FIRST FOCUS
MAKING CHILDREN & FAMILIES THE PRIORITY

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The Honorable Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

**Comments on Interim Final Provisions of the Exchange and Medicaid Rules Released on March 23 and March 27, 2012**
Submitted electronically via www.regulations.gov

Dear Secretary Sebelius:

On behalf of First Focus, I appreciate the opportunity to comment on the interim final rules concerning Exchanges and Medicaid that will implement critical areas of the Patient Protection and Affordable Care Act (P.L. 111-148). First Focus is a bipartisan children's advocacy organization dedicated to making children and families a priority in federal policy and budget decisions. Our core mission is to ensure that all of our nation's children are able to get the services they need and deserve. We submit the following comments on the interim final provisions included in the final Exchange and Medicaid rules published in the Federal Register on March 23 and 27th, 2012 (§435.1200 and §155.302).

## OVERVIEW

Throughout the debate on passage and now implementation of the Affordable Care Act (ACA) (P. L. 111-148), there was agreement that the gains won for children's coverage over the last decade be maintained – that no child should lose coverage because of the passage of the ACA. While there is still much to celebrate in the final rules, there are some provisions that First Focus would like to see changed or strengthened. We respectfully submit our comments and recommendations below.

The final Exchange and Medicaid rules will be critical to our shared goal of creating a simplified, streamlined enrollment and application process and appropriate assistance for applicants in need.

The ACA sought to ensure a simple, unified pathway to health coverage for consumers. We are pleased to see that the final rules offer some important consumer protections, such as:

- Prohibiting states from duplicating verification of information or asking for information or documentation provided earlier in the enrollment process.

- Informing applicants of their enrollment status and final eligibility determination.
- Allowing families to request and receive a full eligibility determination by the Medicaid agency that considers disability-based pathways to coverage.

While we appreciate the inclusion of these provisions, we are very troubled by the ways the final Exchange and Medicaid rules depart from earlier proposed rules – no wrong door. Many provisions would undermine the ACA's clear intent to establish a simple, unified pathway to health coverage for consumers. We are particularly concerned by the decision to allow Exchanges to forego responsibility for conducting Medicaid determinations and, instead, to hand off applications to Medicaid and CHIP agencies for a final eligibility determination. In many states, this decision could lead to the fragmentation of eligibility systems, an issue of particular importance to the nation's children because they often reside in families that will be required to navigate both Exchange subsidies and Medicaid or CHIP. In these families, many of whom are low-income, a range of circumstances—family members covered by different eligibility categories or programs, income fluctuations, household composition changes—could force them to navigate both the Exchange and Medicaid or CHIP during the course of a single benefit year. We respectfully urge the Secretary to reconsider these sections in light of our shared goal to expand health coverage for our nation's most vulnerable children and families.

## BACKGROUND

The Affordable Care Act (ACA) prescribes a seamless, streamlined eligibility process for consumers to submit a single application and receive an eligibility determination for enrollment in any of the insurance "affordability programs" (i.e., advance premium tax credits, cost-sharing reductions, Medicaid, CHIP, and, if applicable in a state, the Basic Health Program). The goal is to create a "no wrong door" approach to coverage that offers multiple ways to apply and ensures that no matter how a family or individual chooses to apply for or renew coverage, they are screened for and enrolled in the appropriate program without having to take any additional or repetitive steps.

In the proposed rules released in 2011, Exchanges were expected to conduct Medicaid determinations and to ensure people were enrolled in the appropriate program. Under the new rules published on March 23 and 27, 2012, however, states can elect to have an Exchange merely conduct a preliminary "assessment" of potential Medicaid eligibility and then relinquish the final eligibility determination to the Medicaid agency (§435.1200 and §155.302). Under such a model, responsibility for key functions may be divided, creating significant risk of a fragmented and uncoordinated system. As noted above, based on the experiences of states seeking to coordinate coverage between Medicaid and separate CHIP programs, we know that "handoffs" between affordability programs can lead to eligible people falling through the cracks even when states have the best of intentions. We also are concerned that states facing political or fiscal constraints may not be as eager to maximize coverage among eligible children and families and this split model provides an indirect means to slow enrollment into Medicaid/CHIP.

## SPECIFIC COMMENTS

Below are the specific recommendations and our thoughts that address the interim rules.

