



October 31, 2011

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Re: File Code CMS-2349-P  
Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010

Submitted electronically to <http://www.regulations.gov>

To Whom It May Concern:

Families USA appreciates this opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Proposed Rule: *Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010, CMS-2349-P*, published in Federal Register, Vol. 76, No. 159, pages 51148 to 51199, on August 17, 2011. Families USA is a national, nonprofit, nonpartisan organization for health care consumers. Our mission is to ensure that all Americans have access to high-quality, affordable health care. Families USA strongly supports comprehensive, affordable health insurance for all residents of this nation.

Families USA believes that these proposed regulations are essential to ensuring that millions of Americans gain access to health coverage that is affordable, comprehensive, and appropriate for their needs. These proposed regulations provide the necessary guidance to ensure that the process to apply for, enroll in, and maintain appropriate health coverage will be simple and effective in time for the Medicaid expansion and the implementation of Exchanges in 2014.

Families USA strongly supports that this proposed rule recommends a simple, seamless application to enroll in all types of coverage; we commend CMS for creating the “no wrong door” approach to streamline enrollment. We strongly support the use of reliable, electronic data to determine eligibility, as it will minimize the application burden on consumers and states. Families USA urges CMS to maintain a strong coordination requirement between the Medicaid program, the Children’s Health Insurance Program (CHIP), the Basic Health Program (if applicable), and the Exchange in order to facilitate speedy enrollment into the appropriate program. We believe that this proposed rule is essential to ensuring effective implementation of the Affordable Care Act.

As you proceed with issuing a final rule, we encourage you to consider the following comments. These comments reflect Families USA’s belief that a consumer-friendly eligibility and enrollment process for Medicaid, CHIP, the Exchange, and other insurance affordability

programs is essential to enrolling millions of Americans in health coverage and ultimately improving the health of the nation.

We thank you for the opportunity to submit our comments and recommendations. If you have any questions, please feel free to contact Dee Mahan by email at [dmahan@familiesusa.org](mailto:dmahan@familiesusa.org) or by phone at 202-628-3030. Families USA looks forward to working with CMS as the federal government and states implement eligibility and enrollment systems and the Medicaid expansion.

Sincerely,

Dee Mahan  
Director, Medicaid Advocacy  
Families USA

## **PART 431 – STATE ORGANIZATION AND GENERAL ADMINISTRATION**

### *Subpart A – Single State Agency*

#### **§431.10 Single State agency.**

##### §431.10 (c)

Families USA believes that it is essential that a government agency or a quasi-governmental agency be responsible for determining applicant eligibility for Medicaid, CHIP, and other insurance affordability programs. It is imperative that nonprofit Exchanges as well as private vendors are not allowed to conduct eligibility determinations, as eligibility determination is an inherently governmental function. The government must be the keeper of private information and be accountable for its privacy, and the government must be accountable for a timely eligibility and enrollment system that preserves due process rights. We urge CMS to state in the final rule that eligibility determinations for Medicaid, CHIP, and Basic Health (if applicable) must only be made by a government agency or a quasi-governmental agency.

We strongly support the statement in §431.10(c)(3) that “There is no conflict of interest by any agency delegated the responsibility to make eligibility determinations.” In order to ensure that eligibility is determined in the best interest of applicants and beneficiaries, it is essential that the agencies determining eligibility do not have conflicting financial interests.

It is somewhat unclear what role, if any, CMS is envisioning private contractors playing in the eligibility determination process. As noted above, we believe that eligibility determinations for affordability programs are inherently governmental in nature. To the extent that the final rule does allow private contractors to play some role in eligibility determinations, we strongly encourage CMS to add a provision that explicitly says that private contractors cannot offer fiscal incentives to their workers or any subcontractors that discourage enrollment. Families USA encourages CMS to add a clause making it clear that a conflict of interest would certainly include any fiscal incentives to minimize enrollment or take other actions to discourage eligible people from securing coverage.

§431.10(c)(3)(iii) requires the Medicaid agency to “guard against improper incentives and/or outcomes.” We urge CMS to use stronger language in the final rule and not simply “guard against improper incentives and/or outcomes,” but rather ensure that such incentives and outcomes are not permitted. The entity determining eligibility, whether it is the Exchange or the Medicaid agency, must be monitored for “improper incentives and/or outcomes;” if any are found, they must be promptly addressed.

**Recommendation: The final rule should state that eligibility determinations for Medicaid, CHIP, and Basic Health (if applicable) must only be made by a government agency or a quasi-governmental agency. Eligibility determination is an inherently governmental function that should not be made by nonprofit Exchanges or third-party contractors. To the extent that the final rule does allow private contractors to play some role in eligibility**

**determinations, we recommend that the final rule include a provision that explicitly prohibits private contractors from offering fiscal incentives to their workers or any subcontractors that discourage enrollment. In addition, the language in §431.10(c)(3)(iii) should be strengthened; improper incentives and/or outcomes should not be permitted; if any are found, they must be promptly addressed.**

§431.10(d) Agreement with Federal or State and local agencies.

Given the different financial arrangements for different populations to be enrolled beginning in 2014 (previous Medicaid eligibles, new Medicaid eligibles, and Exchange/premium tax credit eligibles, each with different levels of federal and state financial participation), clear standards will be necessary to ensure that eligibility determinations are not influenced by the varying federal matching rates at play. Regardless of the kind of Exchange or the entity making determinations, we recommend that the Medicaid and Exchange state plans include strong standards to ensure uniform screening and eligibility determination of all individuals seeking coverage, whether they apply to the Medicaid agency or to an Exchange. Processes must be in place to guide how applications are to be handled and to ensure that determinations of Medicaid eligibility are made accurately, consistently, and quickly.

While not explicitly addressed in the proposed rule itself, the preamble indicates that HHS is considering giving states the option of using “co-location” of Medicaid workers to comply with the merit protection principles outlined in §431.10(d)(5). Families USA supports co-location as it can help increase enrollment, and we encourage CMS to include a provision in the final rule that outlines standards for ensuring that co-located workers play a meaningful role in eligibility determination.

**Recommendation: We recommend that the final rule requires Medicaid and Exchange state plans to include strong standards to ensure fair, uniform screening and eligibility determination of all individuals seeking coverage. The final rule should provide stronger standards for “co-location” in order to ensure that co-located workers play a meaningful role in eligibility determinations.**

**PART 433 – STATE FISCAL ADMINISTRATION**

***Subpart E – Methodologies for Determining Federal Share of Medicaid Expenditures for Mandatory Group***

**§433.202 Scope.**

Families USA strongly supports the principles outlined against which CMS intends to evaluate proposed methodologies for determining what proportion of Medicaid expenditures should be matched at an enhanced rate beginning in 2014, specifically: that no allowable method will establish a shadow eligibility system; that no allowable method will reflect a systematic bias towards either the state or the Federal government; that all allowable methods will limit administrative burden and cost; and, that all allowable methods will be applied transparently

using sufficient data.

#### **§433.204 Definitions.**

The “newly-eligible” definition included in this section of the proposed regulations is different than the statutory definition used to determine eligibility under the Medicaid expansion. Certain states could receive less in federal matching payments for “newly-eligibles” than is appropriate as a result.

In §433.204, the “newly-eligible” definition excludes adults who under current state Medicaid eligibility rules qualify for a state expansion program that does not meet the benchmark benefit standard, or that operates with either an enrollment cap or waiting list. For actual eligibility determination however, the statute includes both of these populations among the “newly-eligible.” Due to this disconnect, certain states could have Medicaid enrollees who are considered “newly-eligible” under the statutory definition for whom they receive only the regular Medicaid matching rate as opposed to the matching rate appropriate for “newly-eligibles” – either the enhanced matching rate in the case of a non-expansion state or the transition matching rate in the case of an expansion state.

Of additional concern, the “newly-eligible” definition in this section when viewed alongside the definition of an “expansion state” at §433.10(8)(iii) creates the potential for certain expansion states to receive only the regular matching rate for all those determined “newly-eligible” under the statute. At §433.10(8)(iii), the criteria defined for an “expansion state” include that the state offer a benefit meeting the benchmark benefit standard. A state such as Utah that has expanded Medicaid coverage for adults but with a lesser benefit would not qualify as an expansion state, but the adults eligible for the limited benefit program also would not be deemed “newly-eligible” for the purposes of the matching rate. Thus, the state would receive neither the transition matching rate appropriate to an expansion state nor the enhanced matching rate appropriate to “newly-eligible” coverage, but instead would receive only the regular matching rate for their expansion population.

**Recommendation: We recommend that both the “newly-eligible” definition in §433.204 and the “expansion state” definition in §433.10(8)(iii) conform to the statutory definition of “newly-eligible” at 1905(y)(2)(A) of the Social Security Act as amended by the Patient Protection and Affordable Care Act. Namely, the definitions should take into account adult status (age over 18), should require the benefit package of an existing expansion program to meet the benchmark benefit standard, and should require that applicants are not excluded from coverage due to capped or limited enrollment.**

#### **§433.206 Choice of methodology.**

Among the suggested methods outlined in the proposed rule, Families USA does not have a preference of one over the other. We do, however, have concerns about potential burdens on applicants, specifically in states that adopt either the threshold or sampling methodology. Unlike the proportion method, either of those approaches could be burdensome on applicants unless

carefully structured. Our recommendations focus on making the process the least burdensome for applicants as possible.

**Recommendation: The regulations speak to the issue of applicant burden at §433.206(d), however, the language could be strengthened in several ways.**

- **The regulation should cross-reference §435.907(c), which establishes streamlined applications.**
- **Language should be added clarifying that applicants will not be unduly burdened; additional questions posed to an applicant should only be permitted if all available electronic data sources have been used to the fullest extent possible and additional data is still necessary. Additional paper documentation should not be required in any event. If additional data is needed, language should be added to clearly state that applicants be informed in easy-to-understand, non-technical language that any additional questions related to determining “newly-eligible” status will not impact Medicaid eligibility; that applicants receive any necessary assistance in providing supplemental information; and, that CMS will establish standards for any additional application questions states will use for purposes of determining the matching rate. These recommendations apply regardless of which methodology a state uses.**

#### **§433.208 Threshold methodology.**

With this method, it is of utmost importance that additional screening questions be minimized or not used at all, if possible. There is a high potential for this method to impose additional burdens on the applicant and the regulations must include language and safeguards to guard against that.

**Recommendations: Families USA has several recommendations regarding this methodology:**

- **We recommend the regulations grant states the explicit option to use MAGI-equivalent standards in evaluating eligibility under the “threshold method”. The preamble language suggests this as an option, but the regulatory language does not. The MAGI-equivalent standard appropriately will take into account disregards and deductions that states use in determining Medicaid eligibility currently. Those with MAGI between the MAGI-equivalent standard for current eligibility and the Medicaid expansion eligibility standard would be deemed “newly-eligible” assuming that they met the assets and disability status standards. States using this option would accomplish the stated goal of providing a simplified eligibility assessment using available data.**
- **We recommend that the language in this section explicitly require states first to gather all necessary supplemental information through electronic data matching, or other processes that require no additional information from the applicant. The**

language in this section also should explicitly require CMS to approve any additional questions asked during the application process for the purpose of the “newly-eligible” determination with emphasis on requiring as little additional information from the applicant as possible.

- **The preamble language indicates that states should not consider their medically needy coverage category in the “newly-eligible” determination. However, the regulations at §433.208(a)(2) are not clear in this regard, instead requiring states to “incorporate state eligibility standards, including disregards and other adjustments that were in place in the State on December 1, 2009”. We are concerned that without explicit direction to the contrary states may interpret this language to require that they evaluate eligibility under the medically needy coverage category for the purpose of the “newly-eligible” determination. We recommend that the regulatory language explicitly indicate this is unnecessary.**
- **The regulations request comment on whether or not asset holdings should be considered under the “threshold method” for “newly-eligible” determination. If states do measure assets as part of this methodology, we recommend that states not be permitted to include questions about assets as part of the application process. States should obtain asset information through use of the Assets Verification System (AVS), or other existing data sources.**
- **The regulations request comment on whether or not disability status should be considered under the “threshold method” for “newly-eligible” determination. First, we recommend that the language explicitly require the state to inform an applicant of their right to ask for a full-eligibility determination if they feel they might be eligible for a more comprehensive set of benefits if determined eligible under a disability category. Then, we recommend that, for the general purpose of the “newly-eligible” determination, applicants should not have to provide any additional information on disability status beyond screening questions to trigger an eligibility determination for a non-MAGI group, if appropriate (see our comments on §435.907 and §435.911). Rather, the state should pull that information from existing data.**
- **CMS states that it would require a state choosing the “threshold method” to receive approval of the detailed methodology of its plan prior to implementation. We strongly support that.**

#### **§433.210 Statistically valid sampling methodology.**

We are very concerned that the sampling methodology will create a “shadow eligibility” system and could impose additional burdens on applicants.

As set forth, it is unclear whether a state would be in contact with an individual included in the sample in order to conduct a full eligibility determination using 2009 rules or if it envisions that

states would use data sources to make that determination. Requiring additional information of individuals is in conflict with the principles laid out at §435.907. Such an approach would also place a disproportionate burden on some applicants and threaten the integrity and perceived fairness of the determination process overall.

**Recommendations: This approach should only be allowed if states can obtain all additional information for the sample through electronic means, without placing any added burden on the individuals in the sample.**

## **PART 435 – ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA**

### *Subpart A – General Provisions and Definitions*

#### **§435.4 Definitions and use of terms.**

##### Caretaker relative

Families USA supports the codification of the definition of a caretaker relative. We also believe the specification that a relative does not have to claim a child as a tax dependent to be considered a caretaker relative is an important addition because it reflects the reality for many families.

##### Dependent child

We also support the codification of the definition of a dependent child. We welcome that CMS has codified the state option to: 1) eliminate the “deprivation” requirement altogether, and 2) establish a higher number of working hours as the threshold for determining unemployment (if deprivation is considered).

