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May 7, 2011

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

RE: Comments on Interim Final Rule provisions of "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010" (CMS–2349–F)

Dear Secretary Sebelius:

We appreciate the opportunity to comment on the interim final provisions included in the final Medicaid rules published in the Federal Register on March 23, relating to the eligibility determinations and enrollment of individuals into health coverage under the Affordable Care Act (ACA).

We believe that the clear intent of the Affordable Care Act is to establish a simple, unified pathway to health coverage for consumers. These rules are critically important to ensure the successful implementation of the ACA and that consumers have a family-friendly and seamless experience in the years ahead. We strongly support the proposed rules' provisions to promote modernized eligibility systems that will rely primarily on electronic verifications, eliminate duplicate requests for information, and strictly limit the use of requirements for paper documentation.

However, we are concerned about provisions of the Medicaid (and Exchange) final rules that allow states to separate the eligibility processes for Medicaid, CHIP, and the Exchange. These provisions are intended, presumably, to accommodate a potential wide variety of state-specific arrangements between state Medicaid and CHIP agencies, state-operated Exchanges, and federally facilitated Exchanges. However, based on our experience here in Texas and our observation of practices and outcomes in other states, we fear that without revisions adding greater clarity to coordination requirements and more specificity and rigor to minimum performance standards, low- and moderate-income Texans may experience delays in eligibility and gaps in coverage.

We have seen such problems in Texas, where the state maintains different eligibility and enrollment systems for Medicaid and CHIP. Despite the fact that state law and rule nominally require seamless referrals between the programs, since 2000 the use of two separate systems in practice has too often resulted in confusion, delays, and abandoned applications. Our observation of Texas Medicaid eligibility policy over more than two decades has been that, absent clear and enforceable minimum performance standards, states may foster delays, understaffing, burdensome paperwork, and poor performance in enrollment and renewal of benefits as a means of slowing or reducing Medicaid and CHIP enrollment.

In Texas, we have also experienced in recent years periods of grave failure in our eligibility systems, which were attributable to poor performance by both contractors and public employees, exacerbated by serious staffing shortages. Poor training and IT failures also contributed to precipitous disenrollment in children's Medicaid, enormous backlogs of several months in applications and renewals, and errors in determinations. These factors resulted in dramatically sub-standard timeliness statistics for Texas Medicaid. Because federal law and rule provided the Secretary with such limited tools for enforcing Medicaid timeliness standards, our state did not make a serious effort to address the systemic problems until financial sanctions were imposed by USDA for the poor Food Stamp/SNAP performance that mirrored the Medicaid processing problems in Texas' integrated public benefits eligibility system. We urge the Secretary to use this opportunity with the interim final rule provisions to eliminate additional avoidable sources of coverage gaps and delays from any source, whether public or private.

We share the concern voiced by many reviewers that the rule allows states that elect to have the Exchange fully determine Medicaid eligibility to do so via private contractors, which could effectively allow a state to privatize a share of unknown magnitude of its Medicaid determinations. This does not seem to have been a provision contemplated by either the ACA or the initial proposed rule of 2011. At the same time, allowing states to require the Exchange to instead hand off "initial assessments" of applications to Medicaid and CHIP agencies for a final eligibility determination creates multiple opportunities to fragment what should be a seamless eligibility system. Our comments are intended to eliminate several ways in which a either the public or private components of a divided system could make it more difficult for families to enroll in coverage, and thus reduce the potential for applications "ping-ponging" between the Exchange, CHIP, and Medicaid.

The safeguards HHS has included in the final rule must be maintained and further strengthened to ensure the most streamlined and accurate system possible. Our comments below focus on how coordination requirements can be strengthened to reduce the barriers faced by families.

Active Approval Process

We fully endorse the recommendation that HHS standards must set a high bar for states to demonstrate that that their chosen arrangement for determining Medicaid and CHIP eligibility of applicants entering via the Exchange "door" can be achieved without harming families. HHS should conduct a readiness assessment for all states opting for bifurcated eligibility systems, as well as for Exchange-operated systems and those of Exchange contractors.

Readiness reviews can ensure that states do not elect the" initial assessment hand-off" model in an attempt to reduce or slow enrollment by eligible families, and that all states have functional systems in place to implement their choice. States should be required to actively demonstrate their operational readiness to implement the more complicated hand-off structure by:

- demonstrating that their Medicaid agency has the capacity to conduct eligibility determinations in full compliance with the final Medicaid eligibility rule, including provisions requiring electronic verification of income;
- establishing for HHS via the use of test cases and other means that their Medicaid IT systems can accept and use data transferred from the Exchange; and
- showing that they can and will agree to all of the coordination protections included in the final rule, including the requirement that they not ask families for information that they already have provided and refrain from unnecessarily re-verifying any data already verified by the Exchange.

We strongly urge HHS to adopt an active approval process and oversight of states' readiness and ongoing performance. States should not be allowed to simply check boxes on an Exchange Blueprint document saying that they intend to do all of these things. States should be required to actively demonstrate their operational capacity to do so.

Elimination of Duplicative Eligibility Determinations.
All agencies involved in eligibility determinations for a state should abide by the same rules and procedures when assessing or determining Medicaid and CHIP eligibility in order to ensure accurate and consistent eligibility determinations. This will help minimize the need for further verification once an application reaches the Medicaid agency and minimize the number of applicants who are bounced between programs or fall through the cracks.

