MACPAC
Medicaid and CHIP Payment and Access Commission

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

RE: CMS-2349-P "Eligibility Changes Under the Affordable Care Act of 2010"

Dear Secretary Sebelius:

The Medicaid and CHIP Payment and Access Commission (MACPAC) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') proposed rule entitled "Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010" (76 *Federal Register* 51148, August 17, 2011).

MACPAC is a non-partisan, independent commission established by the Congress and charged with reviewing Medicaid and CHIP access and payment policies and with making recommendations to the Congress, the Secretary of Health and Human Services (HHS), and the states on a wide range of topics related to Medicaid and CHIP. The Commission is also charged with reviewing Medicaid and CHIP regulations that affect access, quality, or efficiency of health care for the Medicaid and CHIP populations.

The proposed regulation focuses on aligning pre-existing Medicaid and CHIP eligibility, enrollment, and renewal standards with new eligibility expansions and procedures required for Medicaid, CHIP, and American Health Benefit Exchanges (hereafter referred to simply as Exchanges) under the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148, as amended) that are effective beginning in 2014. Exchanges will offer individuals choices for purchasing private health insurance and may also determine individuals' eligibility for Medicaid, CHIP, and premium subsidies. The Commission supports CMS' efforts to establish streamlined, seamless eligibility and enrollment processes across the continuum of programs for which individuals may qualify, including Medicaid, CHIP, and Exchange-based premium tax credits.

Recognizing the challenges inherent in simplifying and aligning the different eligibility pathways and systems for multiple and complex programs, we offer the following comments on issues for CMS to consider. In making these comments, the Commission is guided by the principles of ensuring administrative simplification, maintaining program integrity, and maximizing continuity of coverage and care. Unless otherwise noted, these comments pertain to individuals whose income is determined on the basis of modified adjusted gross income (MAGI).

Aligning Medicaid and CHIP Eligibility Rules with Exchanges

Beginning January 1, 2014, current law provides for the establishment of Exchanges in all states. Coordination of Medicaid and CHIP policies with Exchange policies is intended to promote simplicity for individuals and ease administration for states. Toward that end, eligibility requirements and application processes for Medicaid and CHIP coverage should align as closely as possible with those for the premium subsidies available through Exchanges. To maximize this goal, the Commission offers the following comments for CMS' consideration.

Monthly or projected annual income to determine eligibility for Medicaid and CHIP applicants. For determining eligibility for subsidized Exchange coverage, the proposed rule specifies that projected annual income will be used, prorated to a monthly amount (76 *Federal Register* 50936). For *redetermination* of eligibility for Medicaid and CHIP enrollees, the proposed regulation permits the use of either projected annual income to align with Exchanges or current monthly income. For new Medicaid and CHIP applicants, however, the regulation proposes that states must determine eligibility based solely on current monthly income (proposed §435.603(h)).

Requiring states to use only current monthly income for Medicaid and CHIP applicants could impose unnecessary additional administrative burdens for states due to the lack of coordination with Exchange policies. This policy would require a two-step process for determining applicants' income eligibility: (1) income calculated on a current monthly basis for Medicaid and CHIP, and (2) if ineligible for Medicaid and CHIP, income calculated on a projected annual basis for subsidized Exchange coverage.

When determining current monthly income for Medicaid and CHIP, the proposed regulation permits states to use "a prorated portion of reasonably predictable future income" (proposed §435.603(h)(3)). It is not clear whether CMS intends this option to be equivalent to projected annual income. With the goal of pursuing a streamlined eligibility system, CMS should consider whether to give states the option to align the budget period for Medicaid and CHIP with the Exchange subsidy determinations, by using the same language and framework for both applicants and current beneficiaries.

Aligned coverage months for Medicaid, CHIP, and Exchanges. An earlier Exchange proposed rule stated that coverage through Exchange plans generally begins on the first day of the month (proposed §§155.410 and 155.420, 76 *Federal Register* 41917, July 15, 2011). In contrast, Medicaid coverage can terminate on the day that an individual is determined ineligible. CMS should consider whether to align Medicaid and CHIP coverage months with Exchange coverage months to prevent gaps in coverage that may occur when an individual is determined ineligible for Medicaid or CHIP.

