**DRAFT CCF COMMENTS**

**February 15, 2013**

**PROPOSED RULE ON MEDICAID, CHIP, AND EXCHANGES: ESSENTIAL HEALTH BENEFITS IN ALTERNATIVE BENEFIT PLANS, ELIGIBILITY NOTICES, FAIR HEARING AND APPEAL PROCESSES FOR MEDICAID AND EXCHANGE ELIGIBILITY APPEALS AND OTHER PROVISIONS RELATED TO ELIGIBILITY AND ENROLLMENT FOR EXCHANGES, MEDICAID AND CHIP, AND MEDICAID PREMIUMS AND COST SHARING**

*Please note that CCF is in the midst of continuing to revise and reorganize these comments. We also will be adding additional topics to the document for comment, often borrowing from our colleagues at other organizations with deeper expertise.*

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# MEDICAID ELIGIBILITY AND ENROLLMENT CHANGES

**Extended Eligibility for Low-Income Families §435.112 and §435.115**

**Consider Pursuing Legislative Simplification of TMA.**  We support the proposed changes to the regulations governing the 4-month extension of TMA available to low-income families who qualify under section 1931 of the Medicaid statute. They represent common sense simplifications that allow HHS’s regulations to match the current statutory structure of Medicaid. While outside the scope of the proposed rule, we encourage the Administration to consider pursuing legislative changes that would allow for further simplification of TMA. In particular, it may want to consider pressing for elimination of the four months of TMA coverage in states that otherwise make coverage available to low-income adults and children because they have opted to extend Medicaid to adults up to 138 percent of the federal poverty level, as required by the ACA.

**Extended and Continuous Eligibility for Pregnant Women and Hospitalized Children (§435.170 and §435.172)**

We strongly support the provisions in §435.170 and §435.172, which further clarifies the statutory language in Title XIX that requires 1) pregnant women to be provided with continuous eligibility for coverage through the last day of the month in which the 60-day post partum period ends (including if they originally were enrolled via presumptive eligibility), and 2) hospitalized children to remain eligible for Medicaid – even if they otherwise would age out – through the end of a Medicaid-covered inpatient stay. By implementing these statutory requirements with greater clarity, the proposed regulation would help to promote continuity of care for two groups where it is of the utmost importance – pregnant women and hospitalized children.

**§457.355 Financing of CHIP presumptive eligibility**

The preamble to the proposed rule suggests that states might not be able to secure CHIP financing for the cost of providing presumptive eligibility to children enrolled in a CHIP-financed Medicaid expansion. We believe that this was unintended and ask that the final rule clarify that a state can use Title XXI funds for children covered for a presumptive eligibility period under Title XXI-funded Medicaid or separate state program CHIP coverage.

**Deemed newborn children (§435.117)**

In general, we strongly support the language in the proposed rule making it clear that babies born to all pregnant women covered under a Medicaid state plan, including those covered on a retroactive basis, under a Medically Needy category, and for emergency services only, should be deemed newborns.

**Add deemed newborn coverage to pregnant women enrolled in 1115 waivers.** In the final rule, we encourage you to add that women who become pregnant while enrolled in an 1115 waiver should also have their babies treated as deemed newborns. If this step cannot be taken, then we encourage HHS to require states to alert women who become pregnant while enrolled in 1115 waiver coverage of the importance of informing the state of their pregnancy and potentially securing an evaluation for Medicaid eligibility under a state plan. The state should be obligated to provide women with the pros and cons of securing the “regular” rather than the 1115 waiver Medicaid coverage, including the opportunity to receive a year of stable coverage for their newborns.

**Make deemed newborn coverage mandatory for children who move across state lines.** We appreciate that HHS has proposed giving states the option to treat babies who are moved within their first year of life as deemed newborns, but we believe the Congress intended for the deemed newborn provision to protect all babies born to women enrolled in Medicaid, including those who happen to move during their first year of life. We encourage you to convert the option to a requirement that states provide deemed newborn coverage to babies regardless of the state in which they were born.

