give states the option of providing for twelve-month guaranteed eligibility.

Section 1137 of the Social Security Act ("the Act"), which sets forth the Income and Eligibility Verification System (IEVS), does not mandate that information obtained as part of the IEVS be used at any particular frequency. It also provides that a state's use of such information "shall be targeted to those uses which are most likely to be productive in identifying and preventing ineligibility and incorrect payments . . .". In other words, states enjoy substantial flexibility in using such information to maximize productivity and efficiency.

ACAP is aware of no other provisions in the Act requiring states to reassess eligibility during the benefit period or to redetermine eligibility more often than every twelve months. Regulatory changes to permit states to provide for twelve-month continuous eligibility are within the Secretary's general rulemaking authority under Section 1102 of the Act. It is also authorized by Section 1321 of the ACA, which gives the Secretary authority to issue "such other requirements as . . . appropriate" to meet the requirements of Title 1 of the ACA. Section 1413 of the ACA requires states to coordinate enrollment between Medicaid, CHIP and the state health insurance exchanges, and individuals who do not qualify for Medicaid eligibility must be assessed for eligibility in a qualified health plan (QHP) offered through the exchanges and, if applicable, eligibility for premium assistance including advance payment of such assistance under Section 1412 of the Act. The administrative burden of carrying out these obligations would be substantially reduced if states could provide for twelve-month continuous Medicaid eligibility. Specifically, it would reduce the frequency with which exchanges would be required to evaluate individuals for eligibility for subsidies and to process enrollment applications. Therefore, there is a direct relationship between a change in Medicaid eligibility rules and the operation of the state health exchanges. [10]

Based on the above, CMS has clear legal authority to address this issue as part of its revision to the IEVS regulations and, consistent with current law, may provide states with additional flexibility to guarantee eligibility for the 12-month benefit period without having to apply for a federal waiver. This is an authority CMS should exercise.

As such, we propose that state agencies merely be given the option as a means of avoiding potential adverse coverage disruptions and burdensome and costly administrative oversight.

[10] Although not an issue for this rulemaking, we would also suggest that for those states that opt not to create their own state-based exchange and instead use the federal exchange, that 12-month continuous eligibility be mandatory to reduce the burdens on the federal exchange.

This would require modifications to proposed 42 CFR §435.916(c) and (d) and to 42 CFR § 435.952 to clarify that information received by the agency about changes in an enrollee's circumstances, whether through the IEVS or reported by the individual, could be used, at the state's option, at the time of the next scheduled redetermination and need not be used between eligibility periods. These changes would allow states the option of maintaining Medicaid eligibility until the time of redetermination and would eliminate the endless cycle of mid-enrollment shifts and coverage disruptions. This, in turn, would reduce the anticipated administrative burdens associated with coordinating eligibility and benefits between state Medicaid programs and state run exchanges. It would also support the over-arching goals of the ACA of expanding coverage, improving care and lowering costs. When combined with ACAP's earlier recommendation (see page 9 under "ACA Provision" bullet) to permit states to align redetermination dates within a family, this flexibility would enable parents and their children to have consistent, aligned, eligibility periods which would promote continued coverage.

As noted above, loss of Medicaid coverage makes it more difficult to assure quality of care. Gaps in coverage mean individuals forgo needed primary and preventive care including management of chronic conditions. Although the advent of the state health care exchanges may allow individuals who lose Medicaid coverage to qualify for premium subsidies to allow them to purchase health care through the exchanges, continuity of care would still be disrupted as individuals would need to enroll in new benefit plans and identify new primary care and other providers. This constant movement of individuals back and forth between Medicaid and private insurance plans participating in state health exchanges also creates additional administrative burdens for state and local agencies responsible for making eligibility determinations.

For all of the above reasons, we ask that CMS implement regulatory modifications so as to permit state Medicaid agencies the option to provide individuals with twelve-month guaranteed eligibility.

- **Clarification of State Flexibility With Respect to Use of IEVS Information**

Regardless of CMS' disposition on the twelve-month guaranteed eligibility issue discussed above, gaps in coverage could be reduced and continuity of care improved if CMS were to clarify the scope of state flexibility with respect to use of IEVS and information provided by recipients that may impact eligibility. Current law permits states to use IEVS information in a way that maximizes efficiency and cost-effectiveness. This reasonably includes the right to decide when to use certain information including deferring any eligibility redetermination until the end of the individual's enrollment period. This is consistent with the following language in Section 1137(a)(4)(C) of the Act that specifically states:

> The use of such information shall be targeted to those uses which are most likely to be productive in identifying and preventing ineligibility and incorrect payments, and no State shall be required to use such information to verify the eligibility of all recipients.

This provision of the Act was added as an amendment to the original law specifically to ensure state flexibility with respect to use of IEVS information.[11] The legislative history of that amendment provides additional insight into Congressional intent:

> To insure that the required matches are cost-effective verification processes, the States should be allowed to prioritize and target the follow-up of case records based on match findings. For example, following up on individuals whose unearned income exceeds certain tolerance levels is more efficient than verifying every case with unearned income.[12]

CMS regulations at 42 C.F.R. § 435.953(a) echo this directive, allowing states to use information in a targeted way that results in maximum productivity.

> . . . the agency may either review and compare against the case file all items of information received or it may identify (target) separately for each data source the information items that are most likely to be most productive in identifying and preventing ineligibility and incorrect payments.

