October 31, 2011

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

Re: Medicaid Program: Eligibility Changes Under the Affordable Care Act

Dear Sir/Madam:

Thank you for giving the State of Vermont the opportunity to comment on the captioned proposed rules.

We applaud and support the important mission of bringing into close coordination each state's Medicaid program and health benefit exchange. We hope our comments are consistently supportive of that goal. Our comments begin with some general observations followed by section-specific comments in the order of appearance in the rules.

Medicaid NPRM
42 CFR Parts 431, 433, 435, and 557

General comments:

1. The Medicaid NPRM does not address the coverage groups that are identified in 42 CFR Part 435, subparts B and C that, in light of the Affordable Care Act (ACA), appear to be obsolete or changed. In the Overview to the Proposed Rule, CMCS states that it intends to issue additional proposed rules addressing this. However, states need this information now to plan for and implement necessary system changes. The final rule should clearly identify those coverage groups that survive the ACA, and delete those that have been rendered obsolete.

   To support states in developing a coordinated eligibility and enrollment system for all insurance affordability programs, § 1943(b)(3) and § 1413 of the ACA direct the Secretary to develop and provide States with a single, streamlined application. States are required to make this application available through a variety of formats including the internet, telephone and paper. If states are to be able to meet their implementation deadlines, it is imperative that CMS publish the application in the near future.

   Like many states, Vermont operates an integrated public-benefits eligibility system. This approach is based on many of the same policy objectives that motivate federal healthcare reform. Like its federal partners, Vermont strives to provide its citizens with a simple, streamlined, and uniform process for applying for public benefits. In many respects, the eligibility changes proposed in the Medicaid NPRM will support the operation of an integrated eligibility system: The promotion of electronic data-matching, enhancement of web-based services, and alignment of the methods for determining health-care eligibility all work to promote this objective. Other changes however, will

make it significantly more difficult to align health care eligibility with other programs. Conversion to the MAGI income standard and adoption of tax-based concepts of household composition and financial responsibility diverge significantly from how eligibility is determined in sister programs like SNAP. We seek clarification of the approach states like Vermont should take in reconciling the new health-care eligibility requirements and business processes with those of other benefits programs.

The ACA preserves the Medically Needy coverage groups and exempts them from MAGI-based financial methodologies. We ask that CMCS clarify the interplay between insurance-affordability paradigm and MAGI financial methodologies and Medically Needy coverage, including whether an individual who is over income for Medicaid enrolls in a QHP with premium assistance will be able to spend down into Medically Needy coverage. Generally, we are concerned about how the inevitable transitions back and forth between Medicaid and premium tax subsidies are best managed.

The ACA preserves the Transitional Medicaid (TM) categories as mandatory coverage groups. One of the three groups–families terminated from AFDC solely because of earnings, hours of employment, or loss of earned income disregards–is up for reauthorization in 2013. Two other TM categories–coverage for those who lose AFDC due to child support or spousal support–will not necessarily be reviewed at that time. States will need guidance on how to deal with the complexities of operationalizing these groups within the new eligibility paradigm.

Electronic verification-of-eligibility requirements and real-time eligibility determinations are cornerstone features of the new rules. Yet, so far, states have received very little detail about how these processes will work. If states are to meet their implementation deadlines, it is imperative that CMS provide this guidance in the immediate future.

States will need to convert a number of income standards to MAGI-equivalent standards. CMCS has indicated that guidance as to how this is to be accomplished is forthcoming. If states are to meet their implementation deadlines, it is imperative that CMS provide this guidance in the immediate future.

States are required to use available databases to attempt to automatically review eligibility at the time of annual renewal. If the state is unable to administratively renew eligibility, it must send the individual a pre-populated recertification form. The technical requirements and feasibilities of these processes are far from clear. Again, if states are to meet their implementation deadlines, it would be helpful if CMS provided this guidance in the near future.

