



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 Medicaid and Exchange Rules Released on March 23 and March 27, 2012

Dear Secretary Sebelius:

We appreciate the opportunity to comment on the interim final provisions (§435.1200, §457.348, and §155.302) included in the final Medicaid and Exchange rules published in the *Federal Register* on March 23 and 27, 2012, relating to the eligibility determinations and enrollment of individuals into health coverage under the Affordable Care Act (ACA). In addition, this letter provides comments on §155.220 relating to the role of brokers in enrolling people in coverage and the safeguarding of information in §431.300 and §431.305.

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. Because it will be so critical for Exchanges to function smoothly in tandem with states' Medicaid and CHIP programs we are submitting our comments on these two rules together.

The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center whose mission is to expand and improve health coverage for America's children and families. Central to our work is providing research and policy assistance to state administrators and state-based organizations on strategies for covering children and their families through public insurance affordability programs, especially Medicaid and CHIP. We conduct research and analysis to inform federal and state policymakers about issues impacting children and families in health care reform and to improve Medicaid and CHIP, particularly around streamlining enrollment and renewal systems.

COMMENTS ON COORDINATION PROVISIONS (§435.1200, §457.348 and §155.302)

Overview

§435.1200, §457.348, and §155.302 of the latest Exchange and Medicaid rules represent a marked departure from the original proposed rules and, we believe, from the clear intent of the Affordable Care Act that states 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 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. As a result, it is the nation's children who will most frequently be in the crossfire if states fail to establish simple, user-friendly eligibility and enrollment systems.

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, Medicaid, CHIP, and the Basic Health Program, if applicable). 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 ensure people were enrolled in the appropriate program. Under the new interim final 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, §457.348, and §155.302). Under such a model, responsibility for key functions will be divided, creating significant risk of a fragmented and uncoordinated system in some states. Based on the experience of states seeking to coordinate coverage between Medicaid and separate CHIP programs, we know that "hand offs" 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 interested in minimizing enrollment for political or fiscal reasons could hide behind this handoff model as an indirect means to slow down enrollment in Medicaid/CHIP.

Additionally, the interim final rule (§155.302(b)(4)(A)) requires states operating a bifurcated system to provide applicants with the opportunity to withdraw their application

for Medicaid if they are found to be potentially ineligible for coverage by the Exchange. Such a request would be highly confusing for families, especially as many will find themselves split between different affordability programs.

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. Additionally, HHS should revisit the decision to allow states to bifurcate their eligibility systems in 2016, similarly to how it has proposed reconsidering decisions relating to essential health benefits and minimum value.

1. Active Approval Process

We believe that 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 can do so without harming families. To that end, HHS should require states seeking to bifurcate their eligibility systems to actively demonstrate 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; and 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. Elimination of Duplicative Eligibility Determinations.

The interim final regulations (§435.1200(d)) require that the agency receiving the case accept any finding relating to eligibility criteria from the transferring agency (as long as such findings are made in accordance with the states' policies and procedures) and not request any information or documentation already supplied by the applicant. Such a requirement could streamline the eligibility process, as neither agency would be duplicating verification processes that have already been completed. It could also help safeguard applicants from having to submit or resubmit supporting documentation.

This requirement should be retained, but strengthened in the final regulation, as the concern remains that states could 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. 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. If such data are unavailable, states should be required to accept verification from a sister agency, whether or not the procedures and standards exactly mirror those that they would use. 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 and verification procedures.

In addition, the proposed regulations require that the Medicaid program notify the transferring program that it has received the electronic account and the final eligibility determination. This communication between agencies will help to ensure that applicants are not lost in the transfer and should be retained in the final rule. 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.

3. Strengthen Timeliness and Performance Standards

We are concerned that the timeliness standards outlined in the latest rule provides states with up to 45 days to conduct eligibility determinations for most individuals and 90 days for people seeking coverage under a Medicaid category for people with disabilities. 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 for people not being evaluated for disability-based coverage or more than 60 days for those applying on the basis of disability.

