NATIONAL ASSOCIATION OF
Community Health Centers

May 7, 2012

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

Re: Medicaid Program; Eligibility Changes in the Affordable Care Act of 2010, Interim Final Rules

Dear Sir or Madam:

The National Association of Community Health Centers, Inc. ("NACHC") submits the following comments in response to the interim final rule regarding Medicaid eligibility published by the Centers for Medicare and Medicaid Services ("CMS") on March 23, 2012. 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.

I. Background on FQHCs

There are, at present, more than 1200 FQHCs 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 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.

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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 appreciates the many improvements that have been made to the proposed regulation issued in August 2011. However, we are concerned with several of the new options proposed in the interim final rule. We address below several of these concerns and provide recommendations, accordingly.

435.912 Timely Determination of Eligibility

We support the addition of this paragraph, which requires Medicaid determinations to be made promptly and without undue delay. However, we believe the regulation leaves open the possibility of unnecessary delay in the eligibility determination process, particularly when the process is bifurcated between agencies. In keeping with Section 1413 of the Affordable Care Act, consumers should be able to apply for coverage using a "single, streamlined form" to apply for all insurance affordability programs. There should be a unified process with a single set of timeliness standards that apply regardless of the ultimate outcome of the eligibility determination. The preamble to the rule clearly envisions real-time eligibility determinations for insurance affordability programs; however regulation text does not fully implement this approach.

Recommendation on outer limits: We believe the proposed timelines should be shorter than those suggested, which remain unchanged from those already in place for Medicaid (90 days for disability related determinations and 45 days for all other determinations). The original outer timeliness limits in Medicaid were created at a time when the application process was reliant on in-person interactions and paper-based verification using standard mail. In keeping with the notion that improved

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

technology will enable faster determinations, even for more complex cases, we recommend revising the current outer limits to 60 days for disability-related determinations and 30 days for all other determinations.

Recommendation on general standard for simple determinations: We suggest that the regulation stipulate more specific parameters for simple MAGI determinations when all applicable eligibility information is readily available. For example, for applications submitted electronically (either through the online application or over the phone), if all of the information needed to make a determination is available on the application and/or from electronic databases, the determination should be made within one business day of receipt of the application.

Likewise, when a Medicaid agency is evaluating an applicant for potential eligibility for other insurance affordability programs, if the applicant appears not to be eligible for Medicaid, the agency should be required to transfer the electronic account to the other relevant insurance affordability program within one business day of receipt of the application.

In slightly more complex cases, when a Medicaid eligibility determination is contingent on the applicant providing documentation, we propose that CMS consider the feasibility of a "stop the clock" provision, so that the applicant has adequate time to collect any needed documentation. When such documentation has been provided, the state should have no more than three days to make its final determination.

Recommendation on applicable time period: Paragraph (c)(1) states that the timeliness and performance standards "must cover the period from the date of application or transfer from another insurance affordability program to the date the agency notifies the applicant of its decision or the date the agency transfers the individual to another insurance affordability program." This language could be read to provide that the "timeliness clock" would reset each time an individual's application was handed off from one agency to another, effectively multiplying the number of days between the date of application and the date by which an individual has a right to a determination. If our suggested timeliness standards are adopted, this is less problematic, since non-complex cases would still need to be resolved within approximately a week. However, if shorter standards are not adopted, this could result in months-long delays before a determination is made, with little or no recourse for the consumer. Given the streamlined enrollment procedures envisioned by Section 1413 of the Affordable Care Act, we believe it is necessary for CMS to clarify that the outer limits of the timeliness standards apply to the entire process from the time an application is submitted until all individuals seeking coverage through the application have received eligibility determinations, regardless of the number of transfers between insurance affordability programs.

435.1200 Coordination of Eligibility and Enrollment among Insurance Affordability Programs – Medicaid Agency Responsibilities

457.348 Determinations of CHIP Eligibility by Other Insurance Affordability Programs

457.350(a), (b), (c), (f), (i), (j), and (k) Eligibility Screening and Enrollment in Other Insurance Affordability Programs (by CHIP agencies)

These sections implement the Medicaid and CHIP provisions of the Affordable Care Act's "No Wrong Door" approach (as described in Section 1413 of the ACA) for streamlined eligibility and enrollment in insurance affordability programs. NACHC is concerned, however, that the eligibility and enrollment regulations for Medicaid/CHIP and exchanges allow for unnecessary bifurcation in the eligibility and enrollment process that undermine the intent and goal of the "No Wrong Door" approach. As a result, eligible individuals may fall through the cracks as their applications are handed off from agency to agency, and states may waste scarce administrative dollars conducting unnecessary and inefficient determinations. We provide, therefore, several recommendations relevant to the Medicaid/CHIP regulations on this issue.

Recommendation: Clarify that the agreements referenced in paragraph 435.1200(b)(3) on the delineation of eligibility determination responsibilities between Medicaid agencies and other insurance affordability programs must be approved by CMS and must be readily available to the public on the state Medicaid agency's as well as CMS's website, not simply available to the Secretary of HHS upon request. The public should also be given opportunities to provide input on these agreements and any major changes to such agreements in the future. We recommend the same clarifications with respect to the agreements described in 457.348(a).