Section-Specific Comments:

§ 435.116 and § 435.603(b). Under § 435.116, as it is currently drafted, in determining household size, "the unborn child or children are considered members of the household." Thus, in the case of multiple fetuses, each counts as a household member. The NPRM drops this provision from proposed § 435.116. Proposed § 435.603(b) provides, instead, that "[i]n the case of determining the family size of a pregnant woman, the pregnant woman is counted as 2 persons. In the case of determining the family size of other individuals who have a pregnant woman in their household, the pregnant woman is counted, at State option, as either 1 or 2 persons." Thus, under the rule, as proposed, states will no longer be permitted to count multiple fetuses in determining the household

size in families with pregnant women. In the comments to § 435.603, CMCS notes that, under the IRS definition of family size, pregnant women count as one person for purposes of eligibility for advance payments of the premium tax credit. It explains that it is deviating from the IRS rule in this regard, because "[c]ounting the pregnant woman as a household that will be comprised of two for Medicaid eligibility purposes essentially anticipates the change in household size that will occur after the birth." As the current standard more perfectly achieves this goal, we recommend that the proposed rule be modified to allow states to count all of the pregnant woman's unborn children in determining household size.

§ 435.119 Coverage for Individuals Age 19 or Older and Under Age 65 at or Below 133 Percent FPL. A subset of individuals who are eligible for the Medicaid Working People with Disabilities program, MWPD, in Vermont may lose Medicaid coverage through the requirements of this section of the rule.

Having Medicaid eligibility and coverage has been incredibly important to all of the beneficiaries in this program since the year 2000. The proposed federal rule states that coverage for adults must be provided for:

Individuals who:

1. *Are age 19 or older and under age 65*
2. *Are not pregnant*
3. *Are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act*
4. *Are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State Plan in accordance with subpart B of this part: and*
5. *Have Household income that is at or below 133 percent of FPL for household of the applicable family size.*

Under the proposed rules individuals currently who are on MWPD but are not on Medicare because they are in the two-year waiting period for Medicare and are above 133 % FPL would not be provided coverage by Medicaid. Currently MWPD eligibility goes to 250% of FPL for the individual.

The other part of this section that is problematic for the MWPD eligibility is that the proposed eligibility is for household income at or below 133 percent of FPL. MWPD eligibility can currently be done by looking at the participant's income only and take into consideration assets. These changes do not look at assets when determining eligibility.

The rule should be revised to continue the current eligibility standards for this group of individuals with disabilities, because the eligibility for Medicaid frequently provides needed supports for the individual to retain his/her employment. In the alternative, the rule should be revised to allow current MWPD program participants to retain Medicaid eligibility (a "grandfather" clause).

§ 435.603(a) Grace Period for Application of MAGI to Current Beneficiaries. The proposed rule requires states to review eligibility for all those currently enrolled in the program on January 1, 2014 in order to determine whether the grace period applies. The intent behind the rule seems to be to allow individuals who would lose eligibility to have until the next redetermination. The same result could be achieved with a lesser administrative burden on the state if the rule was amended to allow states to convert to the new standard upon the regularly scheduled redetermination.

§ 435.603(f) Proposed Rules for Determining Household Composition Under MAGI Based Methods. This provision of the Modified Adjusted Gross Income (MAGI) based requirements will be detrimental to individuals who are currently on the MWPD and not on Medicare over 133% FPL. The redetermination of individuals on the Medicaid Buy-In program and ongoing determinations of like individuals would require that they be reviewed as part of a household (including the income of a spouse) rather than reviewed individually. The rule does not speak to any applicable disregards that would allow a working disabled person to retain Medicaid eligibility. The state requests that the rule be amended to ensure individuals in the MWPD program retain eligibility under current rules. In the alternative, the rules should be revised to allow current participants to remain in the Medicaid Working People with Disabilities program (a "grandfather" clause).

§ 435.603(i) Retention of Existing Financial Methods. This provision allows for exceptions to the MAGI based method for determining eligibility for Medicaid and spells out in paragraphs (i)3 through (i)6 which populations are not subject to MAGI. Even with these exceptions it is not clear that that a current Medicaid Working People with Disabilities enrollee would be allowed to participate given the requirements of the Adult group PPACA eligibility process. It is also unclear whether individuals who are allowed to access both Long Term Care Services as well as Working People with Disabilities services will retain eligibility. The rule should be amended to provide participants in these 2 eligibility groups to retain eligibility for both programs or, in the alternative, Vermont requests that the rule be amended to provide an exception to allow participants to continue coverage through the Medicaid Working People with Disabilities program.

