Charles N. Kahn III
President and CEO

October 31, 2011

Donald M. Berwick, M.D., M.P.P.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-2349-P, Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010; Proposed Rule; 76 Fed. Reg. 51148 (August 17th, 2011)

Dear Dr. Berwick:

The Federation of American Hospitals ("FAH") is the national representative of some 1000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching, short-stay rehabilitation and long-term care hospitals in urban and rural America, and provide a wide range of ambulatory, acute and post-acute services. Our hospitals have long been a critical part of the health care safety net serving vulnerable patients in urban and rural communities, and our role as safety net providers will continue to expand as Medicaid enrollment increases and Affordable Health Exchanges ("Exchanges") become operational in 2014. As such, we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' ("CMS") proposed rule concerning the eligibility changes in Medicaid due to the Patient Protection and Affordable Care Act (ACA) ("Proposed Rule" or "NPRM").

We commend CMS for its efforts to simplify Medicaid and CHIP eligibility and enrollment as well as coordinate the proposed rules and guidance related to Exchanges. We certainly support CMS' intent to ensure that individuals are quickly and efficiently afforded coverage through either Medicaid or other appropriate health programs. Once enrolled, it is equally important that individuals maintain coverage and avoid coverage gaps by ensuring seamless transitions between Medicaid and the Exchanges. The FAH has focused its comments on these two critically important issues of enrollment and seamless coverage.

(1) **CMS should explicitly preserve hospitals' role as facilitators of Medicaid and CHIP eligibility and enrollment, and should enable hospitals to act as Navigators and to facilitate enrollment for the Exchanges and other insurance affordability programs.**

Hospitals have long played an important role in facilitating the enrollment of individuals in Medicaid and CHIP. Hospitals direct, face-to-face interaction with patients provides a unique opportunity to reach and educate eligible individuals, and our long history with Medicaid and CHIP has ensured that we have the expertise to assist these populations. **We urge CMS to continue to leverage our accumulated experience and significant investments in staff and other resources focused on eligibility by ensuring hospitals are recognized in any systems designed to coordinate enrollment in Medicaid, CHIP, and other insurance affordability programs.**

For instance, in 431.10(c)(iii), CMS proposes to allow Medicaid agencies to delegate their MAGI eligibility determination functions to Exchanges operated by governmental entities. This is permitted as long as the single State agency remains solely responsible for setting eligibility policies. **We urge CMS to require single State agencies that delegate eligibility determinations to the Exchanges to ensure hospitals remain a portal for enrollment in Medicaid and CHIP.**

Hospitals' deep history with Medicaid and CHIP also makes them uniquely qualified to facilitate enrollment for the Exchange. Hospitals face-to-face interaction with patients makes hospitals a natural point of access not only for Medicaid and CHIP, but also for all insurance affordability programs. Allowing hospitals to perform these functions aligns clearly with the ACA's goal of creating a seamless, simplified system of coordinated eligibility and enrollment between insurance affordability functions.

Ensuring hospitals' role as Navigators will also advance the goal of building a simplified, coordinated eligibility and enrollment system for all insurance affordability programs. As further detailed in the FAH's comment letter on the Exchange proposed rule[1], the ACA permits providers to serve in the role of Navigators, but that proposed rule establishing exchanges does not explicitly recognize that providers can serve in this role. The Exchange Proposed Rule proposes that the Exchanges include at least two of the types of entities listed as acceptable Navigators in the ACA, and **the FAH strongly recommends that CMS set a minimum requirement allowing provider organizations to serve as one of the two types of entities that can be Navigators**.

[1] FAH Comments submitted September 30th, 2011 concerning 76 *Fed.Reg.* 41866, http://www.fah.org/fahCMS/Documents/On%20The%20Record/Public%20Comments/2011/CMS_letter_on_Exchanges_and_QHPs_-_9-2011.pdf.

(2) CMS should ensure Medicaid beneficiaries do not experience gaps in coverage when transitioning between Medicaid and the Exchanges.

As individuals' circumstance change, their eligibility for the different insurance affordability programs may switch between Medicaid, CHIP, advance payments for premium tax credits and cost-sharing reductions, and any Basic Health plans established by States. Ensuring that beneficiaries do not experience gaps in coverage due to these transitions is critical, and the FAH appreciates CMS's efforts to minimize disruption in coverage for beneficiaries transitioning between insurance affordability programs.

However, in coordinating this Proposed Rule with the Exchange proposed rule, CMS acknowledges that beneficiaries transitioning from Medicaid to the Exchanges may experience a month (or potentially longer) without coverage. In section 155.410 of the Exchange proposed rule, CMS recommends that enrollment in a QHP begin on the first day of the month. For individuals applying for coverage on or before the 22nd of a given month, coverage under a QHP at the earliest would begin on the first day of the following month. For individuals applying for coverage after the 22nd of the month, plans would be permitted to begin coverage on the first day of the second month. Since Medicaid terminations can occur at any time during the month, the timeline for coverage under a QHP can lead to significant coverage gaps for individuals.

The Proposed Rule proposes to partially address this issue by adding a provision that extends Medicaid coverage until the end of the month that the appropriate termination notice period ends. While the FAH supports this suggestion as a partial solution, the recommendation does not appear to fully address the gaps in coverage individuals may experience, especially if their Medicaid coverage is terminated towards the end of the month. **At a minimum, the FAH recommends that CMS allow individuals to maintain their Medicaid coverage for an additional month in circumstances where late-month Medicaid terminations would not provide beneficiaries sufficient time to apply for QHP coverage to begin in the following month.** That is, Medicaid termination notices would need to be provided with sufficient time to allow individuals to apply for a QHP well in advance of the 22nd day. CMS would be required to establish an explicit threshold date before which beneficiaries would be required to receive notice of Medicaid termination. If notice is received after this threshold date, then beneficiaries would retain Medicaid coverage for an additional month. This policy could be further extended to require Medicaid programs to cover beneficiaries until eligibility determinations in other insurance affordability programs are complete. This would guard against gaps in coverage due to unforeseen delays during the assessment of eligibility for other programs.

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The FAH appreciates the opportunity to comment on the Proposed Rule. If you have any questions about our comments or need further information, please contact me or Elizabeth Ward of my staff at (202) 624-1500.

Sincerely,