### Streamline and Eliminate Duplicative Eligibility Determinations

Under 45 CFR § 155.302(b)(1) in the Exchange final rule, the Exchange bases its assessment of Medicaid and CHIP eligibility "on the applicable Medicaid and CHIP MAGI-based income standards and citizenship and immigration status, using verification rules and procedures consistent with 42 CFR parts 435 and 457, *without regard to how such standards are implemented by the State Medicaid and CHIP agencies*." (Emphasis supplied.) By departing from Medicaid rules and procedures, the Exchange could classify consumers as Medicaid-eligible though the state could find them ineligible. As a result, a child or family who applies for coverage through the Exchange could have their file sent to the Medicaid agency, which would then return the file to the Exchange, after each agency found the applicant ineligible. Such "bouncing" back and forth between programs increases the danger of coverage gaps and wastes administrative resources.

To prevent this, the Exchange's assessment of Medicaid and CHIP eligibility should apply the state's eligibility rules and verification procedures, thereby coming as close as possible to the results that the state would achieve. Such rules and procedures, including the verification plan described in 42 CFR §§ 435.945(j) and 457.380(j), should be included in the interagency agreements required by 42CFR §§ 435.1200(b)(3) and 457.348(a).

This regulatory change would help the latter provisions accomplish their important goal. They specify that Medicaid and CHIP programs must: "Accept any finding relating to a criterion of eligibility made by [the Exchange], without further verification, if such finding was made in accordance with policies and procedures which are the same as those applied by the agency or approved by it in the [interagency] agreement" with the Exchange. If the final regulation is modified as proposed here, Exchange findings during an assessment will be substantially more effective in streamlining the later enrollment of eligible children into Medicaid and CHIP, eliminating redundant administrative procedures that could otherwise interrupt or prevent coverage.

Additionally, we believe that if a state is going to be allowed to adopt a more complicated eligibility system than necessary, it should be required to first establish that it could do so without harming families. To that end, HHS should require states seeking to bifurcate their eligibility systems to actively validate their operational readiness to implement this more complicated structure by 1) demonstrating that their Medicaid agency has the capacity to conduct eligibility determinations in full compliance with the final Medicaid eligibility rule, including provisions requiring electronic verification of income; 2) establishing for HHS via the use of test cases and other means that their Medicaid IT systems can accept and use data transferred from the Exchange; 3) showing that they can and will agree to all of the coordination protections included in the final rule, including the requirement that they not ask families for information that they already have provided and refrain from unnecessarily re-verifying any data already verified by the Exchange. It should not be enough for states to simply check boxes on an Exchange Blueprint document saying that they will do all of these things; they should be required to actively demonstrate their operational capacity to do so

## Require Timely Eligibility Determinations

We are concerned that the timeliness standards outlined in the Medicaid rule provides states with up to 45 days to conduct eligibility determinations for individuals without disabilities and 90 days for people seeking coverage under a Medicaid category for people with disabilities. For children, and especially children with disabilities, and pregnant women, these time-periods are excessively long. Consider, for example, that the American Academy of Pediatrics' Bright Futures guidelines expect newborns to see their health care providers three times by the time that they are one month old, making it imperative that they not have to wait 45 days for coverage. Similarly, prenatal care is critical to ensure healthy birth outcomes. Delaying these crucial services, especially for high-risk pregnant women who are more likely to be on Medicaid, could jeopardize the health of the mother and her child, increasing the risk of preterm birth and low birth weight. Delays also could disrupt health services for children with complex medical conditions, who need reliable and continuous care.

Particularly because the federal government is making a massive investment in new eligibility system technologies, we recommend that the final rule require eligibility determinations to occur within a few days or even on the same day if electronic data are available to verify eligibility. Moreover, under no circumstances should eligibility determinations take more than 30 days, with a 60-day ceiling for those being evaluated for disability-based coverage. Any transfers between Medicaid or CHIP and the Exchange should be completed within a day and remain subject to the maximum of 30 or 60 days (i.e., the clock does not reset when a case is transferred). In addition, HHS should establish clear performance standards to measure the overall performance across all applicants with a clear expectation that eligibility will be determined quickly and for the vast majority of applicants well before the expiration of the 30-day maximum period. Finally, the Exchange rule should be aligned with and reflect the timeliness and performance standards for Medicaid to ensure expectations are consistent. Given that the ACA provided significant funds for states to update their enrollment technology and improve program efficiencies, we believe that expecting real-time determinations is not unreasonable. In fact, the technology provisions within the ACA created that expectation for many.