##### Pregnant woman

Families USA supports the explicit inclusion of the “post-partum” period in the definition of pregnant woman. While this eligibility category exists in the statute, it was not previously mentioned in the regulations describing the mandatory categories of eligibility and therefore is a welcome clarification.

### *Subpart B – Mandatory Coverage*

#### Consolidation of Eligibility Groups

We support the consolidation of existing mandatory and optional eligibility groups into three categories starting in 2014: parents and other caretaker relatives (§435.110), pregnant women (§435.116), and infants and children under age 19 (§435.118). We understand that these categories will complement the new adult group (§435.119).

## Income Standard

For each of the new eligibility categories, states are required to establish income standards in state plans using the minimum and maximum income tests set out in these regulations. Yet HHS is not requiring states to convert their current *minimum* eligibility standards to a MAGI-equivalent standard. This means that states will not have to account for disregards that are currently employed in the state when determining the minimum income standard for MAGI-based Medicaid. As a result, under the proposed rule, individuals currently eligible under some of the mandatory categories will lose eligibility. This is not in keeping with Section 2002 of the statute which says in part, “A State shall establish income eligibility thresholds for populations to be eligible for medical assistance under the State plan or a waiver of the plan using modified adjusted gross income and household income that are not less than the effective income eligibility levels that applied under the State plan or waiver on the date of enactment of the Patient Protection and Affordable Care Act.”

In the preamble discussion of these new eligibility categories, HHS indicates it considered whether or not states should convert the federal minimum income standards prescribed in the statute to a MAGI-equivalent standard based on the income exclusions and disregards currently used by the state. HHS admits that doing so would maintain eligibility for individuals who may otherwise lose Medicaid due to the elimination of income exclusion and disregards under MAGI. But this would result in different minimum income eligibility standards applied across states and reduce eligibility simplification, and therefore HHS decided not to require conversion to MAGI-equivalent standards.

Yet in the preamble under Proposed Methods for Counting Income Based on MAGI, §435.603(e), HHS indicates that to

“account for the general elimination of income disregards and to ensure continued coverage at pre-Affordable Care Act levels, per section 1902(e)(14)(A) and (E), States will convert current income standards for eligibility groups under which financial eligibility will be based on MAGI to a ‘MAGI-equivalent’ income standard.”

Therefore the proposed rules are inconsistent and contradictory. In one section, HHS requires states to convert income standards for eligibility to a MAGI-equivalent standard, while in another section it does not.

In addition, the “net equivalency” section of the ACA clearly requires states and the Secretary of HHS to establish an income equivalent test that ensures children eligible for Medicaid do not lose coverage.<sup>1</sup> Despite this, HHS made a policy decision not to require states to convert their minimum eligibility standard to a MAGI-equivalent standard and does not believe the impact on eligibility will be significant. We do not agree with this and below we list the implications of HHS’ decision on the different eligibility groups.

### **§435.110 Parents and other caretaker relatives.**

For parents and other caretaker relatives, the proposed rule sets the minimum eligibility level at the state's AFDC standard in effect as of May 1, 1988. This is clearly an outdated standard which has no relation to current incomes or expenses, and no relation to most states' current eligibility guidelines. HHS says if individuals in this category lose eligibility under section 1931 (if a state reduces coverage to the minimum permitted under the statute), these individuals will still retain eligibility under the new adult group. Yet we do not know what scope of benefits individuals in the new adult group will receive, making it difficult to assess the impact of this change. Important benefits may be lost for these individuals in states that choose to provide more restrictive benchmark plans to the new adult group.

**Recommendation: To arrive at a minimum income standard, require states to convert their minimum eligibility levels for parents and caretaker relatives to a MAGI-equivalent standard, taking into account incomes and disregards used in the state as of the date of enactment of the Affordable Care Act.**

**§435.116 Pregnant women.**

The proposed rule sets the minimum income standard at the higher of 133 percent of FPL or such higher standard as the state had established as of December 19, 1989 up to 185 percent of FPL. Again, this latter standard is outdated. All but nine states currently provide Medicaid eligibility to pregnant women with incomes above 133 percent of FPL, and 18 provide Medicaid eligibility to pregnant women with incomes above 185 percent of FPL. HHS admits that pregnant women would be affected if a state were to decrease its income standard to the statutory minimum level because the MOE for pregnant women ends in 2014 and there is no other coverage group to which affected pregnant women can be transferred. Therefore, HHS indicates a woman in this situation would "likely become eligible for advanced payments of the premium tax credit for enrollment through the Exchange." This will most likely mean a less generous benefit package for pregnant women, and higher premiums and cost-sharing.

**Recommendation: To arrive at a minimum income standard, require states to convert their current eligibility level for pregnant women to a MAGI-equivalent standard, taking into account incomes and disregards used in the state as of the date of enactment of the Affordable Care Act.**

**§435.116 (d) Covered services.**

States will have the option of offering some pregnant women a limited benefit package that only covers "pregnancy related services." States are only required to cover full-scope Medicaid for women with income below the AFDC income standard in effect as of May 1, 1988, which is significantly less than 133% FPL. This authorizes states to provide fewer services to pregnant women than to adults in the 133% adult expansion group who are not pregnant.

This is problematic because pregnant women will not qualify for the new adult expansion category because they are excluded by statute. And, those who are under 133% FPL cannot qualify for coverage through the Exchange. Further, depending on final rules, those with income

over 133% FPL might be excluded from the Exchange for having other governmental coverage – an outcome we do not recommend if the limited benefit option remains. Thus, there is a segment of low-income women who may not have full-scope health insurance under any of the ACA’s options. HHS should modify this regulation to prevent this from occurring since Congress did not intend to make low-income pregnant women eligible for a more limited scope of benefits than other adults with the same income. Both mother and baby are much more likely to have healthy outcomes if they receive full health care benefits.

**Recommendation: HHS should eliminate the state option in §435.116(d)(1) to provide limited benefits to pregnant women. However, the option to provide enhanced pregnancy-related services as set in §440.250(p) should remain. Pregnancy-related services should be broadly defined since almost any medical condition can impact or complicate a pregnancy. Most states have recognized that all health services provided to pregnant women are pregnancy-related. Therefore HHS should accept the policy of most states as its own. Ultimately, HHS must align coverage for pregnant women with the coverage provided to all other adults.**

#### **§435.118 Infants and children under age 19.**

HHS states that the impact to children will not be significant because eligibility standards for children must be maintained through September 2019, in accordance with MOE provisions. We are concerned about children who will be affected when the MOE expires if a State were to drop coverage to the minimum level permitted.

**Recommendation: In future rulemaking, we encourage CMS to address the issue of children who will be affected when the MOE expires if a state drops coverage to the minimum level permitted.**

#### **§435.119 Coverage for individuals age 19 or older and under age 65 at or below 133 percent FPL.**

Families USA supports this section of the regulations which implements the statutory requirement to provide coverage to adults age 19-65 who have incomes below 133 percent of poverty.

Many people who were previously uninsured will gain coverage under this new adult group. Since the benefits currently received by people with disabilities may be more comprehensive than those received by people in this new income group, it is important to inform applicants of other pathways to coverage, and to allow people placed in this category to move into the disabled adult category if they are found to have a disability. (See our comments on sections 435.907 and 435.911). Subsection (c) states that a state may not cover parents or relatives living with a dependent child unless the child is receiving coverage. Please clarify that this does not apply when parents/caretakers are receiving Medicaid as part of a different coverage group. For example, a parent with a disability may receive coverage with a much higher income under ticket to work, a home and community-based care waiver, or through spend-down. Nonetheless, depending on the household income, the child may not qualify for Medicaid, CHIP, or affordable

coverage. If federal rules do not provide a pathway to affordable coverage for the child, the disabled parent should not be barred from Medicaid participation.

**Recommendations: Clarify that §435.119(c)(1) only applies when parents are receiving coverage under the adult expansion (“VIII group”) category. See our comments later regarding information and screening for adults who might be eligible for Medicaid under other categories.**

### *Subpart C – Options for Coverage*

#### **§435.218 Individuals above 133 percent FPL.**

We support the creation of this new eligibility group which provides a mechanism for states to cover individuals whose income exceeds the state’s income standard for mandatory coverage. HHS describes this as an alternative to income disregards which were used to expand eligibility but will no longer be available in 2014. States could also use this option to serve people who were previously covered under 1115 waivers. The creation of this group does not address the issues raised in the previous section regarding MAGI-equivalency conversion because providing coverage under this new eligibility group is optional for states. It is also not clear what benefit package will apply to this group. We strongly recommend that states have the option of providing the full Medicaid benefit package via the Section 1937 benchmark option, as has been CMS’s interpretation of the benefits that may be provided to early VIII group expansions.

In the preamble, HHS indicates that to ease the administrative burden on states and to make it easier for states to enroll eligible individuals under the simplest eligibility category, it has proposed that an individual who is under 65 years old and has income above 133% FPL should be determined eligible under this group, unless based on the information available from the application, the individual can be determined eligible under another eligibility group. However, as an exception, if an individual appears to be eligible as “medically needy” based on information provided, he/she can still be enrolled in this optional group. HHS only mentions this exception in the preamble, and we recommend it should be included in the text of the rule. In addition, the regulation should also clarify that this principle applies to spend down recipients in 209(b) states.

We support the inclusion of children, if they are not already eligible for Medicaid, in this new optional group. HHS mentions that if a state currently covers children with incomes above 133% FPL in a separate CHIP program, but adopts coverage under this group, the state will shift the children from CHIP to Medicaid. States will still be able to claim enhanced FMAP under title XXI for such children.

This is a positive result because it will enable children to receive full Medicaid coverage, including Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits and enhanced appeal rights.

Coverage under the new optional group will be beneficial to some individuals, but can also potentially be detrimental to those with disabilities, who are eligible for traditional Medicaid, but

are not being screened for this coverage and are therefore provided a lesser benefits package under this new eligibility group. Please see our comments to §435.119.

In addition, we recommend a change in §435.218(b)(2) to make it clear that the exception to the rule that Medicaid cannot be provided to higher income individuals before lower income individuals applies only if the state decides to cover particular categories such as pregnant women or children. This is clear in the preamble and the underlying statute but not in the language of the proposed rule, which is broader.

**Recommendations: We ask CMS to clarify that states can provide the full Medicaid benefit package to optional categories. In the final rule, §435.218(b)(1)(iii) should be amended as follows:**

**“Are not otherwise eligible for and enrolled for optional coverage under a State’s Medicaid State plan in accordance with subpart C of this part, based on information available to the State from the application filed by or on behalf of the individual, except if based on the information provided, the individual appears to be eligible as medically needy. These individuals can still be enrolled in this optional group.”**

**Clarify both here and in Subpart J that states may continue to screen and enroll people in other categories of coverage, even once they have been provided coverage under this optional category. For instance, if people would get back bills paid through a Medicaid spend-down or would get more comprehensive benefits as a person with disabilities, states should continue to screen for and offer that coverage.**

#### *Subpart E – General Eligibility Requirements*

##### **§435.403 State residence.**

###### **§435.403(h) Individuals age 21 and over.**

Families USA strongly supports HHS’ decision to remove the regulatory language requiring permanency and intent to “remain[ing] permanently and for an indefinite period.” Replacing this language with the term “reside” and providing that an individual is a resident if he has entered the state with a job commitment or seeking employment is a very positive step. It will help clarify and reinforce the statutory requirement that individuals must be considered state residents even if they lack a fixed address and helps ensure that migrant and temporary workers are able to establish residency.<sup>2</sup>

We welcome the statement in the preamble that information regarding immigration status is only one piece of evidence regarding an individual’s residency and specifically stating that a temporary or time-limited status does not mean that the individual is not a state resident. The fact that an individual has an immigration status that is temporary does not necessarily indicate that he is visiting for personal pleasure or to obtain medical care. Such individuals should be given every opportunity to present evidence demonstrating that they do in fact reside in the state.

To ensure that individuals have this opportunity, we urge HHS to amend the State Medicaid Manual and delete contradictory guidance. In the Manual, HHS instructs states that certain individuals are ineligible for Medicaid because of their temporary admission status, including “foreign students [and] temporary workers including agricultural contract workers.”<sup>3</sup> This is inconsistent with HHS’ recognition that a temporary or time-limited status does not preclude state residency and should be removed from the Manual to eliminate any possible confusion.

HHS specifically requested input on whether to change the current state residence policy for individuals living in institutions who do not have the capacity to express intent. We believe that change is necessary. Under current regulations, the residence of an individual who is not placed by a state is usually the residence of the parent or guardian at the time of placement. This can create problems when the parent or guardian of such an individual moves to a different state and wants the institutionalized individual to move to the new state as well.

**Recommendation: Families USA urges HHS to amend the State Medicaid Manual and remove guidance that contradicts with HHS’s recognition that a temporary or time-limited status does not preclude state residency. We suggest amending the current regulations at §435.403 to provide that the state of residence for all individuals who lack the capacity to form intent be chosen by the parent or guardian. The exceptions would be if the parent or guardian has abandoned the individual, if an individual has been placed by a state, or, in the case of an individual who lost the capacity to form intent after age 21, there is no legal guardian.**

§435.403(h)(4)(i) Individuals under age 21.

We generally support HHS’ decision to consolidate the definitions of residency for children and eliminate reference to the AFDC program rules, particularly since the AFDC regulation includes the permanency requirement that has now been eliminated. We also concur with HHS’ recognition and clarification that the parents’ residence alone does not determine a child’s residence.