There are precedents for this approach. Several groups of Medicaid enrollees are currently covered through the end of the month (or beyond) in which they have been determined ineligible. Examples of these types of policies include: Medicaid enrollees in managed care, where enrollment is generally for the full month; pregnant women, whose coverage extends at least 60 days post partum; parents who are provided Transitional Medical Assistance (TMA) for several months after an income change would otherwise make them ineligible for Medicaid; and

children in states with continuous eligibility policies, where changes in family income need not be reported until the next redetermination. Because of the prevalence of these policies currently, the aggregate impact of aligning coverage months with Exchanges should be relatively small, although not completely inconsequential for all states. However, the alignment of coverage may be much more significant and valuable to enrollees who might otherwise be uninsured and therefore unable to receive necessary services for that short period.

Annual redeterminations. Under existing regulations, Medicaid eligibility must be redetermined "at least every 12 months" (§435.916(a)). The proposed regulation generally requires states to schedule redeterminations for enrollees whose eligibility is based on MAGI once every 12 months, eliminating more frequent redeterminations. This approach promotes continuity of coverage that is consistent with annual redeterminations of eligibility for premium tax credits available through Exchanges. The proposed rule's revision of existing Medicaid and CHIP regulations appears to provide an effective approach to align with Exchange renewal processes as well as to establish simplified renewal policies and procedures using information available to states.

Interaction between Exchange coverage and CHIP waiting periods. Most states' CHIP programs require children to be uninsured for a period of time before being eligible for coverage. It is not clear how such policies would interact with Exchange coverage and whether these waiting periods would be appropriate in 2014. CMS could consider clarifying whether CHIP waiting periods will still apply beginning in 2014 and, if so, whether children in a waiting period would be eligible for subsidized Exchange coverage.

FMAP for Newly Eligible Individuals

Under PPACA, beginning January 1, 2014, states with Medicaid programs will be required to cover individuals in the new adult group. The new adult group is to consist of individuals age 19 to 64 who are not pregnant, not eligible for Medicare, not otherwise eligible for most other mandatory Medicaid eligibility pathways, and who have family income at or below 133 percent of the federal poverty level (FPL), as counted under MAGI. Within this new adult group, the law makes a distinction between those who are considered newly eligible—that is, individuals in the adult group who generally would *not* have been eligible for Medicaid using states' criteria in effect on December 1, 2009—versus those individuals in the adult group who were previously eligible based on the December 1, 2009 criteria. States will receive the newly eligible Federal Medical Assistance Percentage (FMAP) for individuals in the adult group who are determined newly eligible; for 2014 to 2016, the newly eligible FMAP is 100 percent, phasing down to 90 percent by 2020. The newly eligible FMAP will not be available to states for individuals in the adult group who would have been eligible using the December 1, 2009 criteria. The proposed rule provides three alternative methodologies for states to use in determining which individuals in the adult group qualify for the newly eligible FMAP.

Consistent methodology. While the Commission appreciates CMS' consideration of the importance of state flexibility by proposing three potential alternative methodologies from which the states can choose, CMS should consider using a single, consistent approach for determining the appropriate proportion of adult group enrollees who are newly eligible. It is important that the methodology consistently and equitably determine the substantial federal

payments to states that are at stake, while also helping to ensure that audits and other program integrity activities can assess whether those payments were determined accurately.

Challenges to using survey data to support the "CMS established FMAP proportion" alternative. The third alternative methodology, the "CMS established FMAP proportion" (proposed §435.212), may present several challenges in determining which individuals are newly eligible. This option relies on state-by-state estimates established by CMS, using data sources including, but not limited to, the Medical Expenditure Panel Survey (MEPS) and the Medicaid Statistical Information System (MSIS) to model the number of individuals in a state who would be eligible under the adult group, the percentage of those eligible who would actually enroll, and the percentage of those enrolled who would not have been eligible based on the state's December 1, 2009 criteria.

