NAMD
National Association of Medicaid Directors

October 31, 2011

Dr. Donald M. Berwick, M.D.
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Steven T. Miller
Deputy Commissioner for Services and Enforcement
Internal Revenue Service
1111 Constitution Avenue, NW.
Washington, DC 20224

Subject: **NAMD comments filed on:**
Eligibility Changes Under the Affordable Care Act of 2010 (CMS-2349-P);
Exchange Functions in the Individual Market: Eligibility Determinations;
Exchange Standards for Employers (CMS-9974-P); and
Internal Revenue Service: Health Insurance Premium Tax Credit (REG-131491-10)

Dear Dr. Berwick and Mr. Miller:

On behalf of the nation's Medicaid directors, the National Association of Medicaid Directors (NAMD) is submitting comments on the three proposed regulations issued by your agencies on August 17, 2011, related to new Medicaid eligibility rules, Health Insurance Exchange functions, and health insurance premium tax credits. We appreciate the opportunity to provide observations and recommendations to help enhance and refine the foundation that the federal agencies have sought to provide in these proposed regulations.

Medicaid directors believe these three regulations are inherently linked. For this reason NAMD is submitting a single letter in response to the three proposed rules. This letter consolidates our comments and is intended to further elucidate the key areas where coordination between the agencies is needed to advance policy solutions for states, and Medicaid programs in particular.

Medicaid directors also appreciate that the Centers for Medicare and Medicaid Services (CMS) proposes to provide states with several options in major new areas of policy development, including the determination of methodology for estimating the size of the expansion population, further consolidation of Medicaid eligibility categories, and certain aspects of the eligibility determination process. The forthcoming changes to Medicaid eligibility, the launch of Health Insurance Exchanges, and the availability of the new health insurance premium tax credit program have the potential to cause dramatic shifts in the health care marketplace and services, particularly in the early years of these policy changes. In turn, we urge the federal agencies to use your

discretion to provide states with the tools needed to quickly adapt to evolving programmatic and marketplace dynamics.

While the proposed regulations cover numerous topics of importance to Medicaid directors, NAMD's comments focus on several key themes: maximizing coordination between federal agencies as well as with states; simplification of business practices that enable states to remain nimble in adapting to policy and operational developments; providing certainty for data sources and vehicles for information exchange; alignment of existing federal rules with the proposed rules to limit state exposure; and early and frequent collaboration between federal agencies and state to meet operational challenges posed by aggressive timelines and finite resources.

Included below are NAMD's overarching comments which we believe will help enhance and refine the foundation that the federal agencies have sought to provide in these proposed regulations. Following these overarching points, NAMD is providing more specific comments on several fundamental aspects of the three proposed regulations.

In addition, the enclosed table includes specific examples of case scenarios identified by states, many of which have previously been shared with CMS. NAMD also requests that CMS compile all unique case scenarios received from any source and in a single document respond to each. We respectfully request cross agency collaboration as well as further consultation with states to develop clear, concise policy solutions to these real world scenarios.

Overarching themes for refining proposed regulations

- **Timely, comprehensive information is essential for meeting deadlines**. Medicaid directors believe that resource constraints, capacity limitations, and the lack of timely, comprehensive information could present significant challenges for many states as they work to implement the Medicaid expansion within the statutory deadlines. Medicaid agencies have twenty-four months to plan for and implement the Medicaid expansion while ensuring appropriate coordination and functionality with new Health Insurance Exchanges. However, as proposed, the regulations lack key pieces of information essential to the business and operational components for building new systems and developing policy and protocols. Medicaid directors, working via their state specific teams and through NAMD, would like to work with the federal agencies to ensure states have timely information necessary to operationalize the proposed rules.

- **Program integrity rules need clarification and alignment**. States believe the vision articulated in the proposed rules could dramatically simplify the eligibility determination and verification process for applicants and advance real-time eligibility decisions for many more applicants. However, Medicaid directors also believe these policy goals require more intensive consideration with respect to federal program integrity regulations. If Medicaid programs rely

less on paper documentation and increase reliance on attestation and electronic verification, Medicaid directors request greater certainty that this change will not carry financial exposure for states, provided that they otherwise have the appropriate policies and procedures in place. Further, NAMD recommends that the federal agencies evaluate, consolidate and clarify program integrity regulations, guidance, and programs as soon as possible to ensure these align with the proposed rules. In instances where statutory requirements impede the agencies from reducing duplication and administrative burden, we urge you to clearly identify the options for policy solutions so they may be advanced for consideration by the Congress.

- **Federal agency coordination is vital for consistent, timely guidance to states.** Medicaid directors believe the dynamics between the Exchanges and Medicaid make a multi-pronged approach to coordination between the two different programs pivotal. This approach must include ongoing intra- and inter-agency coordination at the federal level as well as coordination with states. As you refine these proposed rules, stronger federal agency communication could help provide states clear, coordinated, and comprehensive information in the most expeditious manner possible.

