



A Passionate Voice for Compassionate Care

October 31, 2011

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Department of Health & Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

REF: CMS-2349-P: Medicaid Program: Eligibility Changes Under the Affordable Care Act of 2010

Dear Dr. Berwick:

On behalf of the Catholic Health Association of the United States (CHA), the national leadership organization of the Catholic health ministry representing more than 2,000 Catholic health care sponsors, systems, hospitals, long-term care facilities, and related organizations, I am pleased to provide comments on the referenced notice of proposed rulemaking (NPRM) on eligibility changes in the Medicaid program under the Patient Protection and Affordable Care Act (ACA). The proposed rule would implement the Medicaid coverage expansion and related provisions that link Medicaid to the premium tax credits and other Insurance Affordability programs which are a central element of achieving the ACA's goal of substantially reducing the number of uninsured Americans. To work best for individuals, the links between these programs must be seamless so that individual can navigate them in a way that prevents gaps in coverage and avoids shifting individuals between coverage programs over the course of a year. CHA strongly supports HHS' efforts to create a simplified, streamlined application and eligibility process that ensures low income individuals eligible for Medicaid and the Children's Health Insurance Program (CHIP) will get the coverage they are entitled to. We are pleased to offer the following comments to help achieve that goal.

1. Changes to Medicaid Eligibility

Coverage for Pregnant Women: CHA appreciates the steps taken in the proposed rule to simplify the myriad of Medicaid eligibility categories in light of the ACA coverage changes. **With regard to pregnant women we are very concerned that the proposed section**

435.116(d), which would allow a state to elect to provide only pregnancy-related services for women above a state-determined income threshold, could result in low income pregnant women receiving less comprehensive benefits than non-pregnant women of the same income level. To prevent this outcome, it is essential that CMS align coverage for pregnant women with the full range of coverage provided to other adults. One way CMS might achieve this is by broadly defining “pregnancy-related services” to include the full range of health services under Medicaid. Any health services provided to a pregnant woman are pregnancy-related, as many states already recognize. Additionally we support the proposal to allow states to continue to elect to provide enhanced pregnancy-related services specifically for pregnant women as well as the proposed codification of a definition of pregnant woman that includes the 60-day post partum period.

2. Financial Methodologies for Determining Medicaid Eligibility Based on MAGI

The ACA requires that for the most part, beginning in 2014, Medicaid eligibility will be determined on the basis of income and household definitions that apply to individuals under section 36B of the Internal Revenue Code, which are the definitions used to determine eligibility for the premium support tax credits. Specifically, income will be based on modified adjusted gross income (MAGI) as defined in section 36B, and this definition will apply not only to the new eligibility category for adults under age 65, but to existing Medicaid eligibility categories that cover most current Medicaid beneficiaries.

The proposed rule addresses several issues that result from the differences between current Medicaid income eligibility standards and the rules under section 36B. CHA recognizes that the application of the MAGI will inevitably result in some people who would be eligible for Medicaid today becoming eligible instead for premium tax credits applied to coverage purchased through the Exchange. **We encourage that CMS continue to work to avoid unnecessary disruptions in coverage for current Medicaid beneficiaries, as future guidance is developed for states on specific methodologies for determining MAGI-equivalent income standards,**

Point in time measurement of income. Because Medicaid income eligibility is determined on a monthly basis and the premium tax credit income eligibility is annualized, individuals with fluctuating monthly income could be shifted back and forth between the two programs over the course of the year. A study by Benjamin Sommers and Sara Rosenbaum found that half of individuals with incomes under 200% of the federal poverty level could be shifted between Medicaid and premium support tax credit coverage purchased through the Exchange. Moreover, as pointed out in the preamble, some individuals could potentially face a period of uninsurance if their income in a given month is too high for Medicaid eligibility but their projected annual income would be too low for eligibility for premium subsidies in the Exchange.

In an effort to minimize these effects, CMS proposes to provide states flexibility to recognize reasonably anticipated future changes in income when determining Medicaid eligibility, and in particular to allow states to maintain Medicaid eligibility for individuals whose annual income

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based on MAGI methods remains at or below the Medicaid income standard. In this way, states could act to prevent individuals from shifting back and forth between the programs even for small changes in income.

