



October 31, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-2349-P**
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010

To Whom It May Concern:

The National Association of Community Health Centers, Inc. (“NACHC”) submits the following comments in response to the proposed rule regarding Medicaid eligibility published by the Centers for Medicare and Medicaid Services (“CMS”) on August 17, 2011. NACHC is the national membership organization for federally supported and federally recognized health centers (referred to here interchangeably as “health centers” or “FQHCs”) throughout the country, and is an Internal Revenue Code Section 501(c)(3) organization.

NACHC is limiting its comments to issues that are of particular importance to health centers in their efforts to play a critical and supportive role in the expansion of Medicaid eligibility and the implementation of health reform as provided in the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, enacted on March 23, 2010; and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, enacted on March 30, 2010. (Following CMS’s practice, we refer below to these two pieces of legislation, collectively, as the Affordable Care Act, or “ACA.”)

I. Background on FQHCs

There are, at present, more than 1200 health centers with over 800 sites serving more than 20 million patients nationwide. Most of these FQHCs receive federal grants under Section 330 of the Public Health Service Act (42 U.S.C. § 254b) from the Bureau of Primary Health Care (“BPHC”), within the Health Resources and Services Administration (“HRSA”). Under this authority, health centers fall into four

MAIN OFFICE
7200 Wisconsin Ave, Suite 210
Bethesda, MD 20814
301-347-0400
301-347-0459 fax

FEDERAL AND STATE AFFAIRS OFFICE
1400 Eye Street NW, Suite 910
Washington, DC 20005
202-296-3800
202-296-3526 fax

general categories: (1) those centers serving medically underserved areas (invariably poor communities), (2) those serving homeless populations within a particular community or geographic area, (3) those serving migrant or seasonal farm worker populations within similar community or geographic areas, and (4) those serving residents of public housing. Except for a limited number of public health centers (*i.e.*, health centers operated by local governmental units such as health departments), each health center is a charitable, nonprofit, tax-exempt Internal Revenue Code Section 501(c)(3) corporation formed under the laws of the State in which it operates.

To qualify as a Section 330 grantee, a health center must be located in a designated medically underserved area or serve a medically underserved population. In addition, a health center's board of directors must be composed of at least fifty-one percent (51%) users of the health center, and the health center must offer services to all persons in its catchment area, regardless of their ability to pay or insurance status.

BPHC's grants are intended to assist health centers in covering the otherwise uncompensated costs of providing comprehensive preventive and primary care and enabling services to uninsured and underinsured indigent patients, as well as maintaining the health center's infrastructure. Patients from eligible communities who are not indigent and able to pay or who have insurance, whether public or private, are expected to pay for the services rendered.

II. Comments

The ACA dramatically expands Medicaid eligibility, effective January 1, 2014, by creating a new mandatory eligibility group comprised of adults under age 65, with incomes under 133% of the federal poverty level (FPL), who are not eligible for Medicaid under a pre-existing mandatory eligibility group, and who are citizens or are non-citizens entitled to Medicaid under applicable rules ("the adult group"). This represents the first time that a Medicaid mandatory eligibility category has applied to adults based strictly on income. The law makes federally-supported health coverage available for the first time to non-disabled childless adults.

Effective implementation of this unprecedented Medicaid eligibility expansion is important to health centers, just as health center participation is critical to the success of the eligibility expansion. Health centers provide critical cost-effective and cost-efficient primary and preventive health care and enabling services to a predominantly low-income population, and they embody principles of patient-centered primary care that Congress sought to propagate through various provisions of the ACA. Almost 72% of health center patients have income at or below the poverty level, and 93% of patients have income of less than twice the poverty level. Almost 39% of health center patients are Medicaid beneficiaries, as contrasted with 15.7% of the U.S. population at large. As a result of the coverage expansion mandated by the ACA, health centers' total patient base is projected to rise from 19.5 million in 2010 to 50 million

by 2019, and the portion of patients who are Medicaid beneficiaries is expected to rise from 39% to 44% by 2019.¹

NACHC applauds CMS for including in this proposed rule provisions to make Medicaid eligibility standards more straightforward and easier to navigate for applicants and beneficiaries. The proposed rule also seeks to harmonize the Medicaid eligibility standards and processes with comparable rules on the Affordable Insurance Exchanges (“Exchanges”) and associated premium tax credit and cost-sharing reduction programs (collectively, “Exchange subsidies”), and with the Basic Health Program.² Such coordination is important to NACHC. Given the large number of low-income patients served by health centers, administrative glitches or coverage gaps caused by lack of coordination among the insurance affordability programs would have a negative effect on health centers and their patients, causing both interruptions of care and increased administrative costs. NACHC urges CMS, in the final regulation, to resolve remaining inconsistencies between Medicaid and Exchange eligibility standards and processes, which could result in coverage gaps.