- **Consult with states to develop reasonable solutions to pressing policy and operational questions.** Federal agencies also must make consultation with Medicaid directors a regular step during refinement of these proposed rules and development of any forthcoming guidance. Further, we recommend that whenever possible federal agencies seek to build on and defer to the vast state operational experience in planning, building, and implementing large public programs. To this end, a multifaceted coordination strategy would assist federal and state agencies in concisely identifying reasonable policy solutions and the areas where it is practical to defer to state- specific solutions. We also believe this approach could facilitate the policies and programs that are most cost-effective for taxpayers. The National Association of Medicaid Directors is prepared to facilitate this communication on behalf of all Medicaid directors.

- **Leverage state expertise to simplify, streamline and contain costs.** Medicaid directors support retaining provisions of the proposed regulations that are intended to simplify and consolidate certain policies and interactions between programs, for example the proposed consolidation of existing eligibility rules and the ability for states to further simplify. We believe that CMS and IRS should use their discretion to provide states the greatest flexibility possible with respect to choosing which components and functions of "real-time" eligibility states will pursue, including extending the eligibility determination function for Medicaid and other public assistance programs (e.g. TANF, SNAP) and application/enrollment or related forms.

Additional NAMD comments on proposed regulations for Medicaid eligibility, Exchange functions, and premium tax credits

The National Association of Medicaid Directors (NAMD) respectfully submits the following detailed comments for consideration.

Timelines

- NAMD is concerned that for many states the combination of diminished state capacity and limitations on vendor expertise, among other outstanding policy issues and requirements, present a significant challenge to meeting the statutory deadlines. States are in the process of or will soon need to write business requirements for new Medicaid and related systems, but they first need information on how various aspects of the two programs will interact and synch together. With regard to vendor capacity, NAMD believes there are serious limitations to both the expertise and capacity of vendors to meet simultaneous requests from the federal government and states to design, build and implement programs that will meet specifications, many of which are dependent on information and policy decisions that have not been provided. The short timeline has caused some states to begin drafting requirements which may not coincide with the final federal requirements, resulting in a rework effort that could be costly in terms of human resources and state and federal expenditures.

- We encourage federal agencies to begin working with states to develop transitional, phase-in, and contingency plans, to be deployed in the event that some states are unable to establish a seamless, coordinated system and networks to conduct real-time eligibility determinations and interact with the Exchange (federal or state operated) by the statutory deadlines. There are two main reasons for contingency planning. First, as noted above, the content and scope of information currently available to states to build new or expand Medicaid eligibility systems and build interactions with the Exchange is inconsistent with the reality of what is possible based on workforce capacity, contracting and procurement timelines, scope of the system requirements and other state-specific factors. In addition, the Medicaid experience transitioning Medicare and Medicaid dually eligible individuals to the Medicare Part D prescription drug program offers sound evidence of the need for transitional and contingency planning. These are prudent steps in the best interest of current and future Medicaid enrollees and applicants.

Business rules for program integrity

- Medicaid directors appreciate CMS' ongoing support for state program integrity efforts. However, the proposed regulations fail to strike the appropriate balance with program integrity standards and in some instances seem to conflict with existing program integrity policies and

procedures. States recommend clarifying program integrity rules and expectations as soon as possible.

- In particular, states face significant exposure under current program integrity standards if they are to shift from less documentation and relying more on self-attestations for eligibility determinations, as envisioned in the proposed regulations. Many states anticipate that the available data will be insufficient for conducting the type of eligibility determination that Medicaid requires and/or the data could contain extensive errors. In such situations, states have the option to utilize self-attestation. However, the disconnect between the proposed rules and Medicaid's federal program integrity standards pose significant exposure to states for aggressively adopting self-attestation. In addition, states request clarification about the appropriate look-back period for self-attestation.

- NAMD also wishes to stress that in a number of states self-attestation is not an acceptable strategy – in the current program and in the eligibility paradigm beginning in 2014. We strongly encourage CMS to consider how states that choose not to permit self-attestation can operate a robust and highly automated eligibility system.

- State experience demonstrates that it is more efficient to incorporate program integrity rules and develop procedures at the front end. Further, we strongly encourage federal agencies to consult with states at the front end to streamline and align program integrity rules with the proposed Medicaid and Exchange eligibility paradigms. For example, states and the federal government must agree on the parameters for viable alternatives for sources of information/data to determine eligibility. While states do not support detailed federal requirements on appropriate databases, advance agreement on these data sources is necessary to minimize state exposure and disconnects later in the eligibility determination and redetermination processes.

- In addition, the rules for the payment error rate measurement (PERM) program are incompatible with the new requirements and, at least in part, duplicative of the Medicaid eligibility quality control (MEQC) requirements. NAMD recommends that if CMS continues to evaluate states based on perm criteria, the agency must also readjust perm rules to conform to the provisions of the proposed regulation. CMS should consider how states can balance the need for program integrity with the changes in verification requirements to ensure states are not penalized when a program integrity review is completed. NAMD requests that CMS use its authority to provide states with a "safe harbor" from quality control and perm reviews during the transition to the new eligibility rules and systems.