It is also concerning that these outside limits could be violated in the situation where a case is transferred between agencies, as the clock appears to reset when such a transfer occurs. We understand the concern that if an application is transferred later in the process, the receiving agency may have a limited amount of time to make an eligibility determination. However, given that the transfer is required to occur through an electronic interface, we believe that additional guidelines should be required so that applicants do not find themselves in limbo for extended lengths of time, thereby abandoning the real-time eligibility determination envisioned under the ACA.

In order to protect against this prospect, additional timeliness standards should be incorporated into the final rule (or at minimum sub-regulatory guidance). For example, standards could be established in circumstances where an applicant is determined potentially eligible for another insurance affordability program and his/her electronic account must be transferred for a full determination. In addition, when establishing performance standards, benchmarks should be used to evaluate a state's ability to process applications "promptly and without undue delay." For example, states should be required to process a certain percentage of applications within 10 days. Establishing additional requirements within the 45-day outer limit would help ensure that the majority of cases

have eligibility determined within that time period. As mentioned above, this process is anticipated to be automatic and required to occur through an electronic interface, as such, these requirements seem reasonable.

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.

The interim final rule also proposes that states administering a separate CHIP program are able to define the date of application. Such flexibility could result in disparate application dates across programs and should not be allowed in order to ensure 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.

Additionally, as mentioned in the proposed regulation, timeliness and performance standards need to be included in the State plan and would be subject to approval by the Secretary. Such a requirement should be retained in the final regulation and as data matches and technology improve, expectations of timely processing should be adjusted accordingly. Also, in order to receive the enhanced administrative matching rate for systems, states need to meet certain criteria. By further tying the timeliness standards in processing applications to the systems criteria, for example, by requiring states to conduct readiness assessments documenting their ability to adhere to the guidelines, states would have a greater incentive to meet the standards.

4. Greater 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.

COMMENTS ON THE ROLE OF BROKERS IN ENROLLMENT (§155.220)

Background

The latest version of the Exchange rule clarifies in §155.220 that brokers and agents may enroll people in qualified health plans (QHPs) in a manner that constitutes enrollment via an Exchange (and, hence, triggers potential eligibility for advance premium tax credits (APTCs) and cost-sharing reductions (CSRs)). In addition, §155.302(a)(3) indicates that brokers and agents can assist people in applying for APTCs and CSRs. Under the regulation (§155.220(a)(3)), agents and brokers would be required to comply with the terms of an agreement with the Exchange, including a requirement to: 1) register before assisting consumers, 2) receive training, 3) comply with the privacy and security standards of the Exchange, and 4) abide by state law.

We believe that stronger federal standards are needed in this portion of the rule to appropriately define the role of agents and brokers. Such standards are important because Exchanges represent a new and unique marketplace serving a very different population than agents and brokers generally assist. The Exchanges are intended to be consumer-friendly marketplaces where families find important, unbiased information on which to make smart decisions about their health insurance. Brokers and agents can play a constructive role in this new system if they are unbiased and provide useful and family-specific assistance to customers. As noted above, it is particularly important that agents and brokers have the capacity to help families navigate the full array of affordable coverage options because so many families will have adult members who qualify for subsidized Exchange coverage while their children qualify for Medicaid or CHIP.

Specific Comments

1. Strengthen Requirements for Brokers Assisting with Enrollment in Coverage

HHS should strengthen the interim regulation to ensure that when states choose to allow agents and brokers to assist with applications for financial assistance through the insurance affordability programs that the agents and brokers are held to the same high expectations that are required of navigators, including:

- a. Demonstrating to the exchange that they have adequate ability to serve the needs of low-income and hard-to-reach populations; and
- b. Abiding by conflict of interest standards that, at a minimum, ensure they act in the best interest of the client or consumer and that prohibit steering enrollees toward specific plans or other activities that potentially undermine the success of the exchange.

In addition, the final rules include a number of requirements for web sites used by agents and brokers that should also apply specifically to agents and brokers that assist with enrollment, such as providing information that shows the full range of coverage options available to a consumer through the exchange.

States should also be required to develop rules that specify when, how, and what agents and brokers must disclose to consumers regarding: 1) any financial compensation provided, 2) any conflicts of interest the agent or broker has and 3) the fact that consumers are not required to use an agent or broker to apply for insurance affordability programs, compare plans and coverage options, receive other benefits of the Exchange, or enroll in a QHP.