In addition, NACHC commends the provisions in the proposed rule that facilitate eligibility for migrant and seasonal farm workers, groups of special concern to NACHC but urges CMS to include provisions in the final regulation that would improve access to coverage for this group.

A. State Flexibility in Implementing Eligibility Reforms

Many of the Medicaid eligibility reforms in the CMS proposed rule are optional to States. In general, where an eligibility reform is necessary for the system to function well, NACHC believes that CMS should not leave the decision to State discretion.

The Exchanges (and the Exchange subsidies) will be subject to relatively uniform eligibility rules nationwide. See PPACA § 1322(b)(2). If HHS intends to coordinate the eligibility rules for Medicaid and for Exchange subsidies, then CMS should impose more uniform requirements on Medicaid programs nationwide with respect to eligibility processes. The rationale for greater uniformity across states with respect to eligibility processes is particularly strong in light of the fact that, through the creation of the “adult group,” Congress has authorized a more uniform approach to substantive eligibility standards.

B. Periodic Redetermination of Medicaid Eligibility (Proposed 42 C.F.R. § 435.916)

CMS has included provisions in the proposed rule that prolong Medicaid eligibility periods and streamline the eligibility redetermination process in order to reduce “churning” among the insurance affordability reforms. Churning occurs when enrollees experience repeated fluctuations in income that cause them to lose eligibility under one insurance affordability program and gain eligibility under the other. CMS notes in the preamble to the proposed rule that churning is “administratively costly and burdensome for the agency, health plans, and consumers, and is disruptive to continuity of care.” 76

¹ See Kaiser Comm’n for Medicaid and the Uninsured, *Community Health Centers: Opportunities and Challenges of Health Reform* (Aug. 2010), Fig. 9.

² Following CMS’s terminology, we refer to Medicaid, the Exchange subsidies, CHIP, and the Basic Health Program collectively as the “insurance affordability programs.”

Fed. Reg. at 51155. Churning is of particular concern to health centers, since an estimated 71% of health center patients have family income at or below the poverty level. As CMS notes in the preamble to the rule, fluctuations of income within the year are common for migrant and seasonal farm workers, and thus churning may be a particular problem for this group, many of whom are served by health centers. *Id.* at 51156.

1. 12-Month Eligibility Period (subsection (a)(1))

NACHC commends CMS for amending the Medicaid eligibility rules to require that States conduct eligibility redeterminations only once every 12 months for eligibility groups subject to the modified adjusted gross income (MAGI) standard (hereinafter, “the MAGI groups”). The provision does not guarantee a continuous year of eligibility, since redeterminations may be conducted more frequently if Medicaid obtains information suggesting the need for a new eligibility review, but it will lead to longer periods of coverage. The requirement also aligns Medicaid with the Exchanges, since the Exchanges are required to use 12-month eligibility periods. See HHS, Proposed Rule, Exchange Functions in the Individual Market; Eligibility Determinations, 76 Fed. Reg. 51202 (Aug. 17, 2011) (“Exchange proposed rule”).

2. Streamlined Redetermination Process (subsection (a)(2))

The Medicaid proposed rule also encourages continuity of coverage by creating a streamlined Medicaid eligibility redetermination for the MAGI groups. Medicaid agencies “must make a redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual’s account or other more current information available to the agency. . .” Proposed 42 C.F.R. § 435.916(a)(2). CMS is implementing this policy in the expectation that almost all information needed to determine or redetermine eligibility can be verified through the “data match” program required under the ACA and the proposed rule (see PPACA § 1413(c)(2) and proposed 42 C.F.R. § 435.949), effectively eliminating the need for a new application at the redetermination stage. All insurance affordability programs are required to use the data match to verify eligibility.

As discussed further in NACHC’s comments concerning residency, however, NACHC is concerned that the proposed rule gives States too much flexibility to demand that applicants and beneficiaries submit documentation, rather than relying on the data match, with the result that the streamlined redetermination process is effectively at the State’s option. NACHC would favor a regulation that clearly requires the agency to use the data match to redetermine eligibility. NACHC recommends that CMS promulgate a final regulation whose redetermination provisions more closely resemble the Exchange proposed rule. See Proposed 45 C.F.R. § 155.535, 76 Fed. Reg. 51235.