§ 435.911(c)(1) MAGI Screen. The provisions in § 435.911(c)(1) which require prompt furnishing of Medicaid benefits to individuals should be revised to allow the income of an individual with a disability to be reviewed as an individual household, rather than in the family household. This provision should also be amended to allow for exceptions for individuals in the Medicaid Working People with Disabilities program.

§ 435.940 through § 435.960 and § 457.380. In our comments to the NPRM for Part 155 of the proposed Exchange rules, we pointed out several places in which it appears that the Exchange verification procedures differ from those that are proposed for Medicaid and CHIP. As, in many places, the same staff will be applying these procedures to simultaneously determine eligibility for all insurance-affordability programs, we believe that these procedures should be identical. We, therefore, reiterate our related comments to the Exchange rule below:

3. § 155.315(b)(2): This provision states:

> "For an applicant who has documentation that can be verified through the Department of Homeland Security and who attests to lawful presence, or who attests to citizenship and for whom the Exchange cannot substantiate a claim of citizenship through the Social Security Administration, the Exchange must transmit information from the applicant's documentation and other identifying information to HHS, which will submit necessary information to the Department of Homeland Security."

   a. We seek clarification regarding how the Exchange will know at the time of application whether an individual has documentation that can be verified through the Department of Homeland Security.

b. If the Exchange cannot verify citizenship through a data match with the Social Security Administration, it will not know whether the individual has documentation that warrants a second attempt to data match with DHS.

4. § 155.315(b)(3):

a. This provision establishes the procedures to be employed in the verification of citizenship. By and large, it incorporates the procedures outlined in § 155.315(e)–the paragraph that deals with verification in the case of general inconsistencies. However, in § 155.315(e), the applicant's response period begins on the day that notice is sent. Here, in contrast, the period begins on the day that the individual receives the notice.

i. This difference will likely be confusing to state-level staff. It appears that the date of receipt is used here to mirror the standard used in the analogous Medicaid context. Here, however, the standard includes a definition of "receipt date," which is not a part of the Medicaid standard. All of these provisions should be reconciled. Perhaps the 90-day period across both rules could use the receipt date, subject to the definition that is included in this section.

ii. It is not clear whether this paragraph is intended to preempt the provision in § 155.315(e) that allows the Exchange to grant a good-faith extension of the response time. If so, that should be clarified.

(1) If the rule permits the Exchange to grant a good-faith extension in the citizenship context, it will be inconsistent with the Medicaid standard: In its State Health Official Letter on this topic, CMS stated that, if "[a]fter 90 days, if the inconsistency has not been resolved or documentary evidence of citizenship or nationality has not been provided, the State must disenroll the individual with timely and adequate notice within 30 days." CMS State Health Officer Letter No. 09-016 (CHIPRA, No. 11, Dec 28, 2009), p. 6.

5. § 155.315(e): The Exchange rule for resolving inconsistencies should be identical to the Medicaid rule on this topic. However, as they now stand, there are several significant differences:

a. 42 CFR § 435.949(b) requires states to use HHS's electronic service in the first instance, if data is available through the service. The Exchange rule does not include a similar requirement.

b. This rule requires the Exchange to make a reasonable effort to resolve the inconsistency, before asking the applicant for additional information. The Medicaid rule does not contain a parallel requirement.

c. The Exchange rule requires the Exchange to grant benefits to otherwise-eligible individuals pending completion of the verification process and provides a

procedure for action if the Exchange is unable to verify eligibility at the close of the response period. The Medicaid rule does not contain parallel provisions. In fact, 42 CFR § 435.911(c) seems to provide for enrollment pending completion of eligibility only during the time that the agency is providing a reasonable opportunity to provide documentation of citizenship or immigration status.

d. § 155.315(e)(3): It does not appear that the proposed Medicaid rule provides for a good-faith extension of the verification response period. The Exchange and Medicaid verification rules should be identical: Both should allow for a good-faith extension or neither should.

§ 435.949 Verification of information through an electronic service. It would be very helpful to the states if the "hub" included federal data sources like Veteran's Administration, Tri-Care, and Office of Personnel Management.

We hope these comments will be helpful in your consideration of ways to make these rules as effective as possible in enabling the harmonization of state exchanges and Medicaid programs.

Sincerely,

Robin Lunge
Director of Health Care Reform
State of Vermont