We believe, however, that it is problematic that state Medicaid agencies will continue to have flexibility to establish state-specific rules governing residency for students. This is particularly true because, as HHS acknowledges, the Exchange residence definition allows the parent to choose a child’s residence. HHS has requested input as to whether a uniform residence standard should be applied. We believe it is desirable to have one federal definition of state residence for students and that it be the state chosen by the parent. A consistent definition will ensure that there are not conflicting rules in different states. Otherwise, there is a risk that an out-of-state student could be left with no state of residence. Moreover, a uniform rule will help to generally promote establishment of the coordinated eligibility and enrollment system established under ACA §1413 and §2201.

**Recommendation: We recommend adding the following language to §435.403 as new subparagraph (i)(3):**

**“(3) For an individual under age 21 who is not emancipated or married, is not institutionalized, is capable of indicating intent, and is a full time student living in a different state than his parent or guardian, the state of residence is either the state of residence of the parent or guardian or the state in which the student is attending school, as indicated by the parent or guardian.”**

*Subpart G – General Financial Eligibility Requirements and Options*

**§435.603 Application of modified adjusted gross income (MAGI).**

Families USA supports the overall attempt to simplify and facilitate seamless coordination between insurance affordability programs by using a standard income methodology (Modified Adjusted Gross Income; MAGI), particularly given that asset tests will no longer be permitted, since these are administratively burdensome and would inhibit achievement of the vision for simple, streamlined enrollment. Replacing the complex array of income disregards with a single disregard of five percent of the federal poverty level will also make eligibility determinations easier.

**§435.603(a) Basis, scope, and implementation.**

*Grace period for application of MAGI to current beneficiaries*

Paragraph (a)(3) of the proposed rule states that for determining ongoing eligibility for those deemed eligible before December 31, 2013 and receiving Medicaid as of January 1, 2014, the use of the MAGI methodology will not be applied until the next regularly-scheduled redetermination or March 31, 2014, whichever is later, if that individual would lose eligibility as a result of the shift to MAGI. Allowing for such a grace period will ensure that individuals are able to maintain their coverage during the initial transition to the MAGI methodology. It does, however, require states to review eligibility for all those currently enrolled in the program on January 1, 2014 (and subject to the new MAGI methodology). As is required under the regulation for redeterminations (§435.916), Families USA strongly believes that states should conduct these reviews based on information already available to the state and without any additional burden on the beneficiaries.

In addition, Families USA strongly recommends that this grace period is carried over to children in the Children’s Health Insurance Program (CHIP). In order to consistently apply the new MAGI-based income levels across programs, as well as to ensure that children in CHIP are given the same protections as those in Medicaid, §457.315 should also incorporate §435.603(a)(3).

This provision in paragraph (a)(3) is based on Section 2002 of the ACA, but as written leaves some confusion for how Exchanges—which are to begin the initial open enrollment period in October 2013—are to handle those determined Medicaid-eligible during the initial open enrollment period, as these individuals may be receiving Medicaid benefits as of January 1, 2014. During open enrollment in 2013, there will be individuals who will apply for premium credits in the Exchange, but will be found to have income that will make them newly eligible for Medicaid beginning on January 1, 2014. It is important for CMS to think through how to best ensure that these individuals whose incomes are too low to be eligible for the Exchange/premium credits will

be notified of their potential eligibility for Medicaid and do not have to reapply for Medicaid coverage on January 1, 2014.

**Recommendation:** As states review eligibility for those currently enrolled in Medicaid and subject to the new MAGI methodology on January 1, 2014, states should conduct reviews based on information already available and should not collect any additional information from beneficiaries in order to ensure that this process is not burdensome for beneficiaries.

**In the final rule, we also strongly recommend that this grace period for the application of MAGI to current Medicaid beneficiaries is carried over to children in CHIP. It is critical that children in CHIP are afforded the same protections as those in Medicaid. Therefore, we recommend that section §457.315 of this proposed rule should also incorporate §435.603(a)(3).**

**We urge CMS to think through how to best ensure that individuals who apply for coverage during the first initial enrollment, beginning in October 2013, whose incomes are too low to be eligible for the Exchange/premium credits will be enrolled in Medicaid with coverage effective on January 1, 2014 and do not have to reapply for Medicaid coverage once the expansion is in effect.**

#### *Conversion to MAGI*

To account for the elimination of income disregards and ensure the continued coverage at pre-ACA levels, states must convert their current income standards to a “MAGI-equivalent” standard for all groups for which eligibility will be determined using MAGI. The preamble to the regulation indicates that separate guidance will be issued outlining the methodologies states may use to arrive at these equivalent standards. While the methodology and process for doing the MAGI conversion is not laid out in this proposed regulation, we strongly recommend that the approach taken to develop such methods and standards be public and transparent, both at the national and the state level, as the stakes are incredibly high for current and future Medicaid beneficiaries.

The preamble to the regulation also discusses allowing states to convert to MAGI prior to 2014 using a §1115 waiver. As with the conversion process itself, the application and approval process for such waivers should be public. While the proposed regulations outlining the transparency requirements for §1115 waivers have not been finalized, the public notice and comment requirements in those proposed regulations were strong and should, *at a minimum*, be followed in such cases where a state is seeking a waiver to implement the MAGI conversion prior to 2014.

**Recommendation:** As states convert their current income standards to a “MAGI-equivalent” standard, we strongly recommend that the approach taken to develop such methods and standards be public and transparent, both at the national and the state level. For states that choose to convert to MAGI prior to 2014 using a §1115 waiver, it is again crucial that the approval process be public and follow the requirements outlined in the transparency requirements for §1115 waivers.

### *Converting minimum eligibility thresholds*

§1902(e)(14)(A) requires states to develop thresholds that are not less than the effective income levels in place at the time of enactment. In proposing a simplified approach to eligibility based on the new MAGI methodology, the intent is that eligibility will not change for any of the populations. However, the conversion to MAGI is only required for the maximum effective income levels, not the minimum standards. The preamble to the regulation states that CMS considered converting the minimums to protect eligibility for those who would lose coverage if a state reduced eligibility to the minimum standards, but chose not to as it would result in different minimum eligibility standards across states and reduce simplification.

However, the minimums, at least as they apply to §1931 coverage for parents (the group most likely to be impacted by such an exclusion), are already disparate throughout the states. Additionally, it is unclear what simplification is lost as a result of such a conversion. The ACA clearly states that a conversion to MAGI is required not only for the purpose of determining income eligibility, but also for “any other purpose applicable under the plan or waiver for which a determination of income is required.” As those parents who are covered under §1931 are entitled to a different benefit package than those found to be newly-eligible, it is important to maintain the minimum standards and convert them to MAGI so that these parents continue to receive the benefits they are currently afforded.

**Recommendation: We believe that it is important for CMS to maintain the minimum standard and convert them to MAGI so that §1931 parents continue to receive the benefits they are currently afforded.**

### §435.603(d) Household income.

#### *Not counting income of non-filers in determining household income*

Under (d)(2), the income of an individual who is included in the household of his or her parents, but is not required to file a tax return, is not included in the household income. This is the case whether or not he or she chooses to file a return. In order to be exempt from filing a tax return, these dependents would be earning relatively little. In the 2010 tax year, for example, they could not earn more than \$5,700 annually (the threshold to file taxes as a single individual under age 65 who is claimed as a dependent). As their income is minimal and would not likely be available for the purchase of health insurance coverage, excluding it from the calculation of household income in determining Medicaid eligibility is appropriate.

#### *Children claimed as tax dependents by non-custodial parents:*

Under (f)(2)(iii) and (f)(3) for this section, children who are claimed as tax dependents by their non-custodial parent would be considered in the same household as the custodial parent for the purposes of Medicaid eligibility. We strongly support HHS’ decision to *not* require the child to obtain coverage with the non-custodial parent who claims the child as a tax dependent since this will ensure the child is not determined eligible for a program unavailable in the state in which he or she actually resides.

**Recommendation: While we do not have specific recommendations on how HHS can**

address these complex issues, we recommend that HHS adhere to the following principles in developing guidance:

- **As much as possible, HHS should develop a policy that would result in the child obtaining the most comprehensive coverage for which he or she is eligible.**
- **The process should ensure the protection and privacy of information of each of the parents in determining which coverage the child should get.**
- **The process should follow the general principles, reflected in the proposed rules, of not requiring more information than is necessary to make an eligibility determination.**

*Counting “actually available cash support” as income*

We recommend removing (d)(3) which would require the states to count actually available cash support in certain instances. In determining eligibility for individuals who are claimed as tax dependents, but are not the spouse or child of the taxpayer (e.g., children claimed by their grandparents, or a niece claimed by her aunt), the proposed rules would require states count actually available cash support provided by the taxpayer who is claiming the individual as a tax dependent. We believe this requirement is unnecessary, as well as difficult to implement and enforce.

In these instances where a taxpayer is claiming someone who is not their spouse or their natural, adopted or step child, we agree that it is appropriate to apply the rules in (f)(3) in determining the household and household income of the individuals being claimed as tax dependents. However, we also believe that it is unnecessary to require states to count actually available cash support provided by the taxpayer in determining the household income of the tax dependent. In most cases, the amount of cash support provided, such as allowances or cash gifts, is not likely to be enough to make the individual being claimed as a tax dependent ineligible for Medicaid. Moreover, it is nearly impossible to verify the amount of the cash support.

**Recommendation: The requirement to count actually available cash support would pose additional, unnecessary burdens on people applying for Medicaid, as well as state workers who would need to collect and verify the information. We recommend dropping this requirement in the final regulations.**

§435.603(e) MAGI-based income.

We understand the rationale provided by HHS for retaining current Medicaid rules around lump sum income, which would count it as income in the month in which it was received and as a resource in the following month. However, we believe this could lead to a gap in coverage in certain circumstances. For example, individuals who have lump sum income that would bring their monthly income at the time of application over 138 percent of the poverty line, but whose annual income is less than the Medicaid eligibility threshold, could be considered ineligible for both Medicaid and the premium credits. To prevent such gaps, we recommend requiring states to take into account reasonably predictable decrease in future income – such as the unavailability of the lump sum income in future months – in determining eligibility. Currently, (h)(3) would allow

states to do this, but we recommend making it a requirement instead.

We also support retaining current Medicaid treatment of certain scholarships and grants. Despite the fact that it would result in some misalignment, we believe that continuing to exclude certain student-earned income in determining Medicaid eligibility is important to keep students from having to choose between forgoing education-related aid or Medicaid.

**Recommendation: Make the option at paragraph (h)(3) for states to take into account predictable drops in future income a requirement, to ensure that individuals in this situation are identified, assigned an income that best matches the reality of their available resources, and appropriately enrolled in the coverage for which they are eligible without delay.**

**We recommend supporting exclusion of certain educational scholarships and grants. We believe it is an important provision and will keep students from having to choose between forgoing student employment or Medicaid.**

#### §435.603(f) Household.

In developing the rules around household composition for Medicaid, we recognize the tension between aligning Medicaid rules with the premium tax credit rules and ensuring that individuals now eligible for Medicaid do not lose eligibility as a result of the new rules. We believe that in attempting to strike the proper balance, the proposed rule is far too complex. Many individuals and families would have difficulty understanding the proposed household rules, and in some instances the proposed rules would split families across different coverage programs for arcane reasons.

The proposed rules would apply a different method for determining the household of an individual based whether the individual is: (1) a taxpayer; (2) a taxpayer's dependent; or (3) a non-filer or someone who is not claimed as a tax dependent. However, even though the proposed Medicaid household rules are now framed in tax terms, in many instances the rules do not align with the premium tax credit rules for determining who is in a household. Moreover, in some cases the same family will be treated differently depending on how they file their taxes.

We have identified situations in which we believe the outcome of the proposed rules is extremely problematic. We discuss those situations in more detail below and provide recommendations on how to address them. However, it is hard to know whether we have accounted for all such situations. We urge HHS to revisit the proposed rules and thoroughly examine various scenarios to identify problematic outcomes, so that they can be addressed before a final rule is issued.

In addition, based on the situations we have identified, we are particularly concerned that because of the different treatment of income for Medicaid and premium credits, some people might fall in a situation where they are ineligible for either program. We recommend a "safe harbor" for these individuals.

**Recommendation: In the final rule, HHS should recommend the creation of a “safe harbor” for individuals found ineligible for Medicaid and premium tax credits based on the different treatment of income. The creation of a “safe harbor” should ensure that these individuals are eligible for Medicaid when application of the income counting rules yields a decision of ineligibility for both Medicaid and premium tax credits.**

#### *Treatment of Married Couples*

We support retaining current Medicaid rules that limit the inclusion of spouses in each other’s household to those who are living together. We also support HHS’s decision not to adopt the rule applied to eligibility for premium credits and require married couples to file a joint return in order to be eligible for Medicaid. We believe that these provisions are particularly important in protecting individuals who are victims of domestic violence. Requiring married couples to file a joint return or to include information about the spouse they do not live with, could lead individuals in domestic violence situations to forgo Medicaid.

In most cases, applying the proposed rules yield the appropriate outcome in families where the parents are married and the parents file a joint return. However, the outcome is vastly different and very complicated when the parents file separate returns. As noted previously, we support HHS’s decision to not require married couples to file a joint return to be eligible for Medicaid. However, we recommend that HHS revise its methodology for determining family size for various members of the household in cases where married parents living together file separate tax returns. Under the proposed methodology, each spouse is included in the household of the other spouse despite their filing status. However, the spouse filing a separate return and not claiming the child does not get included in the household of the child.

**Recommendation: In the case of married couples who live together, we recommend always treating them as filing jointly – and using the rules that apply to married couples filing jointly – regardless of how that couple files taxes. We believe that this approach makes more sense since it would attribute the same income and household size to the different members of the family, ensuring that they are able to get coverage together as a family.**

#### *Unmarried Parents*

We recommend that Medicaid follow the same rule as for premium credits for unmarried parents who have a child in common and who live together but cannot file a joint return. For such families, the problems with the proposed rule are illustrated in the example below.