Verification and real-time eligibility determinations

- States request that CMS define parameters for real-time while providing states flexibility to establish policies and procedures for real-time eligibility determinations. Medicaid directors

also respectfully request that the federal agencies work with states to set reasonable expectations for real-time eligibility determinations with regard to federal guidance as well as any educational and public relations activities. We believe policymakers, stakeholders, and particularly consumers need clear, realistic explanations of real-time determinations and what consumers should expect. Specifically, many Medicaid directors believe that the success of "real-time" eligibility decisions will hinge on the scope of access and quality of the data from federal agencies, including the IRS. Thus, while extensive planning is underway to streamline and automate the application process, a significant number of Medicaid applicants may not receive a "real-time" eligibility decision. We believe it is prudent for federal and state partners to collaborate on ways to appropriately convey this understanding to the public.

- States support the flexibility afforded by the regulations to determine what is "useful" and "reasonably compatible." Medicaid directors recommend establishing a process by which states would submit a plan to notify the federal government of the data sources it will use in its eligibility determination and renewal procedures. This process would, in part, allow for addressing program integrity protocol during the development of systems and processes.

- Based on the proposed rules, it remains unclear whether states will have the information necessary for real-time eligibility determination as envisioned in the statutory language and preamble to the proposed regulation for Medicaid eligibility. Many states anticipate that income verification and eligibility determinations for a large percentage of the Medicaid population will be based on sources or procedures other than the federal hub.

- States request clarification and additional information concerning the data that will be provided by the Internal Revenue Service (IRS) or federal data that will otherwise be available to states to conduct eligibility determinations. The lack of clarity regarding IRS data fields and processes impedes states' ability to finalize business requirements and move forward in IT and related procurement processes. The lack of specifics in several key areas presents additional challenges for Medicaid programs as they seek to create new applications or amend existing applications to align with federal data and requirements.

- Medicaid directors wish to stress the importance of the quality and level of detail of the IRS data that is envisioned in making real-time eligibility determination. For example, to date, it remains unclear whether the IRS data will provide information necessary to determine the family size and income delineation needed to provide an eligibility determination.

- Medicaid directors also request further guidance regarding IRS security restrictions, and specifically whether these may limit states' access to and utilization of the data in a relevant way. State Medicaid eligibility systems should have access to IRS data for workers to view the information, and clearance to allow the information to be added to the state eligibility system without a state or Exchange worker having to re-key the information into the system. States would utilize this information to award or deny a case, without contacting the

applicant or requesting additional verification. In addition, states require authority to use IRS data obtained for a Medicaid eligibility determination to screen applicants for other public assistance programs e.g., SNAP or TANF.

- In addition to access to data, there is significant uncertainty concerning the quality of the data. At this time, it appears that states will obtain IRS data fields that could be inconsistent or based on individual or family factors that are traditionally dynamic, such as income and family status. While automation and self-attestations are options in some states and situations, state data sources and policies may result in eligibility decisions that are not "real-time." Federal policies should be adjusted accordingly and defer to states to determine the data sources and procedures for handling such cases.

- States request clarification concerning how projected annual income relates to income averaging rules in Medicaid. The proposed rule states, "[For tax credit eligibility calculations] Household income is determined on an annual basis and is prorated for each month to determine the monthly premium assistance amount." NAMD's members are concerned Medicaid is directed to implement two different standards, that is, Medicaid eligibility is prospective and based on point-in-time income while the premium tax credit is based on the previous calendar year – creating a disconnect that presents significant operational challenges. States recommend federal agencies provide a crosswalk of the income methodologies and an explanation of the system implications of the different tax credit and Medicaid approaches on this and related income issues. In addition, states seek clarification that it is acceptable to use prospective annual income to align with the exchange rules. Medicaid directors believe CMS must find interpretations of the law that will support parallel rules for both public benefits.

- Regarding point in time eligibility determinations, states request that the federal agency clarify whether such a determination must always be made. If so, resolution of policy and operational questions is needed to reconcile the use of point in time with the MAGI methodology. Medicaid directors also request clarification for how to operationalize the eligibility determination and reconciliation policies.

- States request guidance on how to account for the income deductions that will be calculated into the IRS income tax return that will not carry over to point-in-time income information from a Medicaid applicant.

- Over time, consolidation and automation of the eligibility process holds the potential to minimize resource intensive application assistance. However, without real-time eligibility determination processing, states will have to absorb a much higher administrative burden than expected for thousands of new recipients, particularly in the early years of the Medicaid expansion.

- States request clarification concerning when self-attestation is sufficient for the eligibility determination, particularly so that states can develop and apply program integrity compliant policies and procedures. States also seek confirmation in proposed regulations and guidance that states may request additional verification should conflicts arise with an individual's attestation.

State specific FMAP determination

- Medicaid directors support the proposed provisions that would provide states options so that they are not obligated to operate dual or so-called shadow eligibility systems.

- We also support proposed provisions that provide options to states for the methodology to project the new adult population, and in turn, the enhanced FMAP, including provisions that allow states to seek approval for state-specific methodologies. Given the significant uncertainty surrounding the actual enrollment and shifts in public coverage program policies, we request that CMS maintain flexibility for states to use these and other optional methodologies that may be included in the final rule. In addition, we request that the rule be modified to allow states to change methodologies more often than every three years, as currently proposed. This is particularly important in the early years of the expansion because we believe states and CMS will need to refine the available options. During this transitional period, states should not be locked into an experimental option that turns out to be inaccurate and/or inefficient to administer.