**Adopt a simple policy of deemed newborn coverage for all babies born to women enrolled in separate CHIP programs.** We believe that Congress clearly intended for all babies born to pregnant women enrolled in Medicaid or CHIP to secure a year of stable coverage during the critical first 12 months of life. So, we encourage you to make it a requirement that states provide deemed newborn coverage to any baby born to a woman enrolled in CHIP, regardless of whether she happens to be enrolled as a targeted low-income pregnant woman or targeted low-income child. Not only is such a policy more consistent with congressional intent, but it would greater simplify administration of the deemed newborn policy. Otherwise, to secure deemed newborn coverage for her baby, a pregnant teenager would need to alert her state to her pregnancy and request to be switched from the category of “targeted low-income child” to “targeted low-income pregnant woman”. Such a policy would be silly and burdensome on pregnant teenagers and states alike, and would be entirely unnecessary if HHS simply adopted a clean requirement that all babies born to women enrolled in separate CHIP programs should receive deemed newborn coverage.

**§435.1100-1103 Presumptive eligibility**  
  
We support that the state may continue to use gross income as the standard for determining presumptive eligibility (§435.1102(a)). However, allowing states to alternatively require that qualified entities make a reasonable estimate of MAGI household income using simplified methods prescribed by the agency is likely to make it more difficult for qualified entities.

**Recommendation:** We recommend keeping the basis of presumptive eligibility determination at a gross income level.

We support disallowing qualified entities to delegate their authority to another entity (§435.1102(b)(2)(vi)).   
  
We support a requirement that states establish oversight mechanisms to ensure the integrity of presumptive eligibility (§435.1102(b)(3)). The two most important criteria for evaluating the effectiveness of the presumptive eligibility program are: 1) to evaluate the proportion of individuals determined presumptively eligible that submit a complete Medicaid application, and 2) the proportion of those who do apply who are determined eligible for Medicaid going forward. These two measures could be developed into standards that qualified entities are required to meet in order to maintain their authorization. This is similar to what is proposed under (§435.1110(d)) allowing states to disqualify hospitals that do not meet state-determined standards and additional comments are noted in that section.   
  
We also support that states be prohibited from requiring verification as this is contrary to the concept of “presumed” eligibility based on preliminary information (§435.1102(d)(2)). Often individuals need urgent access to health care services when being determined presumptively eligible and additional requirements beyond those that are statutorily required would potentially delay care and have additional health and cost consequences.  In this regard, we note there is no statutory basis for assessing presumptive eligibility on any basis other than income. §1920(b)(1)(A) and §1920A(b)(2)(A) of the Social Security Act indicate that the qualified provider or entity determines eligibility for the pregnant woman or child on the “basis of preliminary information, that the family income of the (woman or child) does not exceed the applicable income level of eligibility under the State plan.” Furthermore, §2001(a)(4) of the ACA adds a new §1920(e) of the SSA and extends presumptive eligibility under to other groups “in the same manner as the State provides for such a period under this section or section 1920A.”

**Recommendation:** Delete the additional options for making a presumptive eligibility determination at §435.1102(1).

While we believe that pregnant women should receive all services necessary to ensure her health which impacts the health of the baby, we understand that the basis of limiting benefits to ambulatory prenatal care (§435.1103(a)) is limited by statutory authority.

**Recommendation:** It would be helpful for CMS to provide a definition of ambulatory prenatal care in sub-regulatory guidance.

We support the extension of presumptive eligibility to other individuals (§435.1103(b)) in a way that is consistent with the implementation of presumptive eligibility for children and/or pregnant women.  
  
**§435.1110 Presumptive eligibility standards determined by hospitals.**  
  
We support that hospitals, now authorized by the ACA to conduct presumptive eligibility determinations regardless of whether a state has adopted presumptive eligibility for eligible individuals, must determine in accordance with policies and procedures established by the state and consistent with §435.1102 and §435.1103. It is important to take maximum advantage of the presumptive eligibility process to ensure that eligible individuals complete the full Medicaid eligibility process in order to secure ongoing coverage. Thus, we agree that states should have the option to require hospitals to assist individuals in completing and submitting the full application and understanding any documentation requirements (§435.1110(b)(2)).