Consider a couple, Bob and Mary, who are the unmarried parents of a child, Peter. Because they are not married, they cannot file taxes together. Bob claims Peter, while Mary files taxes separately. Bob’s annual income is \$16,000. Mary’s annual income is \$13,000. Because the income of both parents is counted in determining eligibility of the child, in this scenario the child would end up in premium credits, whereas both the parents would end up in Medicaid. Application of the proposed rules would split the child’s coverage from the parents’ coverage, despite the fact that they live together and have the same income available to them.

Alternatively, if Medicaid follows premium credit rules for determining the household in this

situation, only the income of the parent claiming the child would be considered, and the child would have the same poverty level income as the parent claiming the child. This would result in the child generally getting coverage with the parent that claims him or her on the tax return.

**Recommendation: Medicaid should follow the same rule as for premium credits for unmarried parents who have a child in common and who live together but cannot file a joint return. Application of the proposed rules in this NPRM would split the child's coverage from the parents' coverage, despite the fact that they live together and have the same income available to them.**

§435.603(h) Budget period.

In the proposed rule, the budget period for applicants and new enrollees is based on current monthly income. For those already enrolled, a state may determine eligibility based on either current monthly income or projected annual income for the current calendar year. Since eligibility for premium tax credits in the Exchange will be based upon annual household income, we support states' flexibility to determine ongoing Medicaid eligibility in the same way. As a recent study suggests, low-income households experience frequent fluctuations in income throughout the year.<sup>4</sup> Ensuring alignment between programs as much as possible will minimize potential gaps in coverage, and minimize the extent to which an individual or family toggles between eligibility for different programs over the course of the year.

While we strongly support the provision at paragraph (h)(3) to allow states to adopt reasonable methods to account for predictable increases or decreases in income, we believe that this should be a requirement for states rather than an option and that the requirement should apply to both new applicants and current enrollees. This will simplify the determination process, particularly when state and federal databases are not timely or accurate and do not reflect an individual's actual circumstances. They will also help ensure that individuals are determined eligible and enrolled in the appropriate program at the time of initial application. It would be counter to the purpose of the law to require an individual to enroll in an Exchange plan with a premium tax credit because the applicant had a current monthly income that equated to a federal poverty level significantly higher than their federal poverty level would be if it were based upon projected annual income (for example, in the case of an individual who works in a school, but does not have summer employment, or for a seasonal retail worker who has income for a limited number of months of the year).

**Recommendation: We recommend requiring that states account for predictable changes in income when determining income as part of the eligibility determination. When such changes are being taken into account, states should accept an individual's attestation or explanation of such changes as sufficient verification whenever possible.**

*Subpart J – Eligibility in the States and District of Columbia Applications*

§435.905 – Availability of program information.

In 2014 the need for information about Medicaid and other health coverage programs will be even greater than it is now due to the requirement that all individuals obtain coverage. We support many aspects of the proposed rule on availability of program information and offer recommendations to make it stronger.

#### §435.905(a)

Families USA supports the requirement that Medicaid (and CHIP) agencies make available program information related to eligibility requirements, services, and rights and responsibilities of applicants and beneficiaries to individuals who request such information. We commend HHS in making program information available in various formats (electronically, paper, and orally as appropriate). We recommend that HHS clarify that the information must be available through the state and/or agency website and that it must be linked to the Exchange website as required by Section 2201 if the ACA which amends the Social Security Act by adding section 1943(b)(4).

In addition, the proposed rule is ambiguous in referring to the availability of program information that Medicaid and CHIP programs must make available to consumers and how that coordinates with the Exchange. The rule should clarify that the Exchange website must also provide information about Medicaid and CHIP and links to state Medicaid and CHIP websites. Moreover, Medicaid agencies should provide information about all insurance affordability programs rather than just limiting information to Medicaid.

Families USA also recommend that HHS expand the list of program information listed in §435.905(a) to provide consumers with more information. See below for full list.

**Recommendation: The final rule should clarify that program information must be available through the state and/or agency website and must be linked to the Exchange website. In addition, the Exchange website must also provide information about and include links to state Medicaid and CHIP programs.**

**The final rule should expand the list of program information listed in §435.905(a) to provide consumers with the following information:**

- **the application and renewal processes;**
- **the availability of assistance with applying for and renewing coverage;**
- **details on covered benefits, including details on benchmark benefit packages or benchmark equivalent benefit packages for newly eligible adults;**
- **agency responsibilities; and**
- **consumer appeals (which was previously required to be available in bulletins and pamphlets and was eliminated by the replacement of the current §435.905(b)).**

#### §435.905(b)

We also support the requirement that specifies that the program information must be accessible to persons who are disabled and those who have limited English proficiency (LEP). The final

regulation should retain this requirement and should specify that program information in all modalities (i.e. paper, online, oral, etc.) should be available in plain language at an appropriate reading level, should be available in multiple languages meeting the meaningful access standards for persons with limited English proficiency, and should conform to rules ensuring equal access to persons with disabilities.

**Recommendation: The final rule should specify that program information in all modalities (i.e. paper, online, oral, etc.) should be available in plain language at an appropriate reading level, should be available in multiple languages meeting the meaningful access standards for persons with limited English proficiency, and should conform to rules ensuring equal access to persons with disabilities. Specifically, the written information should be available in all languages where the lesser of 5 percent of the population or 500 LEP individuals in a service area speak a language. If there are fewer than 50 persons in a language group that reaches the 5 percent trigger, the information does not have to be translated but instead should have a tag line providing notice in the primary language of the LEP language group of the right to receive competent oral interpretation of those written materials free of charge. Oral language assistance for those seeking program information from the agency in person or over the phone should be provided in a timely fashion; this could include using a language line contract to connect to interpreter services.**

#### **§435.907 Application.**

##### §435.907(a)

§435.907(a) explains that states must require an application for insurance affordability programs. Families USA is concerned that the requirement could be interpreted to negate Express Lane Eligibility (ELE), or the automatic enrollment option, allowed by section 203(a)(1)(D) of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA). This option allows states to automatically enroll children in Medicaid and CHIP without an application. To complete an eligibility determination using this option states must have sufficient information about children from Express Lane agencies or other data sources. ELE requires states to provide families with information about services provided through Medicaid or CHIP, cost-sharing responsibilities, renewal requirements, and other program requirements. Families must affirmatively consent to the enrollment of children but they are not required to complete an application. Although the authority for the ELE demonstration expires September 30, 2013, Families USA believes that the final rule should be written with the assumption that the authority to continue using ELE will be authorized. We do not believe it is the intent of the ACA to prohibit ELE (since it is explicitly mentioned, for example, as an exception to applying the MAGI methodology), and so Families USA strongly recommends that the final rule clarify that ELE will still be allowed.

Families USA fully supports that this section of the proposed rule allows for “the applicant,” “an authorized representative,” or “someone acting responsibly for the applicant” to file the streamlined application. It is important to allow for representatives to act on behalf of the applicant in situations where the applicant cannot apply on his or her own. As further guidance is

developed, HHS may want to consider what information should be required from individuals “acting responsibly for the applicant,” such as contact information and declaration of relationship to the applicant, to prevent fraud and mistakes.

**Recommendation: Families USA strongly recommends that the final rule clarify that Express Lane Eligibility will be allowable. We encourage further discussion on what information should be required from individuals “acting responsibly for the applicant,” such as contact information and declaration of relationship to the applicant, in order to prevent fraud and mistakes.**

#### §435.907(b)

Families USA strongly supports that §435.907 of the proposed rule codifies Section 1413(b)(1)(A)(i) of the Affordable Care Act which requires the use of a single, streamlined application that can be used for all insurance affordability programs. The use of a single, streamlined application is essential to ensuring that there is “no wrong door” for consumers. We recommend that this section explicitly state that the application must only require applicants to answer questions relevant to their eligibility determination. States should be required to clearly mark optional questions and allow applicants to proceed without completing such optional questions.

As required by Section 1413(b)(1)(B) of the Affordable Care Act, the rule allows states to choose to use the application developed by HHS or to create an alternative application, subject to the approval of the Secretary. We strongly support that the proposed rule requires that alternative applications cannot be more burdensome than the application developed by HHS.

Families USA believes that it is important that all forms related to enrollment should, to the greatest extent possible, be prepopulated using information already gathered in the application and through electronic data matches. This will minimize the amount of duplicative information an applicant needs to provide. In addition, in order to ensure the security and privacy of an applicant’s information, only information essential to the enrollment process should be made available to the health insurance plan. For example, specific information about an individual’s income should not be provided to the plan.

We ask that CMS clarify that nothing in the rule should be interpreted as preventing a state from using a multi-benefit application (for example, for health coverage, SNAP, and TANF) in addition to the single streamlined application for health coverage. Not all health coverage applicants will wish to apply for other programs, but those who do should still have the ability to apply using a multi-benefit application.

The preamble of this proposed rule indicates that accessibility and readability will be addressed in further guidance. However, we recommend that the final rule reiterate that people who are disabled and/or Limited English Proficient (LEP) should have equal access to applications, regardless of whether the application is provided by HHS or is an alternative application approved by the Secretary. Our specific recommendation for ensuring accessibility and

readability for people who are LEP is consistent with our recommendation for §435.905(b).

**Recommendation: The final rule should clarify that the application must only require applicants to answer questions necessary to determine eligibility. All optional questions should be marked as optional. We strongly recommend that all forms related to enrollment should, to the greatest extent possible, be prepopulated using information gathered in the application process. In addition, in order to protect applicant privacy, only information essential to the enrollment process should be available to the health insurance plan. CMS should clarify that nothing in this rule prevents a state from using a multi-benefit application (to apply for other human services programs) in addition to the single streamlined application for health coverage. The final rule should reiterate that the application form(s) for insurance affordability programs must be accessible to persons with disabilities and/or LEP. Please see our specific recommendation for ensuring accessibility and readability for people with limited English proficiency in our recommendation for §435.905(b).**

#### §435.907(c)

§435.907(c) allows states to select to use the single, streamlined application with supplemental forms or use an alternative application form approved by the Secretary to collect information needed to determine eligibility on a non-MAGI basis. This section of the proposed rule does not specify that such supplemental forms and alternative applications must be held to the same standards of the single, streamlined application. If left unchanged, individuals in the non-MAGI population, including persons who are aged, blind, and disabled, could be required to complete applications that are unnecessarily burdensome. The final rule should require that these forms and alternative applications only require the minimum additional information necessary to determine eligibility, primarily rely on existing databases for required information, and be structured to maximize applicants' ability to complete the forms, as written in §1413(b)(1)(A) of the Affordable Care Act. Although the preamble indicates that supplemental, as well as alternative, forms must be approved by the Secretary, it is unclear in §435.907(c) whether this requirement applies to supplemental forms. Additionally, the content and the number of additional forms should be reviewed and approved by the Secretary to ensure that the forms are not unduly burdensome or duplicative.

Families USA is concerned that this proposed rule does not require states to ask any screening questions in the application process to determine whether an applicant may benefit from an additional evaluation based on non-MAGI criteria. Nor is a state required to explain the advantages, if any, of receiving coverage under a non-MAGI group, and the need for a further determination, to obtain such coverage. The proposed rules do not provide an explanation as to how a state is supposed to determine when an individual may be eligible for non-MAGI based eligibility, and therefore use the supplemental or alternative application forms.

It is important for HHS to recognize that there are certain situations when additional information is necessary to determine eligibility, and therefore HHS must allow the submission of such information in order to make an accurate eligibility determination. Yet, it is essential that HHS

make sure states do not make their applications overly complicated. Electronic applications should use dynamic questioning in which responses to earlier questions are processed and only relevant subsequent questions are asked in order to minimize the number of questions each applicant has to answer based on their individual circumstances. Screening questions that ask applicants if they are disabled or someone in their household is disabled should also be incorporated into paper and in-person application processes to trigger review under a non-MAGI eligibility group, if appropriate, based on the information provided. If additional information is required and the state has elected to use additional forms, only those forms that are needed to make the determination should be sent to the applicant.

Families USA is also concerned that this section of the proposed rule is inconsistent with the proposed Exchange regulation. 45 C.F.R. §155.345 of the Exchange proposed rule requires all individuals applying through the Exchange to receive a “basic screening” for non-MAGI eligibility. But the same is not required of the Medicaid agency in these regulations. This inconsistency could lead to different results based on where the individual applies for Medicaid coverage.

42 U.S.C. 1396u-7(a)(2)(B) exempts individuals who qualify for Medicaid on the basis of being disabled from benchmark benefits. Individuals who meet Medicaid’s financial and disability requirements qualify for Medicaid on that basis, whether or not the state evaluates them for such coverage. In order to fulfill the requirements to determine eligibility in the “best interest” of the beneficiary, we urge you to require states to (1) ask a screening question on the application to determine if the applicant has a disability; (2) furnish MAGI-related benefits without delay, but continue processing the application for disability-related Medicaid benefits within currently required timeframes.

**Recommendations: The final rule should specify that supplemental forms and alternative applications for determining eligibility on a non-MAGI basis must be held to the same standards of the single, streamlined application as described in §1413(b) of the Affordable Care Act and §435.907 of this proposed rule. Supplemental forms, and their content and quantity, should be reviewed and approved by the Secretary to ensure that the forms are not unduly burdensome or duplicative.**

**Clarify in the final regulations that applicants have the right to request and receive an eligibility determination under non-MAGI based rules, and explicitly state that applicants have the right to coverage in the best eligibility category for which they qualify.**

**Require all states to ask in their applications (streamlined, alternative, web-based, and paper) whether the applicant or someone in the applicant’s household is disabled. Although those eligible under MAGI rules should receive at least the MAGI-related benefit package immediately, if the answer is “yes” to the disability question, require a “duty to assist” on the part of the state Medicaid agency or another entity taking the application to make sure the individual is enrolled in the best eligibility category they qualify for (even if that is a non-MAGI category) at least within currently required timeframes for applicants with disabilities.**

**Include additional accountability measures by which HHS will monitor states' implementation of these rules to ensure beneficiaries receive the most appropriate form of coverage. Thus, HHS should review states' policies and practices to insure individuals with disabilities and "medically frail" individuals receive the coverage to which they are entitled.**

§435.907(d)

Families USA strongly supports that the single, streamlined application can be submitted through several pathways, including online, by phone, by mail, in person, and by fax. Applicants will have different needs and will require different levels of assistance, making all of these avenues of applying for coverage necessary. Having several pathways to apply for coverage will help to maximize successful enrollment. In particular, we strongly support that §435.907(d)(4) codifies §1413(b)(1)(A)(ii) of the Affordable Care Act in that it requires that consumers be able to file an application in person. Families USA feels that it is crucial to allow applicants to submit an application in person, as consumers will have varying levels of access to the internet and comfort in applying for coverage online or over the phone.