Paragraph (d) (and corresponding CHIP language at 457.348(c)) outlines how Medicaid agencies are to handle applications that are screened by another insurance affordability program as potentially Medicaid eligible and transferred to the Medicaid agency. We are concerned that Medicaid agencies may largely repeat eligibility determinations already conducted by an exchange if they opt to use different policies and procedures for Medicaid determinations than the exchange. In the transfers from an exchange to a Medicaid agency referenced in paragraph (d), the exchange is obligated to transfer any information that was collected and verified to the Medicaid agency. Medicaid agencies are obligated to accept and use the data unless they elect to apply different policies and procedures than those used by the exchange. This could result in some states having two parallel tracks of eligibility policies and procedures: one set that is consistent with federal rules and used by the exchange to make Medicaid assessments, and one set that is actually used by the Medicaid agency for determinations. To the extent that the latter set of rules requires more or different kinds of verification, the consumer could be asked to prove the same eligibility criteria in multiple ways.

The option to bifurcate the eligibility process appears to be inconsistent with the language in paragraph (a) of section 1413 of the Affordable Care Act, which states that "[I]f an individual applying to an exchange is found through screening to be eligible for medical assistance under the State Medicaid plan under title XIX…the individual is enrolled for assistance under such plan." These additional verifications for a Medicaid agency may also constitute a deviation from the requirement in paragraph (b)(1)(A)(i) of section 1413 for "a single, streamlined form that can be used to apply for all applicable state health subsidy programs within the state." Further, paragraph (b)(2) of the same section requires

that applicants "shall receive notice of eligibility for an applicable state health subsidy program without any need to provide additional information or paperwork unless such information or paperwork is specifically required by law when information provided on the form is inconsistent with data used for the electronic verification or is otherwise insufficient to determine eligibility." We believe the new option for exchanges *not* to conduct Medicaid determinations could result in a system that is inconsistent with section 1413 and unnecessarily shifts additional burden onto consumers without having any apparent benefit to the entities administering the programs.

Recommendation: In states that choose to coordinate eligibility using an arrangement in which an exchange provides assessments rather than determinations of Medicaid eligibility, the Medicaid agency should be required to ensure that any databases or verification procedures it uses are equally available to the exchange to use. This will ensure that assessments conducted by exchanges are as robust as possible, so that when the account is transferred to the Medicaid agency, the final determination can be made as quickly as possible without requiring additional information from the consumer. This may be the intent of the rule as written, however, we believe it would strengthen the rule to clarify that Medicaid agencies must agree to grant the exchange access to any databases it uses for Medicaid eligibility determinations.

Recommendation: State Medicaid agencies should be required to demonstrate to CMS that they have the capacity to fulfill their responsibilities with respect to receiving Medicaid assessments and making final eligibility determinations without making the process more cumbersome for consumers than if the exchange were permitted to make Medicaid eligibility determinations. Specifically, CMS should require concrete demonstration, via a readiness assessment (for example, by accepting and processing test cases transferred from the exchange) and other means, that the state's Medicaid agency has the capacity to (1) conduct MAGI eligibility determinations in accordance with the new rules (including eligibility rules and verification procedures); (2) accept electronic information via secure electronic interface from an exchange; and (3) process eligibility determinations without any re-verification of existing data. We believe that there should be a preference for non-bifurcated, fully-integrated enrollment systems that limit the number of transfers and "hand-offs" during eligibility determinations.

We support the provisions in paragraph 435.1200 (f), which require Medicaid agencies to create a public website that operates in conjunction with, or links to, the exchange and CHIP websites; supports applicant and beneficiary activities; provides information in plain language; and complies with accessibility standards for people with limited English proficiency and for people with disabilities. We suggest one clarification below to the provision at paragraph (f)(ii), to ensure Medicaid enrollees can report changes in circumstances through such a website.

Recommendation: In paragraph (f)(ii), include "reporting changes in circumstances" and "accessing account information" to the list of beneficiary activities that a Medicaid website should support.

457.340(d) Timeliness Standards for CHIP Eligibility Determinations

NACHC supports the requirement that CHIP eligibility determinations be made "promptly and without undue delay", consistent with the standards described for Medicaid determinations at 435.912. We share the same concerns with timeliness standards for CHIP determinations as we expressed for Medicaid determinations, and we hope that any clarifications made to section 435.912 will also apply to CHIP determinations by way of the existing cross-reference to that section.

We have one CHIP-specific concern. Paragraph (d)(2) requires states to define the date of application. There is not a parallel requirement for Medicaid or exchanges. This sets up a potentially confusing, inconsistent system in which the date of application for an individual receiving a CHIP determination—the date from which the timeliness standards are calculated—could be different than the date of application for other insurance affordability programs. The date of application could even be different for individuals in the same household applying via the same application (e.g. parents likely eligible for premium tax credits in the exchange who have children who are likely eligible for CHIP).

Recommendation: The date of application should be defined the same way across all insurance affordability programs, consequently we recommend removing the ability for the state to define the date of CHIP application by striking paragraph (d)(2).

Thank you for this opportunity to offer our comments on this regulation. If you have any questions, please contact me at rschwartz@nachc.org or at 202-296-0158.

Sincerely,

Roger Schwartz
Associate Vice President of Executive Branch Liaison