CHA appreciates that CMS is addressing this important issue, but we remain concerned about the potential for individuals being shifted back and forth between different programs even with state flexibility. Because Medicaid financing requires a state contribution (other than for the initial three years for the new adult category) and the premium tax credit does not, states may find it financially advantageous to allow individuals to shift out of Medicaid into Exchange coverage whenever possible. **To the extent permitted by the statute, the final rule should require states to take into account reasonably anticipated future income changes in determining and maintaining Medicaid eligibility.** To minimize the chance that projections of increased income are used that turn out to be wrong, which would lead to an inappropriate loss of Medicaid eligibility, states should be required to held to very strict standards in what factors constitute a *reasonable* anticipation of future income increase. **In addition, states should be required to determine continued financial eligibility based on projected annual household income, not monthly income, at least for those individuals who would lose Medicaid coverage based on monthly income.**

Additional complexity will be created in those states that elect to establish a Basic Health Program. In those states, eligibility transitions will be formed between Medicaid and the Basic Health Program and also the Basic Health Program and the premium tax credit. **CHA urges that CMS, in developing the proposed rule for the Basic Health Program, simplify these transitions for beneficiaries and prevent coverage gaps from occurring.**

Exceptions to application of the 36B rules. CMS proposes to create important exceptions to the general rule of applying the 36B definitions of income and household in determining Medicaid eligibility. Several of these proposals are important to recognizing specific family circumstances and encouraging continuity of coverage. **In particular, we support the proposal to codify existing Medicaid rules in determining eligibility of individuals who are claimed as a tax dependent by another taxpayer who is not a spouse, parent, or step-parent.** This will continue Medicaid practice in cases such as a grandparent caring for a grandchild, under which only actually available cash support provided by the grandparent would count as income for the purposes of determining the eligibility of the child. As is noted in the preamble, application of 36B household definitions in these cases would force these taxpayers to either give up a tax advantage or finance health insurance for their dependent, even though they have no legal responsibility to provide such support.

CMS proposes to maintain the existing Medicaid principle regarding parents' legal responsibility for the children living with them. **CHA supports the proposal that regardless of whether a non-custodial parent claims a child as a dependent, the policy of treating a child as a member of his or her custodial parent's household would be continued.**

Finally, it is very important that a pregnant woman always be considered a household of two for the purposes of determining Medicaid eligibility whether for herself or for any family members with whom she resides. This will provide for continuity of coverage because the household size will increase once the child is born. Otherwise, some families may be initially enrolled in coverage through the Exchange and then shifted to Medicaid once the child is born. The final rule should not include the proposal to give states the option of counting a pregnant woman as only one person when determining the family size of individuals with a pregnant woman in their household.

3. Application and Enrollment Procedures for Medicaid

Encouraging participation of eligible individuals in Medicaid is critical to assuring access to needed health services and in achieving the ACA's goal of minimizing the number of people who go without health insurance coverage. Simplifying the application and enrollment procedures, assisting individuals who need additional help in applying, and taking steps to eliminate other barriers that discourage individuals from applying for Medicaid are all important elements in ensuring that eligible individuals are enrolled.

Single application form. **CHA supports instituting a single streamlined application form to simplify Medicaid enrollment and coordinating eligibility determinations made by the Medicaid program and the Exchange.** The single form that the Secretary will develop should collect sufficient information to determine eligibility while minimizing the burden on applicants. In addition to the application form itself, all communications with applicants and application procedures should be made as easy as possible for applicants, taking into account the special needs of individuals with limited English proficiency and persons with disabilities. CMS should apply the same high standards in developing the single national streamlined form and in approving state forms, whether they are supplemental forms for determining eligibility on a basis other than MAGI or combined state alternative forms to be used for both MAGI and non-MAGI based eligibility determinations. CHA also supports the requirement that states provide individuals with assistance in the application and redetermination processes in a manner that is accessible to those with limited English proficiency or with disabilities.

Information requested from non-applicant immigrants. In order to ensure that all eligible individuals are encouraged to apply and enroll in Medicaid, **CHA is very supportive of the proposal to maintain and codify Medicaid policy that non-applicants may not be required to submit their Social Security number, or information regarding their citizenship, nationality or immigration status.** States may request information concerning Social Security numbers of non-individuals only if it is entirely voluntary, does not affect whether the application is considered complete, and the individual is told how the information will be used. The regulations should make clear that states may not ask about the citizenship or immigration status of non-applicants.