2. Require Monitoring and Public Reporting of Data on Agents and Brokers

States that opt to permit brokers to serve the “assistance” function outlined in §155.220(a)(3) should be required to include in their exchange Blueprint (or other similar document if the state is performing selected functions in connection with a federally facilitated exchange) details of the compensation arrangements with these brokers. States should be required to describe how they will monitor and minimize adverse selection and prohibit directing enrollees into coverage for reasons unrelated to the consumers’ best interests. This may include the collection of data by exchanges and by HHS to compare the enrollment trends of people enrolling on their own through the exchange to those enrolling through agents and brokers to uncover patterns or evidence of steering. It may also include a requirement that agents and brokers submit to Exchanges all levels of compensation received from QHP issuers as well as non-QHP issuers.

COMMENTS ON PRIVACY AND SAFEGUARDING OF INFORMATION (§431.300 and §155.305)

Background

For many applicants, enrollees, and beneficiaries, privacy and security of personally-identifiable information (PII), including its collection, use, and disclosure by government agencies, is an important concern, especially as breaches of confidentiality and privacy laws by government can have grave consequences. In implementing the ACA, the government will collect, use, and disclose PII through the Federal data services hub and other means. It is critical to ensure that the privacy protections and limits on disclosure and use of the information apply to each entity that receives or transmits the information and at each stage of the eligibility determination and renewal processes.

The final Exchange rules address the critical issue of personal security through an expanded and strengthened privacy rule that applies to both individual market Exchanges and to SHOP exchanges, with civil penalties for violations. In the final Medicaid rules, HHS also applies the Exchange requirements to State agencies and their contractors, extends confidentiality protections to non-applicant information and to the use of an SSN, and applies privacy restrictions broadly to renewal and verification processes.

Specific Comments

HHS has issued several privacy regulations as interim final rules with a request for comment. As a general matter, we support the strongest possible privacy regulations. We understand that restrictions on the ability to collect, use, and disclose personal information

may increase administrative burden, but we believe that because of the sensitive nature of the data collected to determine eligibility, the balance should be weighted in favor of protecting the individual.

1. Support Restricting Information Exchanged by State Agencies.

In the interim final rule, HHS requires that in verifying eligibility State agencies exchange only the information necessary for determining eligibility (§431.300(c)(1)). The interim rule further provides that information received by the Internal Revenue Service (IRS) will be shared only with those law enforcement and intelligence agencies authorized to receive such data through requests related to terrorist activities. We support this rule and recommend it be made final.

We support restricting the information that may be disclosed to only that necessary for program administration. Regulations currently describe the purposes directly connected to the administration of a program to include: establishing eligibility, determining the amount of medical assistance, providing services for recipients, and conducting or assisting an investigation or legal action related to the administration of the plan.

We also support the inclusion of the IRS restrictions regarding the strict confidentiality of tax return information, which is essential to the seamless protection of privacy across agencies charged with implementing the ACA. This IRS confidentiality provision has a long tradition of promoting integrity in the U.S. tax system by assuring taxpayers that the information on their tax returns will never be used for purposes other than revenue collection and its inclusion emphasizes that nothing in the administration of health insurance premium tax credits will undermine that tradition and that protection. However, the exception to §6103 relating to PII pertaining to terrorist activity is also unchanged by the ACA and it is important for consumers to be informed that their confidentiality protection is not absolute.

2. Support Safeguarding of Information Received.

§431.305(b)(6) clarified that an agency regulated by HHS (including Medicaid, CHIP, and the Exchange), must safeguard information received for verifying income eligibility and the amount of medical assistance payments from the Social Security Administration (SSA) or the IRS, in accordance with the requirements of the agency that furnished the information. This rule also provides a cross-reference to the additional IRS and SSA privacy protections, all of which must be included in the body of privacy rights afforded to individuals in implementation of the ACA. We support the application of safeguards to verification procedures generally and to verification of income and medical assistance.