CMS also invited comment on whether the simplified redetermination rules should be extended to the Medicaid eligibility groups that are excepted from the MAGI standard. 76 Fed. Reg. 51166. NACHC supports the addition of such a requirement in the final rule.

C. Application of Modified Adjusted Gross Income (MAGI), Proposed 42 C.F.R. § 435.603

NACHC urges CMS to coordinate the MAGI income rules in Medicaid with the Exchange proposed rule. The ACA requires the use of the MAGI standard to determine eligibility for all insurance affordability programs, with the exception of certain Medicaid eligibility categories excepted from MAGI. PPACA §§ 1331(h), 1401(a), 2002. The Medicaid proposed rule states: “Medicaid, CHIP, and the Exchanges will align the rules and methodologies used to evaluate eligibility for most individuals under all three programs.” Medicaid Proposed Rule, 76 Fed. Reg. at 51150.

In reality, however, the proposed rules leave significant discrepancies in the rules that apply in Medicaid and on the Exchanges, which could result in coverage gaps. One such discrepancy relates to the “budget period” for counting income. The ACA itself creates this discrepancy by requiring States to continue using their present practice of using “point-in-time” income (which refers to a monthly income as of the date the application is submitted) for the initial eligibility determination. Annual income, on the other hand, is used to determine eligibility for the Exchange subsidies. 76 Fed. Reg. 51156. Coverage gaps could arise where an applicant’s point-in-time income is too high to qualify for Medicaid, but her annual income is too low to qualify for an Exchange subsidy.

The Medicaid proposed rule offers States the flexibility to make two reforms in income rules, described below, to limit the adverse impact of these conflicting standards. To best address coverage gaps, the changes should instead be mandatory.

1. Use of Projected Annual Household Income (subsection (h)(2))

CMS determined that although the ACA requires point-in-time monthly income to be used for the initial Medicaid application process, States may choose to base the *redetermination* instead on “projected annual household income.” 76 Fed. Reg. at 51156. This measure would ensure consistency between Medicaid and Exchange subsidy standards for Medicaid beneficiaries (as opposed to applicants). CMS should make this standard mandatory.

2. Predicted Changes in Income (subsection (h)(3))

The proposed rule also gives States the flexibility, in applying the standard of either “point-in-time income” or “projected annual household income,” to take into account “reasonably predictable” future increases or decreases in income. CMS notes in the preamble that such a provision would be particularly useful for seasonal workers. 76 Fed. Reg. 51156. NACHC urges CMS to mandate such a provision in State plans.

D. Effective Date of Medicaid Coverage (Redesignated 42 C.F.R. § 435.915)

CMS notes in the preamble to the Medicaid proposed rule that CMS is considering requiring that State plans provide for termination of Medicaid eligibility to take effect on the last day of a calendar month. See 76 Fed. Reg. 51162. This would minimize coverage gaps that occur when Medicaid coverage terminates before Exchange coverage commences. (Under the Exchange proposed rule published on July 15, 2011, Exchange enrollment may commence no earlier than the first day of the month after a

person loses Medicaid eligibility.) CMS should adopt the last-day-of-the-month provision in the final rule.

Such a rule would also be conducive to efficient contracting in managed care, since State Medicaid agencies typically pay MCOs a per-member-per-month payment, and such payments typically include the entire calendar month.

E. Residency Requirements (Proposed 42 C.F.R. §§ 435.403, 435.945)

NACHC urges CMS to revise the State residency requirements in the proposed rule in order to coordinate the Medicaid and Exchange residency rules, and to fairly treat migrant and seasonal farm workers.

1. State of Residence (42 C.F.R. § 435.403(h))

NACHC supports the re-definition of “State of residence” in the Medicaid proposed rule. Under current Medicaid regulations, the “State of residence,” for individuals age 21 and over who are not living in an institution, is the state where an individual (1) is living “with intent to remain there permanently or for an indefinite period . . .,” or (2) is “living and which the individual entered with a job commitment or seeking employment (whether or not currently employed).” 42 C.F.R. § 435.403(h). The proposed rule revises the first component of the definition to refer to the state where the individual “intends to reside, *including without a fixed address . . .*” Proposed 42 C.F.R. § 435.403(h)(1)(emphasis added). CMS notes that the added language is intended to “ensure a consistent approach for migrant, seasonal workers and other families living in a state while employed or in search of employment.” 76 Fed. Reg. at 51160. NACHC agrees that the provision facilitates this population’s access to needed health services.