§435.907(e)

We fully support that §435.907(e) codifies tri-agency guidance<sup>5</sup> and prohibits states from requiring non-applicants to provide citizenship, nationality, immigration information or social security numbers. However, the final rule should clarify that states' online applications must allow non-applicants to proceed with the application without providing SSNs. In some existing Medicaid and CHIP applications, non-applicants are notified that providing SSNs is voluntary but when they try to proceed with the application they are not able to move on without providing a SSN. In some cases, applicants can bypass the screen requesting the SSN but only after getting multiple pop-up messages strongly urging the non-applicant to provide the information. We recommend that these practices should be prohibited and that non-applicants are reminded that providing an SSN is optional.

**Recommendation: The final rule should clarify that states' online applications for insurance affordability programs must allow non-applicants to proceed with the application without providing their social security number.**

**§435.908 – Assistance with application and redetermination.**

§435.908(b)

Even with the most user-friendly application process, there will be a strong need for multiple forms of assistance. We support the broadening of this section to include both the application and redetermination process. We also support the requirement that Medicaid agencies provide assistance to individuals seeking help with the application or redetermination process, and that this assistance be provided in person, over the phone, and online and in formats accessible for

people with disabilities and those with limited English proficiency.

The proposed rule however does not specify how this assistance should be provided. Consumer groups have commented on the Exchange regulations for consumer assistance tools (42 CFR 155.205), and such standards should also apply to the assistance Medicaid and CHIP agencies are required to provide. We support giving consumers options for obtaining assistance to ensure individuals have choices that meet their schedules, capacity and need. This provision should be retained. However, this provision needs to further specify standards for Medicaid agencies to ensure that assistance is truly accessible. These standards should include providing assistance both during and outside normal business hours. According to research, parents seeking to enroll their children in Medicaid or CHIP often feel the process is too burdensome, for reasons such as being put on hold for too long when trying to get questions answered and not being able to obtain assistance outside normal business hours (during which most parents work and are unable to take time off to go to an eligibility office or access a computer).<sup>6</sup> As HHS develops standards and metrics referenced in several parts of the preamble of this NPRM, HHS should add standards that will ensure adequate access to assistance by measuring agency performance looking at: call abandonment, call wait times, number of days to wait for an in-person assistance appointment, waiting time for online assistance, and other measures.

The ACA mentions in paragraph (b)(1)(F) of Section 1943 that Medicaid and CHIP agencies are to conduct outreach to vulnerable underserved populations eligible for Medicaid or CHIP, including children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS. We recommend codifying this requirement in the final rule. The preamble mentions these requirements, but the regulations should also specifically mention states' responsibility to conduct outreach to vulnerable and underserved populations eligible for Medicaid. The preamble states that HHS will provide technical assistance and subregulatory guidance on application and renewal assistance, but the regulation text should at least mention the responsibility to conduct outreach. Ensuring that the approximately 16 million individuals who will be eligible for Medicaid and CHIP as a result of the expansion are informed of their new eligibility and provided the appropriate assistance to enroll in that coverage is paramount to the success of the expansion.

**Recommendation: We recommend that HHS require Medicaid and CHIP application and renewal assistance meet the same criteria required for Exchange assistance (per §155.205). It is logical to use the same standards, given that with “no wrong door,” an eventual Medicaid or CHIP enrollee may initially enter the application process through an Exchange, and an eventual QHP enrollee may initially enter into the application process through the Medicaid or CHIP agency. The same forms of assistance should be available to applicants regardless of the agency handling the application or the ultimate form of coverage for which the individual is determined eligible.**

**HHS should add standards that will ensure adequate access to assistance by measuring agency performance looking at: call abandonment, call wait times, number of days to wait**

for an in-person assistance appointment, waiting time for online assistance, and other measures.

Families USA also recommends that HHS include language in the final rule to codify the requirement that Medicaid and CHIP agencies conduct outreach to vulnerable and underserved populations. This should include metrics as to how much outreach is required, and what kinds of activities states should engage in to meet this requirement.

**§435.911 Determination of eligibility.**

**§435.911(c)(1) Eligibility determination for mandatory coverage on basis of modified adjusted gross income.**

We support the requirement that Medicaid agencies furnish benefits promptly and without undue delay for individuals determined eligible for Medicaid based on modified adjusted gross income (MAGI). We also support conducting the “MAGI screen” first, since the majority of new Medicaid eligibles will be eligible based on income; this is the most efficient and administratively simple process for both the agency and the applicant.

After a MAGI screen is conducted, we believe that consumers should be given the option to seek a non-MAGI eligibility determination and be provided information that will help them to understand under what circumstances seeking such a determination might be advantageous to them. Consumers who do choose to have a full Medicaid determination should be able to remain enrolled in Medicaid based on MAGI while that determination is being made. Additionally, we believe that states should be required to include a screening question in the MAGI-application process that would indicate that an individual might be eligible for non-MAGI eligibility and would trigger the start of such a review. See our comments for §435.907.

We propose that specific timeliness standards for eligibility determinations and notices should be codified in this regulation.

**Recommendation: After a MAGI screen is conducted, we believe that consumers should be given the option to seek a non-MAGI eligibility determination. Consumer should also be given information that will help them understand under what circumstances seeking such a determination might be advantageous to them and the application should include a screening question that would indicate an individual might be eligible for a non-MAGI category and would trigger the initiation of such a review. However, it is crucial that consumers who are undergoing a full Medicaid determination, whether in response to an application screening question or because they have requested such a determination, be able to remain enrolled in Medicaid based on MAGI while that determination is being made.**

**The timeliness standards should be defined in a manner that prevents gaps in coverage. State agencies should be held to specific standards, and applicants should be made aware of these standards at the time of application. We commend the goal of real-time**

**determinations for as many applicants as possible, but it may not be possible to process all cases in real-time; states should be required to make a determination in a specific timeframe.**

§435.911(c)(2) Eligibility on basis other than applicable modified adjusted gross income standard.

This section instructs the State Medicaid agency to collect additional information from individuals who submit MAGI applications but whose income exceeds the MAGI standard. The preamble makes clear that the term ‘as needed’ refers to collecting information that is needed to make an eligibility determination, however, that is not immediately clear in the text of the regulation. We ask that CMS clarify that the term ‘as needed’ refers to the information needed to make an eligibility determination and not that the State may simply elect not to collect information.

If a State has elected to use a single, streamlined application and supplemental forms for non-MAGI application with additional forms, we ask that only those forms that are needed to make an eligibility determination be sent to the applicant. The regulations should make clear that the request should be tailored to that particular applicant. Similarly, if the State has elected to use a modified application for the non-MAGI population, the applicant should be sent a modified application with the already submitted information pre-populated into the application.

The rule should encourage States to work to extend the enrollment and data sharing benefits for the MAGI applicants to the non-MAGI applicants. This is particularly useful for non-MAGI benefits such as the Medicare Savings Programs (MSPs), which in many States already require only minimal proof of income and assets. Such benefits could easily be folded into the data sharing eligibility and enrollment improvements extended to MAGI applicants. Additionally, the regulations should encourage States to explore other alternatives such as self-attestation of income and/or assets.

When an individual is awaiting a Medicaid determination for a non-MAGI eligibility category, the individual should be enrolled in Medicaid or given then option to enroll in Exchange coverage with a premium tax credit (depending on the individual’s income-eligibility for either program).

**Recommendation: In the final rule, when referring to the Medicaid agency’s responsibility in collecting additional information from individuals who submit MAGI applications but whose income exceeds the MAGI standard, HHS should clarify that the term “as needed” refers to whether additional information is needed to make a determination for a non-MAGI Medicaid eligibility decision and not that the State may simply elect not to collect information.**

**If a State has elected to use a single, streamlined application and supplemental forms for non-MAGI application with additional forms, it is crucial that only those forms that are needed to make an eligibility determination be sent to the applicant. If the State has elected**

**to use a modified application for the non-MAGI population, it is important that the applicant should be sent a modified application with the already submitted information pre-populated into the application.**

**The final rule should encourage States to work to extend the enrollment and data sharing benefits for the MAGI applicants to the non-MAGI applicants. Medicaid agencies could, for example, utilize State income tax data or asset verification systems to verify information submitted by non-MAGI applicants, rather than requesting additional proof from applicants. In addition, the regulations should encourage States to explore other alternatives such as self-attestation of income and/or assets.**

#### **§435.916 Periodic redeterminations of Medicaid eligibility.**

Families USA strongly supports the overall approach of this section. We believe these rules will reduce administrative burden on states and improve retention among eligible beneficiaries. The proposed changes build on state practices that have had documented success in reducing staff time, decreasing churn and improving program integrity. These rules additionally come close to aligning Medicaid rules with those proposed for the premium tax credit.

#### **§435.916(a) Redetermination of individuals whose Medicaid eligibility is based on modified adjusted gross income.**

We support the requirement that states make redeterminations without requiring information from the enrolled individual (if it is possible to do this using information already available to the agency) and without requiring the enrolled individual to sign and return a notice. When existing data cannot be used to make a redetermination, we support the requirement that Medicaid agencies use a pre-populated form that the enrollee can respond to online, by phone, by fax or by mail to quickly and easily update their information and retain coverage.

We also support the proposal that states redetermine eligibility only once every 12 months for all individuals subject to MAGI-methodologies. This is a departure from existing rules, which require redeterminations at least every 12 months, but we strongly support it. A twelve-month eligibility period would be consistent with that established in the Exchange and would simplify and streamline state and federal administrative processes. However, we are concerned that the current drafting may be interpreted similarly to existing rules, and that states may choose to require regular recertifications at more frequent intervals than once every 12 months. Additionally, this regulation only applies to beneficiaries found eligible for Medicaid based on MAGI; the final rule should retain this requirement and it should be extended to apply to Medicaid beneficiaries that are found eligible for Medicaid on a non-MAGI basis.

Families USA is concerned that the requirement in paragraph (a)(4) does not go far enough in ensuring seamless transitions between Medicaid and other insurance affordability programs. It appears to require the Medicaid agency to “assess” an individual no longer eligible for Medicaid for eligibility for other programs and transmit the electronic account. However, according to Section 1413 of the ACA, the Medicaid agency should actually be making a new determination

of eligibility. In fact, in order to realize a fully seamless and coordinated system, a denial of eligibility for Medicaid should never be issued in isolation; with a few exceptions based on immigration and incarceration status, a denial for one program should always be accompanied with an eligibility determination for another program (even if this is simply eligibility to purchase coverage in an Exchange, without a premium tax credit).

**Recommendations: CMS should clarify that the intent of this provision is to require states to recertify only once every 12 months, unless data available to the state suggest an individual’s circumstances may have changed prior to the end of the 12-month period or in cases when an earlier recertification will facilitate coordinated eligibility time periods among members of a household. The “only once every 12-month” recertification requirement should apply to those eligible on both a MAGI and non-MAGI basis. We recommend that the final rule require states to allow a grace period alluded to in paragraph (a)(3)(iii) during which a renewal form can be accepted and used to continue an individual’s coverage, rather than allowing the coverage to lapse and requiring the individual to initiate a new application process. We ask that the final rule require that if an individual is determined ineligible for Medicaid (or CHIP) at renewal, the denial of Medicaid (or CHIP) should be accompanied by a determination of eligibility for another insurance affordability program, if applicable, and the individual should receive the Medicaid denial and the determination for another program at the same time.**

§435.916(b) Redetermination of individuals whose Medicaid eligibility is determined on a basis other than modified adjusted gross income.

Paragraph (b) addresses redetermination for individuals eligible for Medicaid on a non-MAGI basis. In the preamble HHS seeks comment on whether to extend the MAGI renewal rules and processes to non-MAGI beneficiaries. We strongly support the principles set out in §435.916(a) and would support extending them to all beneficiaries.

**Recommendation: The final rule should extend the MAGI renewal rules and processes set out in §435.916 to all beneficiaries, including non-MAGI beneficiaries.**

§435.916(c) Procedures for reporting changes.

Paragraph (c) requires states to have procedures in place for enrollees to report any changes in circumstances that may affect their eligibility. This duty to report is not clearly defined, and we are concerned that enrollees will not have adequate information as to the kinds of changes that need to be reported.

Additionally, the redetermination process is an opportunity for State Medicaid agencies to determine if there has been a change in the beneficiary’s health status, for example if an individual has become disabled and might be eligible for additional benefits. States should be required to capture information on significant changes in enrollees’ health status that could trigger a redetermination under a non-MAGI category. The mechanisms used to capture such information should not be unduly burdensome on individuals or states and should rely on data

available to states to the extent possible.

**Recommendations:** In order to reduce confusion among enrollees and ensure states are not burdened with processing reports of changes in circumstance that are insignificant or irrelevant to eligibility, we recommend that the final rule clarify that enrollees should be required to report major changes such as moving out of the state, loss or gain of a household member, or new employment. They should not be required to report small fluctuations in income. States should provide the individual with a dollar amount that equates to the upper eligibility threshold for Medicaid in the state for the individual's family size, and only require reporting of income changes that approximate this amount. We encourage future rulemaking to include a mechanism to require states to capture changes in health status that could trigger an applicant's reclassification into a non-MAGI category. It will be crucial to ensure that this mechanism would not be unduly burdensome to applicants or states.