4. MAGI Screen and Eligibility on the Basis of Disability

CMS proposes that Medicaid applicants first be screened for eligibility under the appropriate MAGI rules, and only if they are found to be ineligible, then be screened for eligibility under non-MAGI based standards, such as those that apply to individuals on the basis of disability. CHA agrees that this approach would ensure quick enrollment of many eligible individuals into Medicaid coverage, but we are concerned that in some cases individuals who may be eligible on the basis of being disabled will be enrolled in the new adult category on the basis of MAGI, which may result in the inappropriate loss of benefits if the state's benchmark benefits are not as generous as those that are provided for individuals eligible on the basis of being disabled.

The ACA requires that individuals eligible for Medicaid on the basis of being disabled not be subject to the MAGI standard, and **CHA believes the application form therefore must be designed to collect sufficient information to determine which applicants should be screened for eligibility on the basis of being blind or disabled. Furthermore, if the application indicates the individual may be blind or disabled, the state should be required to determine if the applicant qualifies for non-MAGI Medicaid eligibility and to assist the applicant to enroll in the best category for which they are eligible.** Because an eligibility determination on the basis of disability may involve a lengthy process, **we support the proposal to require that these individuals be assessed for eligibility under other insurance affordability programs, so that they may enroll in other coverage if eligible while the Medicaid eligibility determination is pending.**

5. Coverage Month

CMS invites comments on whether, when an individual is terminated from Medicaid coverage, to extend Medicaid coverage through the end of the month of the termination, given that Exchange coverage will begin only on the first of the month. **CHA urges that CMS ensure in the final rule that Medicaid coverage cannot be terminated at a point in time when an individual will be unable to seamlessly enroll in other coverage.** Otherwise, individuals will experience a gap in insurance coverage through no fault of their own. While some exceptions, such as the death of a beneficiary, are appropriate, allowing state flexibility on the timing of terminations is not in keeping with the ACA goals of reducing uninsurance and providing for coordination between Medicaid and Exchange coverage.

6. Periodic Redetermination of Medicaid Eligibility

CHA supports the goal of establishing simplified, data-driven policies and procedures for re-determining and renewing Medicaid eligibility for individuals eligible on the basis of MAGI, under which an individual still eligible based on electronic information available to the state would simply be notified of their continued eligibility. Only when additional information is required to determine continued eligibility would a beneficiary be asked to supply new information. CMS requests comments on the length of time that should be specified for a

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redetermination period in the case of individuals who fail to return a renewal form within the time frame specified, which would have to be at least 30 days. **CHA suggests that to minimize the number of terminations in need of reconsideration, CMS consider a longer minimum period for the initial response to a renewal form, such as 45 days or 60 days, and supports the suggested 90 day reconsideration period, which would be parallel to the 3-month retroactive assistance period provided for individuals who are newly eligible for Medicaid.**

7. Coordination of Eligibility and Enrollment among Insurance Affordability Programs

Coordination between Medicaid and other Insurance Affordability programs, such as the premium tax credit, a Basic Health Program if a state elects to operate one, and the Children's Health Insurance Program (CHIP), is critical to providing a simplified and seamless experience for individuals seeking to enroll in and maintain insurance coverage. As one aspect of coordination, the rule proposes requirements for states in operating an internet web site, linked to other insurance affordability programs. The accessibility of the website to all Medicaid eligible individuals is critical, and **CHA supports the requirement that states must ensure the website is accessible in accordance with the Americans with Disabilities Act and that it provides meaningful access for persons who are limited English proficient.**

8. Application of MAGI to CHIP

The proposed rule includes provisions to implement ACA requirements regarding the use of MAGI, eligibility and enrollment procedures and coordination with other programs that parallel those proposed for Medicaid. As stated above with respect to Medicaid, **CHA urges that CMS ensure in the final rule that CHIP coverage cannot be terminated at a point in time when a child will be unable to seamlessly enroll in other coverage.** Coverage gaps resulting through no fault of the individual should not be permitted to occur.

In closing, thank you for the opportunity to share these comments in regard to the proposed rule on Medicaid eligibility changes under the ACA. We look forward to working with you on these and other important issues to continue to strengthen access to affordable health care. If you have any questions about these comments or need more information, please do not hesitate to contact me or Kathy Curran, Senior Director Public Policy, at 202-721-6300.

Sincerely,



Michael Rodgers
Senior Vice President
Public Policy and Advocacy