2. Attestation of Residence

Today, some Medicaid programs require that applicants demonstrate eligibility by presenting documentation such as utility bills, leases, etc. This is unduly burdensome, and possibly unrealistic, for migrant and seasonal farm workers. The Medicaid proposed rule provides that with respect to the residence requirement (as well as other non-financial and non-immigration requirements), states “*may* accept attestation without requiring further paper documentation . . . of all information needed to determine the eligibility of an applicant or beneficiary for Medicaid.” Proposed 42 C.F.R. § 435.945(b). The use of applicant attestations to prove residency is optional; states may choose instead to use “other reasonable verification procedures.” *Id.* § 435.956(c)(1).

The final CMS rule should require States to accept attestations to prove residency (with limited exceptions), rather than merely offering the option, for two reasons. First, if a state chooses not to accept attestations as proof of residency, it will effectively be unable to implement the simplified Medicaid eligibility redetermination process for MAGI-eligible beneficiaries described above. CMS notes in the proposed rule: “if information available to the agency is sufficient to make a determination of continued eligibility, *including . . . that the individual or family continues to reside in the state*, coverage shall be renewed . . . without requiring further action.” 76 Fed. Reg. at 51166 (emphasis added). The

streamlined redetermination is a key measure to prevent coverage gaps and cannot be implemented unless states are prohibited from demanding documentary evidence of residency at that stage. Second, a requirement to accept attestations would align the Medicaid regulation with the Exchange proposed rule, which requires the Exchange to “verify an applicant’s residency in the services area of the Exchange by accepting his or her attestation without further verification.” Proposed 45 C.F.R. § 155.315(c)(3) (emphasis added).³

3. Residence in Multiple States

In keeping with other provisions in the proposed rules that facilitate Medicaid eligibility for migrant and seasonal farm workers, NACHC requests that CMS consider promulgating a revision of 42 C.F.R. § 431.52, in order to increase access to Medicaid services for this population.

Presently, 42 C.F.R. § 431.52 provides that a state Medicaid agency in one state (State A) must pay for services furnished to its beneficiary in another state (State B) to the same extent it would pay for services within State A, *if* (1) the beneficiary is a resident of State A, and if one of the following applies: the services are required because of an emergency or because of unavailability of the medical services in State A, or if “it is general practice for recipients in a particular locality to use medical resources in another State.” 42 C.F.R. § 431.52.

NACHC proposes that CMS add a subsection to 42 C.F.R. § 431.52 permitting migrant and seasonal farm workers, as Medicaid beneficiaries of State A, to access full Medicaid benefits in the State where they are temporarily working, State B. Providers in State B would be paid by State A’s Medicaid agency, but would receive the payment to which they are entitled under State B’s State plan. NACHC notes that the States of Texas and Washington have entered into a reciprocal agreement to serve migrant and seasonal farm worker Medicaid beneficiaries in this manner. Such a provision is a sensible proposal that would advance “proper and efficient administration of the State plan,” Social Security Act § 1902(a)(4), and recognize the reality of this group’s health care needs.

F. Treatment of Incarcerated Individuals Under Medicaid (42 C.F.R. § 1009)

NACHC urges CMS to address, through guidance to States and potentially also through revisions to existing regulations, a discrepancy between Medicaid, on the one hand, and the Exchange and Basic Health Program, on the other, in the treatment of persons who are incarcerated pending the disposition of charges.

Under 42 C.F.R. § 435.1009, federal financial participation (FFP) is unavailable for Medicaid services provided to “individuals who are inmates of public institutions.” In contrast, persons who are incarcerated “pending the disposition of charges” are eligible to enroll in QHPs on the Exchange and to

³ The Exchange may nonetheless “examine information in data sources” if the information provided by in the attestation concerning residency is not compatible with other information the applicant provided. *Id.* § 155.315(c)(3). It bears noting that under the Exchange proposed rule, if the state Medicaid agency in which the Exchange is located opts to use electronic data sources to verify residency, the Exchange must “proceed in accordance with” the Medicaid policy. *Id.* § 155.315(c)(2).

enroll in standard health plans in a Basic Health Program. PPACA §§ 1312(f)(1)(B), 1331(e); proposed 45 C.F.R. § 155.305(a)(2).