We support the requirement (§435.1200(d)) that the agency receiving the case accept any finding relating to eligibility criteria from the transferring agency and not request any information or documentation already provided by the applicant. This requirement will streamline the eligibility process, minimize duplication of work, and prevent applications from having to resubmit supporting documentation.

We recommend strengthening this provision in the final regulation, to ensure that states do not needlessly re-verify eligibility criteria if the procedures and standards differ. We encourage you to ensure that the final rule minimizes the degree to which states can conduct duplicative eligibility determinations by requiring states, to the maximum extent possible, use a single shared system between the Exchange and Medicaid/CHIP so that eligibility determinations need to be made only once.

We agree with other commenters that the standards for required agreements between state Medicaid agencies and Exchanges' eligibility systems for insurance affordability programs, to specify that in addition to Medicaid agencies providing to HHS a plan describing verification standards and protocols, states and Exchanges using bifurcated hand-off models would also be required to document all processes for transferring cases and resolving disputes, as well as which party will be responsible for notices, appeals and consumer assistance.

If states are not utilizing a shared system, the final rule should require Exchanges to conduct Medicaid assessments using a state's Medicaid eligibility rules (rather than a generic version of the rules that fail to take a state's policy choices into account), as well as using the same data sources as the state Medicaid agency.

We support the proposed regulation (§435.1200(d)(5)) that requires the Medicaid program to notify other insurance affordability programs when it receives a transferred application. Notification of disposition should be added to the regulation at §457.348 so that it applies to CHIP as well. Additionally, these notification requirements should also be extended to the Exchange. Applicants should also receive a similar notification that their application has been received by the Medicaid agency or Exchange along with contact information should they have questions.

Strengthen Timeliness and Performance Standards
Given the massive investment in new eligibility system technologies being made by both states and the federal government, we feel that maintaining existing "legacy" timeliness standards—adopted when systems relied heavily on paper applications and on some of the earliest computer systems—is inappropriate. Timeliness standards must be modernized to reflect the rule's emphasis on electronic verification, online application, and streamlined systems.

We recommend that the final rule require eligibility determinations to occur within a few days if electronic data are available to verify eligibility. Moreover, under no circumstances should eligibility determinations take more than 30 days for people not being evaluated for disability-based coverage or more than 60 days for those applying on the basis of disability. We agree with other commenters that states and HHS should periodically review and update standards for acceptable processing performance to keep up with the degree to which best practices and evolving technology will increase the speed at which accurate determinations can be made.

We are concerned that §435.912 seems to reset the clock when an application is transferred. This should not be allowed. Timeliness should measure the period between the date an application is submitted for any insurance affordability program to the date a final determination is made. When eligibility systems are bifurcated (the hand-off model), the Exchange's eligibility assessment should be completed within three days, and any necessary application transfer should be achieved in one day. Requiring a quick assessment and electronic transfer will addresses concerns that applications transferred late in the process will not allow the receiving agency sufficient time to make a determination within a 30-day window.

We support the decision to require states to establish performance standards that measure their effectiveness in making efficient and timely eligibility determinations and that these standards be included in the State plan and subject to approval by the Secretary. We recommend that HHS also establish benchmarks for evaluating whether a state's standards reflect the true capabilities of its existing systems and technologies. States' performance on these standards should be subject to rigorous monitoring and enforcement.

All timeliness standards should apply equally to Medicaid, CHIP, and the Exchange so that eligibility is determined promptly and in a consistent timeframe across all programs. If Exchanges are allowed to contract out for eligibility determinations, it must be clear that the contractors and Exchange are held to the same timeliness standards as the Medicaid agency.

The interim final rule (§457.340 (d) and (f)) also proposes that states administering a separate CHIP program be able to define the date of application and eligibility; this would potentially allow the "timeliness clock" to be deemed to start and stop at a different point for members of the same family applying simultaneously. The flexibility proposed could not only result in disparate application dates across programs, but also result in lack of consistency for all family members applying for coverage, regardless of which program they are enrolled in. The date of a CHIP application should be the date of application, consistent with other affordability programs.

Greater Transparency

Eligibility determinations will determine how effective the ACA is in covering much of our uninsured population below 400 percent of the federal poverty level, which includes around 5.5 million Texans.

We believe it is essential that members of the public have the opportunity to learn about and provide input into the way that such determinations are conducted. Interagency eligibility process agreements, including details concerning timeliness standards and coordination across programs, the State plan, and the state's verification plan should be publically available on both the state and HHS websites to provide a greater level of accountability.

§431.10 Single State Agency
We recognize that this section was issued as a final rule, but we ask that you withdraw this provision and seek further comment because the final rule departs sharply from the proposed rule.

We are concerned that states that maintain one eligibility process for Medicaid and the Exchange will be allowed to contract with private entities to determine eligibility for all programs, including Medicaid. We believe that determining Medicaid eligibility is an inherently governmental function that should not be contracted out. Medicaid determinations require access to and use of confidential personal information and have significant and direct fiscal implications for state, the federal government, and families.

Thank you for consideration of our comments on these important rules. Any questions regarding these comments may be addressed to Anne Dunkelberg at dunkelberg@cppp.org or (512) 320-0222 ext. 102.

Sincerely,

Anne Dunkelberg
Associate Director