- Medicaid directors request that CMS revise the proposed rule to provide states additional time to notify CMS of the methodology a state will use to determine the federal share of expenditures. The notification date in the proposed rule is December 31, 2012. According to information provided on the October 27, 2011, webinar for states conducted by RAND and SHADAC, states will have the option to utilize technical assistance for determining MAGI conversion and FMAP methodologies through September of 2012. We believe this timeline is insufficient for states to thoroughly evaluate and make a final decision on this critical issue.

- While Medicaid directors support the provisions of the proposed regulations which provide states with options for determining the FMAP, we request clarification and assistance regarding the calculation of FMAP for the new eligibility group. This clarification is needed to ensure all adjustments are accounted for in an equitable manner.

- For purposes of defining MAGI income, the statute currently excludes certain income and items, including certain Social Security income and child support income. Medicaid directors wish to emphasize that this policy conflicts with current Medicaid eligibility rules, and, as a result, more individuals are expected to become Medicaid eligible. The result is that previous federal estimates may have potentially underestimated the number of individuals who will become eligible for Medicaid as of 2014, and, in turn, understated the cost of the Medicaid

eligibility changes addressed in the proposed CMS regulation. In order to appropriately reflect these significant changes, we request the following revisions:

- CMS should revise its impact statement to reflect inclusion of previously excluded types of income, as appropriate. Going forward, the agency should incorporate this dynamic in its estimates.

- A state will have a range of differential factors impacting its decision about the alternative FMAP methodology approaches, including the effect of several types of previously excluded income for purposes of determining Medicaid eligibility. This dynamic creates exposure to increased costs that will vary by state, but all states will have some exposure. CMS should assist states, upon request, with determining individuals newly eligible for Medicaid as of 2014 and the FMAP level that will apply to these categories of individuals. Federal contractors must account for these factors in any assistance or work conducted with states or on behalf of federal agencies.

- As of 2014, some of the individuals who are determined eligible for Medicaid, may not have qualified based on a state's pre-2014 eligibility policies, specifically because of the requirement to exclude certain types of income. Medicaid directors strongly encourage CMS to explore whether these individuals who are made eligible for coverage as a result of the move to MAGI will be considered "newly eligible" for purposes of increased FMAP beginning in 2014. These calculations have short and long-term budgetary impacts that are currently under consideration in the states.

- Medicaid directors request modification of the definition of "newly eligible" individuals to reflect the statutory language and congressional intent. The statutory language specifies that "newly eligible" individuals includes adults who meet the criteria for the expansion of Medicaid to 138 percent of the FPL and who cannot qualify for full Medicaid benefits (or benchmark or benchmark equivalent coverage) under a state's December 1, 2009, eligibility rules. It also specifies that people who meet a state's December 1, 2009 rules, but who would have been excluded from coverage by a cap or other enrollment limit should be treated as "newly eligible." Currently, however, the proposed rule does not reflect that individuals who qualified only for partial benefits or who would have been denied Medicaid by an enrollment limit under December 1, 2009, rules should be treated as "newly eligible." We request that the final rule accurately reflect the statutory definition.

Development of business requirements

- There are several areas where states require more information in order to develop and finalize the business rules for procurement of eligibility systems. The uncertainty concerning the data

elements for which states will have access presents one of the most significant challenges. As noted earlier, differing timelines for calculating health insurance premium tax credits and Medicaid eligibility also present unique challenges in determining business rules.

- States request more detailed guidance concerning the information they must submit to the federal hub in order to receive information. States also need detailed information on the data the federal hub will provide, including the format/specifications for this data. Specifically, in order to develop the business rules to advance procurement of eligibility systems, states must know what IRS data will be available and the format in which this will be provided. Depending on the format, states may need to dedicate additional funding and workforce resources to translate this data into a useable format and seek verification from consumers.

- This information is also critical as states prepare to move forward with other, related requirements, such as engaging stakeholders to ensure materials and processes are culturally and linguistically appropriate. If states have to speculate on certain critical details, this could result in unnecessary costs and delays. In addition, we request that federal agencies provide states projected timelines as a planning tool.

Application and enrollment forms

- Medicaid directors support maximum state flexibility to implement operational plans to comply with the provisions of the proposed regulations, including those relevant to application and enrollment forms. Maximizing the state options while minimizing the procedural and administrative requirements will help create a climate conducive to state specific needs and dynamics.

- States should be consulted in the development of the federal model application form as this is likely to serve as the basis for many state specific application forms. Federal agencies can help facilitate a streamlined process for consumers that is cost-effective for states and the federal government by supporting states that choose to adapt existing forms or design an alternative, single application form. This approach will also allow for development of an application form tailored to state-specific Medicaid long term care programs.

- States believe a proscriptive approval process surrounding alternative application forms will impede innovation and improvement to eligibility processes. In order to minimize administrative burden and uncertainty in implementation, CMS should promulgate a flexible process whereby states are granted broad and explicit discretion in tailoring a custom application according to their own unique circumstances and demographics. States envision the use of federally delineated criteria or a check list in crafting alternative application forms, in lieu of overly burdensome and time consuming formalities in obtaining initial and subsequent federal approvals. Once approved, maximum state flexibility is needed to modify

details of the alternative application to reflect operational experiences and policy changes, without first obtaining federal approval.

