

May 7, 2012

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 Provisions of the Exchange and Medicaid Rules Released on March 23 and March 27, 2012

Dear Secretary Sebelius:

As organizations that share a strong commitment to the health of our nation's children, we submit the following comments on the interim final provisions included in the final Exchange and Medicaid rules published in the *Federal Register* on March 23 and 27, 2012 (§435.1200 and §155.302).

## OVERVIEW

The final Exchange and Medicaid rules will be critical to our shared goal of creating a simplified, streamlined enrollment and application process and appropriate assistance for applicants in need. The Affordable Care Act (ACA) sought to ensure a simple, unified pathway to health coverage for consumers. We are pleased to see that the final rules offer some important consumer protections, such as:

- Prohibiting states from duplicating verification of information or asking for information or documentation provided earlier in the enrollment process.
- Informing applicants of their enrollment status and final eligibility determination.
- Allowing families to request and receive a full eligibility determination by the Medicaid agency that considers disability-based pathways to coverage.

While we appreciate the inclusion of these provisions, we are very troubled by the ways the final Exchange and Medicaid rules depart from earlier proposed rules. Many provisions would potentially undermine the ACA's clear intent to establish a simple, unified pathway to health coverage for consumers. We are particularly concerned by the decision to allow Exchanges to forego responsibility for conducting Medicaid determinations and, instead, to hand off applications to Medicaid and CHIP agencies for a final eligibility determination. In many states, this decision could lead to the fragmentation of eligibility systems, an issue of particular importance to the nation's children because they often reside in families that will be required to navigate both Exchange subsidies and Medicaid or CHIP. In these families, many of whom are low-income, a range of circumstances—family members covered by different eligibility categories or programs, income fluctuations, household composition changes—could force them to navigate both the Exchange and Medicaid or CHIP during the course of a single benefit year. In fact, the Urban Institute estimates that 75 percent of parents who qualify for subsidized Exchange coverage will have children who qualify for Medicaid or CHIP.<sup>1</sup> Unfortunately, we know that families in this situation are at greater risk of falling through the cracks of coverage and that a fragmented eligibility system will exacerbate this risk. For example, research on the experience with CHIP and Medicaid has shown that children eligible for Medicaid or CHIP with a sibling who is eligible for a different program are more likely to be uninsured, and this likelihood increases significantly in states with separate Medicaid and CHIP programs.<sup>2</sup> As a result, we are deeply concerned that it is the nation's children who will most frequently suffer if states fail to establish simple, user-friendly eligibility and enrollment systems. We respectfully urge the Secretary to reconsider these sections

in light of our shared goal to expand health coverage for our nation's most vulnerable children and families.

## **BACKGROUND**

The Affordable Care Act (ACA) prescribes a seamless, streamlined eligibility process for consumers to submit a single application and receive an eligibility determination for enrollment in any of the insurance "affordability programs" (i.e., advance premium tax credits, cost-sharing reductions, Medicaid, CHIP, and, if applicable in a state, the Basic Health Program). The goal is to create a "no wrong door" approach to coverage that offers multiple ways to apply and ensures that no matter how a family or individual chooses to apply for or renew coverage, they are screened for and enrolled in the appropriate program without having to take any additional or repetitive steps.

In the proposed rules released in 2011, Exchanges were expected to conduct Medicaid determinations and to ensure people were enrolled in the appropriate program. Under the new rules published on March 23 and 27, 2012, however, states can elect to have an Exchange merely conduct a preliminary "assessment" of potential Medicaid eligibility and then relinquish the final eligibility determination to the Medicaid agency (§435.1200 and §155.302). Under such a model, responsibility for key functions may be divided, creating significant risk of a fragmented and uncoordinated system. As noted above, based on the experiences of states seeking to coordinate coverage between Medicaid and separate CHIP programs, we know that "handoffs" between affordability programs can lead to eligible people falling through the cracks even when states have the best of intentions. We also are concerned that states facing political or fiscal constraints may not be as eager to maximize coverage among eligible children and families and this split model provides an indirect means to slow down enrollment into Medicaid/CHIP.

## **SPECIFIC COMMENTS**

While we do not support splitting eligibility responsibilities, if HHS retains this option for states, we believe, at minimum, that the safeguards included in the final regulation need to be preserved and further strengthened to ensure that consumers are enrolled in the appropriate source of coverage in a streamlined fashion. We offer below some specific recommendations on how the coordination provisions of the final rule could be improved.