§435.916(d) Agency action on information about changes.

Paragraph (d) allows the Medicaid agency to redetermine eligibility when it receives information that may affect an individual's eligibility. This is a broad requirement that grants states a great deal of flexibility in choosing when and what kind of information to use. This could result in states needlessly redetermining eligibility for minor changes that are unlikely to affect an individual's eligibility.

**Recommendation:** States should be required to use data that are available, timely, and accurate. Additionally, to the extent that an enrollee is also enrolled in the Supplemental Nutrition Assistance Program (SNAP), states should be required to use the SNAP income findings to help determine ongoing Medicaid eligibility. We also recommend that the final rule require states to notify enrollees of the sources of data the state will periodically assess to confirm ongoing eligibility.

§435.945 General requirements.

§435.945(a)

§435.945(a) of the proposed rule sets program integrity out as a top priority. Program integrity is a critical programmatic component. However, we are concerned that states will use §435.945(a) to justify creating burdensome barriers to “ensure that only eligible individuals receive benefits” and protect program integrity, when such burdensome barriers would actually keep eligible individuals from enrolling. States should have to demonstrate good reason why an enrollment simplification required by these regulations poses a threat to program integrity before they may use this exception to evade their obligation to simplify and streamline the enrollment and renewal process.

**Recommendation:** States must demonstrate a good reason why an enrollment simplification required by the Affordable Care Act and this proposed rule poses a threat to program

**integrity before they use this exception to evade their obligation to simplify and streamline the enrollment and renewal process.**

§435.945(b)

We commend CMS for allowing the Medicaid agency to accept self-attestation without requiring further paper documentation for all information needed to determine Medicaid eligibility, excluding citizenship and immigration status information. The benefits of the administrative simplicity for states and the reduced barriers for clients far outweigh any potential problems from making attestation the default position. We note, in particular, that the extremely poor population that this regulation addresses is a population that will frequently need to rely heavily on attestations because they will not be able to otherwise document informal arrangements regarding income and residence, among other data points.

§435.945(c)

We commend the requirement that states must request and use eligibility information referred to in §435.948 through §435.956, most notably the requirement to use electronic information made available through the federal electronic service established in §435.949 and other electronic federal and state databases. We consider it one of the most important functions of this regulation to require states to ask for information from a consumer *only if* necessary applicant information is not available through other sources, including the centralized federal electronic service. This is a critical requirement that will reduce the administrative burden on states and assist consumers who would otherwise have difficulties producing documentation.

§435.945(d)

We support that the Medicaid agency must share income and eligibility information with other state and federal programs. §435.945(d) requires that the Medicaid agency “furnish, in a timely manner, income and eligibility information” for these other programs. We urge CMS to specify what “timely manner” means, as many states will interpret it differently. We proposed that the final rule define “timely manner” to mean “real time, or as quickly as possible,” in order to allow for fast eligibility determinations for other programs.

**Recommendation: The final rule should specify that the Medicaid “agency must furnish...income and eligibility information needed for verifying eligibility for the following programs” in real time, or as quickly as possible.**

§435.945(f)

Families USA supports that applicants will be given notice of how their information will be obtained and used before it is requested from another agency or program. States should be required to inform applicants of the specific databases from which applicant information will be requested. The notice, electronic or paper, should be written in plain language. While designing this notice, CMS should request consumer input to ensure that the notice is truly accessible to consumers.

**Recommendation: The final rule should require states to inform applicants of the specific data sources from which applicant data would be requested. The notice should be written in plain language. In order to ensure that the notice is accessible, CMS should request consumer input on its design.**

§435.945(h)

Families USA supports the requirement §435.945(h) that electronic information be exchanged securely and confidentially. We recommend that the regulation specify that information can only be requested, shared or used for purposes strictly relevant to eligibility verifications.

**Recommendation: Electronic information exchanged between the Medicaid agency and other agencies or programs must only be requested, shared, or used for purposes strictly related to eligibility verifications.**

§435.945(i)

We commend the requirement in §435.945(i) that states establish formal agreements with other agencies to protect information. We recommend that these formal agreements require that information can only be used for narrow and relevant verification purposes.

**Recommendation: Formal agreements between the Medicaid agency and other agencies or programs must specify that information must only be used for verification purposes.**

**§435.948, Verifying financial information.**

Families USA strongly supports the use of electronic data sources to minimize the need for applicants to provide paper documentation of financial information. §435.948 allows for a verification process that is significantly less burdensome for applicants and states than current Medicaid income verification requirements. However, there is little mention of the need for a timely verification process in order to promote a timely enrollment process. We urge CMS to provide specific requirements throughout §435.948 for agencies to verify financial data in a timely manner. We recommend that the final rule require agencies to verify applicant financial information in real time or as quickly as possible.

**Recommendation: Specific timeliness requirements for the verification of financial information should be added to §435.948. We recommend that the final rule requires agencies to verify applicant financial information in real time or as quickly as possible.**

§435.948(a)

Families USA strongly supports that §435.948(a) requires that Medicaid agencies tap available databases for financial information that may be relevant to an individual's eligibility determination. Making use of existing data to determine financial eligibility is significantly less burdensome for applicants than requiring paper documentation. We strongly support the

requirement that states must conduct data matches through PARIS, SNAP, and other insurance affordability programs. We are concerned, however, that the language in this section requiring Medicaid agencies to request financial information from other state and federal agencies and programs is too vague. §435.948(a) states that Medicaid agencies must request financial information from other state and federal agencies if “such information is useful.” In order to provide more clarity, we suggest replacing the word “useful” in paragraph (a) with the words “available, timely, and accurate”. This will still ensure that states are not required to tap databases that are known to provide data that is too old to be used for eligibility verifications, but will ensure that states attempt to retrieve financial information from other databases before asking the applicant for more information.

In addition, it is important that applicants have the opportunity to attest that financial information obtained from alternate databases is correct or incorrect. We recommend that the final rule requires that applicants be presented with financial information obtained through existing state and federal databases to confirm that the information is correct prior to eligibility determination. If the information is incorrect, the applicant must have the option to provide the correct financial information.

**Recommendation: In the final rule, the word “useful” in §435.948(a) should be replaced with the words “available, timely, and accurate.” The final rule should clearly state that applicants must be presented with the financial information obtained from other state and federal databases before the agency makes an eligibility determination. If the information is incorrect, the applicant must have the option to provide the correct financial information.**

#### §435.948(b)

Families USA strongly supports that Medicaid agencies must obtain information from the federal electronic service, established in §435.949. As recommended in §435.948(a), the final rule should clearly state that applicants must be presented with the financial information obtained from the federal electronic service before the agency makes an eligibility determination. If the information is incorrect, the applicant must have the option to provide the correct financial information.

**Recommendation: The final rule should clearly state that applicants must be presented with the financial information obtained from the federal electronic service before the agency makes an eligibility determination. If the information is incorrect, the applicant must have the option to provide the correct financial information.**

#### §435.948(c)

Families USA supports the requirement in §435.948(c)(2) that Medicaid agencies must request information by SSN or other personally identifying information in the individual’s account if an SSN is unavailable. However, we are concerned that this requirement to use SSNs as the point of entry into electronic verification of financial information will be problematic for mixed status families, in which the applicant or application filer may not have an SSN. We recommend

including references to the requirement that Medicaid agencies must assist individuals in obtaining an SSN.

**Recommendation: Reference the requirement that Medicaid agencies must assist individuals in obtaining an SSN if they do not have one.**

§435.948(d)

We support the requirement that the Medicaid agency may request and use alternative sources of information only if those alternative sources reduce administrative costs and burdens on individuals and states, maximize accuracy, and minimize delay. However, the proposed rule is unclear as to whether agencies would be approved to use such alternatives on a blanket basis (for all applicants at any point in the application process), only when other data sources required in §435.948(a) and §435.948(b) do not yield useable results, or on an individual basis. We ask CMS to provide more detail as to how alternative sources would be used. We recommend that states must be required to get approval from HHS to use alternative data sources.

In addition, §435.948(d) could explicitly allow the Medicaid agency to contact the individual's employer, with the applicant's permission, to obtain financial information when such information is not available through the federal electronic service or through the sources mentioned in §435.948(a) and §435.948(b). This would still be less burdensome on the applicant than requiring them to supply paper documentation, and could also be faster and more efficient.

**Recommendation: The final rule should provide more detail as to how alternative sources of information would be used. The proposed rule is unclear as to whether agencies would be approved to use alternative sources of information on a blanket basis for all applicants, only when other data sources do not yield useable results, or on an individual basis. We recommend that states must get approval from HHS to use alternative data sources. In addition, §435.948(d) should explicitly allow the Medicaid agency to contact the applicant's employer, only with the applicant's permission, to obtain financial information when such information cannot be obtained through the data sources listed in §435.948(a) and §435.948(b), as this would be less burdensome than requiring the applicant to provide paper documentation.**

**§435.949, Verification of information through an electronic service.**

§435.949(a)

Families USA strongly supports the use of a federal electronic service through which States can obtain applicant information from Federal agencies. Using reliable, electronic data from existing databases instead of requiring paper documentation from applicants will greatly simplify the application process for both applicants and states. The federal electronic service will be essential to quickly and successfully enrolling millions of Americans in coverage.

It is unclear if state databases will be allowed to participate in the federal electronic service. State databases, such as state quarterly wage databases, may contain more accurate, up-to-date

financial information than the financial information available through the Department of Treasury. We recommend that HHS consider expanding the scope of information provided by the federal electronic service by establishing linkages to state or other databases that contain reliable, relevant eligibility data. Many individuals who will be eligible for Medicaid or insurance affordability programs will have incomes that fluctuate several times during the year.<sup>7</sup> Therefore, it will be essential to use the most up to date information to determine eligibility in order to reduce the need for paper documentation.

**Recommendation: We ask HHS to consider expanding the scope of information provided by the federal electronic service by establishing linkages to state or other databases that contain reliable, relevant eligibility information.**

**§435.952, Use of information and request of additional information from individuals.**

§435.952(a)

We strongly support that §435.952(a) requires Medicaid agencies to “promptly” evaluate applicant information that may affect eligibility or benefits. This requirement will help ensure timely eligibility determination.

§435.952(b)

§435.952(b) requires that if information provided by or for an individual on the application or renewal form is “reasonably compatible” with electronic information obtained by the agency, the agency must make an eligibility determination or redetermination without requiring further information from the applicant. Families USA strongly supports that Medicaid agencies will primarily rely on electronic data before requesting more information from applicants. However, we urge CMS to set parameters for “reasonably compatible” in the final rule. We are concerned that without a federal standard, states may define “reasonably compatible” too narrowly, which would require applicants to provide more documentation and potentially discourage them from completing the enrollment process. We suggest that the final rule includes the following parameters for “reasonably compatible:”

- If the discrepancy between the applicant’s statement and the information obtained by the agency through a data match would not have the effect of changing eligibility or benefits, then it should be considered “reasonably compatible.”
- For the purposes of renewals, if information has not changed then it should not need to be re-verified. For example, if income from the same job has not changed, it should not need verification.
- To the extent states have flexibility in defining thresholds or other parameters for what should be considered reasonably compatible, states should define “reasonably compatible” in policy (incorporated in manuals and training) and it should be uniformly implemented for eligibility related to all insurance affordability programs throughout the state (including in the case where there is a federal Exchange).

**Recommendation: The final rule must set parameters for what should be considered “reasonably compatible” in order to promote enrollment and minimize burdens on consumers and states. We recommend that CMS include the following parameters for “reasonably compatible” in the final rule:**

- **If the discrepancy between the applicant’s statement and information obtained by the agency from other electronic data sources would not have the effect of changing eligibility or benefits, then it should be considered “reasonably compatible.”**
- **For the purposes of renewals, if information has not changed then it should not need to be re-verified. For example, if income from the same job has not changed, it should not need verification.**
- **To the extent that states have flexibility in defining thresholds or other parameters for what should be considered reasonably compatible, states should define “reasonably compatible” in policy (incorporated in manuals and training) and it should be uniformly implemented for eligibility related to all insurance affordability programs throughout the state (including in the case where there is a federal Exchange).**

§435.952(c)

Families USA commends CMS for allowing applicants to provide a statement of self-attestation when there is a discrepancy in applicant information and information collected by the Medicaid agency. However, because the proposed rule does not require that states accept a statement before requesting paper documentation, we are concerned that many states will not allow for self-attestation. Requiring paper documentation would delay the enrollment process and place more burden on applicants and states. We recommend that the regulation be strengthened to require that states must accept attestation to resolve information inconsistencies unless there is a clear reason not to use attestation under specific circumstances. The benefits of the administrative simplicity for states and the reduced barriers for applicants far outweigh any potential problems from making attestation the default position when there is a discrepancy in information.

When attestation is not possible, it is important that Medicaid agencies provide multiple pathways to submit documentation, and allow for different types of documentation to serve as verification. Consistent with application and renewal provisions, the state must allow applicants to submit documentation online, by phone, by mail, by fax, or in person. Specifically, we recommend that the final rule allow applicants to submit photographs of necessary paper documentation electronically. We envision that applicants would be able to use the cameras on their smart phones and tablet computers (or through technology available through an application assister or Navigator) to take a photograph of the paper documentation and use the same device to email the photograph to the Medicaid or Exchange agency. (For example, we are aware that certain banks have had success in allowing their members to electronically send photographs of checks in order to deposit the checks instead of taking the check to the bank to be manually deposited.) The final rule should contain a list of acceptable alternative verification, including paper documentation provided by the application filer, letters from employers, and applicant-approved telephone contact with a reliable third party.