- States eligibility systems vary in their level of integration with other public programs, with several states having or planning to move towards integrated eligibility systems. Medicaid directors request consideration of states that use an integrated eligibility application for Medicaid and other public assistance programs. States request guidance from CMS on addressing the challenges of delinking applications for Medicaid and other public assistance programs.

Eligibility determination and renewal policies

- NAMD requests that the proposed rules be amended to allow states to retain the option to define administrative renewal policies for all populations, including procedures and timelines. Without flexible models for redeterminations, states could face significant exposure for program integrity violations as well as inappropriate costs. State-determined policies can minimize Medicaid's risk of incurring costs for administrative and services costs, such as capitation payments for individuals who may otherwise be retained yet are no longer eligible for the state's Medicaid program.

  As one example, states should retain the option to determine whether they will complete an annual re-determination for a client that has not returned a response. In addition, we request that CMS revise the proposed rule to provide states with more flexibility to decide when changes in circumstances must be reported. We encourage CMS to consider explicitly giving states the flexibility to establish thresholds for changes that are significant enough to affect eligibility.

- The proposed provisions for revising eligibility determination and renewal rules pose significant exposure for Medicaid programs. Despite increasing attention to and investments in program integrity, Medicaid programs are subject to noncompliance citations for insufficient rigor in eligibility determination and renewal processes, if the audit and eligibility rules are not aligned per our recommendations included above. At the same time, it seems the proposed regulations provide the federal government vastly more protection from vulnerability to program integrity citations than afforded to the states.

- In response, states request revision of the regulations to clarify and assure protection to states for their state-specific approaches to review of eligibility application and redeterminations. For example, states should not be subject to penalties for self-attestation of income, for audits that find an individual's self-attestation of income conflicts with his/her resources, and the use of the minimal level of review that is otherwise consistent with provisions of the proposed regulations and federal policy direction to streamline process and minimize administrative burden.

Alignment between Medicaid and Exchanges

- Generally, significant uncertainty remains regarding the specific interactions between Medicaid and the Exchanges – whether state or federally operated. As noted above, this remains a barrier to states seeking to write and finalize business requirements for new eligibility and related systems.

- Whether an Exchange is operated by the state or the federal government, Medicaid is a critical partner in the seamless, coordinated system envisioned in the proposed regulations. The federal agencies must consult with states in developing the policies, systems, and in determining related operations in order to accurately incorporate and coordinate with state-specific Medicaid policies.

- States believe the federal regulations offer conflicting or unclear direction with respect to alignment of coverage periods between Medicaid, CHIP, the Basic Health Program (where applicable) and the Exchange. Further, we believe states may inappropriately incur additional administrative and medical costs in situations where individuals are shifting or "churning" between public coverage programs and subsidized coverage in the Exchange.

- Directors recommend the federal agencies work with states to develop a seamless and coordinated process with respect to alignment of coverage periods and the redetermination processes with respect to split family coverage. The overlap between Medicaid and the Exchange in these areas requires close coordination within the state during planning and development for the new Medicaid and Exchange paradigm. Because of the implications for Medicaid programs, NAMD recommends that states retain the authority to define administrative issues, such as dates for open enrollment in the individual market and effective dates of coverage. These operational areas are particularly important to designate for state-determination in order to minimize gaps in coverage. For example, Medicaid programs have different service delivery systems and may be able to effectively ensure coverage using policy tools that are unavailable in other jurisdictions.

- If the federal government mandates an extension of Medicaid eligibility to smooth transitions or minimize coverage gaps, states believe the federal government must provide 100 percent FFP or otherwise find a mechanism to ensure that states face no financial liabilities for this "gap coverage."

- Regarding split family coverage, states are considering various options to minimize confusion and waste that can arise for state programs, consumers, and providers. They are evaluating ways to minimize churning as well as to promote the concept of "one family, one card" solutions. We encourage federal agencies to work with states on these innovative and state specific solutions.

For example, states would like the option to allow Medicaid managed care organizations (MCOs) to offer a product in the Exchange. Either because of their own business strategy or agreements with health care providers, the MCOs may wish to limit the availability of the product only to persons who have a dependent in their immediate family that is enrolled in Medicaid or CHIP or has been enrolled in either program within the last six or 12 months. Thus, the product may be available only to a subset of individuals of a particular age in a given rating area (depending on the issuer's preference). The MCOs would provide a single card for use by the entire family while a dependent was enrolled in the Medicaid/CHIP programs and for a defined period thereafter. In this way, the system would reduce discontinuities/disruptions in insurance coverage owing to different eligibility groups and periodic income changes.