§431.10 Single State Agency

We are submitting comments on this section even though it was issued as a final rule. We ask that you withdraw this provision and allow further comment because it departs sharply from what was initially proposed. Moreover, we are concerned about whether it has implications for the ability of states to adopt unified eligibility systems, and believe that these issues should be considered in tandem.

BACKGROUND

The proposed rule would have allowed exchanges operated by governmental agencies to determine eligibility for Medicaid. The preamble explained why historically only public employees have been allowed to determine eligibility for Medicaid, noting concerns that the determination of eligibility involves “discretion or value judgment that are inherently governmental in nature.” It pointed out that section 1413(d)(2)(B) of the ACA “reaffirms the single State agency requirement.” The preamble then noted that exchanges operated by non-governmental entities might have to co-locate Medicaid workers at the exchange to ensure coordination and asked for comment on how to “accommodate the statutory option for a State to operate an Exchange through a private entity, including whether such entities should be permitted to conduct Medicaid eligibility determinations consistent with the law.”

The final rule goes well beyond the issue raised in the preamble regarding how exchanges operated by non-governmental entities can determine Medicaid eligibility. It would allow *any* exchange to contract out the determination of Medicaid eligibility to a private entity. Under the final rule, an exchange operated by a government agency could contract with a private entity to determine eligibility for all insurance affordability programs. This possibility was not raised in the proposed rule.

We believe that evaluating eligibility for health insurance affordability programs is an inherently governmental function that should not be contracted out.¹ For example, it requires access to and use of confidential personal information (e.g., information on income and immigration status) and has significant and direct financial implications for states, the federal government and individuals. To the maximum extent feasible, we encourage HHS to ensure that Exchanges rely on public employees for eligibility determinations. For example, in designing the federally-facilitated Exchange, we urge HHS to use public employees rather than contracting out eligibility determinations to private vendors. Similarly, when the federal government conducts APTC and cost-sharing reduction eligibility determinations on behalf of states, it should use public employees and not private contractors.

We note that the final rule includes stronger standards for the agreements between Medicaid agencies and exchanges that contract out the eligibility determination. We very much support these stronger standards, including the requirement that the single state

¹ OMB Circular No. A-76 (revised 2003) provides guidance on when a function is inherently governmental. It states that: “An inherently governmental activity is an activity that is so intimately related to the public interest as to mandate performance by government personnel. These activities require the exercise of substantial discretion in applying government authority and/or in making decisions for the government. Inherently governmental activities normally fall into two categories: the exercise of sovereign government authority or the establishment of procedures and processes related to the oversight of monetary transactions or entitlements.” Eligibility determinations clearly fit within this description of inherently governmental functions.

agency monitor and take action if it identifies any inappropriate incentives, such as to minimize enrollment in coverage. While we support these stronger standards, we are concerned that the impact of the agreements will be limited by the lack of a contractual relationship between the Medicaid agency and the private entity. If, for example, the performance of the contractor does not meet standards for timeliness or accuracy, the exchange would have to enforce the contractual standards. In some circumstances, a failure to meet performance standards may be due to inadequate staffing, which would require additional funding from the exchange that may not be available. As pointed out in the preamble to the proposed rule, one of the concerns about contracting out the eligibility determination is whether the state “would be able to effectively monitor and if necessary bring that capacity back ‘in house’ if policy implementation issues arose.”²

Finally, we believe that the assertion that private entities can follow merit system personnel practices warrants further discussion and input from knowledgeable parties because it may not be realistic. Regulations of the Office of Personnel Management (OPM) apply when federal law requires that local and state agencies must follow merit personnel systems, as is the case for Medicaid under section 1902(a)(4).³ These standards are specific to governmental employment and differ from the rules generally applied in the private sector. For example, the OPM standards would not allow “at-will” employment, which allows termination without good cause. In the absence of an agreement to the contrary, employment in the private sector is generally presumed to be at-will. Thus it is not clear that a private contractor could or would be able to comply with the requirement for merit system personnel standards as they are defined in the applicable OPM regulations.

Thank you for considering these comments as the Department continues its work to provide gateways to health coverage that work best for our nation’s children and their families.

Sincerely,

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Co-Executive Director

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² 76 Fed. Reg. 51169 (August 17, 2011).

³The regulations are at 5 CFR Subpart F.