This option may create issues for a number of reasons. MEPS does not provide individual estimates for each of the 50 states; thus, additional imputation of the survey data would be necessary to produce state-level estimates, which may not accurately reflect state experience. In addition, surveys, regardless of whether or not they provide state-level estimates, produce results with margins of error. Thus, although the data would produce a specific estimate of the number of newly eligible individuals, the actual number in the state could reasonably be much smaller or larger, with federal Medicaid payments affected accordingly. Although survey data and survey-based models serve an important role in policy analysis and development, determining federal Medicaid payments in this context may not be their best use. The Commission recognizes, however, that there are numerous trade-offs that CMS and states will need to consider in balancing the accuracy of determining who is newly eligible and the simplicity and efficiency of states' administrative efforts.

Clear and simple methods for assigning newly eligible FMAP. The Commission believes that either the "threshold" option (proposed §433.208) or the "statistically valid sampling methodology" option (proposed §433.210) could produce more valid results.

1. Under the "threshold" methodology, states would convert their December 1, 2009 standards to a MAGI-based FPL level that should result in the same number of individuals being determined newly eligible as would full December 1, 2009 eligibility determinations.
2. Under the "statistically valid sampling" methodology, a valid sample of adult group enrollees from a particular year would be selected and run through a full eligibility determination using December 1, 2009 standards to assess whether they were newly eligible. The results of this analysis, which must be completed within two years after the year in question, would be used to determine the final percentage of adult-group spending considered for newly eligible individuals. That year's Medicaid claims would then be adjusted retroactively.

Although both methods could adequately estimate the number of enrollees who would be considered newly eligible, the Commission views the sampling methodology as having additional drawbacks related to the administrative burden for states in developing and operating a sampling methodology. There would also be additional burdens on enrollees who are chosen to be in the sample, to undergo the full eligibility determination using December 1, 2009 standards. If these enrollees were to refuse the full determination process (which could not be required as a condition of eligibility), then states would face additional administrative burdens in attempting to

create the required statistically valid sample of adults. Because the sampling results apply retroactively, this option also creates the potential for sizeable retroactively adjusted federal Medicaid payments, which could make it difficult for states to budget for the program.

In addition, the sampling methodology requires states to maintain the December 1, 2009 standards for performing full eligibility determinations for the sample. It is not clear, however, whether states must maintain December 1, 2009 standards regardless of the methodology used. The proposed regulation appropriately requires verification of results, but it is not clear how results can be verified without states retaining December 1, 2009 standards. Additional CMS guidance in this area would be helpful.

Recognizing the amount of technical expertise required by the states, the Commission believes that specific guidance and technical assistance is needed from CMS in order to operationalize the approach used to determine which individuals are newly eligible.

Areas Needing Further Clarification

The proposed rule proposes a series of state requirements for implementing the eligibility, enrollment simplification, and coordination provisions of PPACA for Medicaid, CHIP, and Exchanges. For states to be able to implement these provisions with a minimum amount of administrative burden, the Commission encourages CMS to provide additional guidance on the following issues:

Consistency in MAGI methodology. In the view of the Commission, it is important that the methodology used for determining MAGI be applied in a clear and uniform manner across states, especially for the national MAGI standard of 133 percent FPL. For example, while the proposed regulation notes that MAGI is not a number on a person's 1040 form but is a methodology for counting income, the methodology apparently utilizes the deductions in lines 23-35 of the 1040 form. The proposed rule does not indicate if these deductions are to be taken into account when conducting the MAGI screen (proposed §435.911) or otherwise calculating income eligibility. The Commission requests that CMS clarify whether these deductions must be taken into account and, if so, the Commission suggests that CMS provide direction to states on how these deductions can be implemented in eligibility procedures.

Treatment of individuals with disabilities in §209(b) states. Individuals who are enrolled in Supplemental Security Income (SSI) are generally eligible for Medicaid. However, eleven "§209(b)" states (42 U.S.C. §1396a(f)) are permitted to use more restrictive criteria than those used for SSI eligibility determinations. In most cases, these more restrictive criteria focus on financial eligibility, but §209(b) criteria can also encompass a more restrictive definition of disability. Because §209(b) authority is codified at a point in the statute that lies outside of the core entitlement provisions of the law (42 U.S.C. §1396a(a)(10)), this can create confusion in the extent to which disabled individuals in §209(b) states are identified as being in a mandatory coverage group—in particular, with respect to determining individuals' eligibility in the new adult group (42 U.S.C. §1396a(a)(10)(A)(i)(VIII)). The Commission suggests that CMS add specific regulatory guidance addressing treatment of adults in §209(b) states.