§435.952(c)(2) states that the Medicaid agency must provide individuals with a “reasonable period” to provide the necessary information. Families USA feels it is important for the Medicaid regulation to be consistent with the Exchange regulation whenever possible in order to prevent confusion and obstacles from enrolling in the appropriate insurance affordability program. Consistent with the provision in the Exchange proposed rule, §155.315 of 45 CFR, which defines the amount of time that applicants have to provide additional information when there are inconsistencies or insufficient information, we recommend the following definition for “reasonable period:” “When the Medicaid agency cannot use electronic data or self-attestation to determine eligibility, the Medicaid agency must provide the applicant with a period of 90 days from the date on which the applicant receives notification of the need to provide additional verification. If working in good faith to provide verification, applicants should not have to reapply if they provide information after the 90-day period.”

**Recommendation: We recommend that the final rule be strengthened to require that when there is a discrepancy in information, state agencies must accept applicant attestation to resolve the inconsistency unless there is a clear reason not to use attestation under specific circumstances. When self-attestation is not possible, the Medicaid agency must allow for multiple pathways to submit documentation (online, by phone, by mail, by fax, or in person) and accept a variety of types of verification (including paper documentation, letters from employers, and applicant-approved telephone contact with reliable third-parties). We recommend that the final rule allow for applicants to submit photographs of acceptable paper verification electronically, using their smart phones, tablet computers, or other technology available through an application assistor or Navigator. We recommend that the final rule provides the following definition for “reasonable period:” “When the Medicaid agency cannot use electronic data or self-attestation to determine eligibility, the Medicaid agency must provide the applicant with a period of 90 days from the date on which the applicant receives notification of the need to provide additional verification. If working in good faith to provide verification, applicants should not have to reapply if they provide information after the 90-day period.”**

#### §435.952(d)

Families USA strongly supports that the agency cannot deny or terminate eligibility or reduce benefits based on information obtained by the agency through a data match without seeking additional information from the applicant. While electronic data matches will greatly simplify the application process, information available through the federal electronic service or other federal and state databases may be out of date or inaccurate, and it is important to give the applicant the ability to provide additional information.

#### **§435.956, Verification of other non-financial information.**

§435.956 (c) State residency.

Families USA strongly supports that the Medicaid agency may accept an applicant's attestation of residency to determine eligibility. Allowing for self-attestation instead of requiring paper documentation will greatly reduce the burden of applying for coverage for applicants and states. We prefer that states accept self-attestation to support consistency of verification among all insurance affordability programs.

§435.956 (e) Pregnancy and household size.

Families USA strongly supports that the Medicaid agency must accept self-attestation of pregnancy and household members, unless the state has information that is not reasonably compatible. Allowing for self-attestation instead of requiring paper documentation will greatly reduce the application burden for consumers and states.

§435.956 (f) Age and date of birth.

Families USA supports that the Medicaid agency may accept an applicant's attestation of age and date of birth to determine eligibility. Allowing for self-attestation instead of requiring paper documentation will greatly reduce the burden of applying for coverage for applicants and states. However, we urge CMS to require that Medicaid agencies "must" accept self-attestation of age and date of birth, unless there is a clear reason to not use self-attestation in a particular circumstance. This will further streamline and simplify the application process for consumers and states.

**Recommendation: The final rule should require that Medicaid agencies must accept an applicant's attestation of age and date of birth to determine eligibility unless there is a clear reason to not accept self-attestation in a particular circumstance.**

*Subpart M – Coordination of Eligibility and Enrollment Between Medicaid, CHIP, Exchanges and Other Insurance Affordability Programs*

§435.1200 Medicaid agency responsibilities.

§435.1200 (c) General requirements.

A "no wrong door" approach to enrollment is a key feature of the Affordable Care Act. This means that applicants should be able to enroll in the form of coverage for which they are eligible, regardless of the agency to which they initially submit an application (Medicaid, CHIP, the Exchange, etc.) or the application method they choose (electronic, telephonic, paper, etc.). Ensuring that state agencies are prepared to handle this high level of "behind the scenes" coordination is essential to accomplishing a streamlined, seamless enrollment process.

We support the requirement that Medicaid and CHIP agencies work truly in tandem with Exchanges so that they do not duplicate any eligibility and verification findings that have already been conducted by Exchanges. We support the requirements that Medicaid agencies enter into agreements with Exchanges and other agencies administering insurance affordability programs.

§435.1200(d) Internet Web site.

We support the requirements that Medicaid agencies maintain a web site that provides information on programs and opportunities to apply and renew that are accessible to people with disabilities and people with limited English proficiency (LEP). While we understand that the agency's intention is to address accessibility in other regulations, we wish to emphasize the importance of making translated materials available on State websites so that LEP individuals can fully participate in these programs and the requirements of Title VI of the Civil Rights Act can be met. Similarly, access for persons with disabilities is critical. We urge that the regulations governing accessibility be specific and thorough, consistent with our recommendations in §435.905(b) and §435.907(b). We also ask the agency to work with the States to develop model forms, uniform vocabulary and other materials so that the States can avoid expensive duplicative efforts and so that a uniformly high quality of translation can be achieved.

Additionally, applicants should be able to fill out and submit applications for all insurance affordability programs from a single site. A webpage that does not allow for online application submission should not satisfy the text of the regulation.

**Recommendations: Clarify that the state Medicaid agency website must allow individuals to complete and submit initial applications and renewals online; that websites that are merely health insurance information clearinghouses do not meet the requirements of this section.**

§435.1200(e) Provision of Medicaid for individuals found eligible for Medicaid by the Exchange and §435.1200(f) Transfer of applications from other insurance affordability programs to the State Medicaid agency.

For individuals determined Medicaid eligible by an Exchange, we support the requirement that Medicaid agencies furnish Medicaid to those individuals “promptly and without undue delay.” Additionally, we support the requirement that an individual's account be promptly transferred to the Exchange or other applicable agency administering an insurance affordability program in the event that an individual is ineligible for MAGI-related Medicaid but is awaiting a determination for a non-MAGI related group. This helps to ensure continuous coverage and smooth transitions between programs. However, we recommend that specific timeliness standards be established and included in the regulations in both of these subsections, consistent with our recommendation in §435.911(c).

**Recommendation: Include specific standards for timeliness, consistent with our timeliness recommendation in §435.911(c). Different standards may be appropriate for different activities. HHS should specify a maximum time period for Medicaid agencies to act on information during the initial application and beneficiary redetermination. There is also a need for timeliness standards for action by the Medicaid agency on an approved application transferred from the Exchange when coverage depends on enrollment in a plan.**

§435.1200(g) Evaluation of eligibility for the Exchanges and other insurance affordability programs.

We applaud CMS for allowing individuals who are eligible for other insurance affordability programs to immediately enroll into these programs while a Medicaid determination regarding eligibility on the basis of being blind or disabled is pending.

However, there will be challenges in ensuring effective coordination among different insurance affordability programs. Clear standards regarding dispute resolution, consumer assistance availability, and notice requirements should be incorporated into the regulations.

**Recommendation: The regulations should incorporate clear standards regarding dispute resolution, consumer assistance availability, and notices. Regulations and future guidance should ensure that consumers have adequate opportunities to have complaints addressed in addition to a formal appeals process. There should be clearly defined points when notices to consumers should be generated, and it should be specified that these must be in clear, easy-to-understand language. There will undoubtedly be cases where disputes arise as to which program should cover an individual or family. There should be clear standards for dispute resolution, without involving any delay in an individual or family receiving coverage. Medicaid coverage should be considered interim coverage in cases where disputes cannot be resolved within the time frame specified for processing an application.**

## **PART 457 – ALLOTMENTS AND GRANTS TO STATES**

### *Subpart C – State Plan Requirements: Eligibility, Screening, Applications, and Enrollment*

#### **§457.315 Application of modified adjusted gross income and household definition; and request to revise §457.560.**

The proposed rule adopts the new Medicaid financial methodologies outlined in §455.603 for CHIP. While we support the alignment of financial methodologies between Medicaid and CHIP, in our comments to §455.603, we raise significant concerns about the complexity of the proposed rule. Those comments also pertain to CHIP.

We note that HHS makes an exception to the application of MAGI for individuals for whom the state relies on a finding of income made by an Express Lane agency. We support this exception, and believe that it is important to maintain this simplification that has already been adopted in some states.

The calculation of family income in CHIP has bearing on cost-sharing as well, set forth in current 42 CFR §457.560, and this section should be updated to better coordinate with other provisions of the ACA. Under §457.560, a family's maximum cost-sharing in CHIP, including premiums, enrollment fees, copayments, coinsurance, and deductibles, cannot exceed 5 percent of family income – which, under this rule, would be calculated based on MAGI. However, unless this is

modified, if the parents bought coverage in the Exchange and a child was enrolled in CHIP, families could end up with unaffordable premiums. This is because, as drafted, the calculation of affordable premiums for the parents does not take into account what they are paying for their child's coverage, and the calculation of CHIP premiums does not take into account what the family pays for the parents' coverage. If this is not corrected, it will result in an inequitable situation: a family with a CHIP-eligible child might end up paying more for their family's coverage than a family with income just over the CHIP income eligibility threshold. Section 1401 of the Affordable Care Act requires that premiums for family silver plans in the Exchange cost no more than 3 percent of household income for a family at 133 percent of the federal poverty level, sliding to 6.3 percent for a family at 200 percent of the federal poverty level; and Section 1402 sets out-of-pocket maximums on cost sharing. §457.560 should be amended to take this into account. A sentence should be added to §457.560 requiring that CHIP premiums be reduced if the total premiums for a family with some members on CHIP and others in the Exchange would otherwise exceed the affordability amounts set forth in sections 1401 and 1402 of the Affordable Care Act.

**Recommendations: Adopt §457.315 but amend §457.560, which is not addressed in the proposed rule but is now calculated based on family income. In §457.560, require that CHIP premiums be reduced if the total premiums for a family with some members on CHIP and others in the Exchange would otherwise exceed the affordability amounts set forth in sections 1401 and 1402 of the Affordable Care Act.**

#### **§457.330 Application.**

The rule states that the state shall use the single, streamlined application required by proposed rule §435.907(b) and should also comply with most provisions in §435.907 except for those related to non-MAGI applicants. We commend HHS for applying the relevant requirements equally to CHIP and Medicaid. Comments that we have made for §435.907 that are applicable to CHIP are as follows:

#### **§435.907(a) – As applied to CHIP.**

§435.907(a) explains that states must require an application for insurance affordability programs. Families USA is concerned that the requirement could be interpreted to negate Express Lane Eligibility (ELE), or the automatic enrollment option, allowed by section 203(a)(1)(D) of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). This option allows states to automatically enroll children in Medicaid and CHIP without an application. To complete an eligibility determination using this option states must have sufficient information about children from Express Lane agencies or other data sources. ELE requires states to provide families with information about services provided through Medicaid or CHIP, cost-sharing responsibilities, renewal requirements, and other program requirements. Families must affirmatively consent to the enrollment of children but they are not required to complete an application. Although the authority for the ELE demonstration expires September 30, 2013, Families USA believes that the final rule should be written with the assumption that the authority to continue using ELE will be authorized. We do not believe it is the intent of the ACA to

prohibit ELE (since it is explicitly mentioned, for example, as an exception to applying the MAGI methodology), and so Families USA strongly recommends that the final rule clarify that ELE is still allowable.

Families USA fully supports that this section of the proposed rule allows for “the applicant,” “an authorized representative,” or “someone acting responsibly for the applicant” to file the streamlined application. It is important to allow for representatives to act on behalf of the applicant in situations where the applicant cannot apply on his or her own. As further guidance is developed, HHS may want to consider what information should be required from individuals “acting responsibly for the applicant,” such as contact information and declaration of relationship to the applicant, to prevent fraud and mistakes.

**Recommendation: Families USA strongly recommends that the final rule clarify that Express Lane Eligibility will be allowable. Families USA encourages further discussion on what information should be required from individuals “acting responsibly for the applicant,” such as contact information and declaration of relationship to the applicant, in order to prevent fraud and mistakes.**

§435.907(b) – As applied to CHIP.

Families USA strongly supports that §435.907 of the proposed rule codifies Section 1413(b)(1)(A)(i) of the Affordable Care Act which requires the use of a single, streamlined application that can be used for all insurance affordability programs. The use of a single, streamlined application is essential to ensuring that there is “no wrong door” for consumers. We recommend that this section explicitly state that the application must only require applicants to answer questions relevant to their eligibility determination. States should be required to clearly mark optional questions and allow applicants to proceed without completing such optional questions.

As required by Section 1413(b)(1)(B) of the Affordable Care Act, the rule allows states to choose to use the application developed by HHS or to create an alternative application, subject to the approval of the Secretary. We strongly support that the proposed rule requires that alternative applications cannot be more burdensome than the application developed by HHS.

Families USA believes that it is important that all forms related to enrollment should, to the greatest extent possible, be prepopulated using information already gathered in the application and through electronic data matches. This will minimize the amount of duplicative information an applicant needs to provide. In addition, in order to ensure the security and privacy of an applicant’s information, only information essential to the enrollment process should be made available to the health insurance plan. For example, specific information about an individual’s income should not be provided to the plan.

We ask that CMS clarify that nothing in the rule should be interpreted as preventing a state from using a multi-benefit application (for example, for health coverage, SNAP, and TANF) in addition to the single streamlined application for health coverage. Not all health coverage

applicants will wish to apply for other programs, but those who do should still have the ability to apply using a multi-benefit application.