### **1. Establish Active Approval Process**

If a state is going to be allowed to adopt a more complicated eligibility system than necessary, it should be required to first establish that it could do so without harming families. To that end, HHS should require states seeking to bifurcate their eligibility systems to actively validate their operational readiness to implement this more complicated structure by 1) 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; 2) 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; 3) 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. It should not be enough for states to simply check boxes on an Exchange Blueprint document saying that they will do all of these things; they should be required to actively demonstrate their operational capacity to do so.

## **2. Eliminate Duplicative Eligibility Determinations.**

We encourage you to ensure that the final rule minimizes the extent to which states can conduct duplicative eligibility determinations. For example, the final rule could require Exchanges to conduct their 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. In the absence of such measures, a Medicaid agency may need to largely repeat an Exchange's "assessment" of potential Medicaid eligibility using slightly different rules. To the maximum extent possible, states should be expected to use a single shared system between the Exchange and Medicaid/CHIP so that eligibility determinations need to be made only once.

## **3. Strengthen Timeliness and Performance Standards**

We are concerned that the timeliness standards outlined in the Medicaid rule provides states with up to 45 days to conduct eligibility determinations for individuals without disabilities and 90 days for people seeking coverage under a Medicaid category for people with disabilities. For children and pregnant women, these time-periods are excessively long. Consider, for example, that the American Academy of Pediatrics' Bright Futures guidelines expect newborns to see their health care providers three times by the time that they are one month old, making it imperative that they not have to wait 45 days for coverage. Similarly, prenatal care is critical to ensure healthy birth outcomes. Delaying these crucial services, especially for high-risk pregnant women who are more likely to be on Medicaid, could jeopardize the health of the mother and her child, increasing the risk of preterm birth and low birth weight as well as other adverse outcomes. Delays also could disrupt health services for children with complex medical conditions, who need reliable and continuous care.

Particularly given that the federal government is making a massive investment in new eligibility system technologies, 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, with a 60-day ceiling for those being evaluated for disability-based coverage. Any transfers between Medicaid or CHIP and the Exchange should be completed within a day and remain subject to the maximum of 30 or 60 days (i.e., the clock does not reset when a case is transferred). In addition, HHS should establish clear performance standards to measure the overall performance across all applicants with a clear expectation that eligibility will be determined quickly and for the vast majority of applicants well before the expiration of the 30-day maximum period. Finally, the Exchange rule should be aligned with and reflect the timeliness and performance standards for Medicaid to ensure expectations are consistent.

## **4. Improve Transparency**

Given the central role that eligibility determinations will play in the effectiveness of the ACA in serving children and others, we believe it would be appropriate that children's advocates, health care providers, and other members of the public have the opportunity to learn about and provide input into the way that such determinations are conducted. Under the latest rule, states are required to establish agreements between the Medicaid agency and the Exchange, including details concerning timeliness standards and coordination across programs. Such agreements should not only be "available" to the Secretary, but should require her/his approval. The State plan, the agreements between state agencies, and the state's verification plan should all be readily available to the public on both the state and HHS websites to provide a greater level of accountability.

## **5. Promote Use of Presumptive Eligibility**

If a state elects to have its Exchange merely conduct a preliminary “assessment” of potential Medicaid eligibility and then relinquish the final eligibility determination to the Medicaid agency, HHS should encourage or require the Exchange to determine a child or pregnant woman to be presumptively eligible for coverage in Medicaid and/or CHIP and immediately enrolled for the duration of the determination process. While such a requirement would not eliminate the problems created by fragmented eligibility systems, it could go a long way toward mitigating the negative effect on children and pregnant women.

Our organizations appreciate your hard work on these interim rules and the addition of safeguards for consumers. Thank you for considering these comments and recommendations as you continue the work to provide gateways to health coverage that work best for our nation’s children and their families.

Sincerely,

American Academy of Pediatrics  
Ascension Health  
Association for Community Affiliated Plans  
Children’s Defense Fund  
Children’s Dental Health Project  
Children’s Health Fund  
Children’s Hospital Association  
Enroll America  
Family Voices  
First Focus  
Georgetown University Center for Children and Families  
March of Dimes  
National Alliance to Advance Adolescent Health  
National Association for Children’s Behavioral Health  
Voices for America’s Children

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<sup>1</sup> Estimates by the Urban Institute.

<sup>2</sup> Hudson, J (2009). “Families With Mixed Eligibility for Public Coverage: Navigating Medicaid, CHIP, and Uninsurance.” *Health Affairs*, 28, no. 4:w697-w709.