Disability determinations for individuals initially enrolled on the basis of MAGI. In an effort to maintain simplicity, the rule proposes a streamlined screening process in which

coverage is provided "promptly" (proposed §435.911) to every individual who (1) has submitted an application, (2) meets the non-financial criteria for eligibility (state residence and citizenship or satisfactory immigration status), and (3) has an income that meets the MAGI income standard. Thus, all individuals who qualify for Medicaid, CHIP, or premium subsidies on the basis of the MAGI screen would qualify for coverage promptly, without regard to whether they were also entitled to Medicaid on the basis of disability.

It may be the case, however, that individuals enrolled in an insurance affordability program based on the MAGI screen may, in fact, qualify for coverage based on disability and, furthermore, that such coverage would be important because of their greater health needs. Given this potential, the Commission believes that it will be necessary to establish a "post-enrollment" process whose purpose is to assist individuals with higher health needs to seamlessly transfer to disability-based Medicaid coverage. CMS could consider addressing this issue through regulatory guidance that provides for post-enrollment screening of individuals who indicate the presence of a disability. This process could assure that individuals initially determined eligible on the basis of MAGI would be screened post-enrollment for the presence of a disability that could result in a shift to a more appropriate basis of eligibility or benefit package. Such a post-enrollment screening process could include (1) disability screening questions on the streamlined application that CMS is developing for states' MAGI-based determinations; (2) a process for following up with individuals who, in their initial applications, have identified themselves as having one or more limitations in their activities of daily living; and (3) a process for providing individuals with information on how to obtain a Medicaid eligibility determination based on disability.

Naming the expansion states. Although the proposed regulation describes the criteria for an expansion state (proposed §433.10(c)(8)), the states are not named. The criteria for expansion states are based on state policies in effect on March 23, 2010. Therefore, after having consulted with states, CMS should be able to provide the list of expansion states based on currently available information. Confirmation of whether states will be considered expansion states would allow states to plan for the federal matching rates that will be available beginning in 2014. In addition, CMS should consider publishing the list of states that qualify for the 2.2 percentage point increase to the FMAP described in proposed §433.10(c)(7).

Issues Requiring Statutory Clarification

In addition to the previous comments raised regarding regulatory changes, the Commission has identified several examples of issues that could be addressed through statutory changes. For example, while the proposed regulation's streamlined categories enable states to more efficiently determine eligibility for Medicaid and CHIP, the Commission notes there are several other ways to provide further streamlining to ensure better coordination of policies. Statutory alignment between the current "parents and caretaker relatives" eligibility group and the new adult group could avoid unnecessary administrative burdens for states that will have to separately determine to which group parents and caretaker relatives belong and the different benefit packages to which they are entitled. Another potential for further streamlining is to evaluate the need for the continued existence of TMA beginning in 2014, since continuous coverage would be available to nearly all of these individuals through Medicaid or Exchanges.

The Commission also notes that maintaining the current Medicaid policy of including total Social Security benefits when determining income may be less burdensome for states compared to the proposed MAGI-based methodology, which requires states to separately calculate applicants' taxable portion of Social Security benefits. To maintain alignment with Exchanges and eligibility determinations for tax credits, this change in the methodology used for calculating MAGI would require legislative action to update the Internal Revenue Code. The Commission recognizes that this revision of how to treat Social Security benefits when calculating MAGI is being addressed in pending legislation. If enacted, the regulation should be amended to reflect these changes.

Conclusion

The Commission encourages CMS to continue to focus on streamlining eligibility and enrollment processes for Medicaid, CHIP, and Exchanges, and to ensure administrative simplification, efficiency, and continuity of coverage. We understand that HHS will be providing guidance on the benefits to be included in the benchmark plans available for those enrolled in the new adult group. Stakeholders may wish to offer additional comments on this proposed rule on eligibility once they have reviewed how it may interact with the rules on benchmark plan benefits. We suggest that CMS coordinate comments on this rule with the other forthcoming regulations.

We appreciate the opportunity to comment on the proposed rule, and we hope that our ongoing analyses will continue to be useful in informing the discussion.

Sincerely,

Diane Rowland

Diane Rowland, ScD
Chair

cc: Donald M. Berwick, MD