The preamble of this proposed rule indicates that accessibility and readability will be addressed in further guidance. However, we recommend that the final rule reiterate that people who are disabled and/or Limited English Proficient (LEP) should have equal access to applications, regardless of whether the application is provided by HHS or is an alternative application approved by the Secretary. Specifically, the final rule should clarify that the application form(s) in all modalities must be written in plain language at an appropriate reading level. The written application, both paper and electronic, should be translated in all languages where the lesser of five percent of the population or 500 LEP individuals in a service area speak a language. If there are fewer than 50 people in a language group that reaches the five percent trigger, the application does not have to be translated but instead should have a tag line providing notice in the primary language of the LEP language group of the individual's right to receive competent oral interpretation of those written materials free of charge. The standard for in-person and telephone applications should be that oral language assistance be provided in an adequate and timely fashion to everyone requesting assistance; this could include using a language line or interpreter.

**Recommendation: The final rule should clarify that the application must only require applicants to answer questions necessary to determine eligibility. All optional questions should be marked as optional. We strongly recommend that all forms related to enrollment should, to the greatest extent possible, be prepopulated using information gathered in the application process. In addition, in order to protect applicant privacy, only information essential to the enrollment process should be available to the health insurance plan. CMS should clarify that nothing in this rule prevents a state from using a multi-benefit application (to apply for other human services programs) in addition to the single streamlined application for health coverage. The final rule should reiterate that the application form(s) for insurance affordability programs must be accessible to persons with disabilities and/or LEP. Specifically, the final rule should clarify that the application form(s) in all modalities must be written in plain language at an appropriate reading level. The written application, both paper and electronic, should be translated in all languages where the lesser of five percent of the population or 500 LEP individuals in a service area speak a language. If there are fewer than 50 people in a language group that reaches the five percent trigger, the application does not have to be translated but instead should have a tag line providing notice in the primary language of the LEP language group of the individual's right to receive competent oral interpretation of those written materials free of charge. The standard for in-person and telephone applications should be that oral language assistance be provided in an adequate and timely fashion to everyone requesting assistance; this could include using a language line or interpreter.**

§435.907(d) – As applied to CHIP.

Families USA strongly supports that the single, streamlined application can be submitted through several pathways, including online, by phone, by mail, in person, and by fax. Applicants will have different needs and will require different levels of assistance, making all of these avenues of

applying for coverage necessary. Having several pathways to apply for coverage will help to maximize successful enrollment. In particular, we strongly support that §435.907(d)(4) codifies §1413(b)(1)(A)(ii) of the Affordable Care Act in that it requires that consumers be able to file an application in person. Families USA feels that it is crucial to allow applicants to submit an application in person, as consumers will have varying levels of access to the internet and comfort in applying for coverage online or over the phone.

§435.907(e) – As applied to CHIP.

We fully support that §435.907(e) codifies tri-agency guidance<sup>8</sup> and prohibits states from requiring non-applicants to provide citizenship, nationality, immigration information or social security numbers. However, the final rule should clarify that states' online applications must allow non-applicants to proceed with the application without providing SSNs. In some existing Medicaid and CHIP applications, non-applicants are notified that providing SSNs are voluntary but when they try to proceed with the application they are not able to move on without providing a SSN. In some cases, applicants can bypass the screen requesting the SSN but only after getting multiple pop-up messages strongly urging the non-applicant to provide the information. We recommend that these practices should be prohibited and that non-applicants are reminded that providing an SSN is optional.

**Recommendation: The final rule should clarify that states' online applications for insurance affordability programs must allow non-applicants to proceed with the application without providing their social security number.**

§457.335 Availability of program information and Internet Web site.

The rule states that the provisions in §435.905 and §435.1200(d) apply to states that administer CHIP separate from Medicaid. We commend HHS for applying these requirements equally to CHIP and Medicaid. Comments we have made for §435.905 and §435.1200(d) that are applicable to CHIP are as follows:

§435.905(a) – As applied to CHIP.

In 2014 the need for information about CHIP and other health coverage programs will be even greater than it is now due to the requirement that all individuals obtain coverage. We support many aspects of the proposed rule on availability of program information and offer recommendations to make it stronger.

Families USA supports the requirement that CHIP agencies make available program information related to eligibility requirements, services, and rights and responsibilities of applicants and beneficiaries to individuals who request such information. We commend HHS in making program information available in various formats (electronically, paper, and orally as appropriate). We recommend that HHS clarify that the information must be available through the state and/or agency website and that it must be linked to the Exchange website as required by Section 2201 if the ACA which amends the Social Security Act by adding section 1943(b)(4).

In addition, the proposed rule is ambiguous in referring to the availability of program information that Medicaid and CHIP programs must make available to consumers and how that coordinates with the Exchange. The rule should clarify that the Exchange website must also provide information about Medicaid and CHIP and links to state Medicaid and CHIP websites. Moreover, states should provide information about all insurance affordability programs rather than just limiting information to CHIP.

Families USA also recommend that the HHS expand the list of program information listed in (a) to provide consumers with more information. See below for full list.

**Recommendation: The final rule should clarify that program information must be available through the state and/or agency website and must be linked to the Exchange website. In addition, the Exchange website must also provide information about and include links to state Medicaid and CHIP programs.**

**The final rule should expand the list of program information listed in (a) to provide consumers with the following information:**

- **the application and renewal processes;**
- **the availability of assistance with applying for and renewing coverage;**
- **details on covered benefits, including details on benchmark benefit packages or benchmark equivalent benefit packages for newly eligible adults;**
- **agency responsibilities; and**
- **consumer appeals.**

§435.905(b) – As applied to CHIP.

We also support the requirement that specifies that the program information must be accessible to persons who are disabled and those who have limited English proficiency (LEP). The final regulation should retain this requirement and should specify that program information in all modalities (i.e. paper, online, oral, etc.) should be available in plain language at an appropriate reading level, should be available in multiple languages meeting the meaningful access standards for persons with limited English proficiency, and should conform to rules ensuring equal access to persons with disabilities. Our specific recommendation for ensuring accessibility and readability for people who are LEP is consistent with our recommendation in §457.330.

**Recommendation: The final rule should specify that program information in all modalities (i.e. paper, online, oral, etc.) should be available in plain language at an appropriate reading level, should be available in multiple languages meeting the meaningful access standards for persons with limited English proficiency, and should conform to rules ensuring equal access to persons with disabilities. Please see our specific recommendation for ensuring accessibility and readability for people with limited English proficiency in our recommendation for §457.330.**

§435.1200(d) – As Applied to CHIP.

Families USA supports that the proposed rule requires states to maintain a website that provides information on the various insurance affordability programs along with an opportunity to apply for and renew coverage and the specific requirement that the website be accessible to people with disabilities and people with limited English proficiency.

**§457.340 Application for and enrollment in CHIP.**

Families USA commends CMS for requiring that states must provide families with assistance in applying for and enrolling in CHIP coverage. We strongly support that non-applicants cannot be required to provide an SSN, consistent with §435.907(e).

The following issues are not specifically discussed in §457.340 of the proposed rule, but they are inherently related to enrollment in CHIP and other insurance affordability programs.

Families USA is highly concerned that CHIP waiting periods will serve as a barrier to enrolling eligible children in CHIP. To comply with federal requirements that states protect against erosion of private coverage, 41 states have implemented waiting periods in CHIP. Families with children eligible for CHIP will not qualify for premium tax credits for their children but will face potential individual responsibility penalties, created by Section 1501 of the Affordable Care Act, if they allow their children to be uninsured. Because these children would have no other access to Minimum Essential Coverage during these waiting periods, the final rule must clarify that CHIP-eligible children in the waiting period qualify for premium tax credits. However, if CHIP-eligible children in the waiting period receive premium tax credits allowing them to purchase coverage through the Exchange, these children would not fulfill the requirement of the CHIP waiting period and never be able to enroll in CHIP coverage. Given this situation, waiting periods create an even larger barrier to coverage for these children. We believe that if a family is eligible for premium tax credits and has children that are eligible for CHIP, their children should be exempt from a CHIP waiting period and permitted to enroll in CHIP.

Similarly, many states have placed caps or freezes on their CHIP programs. Thus, children who would normally be income-eligible for CHIP will be denied due to program caps and freezes. It is essential that children who are denied CHIP coverage are deemed ineligible for CHIP, making them eligible for other insurance affordability programs, including premium tax credits and cost-sharing reductions.

**Recommendation: If CHIP waiting periods remain in effect, the final rule must clarify that CHIP-eligible children in the waiting period with no other access to Minimum Essential Coverage must be eligible for premium tax credits to purchase coverage through the Exchange. However, Families USA strongly recommends that federal guidance should provide an explicit exception to waiting periods for families who qualify for premium tax credits and have CHIP-eligible children. In addition, for states that have placed an enrollment cap or freeze on their CHIP program, it is essential that children who are denied CHIP coverage due to a cap or freeze are officially deemed ineligible for CHIP,**

**allowing them to enroll in other insurance affordability programs, including premium tax credits and cost-sharing reductions.**

**§457.380 Eligibility Verification.**

§457.380(a) General requirements.

Families USA strongly supports that CHIP agencies can continue to accept attestation of all information needed to determine eligibility, except citizenship and immigration status.

§457.380(c) State Residents.

We support that if the CHIP agency does not accept self-attestation of residency, that it must follow rules consistent with those proposed for Medicaid at §435.956(c), amended by any recommendations we have proposed for that section. We prefer that states accept self-attestation to support consistency of verification among all insurance affordability programs.

§457.380(d) Income.

We support that if the CHIP agency does not accept self-attestation of income, that it must follow rules consistent with those proposed for Medicaid at §435.945(b), §435.948 and §435.952, amended by any recommendations we have proposed for those sections.

§457.380(e) Verification for other factors of eligibility.

Families USA strongly supports that the CHIP agency must accept self-attestation of pregnancy and household composition, unless the state has information that is not reasonably compatible. We support that if the CHIP agency does not accept self-attestation for other factors of eligibility, that it must follow rules consistent with those proposed for Medicaid at §435.945(b), §435.952 and §435.956(c), amended by any recommendations we have proposed for these sections. This will ensure consistency of verification among all insurance affordability programs.

§457.380(f) Requesting information.

We fully support the requirement in §457.380(f) that states must primarily rely on electronic data sources to verify applicant information, and that states can only request additional information from an individual unless information from electronic databases is not available or not reasonably compatible. This requirement will minimize the need for applicants to provide paper documentation and thus make the application process less burdensome. We also strongly support allowing states to accept a statement which reasonably explains any discrepancy in data. When applicants do need to provide additional information, we support that applicants be given a “reasonable period” to furnish such information, which we define in §435.952(c) to mean 90 days from which the applicant receives notice of the need to provide the Medicaid agency with additional information. If working in good faith to provide verification, applicants should not have to reapply if they provide information after the 90-day period. We propose that the CHIP

agency follow this definition of “reasonable period” as well in order to promote consistency in verification across programs.

**Recommendation: We propose that “reasonable period,” as referred to in §457.380(f)(2), be defined as 90 days from which the applicant receives notice of the need to provide the CHIP agency with additional information. If working in good faith to provide verification, applicants should not have to reapply if they provide information after the 90-day period. In order to promote consistency across programs, this is the same definition that Families USA proposed in §435.952(c).**

§457.380(g) Electronic service.

We support that CHIP agencies must use the federal electronic service, and we believe that all recommendations proposed for §435.949 should apply to CHIP as well.

§457.380(i) Flexibility in information collection and verification.

We support the requirement that the CHIP agency may request and use alternative sources of information only if those alternative sources reduce administrative costs and burdens on individuals and states, maximize accuracy, and minimize delay. However, the proposed rule is unclear as to whether agencies would be approved to use such alternatives on a blanket basis (for all applicants at any point in the application process), only when other required data sources do not yield useable results, or on an individual basis. We ask CMS to provide more detail as to how alternative sources would be used.

**Recommendation: The final rule should provide more detail as to how alternative sources of information would be used. Consistent with our comments in §435.948(d), we believe that the proposed rule is unclear as to whether agencies would be approved to use alternative sources of information on a blanket basis for all applicants, only when other data sources do not yield useable results, or on an individual basis. We recommend that states must get approval from HHS to use alternative data sources.**

---

<sup>1</sup> *Patient Protection and Affordable Care Act*, Public Law 111-148 (March 23, 2010), as modified by the *Health Care and Education Reconciliation Act of 2010*, Public Law 111-152 (March 30, 2010), Title 2, Subtitle A, Section 2002(a).

<sup>2</sup> 42 U.S.C. 1396a(b)(2).

<sup>3</sup> U.S. Department of Health and Human Services, State Medicaid Manual, §3211.10.

<sup>4</sup> Benjamin D. Sommers and Sara Rosenbaum. “Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges” *Health Affairs*, February 2011 vol. 30 no. 2 228-236.

<sup>5</sup> Department of Agriculture, *Policy Guidance Regarding Inquiries into Citizenship, Immigration Status and Social Security Numbers in State Applications for Medicaid, State Children’s Health Insurance Program (CHIP), Temporary Assistance for Needy Families (TANF), and Food Stamp Benefits* (Washington: Department of Health and Human Services, 2000).

<sup>6</sup> “Consumer Voices: What Motivates Families to Enroll in Coverage?” (Washington: Robert Wood Johnson Foundation, GMMB, and Lake Research Partners, September 14, 2010), available online at [http://www.insurekidsnow.gov/professionals/outreach/webinars/challenging\\_times\\_motivate\\_families\\_slides.pdf](http://www.insurekidsnow.gov/professionals/outreach/webinars/challenging_times_motivate_families_slides.pdf).

---

<sup>7</sup> Benjamin D. Sommers and Sara Rosenbaum, “Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth between Medicaid and Insurance Exchanges,” *Health Affairs* 30, no. 2 (February 2011): 228-236.

<sup>8</sup> Department of Agriculture, *Policy Guidance Regarding Inquiries into Citizenship, Immigration Status and Social Security Numbers in State Applications for Medicaid, State Children’s Health Insurance Program (SCHIP), Temporary Assistance for Needy Families (TANF), and Food Stamp Benefits* (Washington: Department of Health and Human Services, 2000).