## Improve Transparency

Given the central role that eligibility determinations will play in the effectiveness of the ACA in serving children and others, we believe it would be appropriate that children's advocates, health care providers, and other members of the public have the opportunity to learn about and provide input into the way that such determinations are conducted. Under the latest rule, states are required to establish agreements between the Medicaid agency and the Exchange, including details concerning timeliness standards and coordination across programs. Such agreements should not only be "available" to the Secretary, though they should require her/his approval. The State plan, the agreements between state agencies, and the state's verification plan should all be readily available to the public on both the state and HHS websites to provide a greater level of accountability and to allow review and comment from consumer representatives.

## Performance Standards

The final rule seeks to assure good performance by applying consistent requirements to Medicaid, CHIP, and the Exchange. We believe that principle should be extended in several ways.

First, 45 CFR 155.302(d)(2) in the Exchange final rule provides that, if the Exchange assesses rather than determines Medicaid/CHIP eligibility, the Exchange must ensure that: "Such arrangement does not increase administrative costs and burdens on applicants, enrollees, beneficiaries, or application filers, or increase delay." This is a critically important safeguard. It seeks to ensure that consumers do not suffer if an Exchange conducts "assessments" rather than "eligibility determinations." For this regulation to accomplish its objective, however, that same duty must apply to Medicaid and CHIP agencies. The latter agencies will make many of the most important decisions that determine whether bifurcated eligibility increases consumer burdens and delays application processing—the two key factors at the heart of 155.302(d)(2). For example, co-location of Medicaid eligibility workers at the Exchange can prevent delays between the Exchange assessment and Medicaid's determination of eligibility. To ensure that state decisions protect consumers from delays and needless burdens, 45 CFR 155.302(d)(2) must also apply to Medicaid and CHIP agencies, not just the Exchange.

Second, the "clock" for timely processing of applications should start when the consumer submits an application for insurance affordability programs, not when the consumer's file is received by Medicaid, CHIP, or the Exchange. States have the option to use a single eligibility system, thereby eliminating the need to transfer applications from agency to agency. If a state rejects that option and instead adopts a system that requires such transfers, the state should shoulder the corresponding responsibility to ensure that transfers do not cause an unacceptable delay between the consumer's initial submission of an application and the final determination of eligibility.

The final rules contemplate, wisely, that specific rules for performance standards will be developed and modified by CMS over time, reflecting ongoing improvements in the "state of the art." However, even as the regulations leave room for later detailed guidance, they should identify the general topics to be addressed by performance standards. In the Medicaid final rule, for example, 42 CFR 435.912(a)(2) provides that performance standards must "include standards for accuracy and consumer satisfaction." In that same regulation, paragraph (b) likewise requires "performance standards for, promptly and without undue delay" determining Medicaid eligibility. However, performance standards need to go beyond these three items to address such other topics as:

- Procedural denials of eligibility, at application and renewal;
- Eligibility determinations that required asking consumers for documentation or other information outside the standard application form;
- Applications submitted by Navigators, authorized representatives, or other providers of application assistance;
- Renewals; and
- Accessibility, utilization, and completion of applications and renewals for disadvantaged populations, including children with special health care needs and people with limited English proficiency, limited literacy, and disabilities.

## Promote Use of Presumptive Eligibility

If a state elects to have its Exchange merely conduct a preliminary "assessment" of potential Medicaid eligibility and then relinquish the final eligibility determination to the Medicaid agency, HHS should explore whether it has the authority to encourage or require the Exchange to determine a child or pregnant woman to be presumptively eligible for coverage in Medicaid and/or CHIP and immediately enrolled 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 on children and pregnant women.

As always, we appreciate the time and effort HHS puts into researching and formulating these rules and all of the effort put forward to protect children and families. Please do not hesitate to contact First Focus with questions or needed clarification on these comments. Thank you for reviewing and considering our comments and recommendations.

Sincerely,

Bruce Lesley

President