- Medicaid directors have concerns with the proposed "Partnership model" which is intended to provide states options for the functions they wish to control. As such we request that the federal agencies amend this proposal to allow states to retain responsibility for eligibility determinations, while still working in partnership around Exchange development. States have extensive experience in building and conducting eligibility for a number of public programs, including Medicaid, CHIP, and other health care programs. However, we are concerned that as proposed the federal Partnership model does not envision allowing states to retain control over eligibility functions and determinations. It also injects a high element of risk into the design and development, without more detailed information about how the federal functions would operate and interface with state functions and how transaction costs would be allocated between a state and the federal government for particular functions operated by a federal exchange within a state.

Eligibility consolidation and clarification

- States support the proposed provisions to consolidate and simplify current eligibility categories. Consolidation and simplification is crucial for establishing more efficient eligibility systems and improving the consumer experience. To this end, states recommend CMS consolidate eligibility categories to the greatest extent possible beyond what is already proposed in this regulation.

- Further, Medicaid directors request that the federal agencies prioritize making the reporting and business process the least burdensome possible for states as well as consumers. States believe they should not be asked to collect or report data that does not result in any substantial difference in the determination of coverage. In addition, states request that federal agencies align the CMS 37/64 and the process for claiming and reporting with the new categories, to reflect the enhanced FMAP for those childless adults covered by expansion states and the "newly eligible" adults covered by all states.

- States request clarification from the federal agencies concerning Medicaid's five-year bar rule and the interaction with eligibility for tax credits for permanent aliens. The proposed regulations seem to indicate that a lawfully-present alien who is subject to the five-year bar in Medicaid (but who is otherwise eligible for that program) would be eligible for premium tax credits. States believe the same is true for lawful permanent aliens who are ineligible for Medicaid. In addition, Medicaid directors request additional information regarding when states can expect guidance regarding the Medicaid expansion's impact, if any, on the breadth of limited scope eligibility/emergency Medicaid post-2014.

Utilization of public employees in Medicaid and Exchange

- Currently public employees must conduct final Medicaid eligibility determinations. However, this differs from permissible operations in the proposed Exchange regulation. We request that states have the authority to determine whether public or private employees conduct the eligibility determinations for all public coverage programs, including Medicaid, CHIP, the Basic Health Program, and eligibility determinations carried out via an Exchange. Allowing states the option to use private employees could help streamline the program and allow for tighter control of policies and procedures. In addition, the use of private sector employees could result in cost savings at a time when states are seeking to identify efficiencies that do not impede access to services and eligibility.

Benchmark benefit coverage

- States are required by statute to offer benchmark or benchmark-equivalent coverage to the new "adult group" created in section 1902(a)(10)(A)(i)(VIII). However, under existing provisions states are unable to require enrollment in benchmark or benchmark-equivalent coverage to any optional populations above 133 percent of the FPL. Medicaid directors believe that this authority is needed to ensure that Medicaid does not provide a higher level of benefits to individuals with higher incomes than the benefits offered to individuals with lower income. If necessary, we request that HHS work with Congress to advance this change.

Cost allocation

- States appreciate the guidance issued in the tri-agency letter, which helps remove some unnecessary burdens with federal cost allocation processes. However, states believe the cost-allocation policies between Exchanges and Medicaid is still unnecessarily burdensome. For example, some states are planning for a new eligibility system that will determine Medicaid eligibility and premium subsidy eligibility. In such situations where the Medicaid agency has the responsibility for eligibility, the agency must still determine how much to cost allocate to the Exchange. Similarly, in developing the interface between the Exchange and Medicaid, it is unclear which entity bears payment responsibility.

On behalf of the nation's Medicaid directors, NAMD appreciates your consideration of these comments. We stand ready to work with the departments of Health and Human Services and Treasury and related federal agencies to make these necessary refinements to the proposed regulations.

Sincerely,

Andy Allison
Director, Division of Health Care Finance
State of Kansas
Department of Health and Environment
President, NAMD

Darin J. Gordon
TennCare Director
State of Tennessee
Department of Finance and Administration
Vice President, NAMD

Attachments:

Health care reform scenarios

Attachment: Health Care Reform Scenarios

The following scenarios were developed by state Medicaid programs. The intent is to indentify specific policy issues or to describe situations where states require further guidance and clarification. We respectfully request that CMS work with states through NAMD to provide timely information to help resolve these and additional issues that may arise.

#	Scenario	Questions
Household/Household Income		
1	Application submitted by 59 year old grandmother for herself and her 12 year old grandchild. Grandmother does not claim the 12 year old as a tax dependent. The 12 year old receives Social Security Survivors benefits.	Who is included in the household? Under current rules we would consider the 59 year old and the 12 year old in the household. According to 435.603(f)(3) it appears as though we would no longer be considering the caretaker relative in the household. Is this correct? Does the caretaker relative category only apply if the caretaker is claiming the individual on their tax return?
2	Application submitted by 45 year old for herself, her spouse, their 20 year old child, and their 15 year old child. The 20 year old is a full-time student, works, and files a tax return, although not required to do so. The 45 year old claims both children on the tax return. We understand the household consists of the applicant, her spouse, the 20 year old child, and the 15 year old child following 435.603(f)(1).	This is a change from how we currently consider household composition. Currently, the 20 year old would not be considered in the household. We would not count the income of the 20 – year –old because they are not required to file. Is our understanding correct?
3	Same scenario as #2 except the 20 year old is required to file a tax return. We understand the household to be the same as described in #2 and that the 20 year old child's MAGI income would be counted towards the rest of the family's eligibility.	Is it correct that the 20 year old child's income is counted when determining eligibility for the other family members, including siblings?
4	Application submitted by 45 year old for herself, her 18 year old daughter, and her daughter's 2 year old child. The 45 year old claims her daughter and grandchild as a tax dependent.	Currently, we would include everyone together if 18-year-old is fulltime student expected to graduate prior to 19 and the 45 year old by herself and 18 year old/2year old by themselves if 18