Therefore, under existing law, state Medicaid agencies have the discretion to establish criteria, including income screens, for use of IEVS information and information received from recipients to redetermine eligibility outside of the normal twelve-month redetermination cycle. More specifically, the law permits states to consider a number of factors in assessing whether and when to use information which may result in a loss of eligibility. These factors might include, for example, the extent to which income exceeds a certain level (perhaps tied to eligibility for exchange subsidies), the individual's eligibility history (for example, whether they frequently lose and recover eligibility), and the extent to which loss of Medicaid eligibility will negatively impact continuity of care for chronic or acute conditions.

Although ACAP finds the statute to be clear on this issue, the existing regulations and their proposed revisions could create confusion. Specifically, proposed 42 CFR § 435.916(d)(1) states that the agency "must promptly redetermine eligibility when it receives information about changes in a beneficiary's circumstances that may affect

[11] Section 9101 of OBRA 1986 (P.L. 99-509).

[12] Report No. 727, 99th Cong., 2d Sess.424 (1986)

his or her eligibility." However, Section 1137(a)(4)(C) of the Act and existing 42 C.F.R. § 435.953 provide that states may use this information in a targeted way that is most productive.

CMS should provide additional clarification on these provisions since they could be viewed as inconsistent. **Specifically, ACAP asks that the language in existing 42 C.F.R. § 435.953(a) specifically permitting targeted use of information, which would be eliminated under the proposed rule, be retained. Further, ACAP recommends that proposed 42 C.F.R. §435.916(d)(1) be deleted or, at the least, revised** to acknowledge that the state's obligation to redetermine eligibility based on receipt of information about changes in circumstance is subject to the state's right, under 42 C.F.R. § 435.953(a) and section 1137(a)(4)(C) of the Act, to use such information as it determines is most productive.

Finally, CMS should clarify that states will not be sanctioned nor will federal financial participation be denied if they follow reasonable criteria with respect to when they will use information on changed circumstances to minimize mid-enrollment redeterminations.

The above clarifications would allow states, without fear of repercussions, to adopt reasonable standards regarding mid-term eligibility redeterminations. This could significantly reduce the number of individuals who lose Medicaid eligibility prior to the end of their twelve-month benefit period which would, in turn, reduce administrative burdens on state and local agencies, Medicaid managed care plans, and QHPs. More importantly, continuity of care would not be adversely impacted and gaps in coverage would be avoided.

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

- §435.1200 – Medicaid agency responsibilities
  ACAP is very pleased to see, and supportive of, CMS' guidance on the rules for coordination between Medicaid, CHIP, the Exchange and other insurance affordability programs. Once these systems are in place, in concert with the electronic verification processes that are also expected to be in operation, we would expect a substantial diminution in the administrative burden on all parties – applicants, states, CMS, health plans, Exchanges – involved with eligibility determination processes. We support the requirements that Medicaid agencies and Exchanges establish procedures to ensure that applicant information is promptly transferred at appropriate times, that duplicative data requests and verification procedures are avoided, and that Medicaid agencies be required to accept eligibility determinations made by an Exchange without additional review.

As we noted in our comments with respect to §435.911, however, we are concerned that not all states will be able to implement the required system changes to enable them to meet the intent of the regulations in this section. **As such, we recommend that CMS consider developing contingency plans, standards and/or phase-in approaches to reflect the environment which is likely to be in effect as of January 1, 2014.**

Part 457 – Allotments and Grants to States

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

Without referencing specific regulation sections with respect to the Children's Health Insurance Program, ACAP would like to express its general support for CHIP eligibility requirements and the consistency called for among those requirements and similar ones in the Medicaid program. Development, implementation and maintenance of similar standards – be it for eligibility determination processes, redetermination policies, coverage periods, etc – is important to maintain coverage, promote continuity of care, and avoid inappropriate gaps in coverage.

In particular, however, we would like to draw CMS' attention to our comments with respect to §435.915(b) and their applicability to the CHIP program. **We recommend, comparable to our recommendation in the Medicaid program, that individuals determined ineligible for CHIP coverage be retained in the CHIP program, and their CHIP plan enrollment continued, until their eligibility has been determined for other affordable health coverage programs (either Medicaid or Exchange programs). Similarly, we would also recommend that CMS allow children in a CHIP health plan to retain their enrollment in that plan.** Both recommendations will strengthen the state's ability to provide continuity of coverage.

Finally, ACAP would like to express its concern that some current aspects of CHIP implementation do not appear aligned with the vision of the Affordable Care Act. In particular, we note that 'crowd-out" requirements—which often require an uninsured waiting period prior to a family accessing CHIP coverage for its child (ren)—are inconsistent with the requirement that all individuals obtain health insurance coverage. Moreover, if CHIP uninsured period requirements continue, the result could be significant confusion on the part of parents concerning in which program their child(ren) should be enrolled and when, increased financial burdens on families, true uninsured periods for families who cannot afford Exchange policies, and possible tax penalties due to failure to meet health insurance coverage requirements. In addition, states could also be faced with issues about if or when they should initiate efforts to transition children from one insurance product to another. All of these issues counteract efforts that CMS and states have made to support

continuity of care and seamless transitions. **ACAP strongly supports CMS efforts to address these and similar issues in future guidance to states.**

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. While we have provided several recommendations to improve the approach outlined by CMS in these draft regulations, our primary recommendation is that we believe that such efforts would be considerably improved if states were permitted to guarantee Medicaid eligibility for the twelve-month enrollment period without having to apply for a federal waiver. We also recommend that CMS clarify, through regulations, state flexibility with respect to use of IEVS information that may affect eligibility.

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

Attachments