NACHC urges the HHS sub-agencies to resolve this apparent inconsistency in policy concerning services for incarcerated individuals. As one of the key safety net providers (and in many instances, the only such provider) in a community, health centers are responsible for providing services to all residents of the underserved communities in which they are located. Health centers are concerned about the potential deficiencies in care for individuals both during incarceration and upon release. Many incarcerated persons are health center patients before incarceration and if they remain in the community after release, they will remain (or become) health center patients. Allowing persons in jail pending the disposition of charges to continue to receive care is one step, if small, toward ensuring more adequate care for this population.

In particular, following the comments on this topic submitted by the National Association of Counties (NACo), NACHC urges CMS to take the following steps:

1. NACHC commends CMS for the proposed revisions to 42 C.F.R. § 435.907, which specify that an “authorized person acting on behalf of the individual” may submit a Medicaid application. NACHC urges CMS to specify in the preamble to the final regulation that “other authorized person” includes a corrections department employee or other individual working with incarcerated populations. Permitting incarcerated persons to file Medicaid applications would help to facilitate prompt access to services after release.

2. CMS should instruct States that an individual is not considered an “inmate of a public institution,” for purposes of 42 C.F.R. § 1009, if the person is in the institution (a) for a temporary period pending arrangements appropriate to his or her needs, or (2) pending disposition of criminal charges. Such a policy guidance would result in the availability of FFP for this population.

G. Outreach Requirements (PPACA § 2201)

The ACA requires that states conduct outreach and assistance to vulnerable and 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.” PPACA § 2201 (new Social Security Act § 1943(b)(1)(F)). In the preamble to the Medicaid proposed rule, CMS states that it intends to implement this provision through subregulatory guidance. 76 Fed. Reg. at 51161. NACHC urges CMS instead to promulgate a regulation setting forth required outreach activities.

By one organization’s estimate, a vigorous outreach program by states could draw half-again as many new Medicaid beneficiaries (23 million, as opposed to 16 million) to Medicaid programs nationwide by

the year 2019 as a result of the ACA, than if states conducted very little outreach.⁴ Outreach is particularly critical to recruit individuals who may be eligible for the “adult group,” comprised of non-disabled, non-elderly adults who have never before been eligible for government-funded health coverage.⁵ Drawing these uninsured populations into the health care system is a key goal of the ACA, and health centers, which are particularly well-qualified to serve the newly eligible population, have a strong interest in states’ conducting outreach. NACHC urges CMS to implement this statutory provision in a meaningful manner.

H. Coordinated Eligibility and Enrollment Systems; Outstationed Eligibility Workers

Outstationed eligibility workers (OEWs), whom State Medicaid agencies are required to place in FQHCs and disproportionate share hospitals pursuant to Social Security Act § 1902(a)(55), may play a key role in both outreach and in educating prospective beneficiaries about the eligibility determination process. CMS has never promulgated regulations implementing the requirement for States to place OEWs, and the current reform of Medicaid eligibility rules provides an occasion to do so. OEWs, who frequently assist vulnerable and underserved populations, such as persons of limited English proficiency, are uniquely positioned to ensure that the “coordinated eligibility and enrollment system” for the insurance affordability programs (see proposed 42 C.F.R. § 435.1200(c)) is accessible to these populations. NACHC recommends that CMS require, through either a revision to proposed 42 C.F.R. § 435.1200 or in the regulation implementing PPACA § 2201, that States equip FQHCs and disproportionate share hospital OEWs with internet kiosks, so that the web-based application mandated by the ACA (see proposed 42 C.F.R. § 435.1200(d)) is more accessible to low-income consumers without internet access or with limited English proficiency.

Thank you again for the opportunity to comment on this important proposed rule. Please do not hesitate to contact me by telephone at (301) 347-0400 or by e-mail at rschwartz@nachc.org if you require any clarification on the comments presented above.

Sincerely,



Roger Schwartz
Associate Vice President of Executive Branch Liaison
National Association of Community Health Centers

⁴ Kaiser Comm’n on Medicaid and the Uninsured, *Medicaid Coverage and Spending in Health Reform* (2010), Tables 7 and 11.

⁵ A panel of experts recently concluded that about one in six currently uninsured adults with income below 133% FPL (a demographic roughly corresponding to the “adult group”) is seriously mentally ill, and a much larger percentage need some form of mental health or substance abuse services. Kaiser Comm’n on Medicaid and the Uninsured, *Medicaid Policy Options for Meeting the Needs of Adults with Mental Illness Under the Affordable Care Act* (hereinafter, “*Medicaid Policy Options*”) (Apr. 2011), p. 3.