#	Scenario	Questions
		year old does not meet student criteria. Our understanding is that under MAGI all three would be included in the household. Is this correct?
5	Application submitted by 45 year old for herself, her 18 year old daughter, and her daughter's 2 year old child. The 45 year old claims her daughter as a tax dependent but not her grandchild as the grandchild is claimed on the father's tax return. The grandchild does not live with the father.	Currently, we would include everyone together if 18-year-old is fulltime student expected to graduate prior to 19 and the 45 year old by herself and 18 year old/2year old by themselves if 18 year old does not meet student criteria. Our understanding is that under MAGI all three would be included in the household. Is this correct?
6	Application submitted by 50 year old for herself, her 17 year old child, the child's 18 year old spouse, and their 2 year old child. The 50 year old claims her 17 year old as a tax dependent. The 18 year old claims the 2 year old as a tax dependent. They all reside together.	Currently, we would consider the 50 year old a separate household and the other 3 members as their own household. Our understanding is this would remain the same under the new rules because the 17 and 18 year old are married. Is this correct? If unmarried, the 50 year old and the 17 year old are considered one household and the 18 year old and the 2 year old are considered one household. Is this correct?
7	Application submitted by 45 year old for herself, her spouse, her 15 year old child, his 14 year old child, and their 2 year old common child. The couple claim all of the children as tax dependents.	Currently we consider all as one household. Is this the same under new rules?
8	Application submitted by 45 year old for herself, her boyfriend, her 15 year old child, his 14 year old child, and their 2 year old common child. The 45 year old claims the	Currently we consider all as one household. Is this the same under new rules?

#	Scenario	Questions
	15 year old child as a tax dependent. The boyfriend claims his 14 year old child and the 2 year old common child.	
9	Application submitted by 35 year old for herself and her 5 year old child. Her ex-spouse claims the 5 year old on as a tax dependent. They share custody and each parent has the child 50% of the time.	Who is included in the household? Does it depend on whether the child is with the mother at the time of application? Currently the parents decide who applies for the child. Does this change with the new rules?
10	Application submitted by 45 year old for herself, her spouse, her 15 year old child and his 14 year old child. The couple claim both children as tax dependents.	Currently, we could consider this as two separate households because they have no children in common. Under the new rules it appears that this would be considered as one household. Is this correct?
11	Application submitted by 40 year old for herself and her two nieces, ages 5 & 7. She claims both children as tax dependents.	Currently, we would consider this as one household with 3 members. This does not appear to change with the new rules. Is this correct?
12	Application submitted by 59 year old for herself and her 30 year old child. She claims the 30 year old as a tax dependent.	Currently we would consider this as two separate households. This appears to change with the new rules to one household because the 30 year old is claimed as a tax dependent. Is this correct?
13	Application submitted by 42 year old for her 62 year old mother. The 42 year old and her spouse claim her mother as a tax dependent.	Currently we would consider the 62 year old as her own household. This appears to change with the new rules to one household with three members (42 year old, her spouse, and her mother) because the 62 year old is claimed as a tax dependent. Is this correct?

#	Scenario	Questions
	Application of MAGI	
14	Application submitted by 65 year old guardian for herself and her 17 year old grandchild. Grandmother claims the 17 year old as a tax dependent. The 17 year old receives Social Security Survivors benefits. We understand the household consists of the 65 year old and the 17 year old following 435.603(f)(1). The 17 year old is not required to file a tax return.	42 CFR 435.603(i) describes the eligibility groups for which MAGI based methodologies do not apply. Individuals who are age 65 or older are listed as (2). Because we are determining eligibility based on being a caretaker relative and not based on the fact the individual is age 65 or over, do we use MAGI to determine household group and income? Or, do we use MAGI to determine eligibility for the child and our "old" income methodology to determine eligibility for the 65 year old?
15	Same as scenario #10 except the 17 year old is also working and is required to file a tax return. We understand the household still consists of the 65 year old and the 17 year old following 435.603(f)(1).	Same as above.
	Determining MAGI Income	
16	Application submitted for 5 year old and 7 year old children. Each child receives child support in the amount of $500.00 per month. The children's mother is employed and earns $1500.00 per month. She claims both children as tax dependents. Our understanding is that the child support income is not counted because it is not considered taxable income. In addition, income of a child who is not required to file a tax return is not included in the MAGI income determination. The household size is 3 and the total income is $1500.00.	Is our understanding correct?
17	Application submitted by 39 year old childless adult. He works for a company that provides health insurance that is a pre-tax	Because the pre-taxed amount is not considered income for tax purposes, is it excluded for

#	Scenario	Questions
	deduction. The tax return shows $14,231 and he is eligible for Medicaid. However, his paystubs indicate that his gross income is $16,000 and he is ineligible for Medicaid.	Medicaid?
18	Application submitted by 42 year old man for himself, his wife, and their 2 children ages 5 and 7. He is self-employed. His tax return shows $2,150.00 as net self employment for the year. They have no other source of income. He attests that this is still his current net income. Although the amount on his tax return is compatible with his self attestation, we ask more questions to determine how the family is paying their bills, etc. We find that there are several questionable items on the tax return and that they are actually receiving more than $2,150 per year.	Currently, we look at the tax return. Under the new rules, do we explore expenses exceeding income? Do we use the net amount shown on the tax return and his self attestation or determine self-employment income as we do today?
Verification		
19	Income: Individual applies in July, and application states that he works at Home Depot part-time earning $100/week. Electronic data match is initiated using applicant's SSN (assumption: sources are available *and* can provide relevant data): • IRS • State Department of Revenue (State tax data) • Base Wage • The Work Number Response from data sources is received. • IRS shows higher income of ~ $3000/month for the previous year. • Base Wage shows same employer, but quarterly income is also higher at ~ $1,500/month. • The Work Number does not return any data. As the income claimed is less than 1/3 of the	Is this approach correct?

#	Scenario	Questions
	lowest and most recent income from Base Wage, it is determined not reasonably compatible with what individual states on application. Because information is not reasonably compatible, request proof of current income for last 30 days. Give applicant 10 days to provide. This time period can be extended upon request.	
20	Income Individual applies in July. States he works at Home Depot part time earning $100/week. Electronic data match is initiated using applicant's SSN (assumption: sources are available *and* can provide relevant data): • IRS • State Department of Revenue (State tax data) • Base Wage • The Work Number Response from data sources is received. • IRS shows higher income of ~ $3000/month for the previous year. • Base Wage shows same employer, and quarterly income is within $30 of the amount stated on the application. • The Work Number does not return any data. As the income claimed is reasonably compatible with the most recent income from Base Wage, income is considered verified. No additional verification is required.	Is this approach correct?
21	Residency Individual/family applies and the application lists an AZ address.	Is this approach correct?

#	Scenario	Questions
	Electronic data match is initiated using applicant's SSN (assumption: sources are available *and* can provide relevant data): • IRS • State Department of Revenue (State tax data) • State Department of Motor Vehicles Response from data sources is received. Residency is considered verified if: • At least one electronic data source lists an AZ address, and the others do not list an out-of-state address. • Example - DMV returns an AZ address and no data is returned from IRS or DOR Further verification must be requested if: • No data is returned by any electronic verification source, or • Any electronic data source lists an out-of-state address If further verification is needed, request proof of residency with a ten-day due date and examples of types of proof. The ten-day timeframe can be extended upon request.	
22	<u>Household Size</u> Family applies and the household is listed as one parent and two children Electronic data match is initiated using applicant's SSN (assumption: sources are available *and* can provide relevant data): • IRS (tax dependent lived with taxpayer >1/2 the year) • State Department of Revenue (tax dependent lived with taxpayer >1/2 the year) • Medicaid/SNAP/TANF eligibility databases (current or recent household size data)	Is this approach correct?

#	Scenario	Questions
	• Child Support Enforcement (custodial parent data) Further verification is requested **only** if: • None of the data sources have corroborating information, ***and*** • One or more data sources have conflicting information If further verification is needed, request proof of household with a ten-day due date and examples of types of proof. The ten-day timeframe can be extended upon request.	
Reporting and Acting on Changes		
23	Family eligible for Medicaid with household income at 130% FPL. The income increases to 139% 7 months after determined eligible.	What is the "relevant information" that we need to send to the Exchange as described at 435.916(a)(4)?
24	Family eligible for Medicaid with household income at 130% FPL. The income decreases to 90% FPL.	Do they need to report decreases in income? For example if they go from newly eligible group to some other type of coverage; are they still considered "newly eligible"?
25	Family eligible for tax credits through the Exchange. 6 months after approval, the income decreases to 130% FPL.	Do they need to report this change? Do they have to switch to Medicaid? Are they given the choice?
26	Mother, father, and child eligible for Medicaid with income at 130% FPL. The father leaves the household. The income for the mother and child is recalculated and determined to	Do they need to report this change?

#	Scenario	Questions
	be 150% FPL.	What action would we take for the father's eligibility in this situation? Currently we do a redetermination of his eligibility based on his new circumstances (when information is known). What is the "relevant information" that we need to send to the Exchange as described at 435.916(a)(4)?
27	Mother and child eligible for Medicaid with income at 90% FPL. The child's father returns to the home. The income for the family is recalculated and determined to be 200% FPL.	Do we have specific questions related to how this is handled for referring for tax credits? We would discontinue the Medicaid, right?
28	Pregnant individual eligible for Medicaid with income at 130% FPL for a family of two. She has a miscarriage and has no other children. The income for her is recalculated and determined to be 180% FPL for a family of 1 and she is ineligible for Medicaid.	Is she required to report this change? Currently she would receive a postpartum period. Would this change under new rules?