**Recommendation:** We recommend strengthening this provision by requiring hospitals wishing to determine eligibility presumptively must attend training on policies and procedures established by the state.

We also support that hospitals that do not meet state-established standards may be disqualified from determining presumptive eligibility (§435.1110(d)). Such standards could include but not be limited to:

* The proportion of presumptively determined individuals who apply for full ongoing Medicaid without a gap between the end of the presumptive period and the beginning of ongoing Medicaid. States would set a threshold, for example 75% or presumptive beneficiaries, and disqualify hospitals not meeting the standard. The state process could potentially involve a warning to hospitals out of compliance and provide a specific period (i.e. 90 days) for the hospital to meet the standard or lose status as a qualified hospital.

The state could also set a standard for the proportion of who complete the full Medicaid application process and whose eligibility is determined for ongoing Medicaid coverage. Unless circumstances have changed between the presumptive determination and the final determination, this standard serves as a quality measure on the presumptive process.

# CITIZENSHIP DOCUMENTATION AND OTHER VERIFICATION PROCEDURES

**§435.406 Citizenship and non-citizenship eligibility.**

We support the requirement that newborns whose delivery was covered by any category of Medicaid or CHIP are exempt from citizenship documentation rules as the state has evidence that they were born in the United States on or after July 1, 2006 (§435.406(a)(1)(iv)(E)).

**§435.407 Types of acceptable documentary evidence of citizenship.**

We commend HHS for streamlining the complicated requirements of citizenship verification put into place in 2006. These regulations have proven burdensome and administratively costly while resulting in the denial or delay of coverage of eligible citizen children, pregnant women and parents. While we believe the citizenship of the majority of individuals can be verified through the federal data services hub or a direct electronic match with the Social Security Administration, there will be times when other documentation is needed. We believe streamlining of the process and the simplification of the documents that can be used as acceptable documentary evidence will ease the burden on families and states.

We support the clarification of policy regarding citizenship documentation (§435.407(a)), including specifying the types of documents that must be accepted as “stand-alone” documentary evidence of citizenship, including a valid driver’s license issued by a state that verifies the individual’s social security number and citizenship. We believe the specificity of the tribal documents will also be helpful to the states.

We support the simplification of documents that can be used when an individual does not have “stand-alone documentary evidence” to verify citizenship (§435.407(b)) and identity (§435.407(c)) separately, including conducting cross matches to a State vital statistics agency or other data sources.

We support aligning the acceptance of additional documents to verify a child’s identity for all children under age 19 (§435.407(c)(2)). This will enable Medicaid and CHIP agencies will not have to have duplicative processes and procedures.

We support the use of affidavits without requiring notarization for applicants of all ages (§435.407(c)(6)). We also strongly support that there is no longer a restriction against using affidavits for both citizenship and identify. While we don’t believe many individuals will require both affidavits, in some case especially for vulnerable individuals such as homeless persons, the use of both affidavits may be the only way that they will be able to verify their attestations.

We support that the state may rely on verification of citizenship or immigration status by a federal agency or another state, if such verification was made on or after July 1, 2006 (§435.407(d)). This will streamline the process for states using the findings of an express lane eligibility agency that also documents citizenship.

We support the requirement that states must provide assistance to individuals who need help in securing satisfactory documentary evidence of citizenship in a timely manner (§435.407(e)).

We know that the ability to accept a photocopy, facsimile, scanned or other copy of a document will ease the paperwork burden on families and agencies, and expedite access to coverage (§435.407(f)).

**§435.956 Verification of other non-financial information.**

The existence of the electronic data match for citizenship with the Social Security Administration (as authorized by §1902(ee) of the SSA) has proven the efficiency and cost-effectiveness of the electronic process, which will be replicated through the federal data services hub. Thus we strongly support the proposed regulations at §435.956(a) requiring that states must use the federal data services hub as a first step in verifying citizenship or immigration status.

We also support that when the federal data services hub is not available, states are required to use the electronic data match with the SSA to verify citizenship (§435.956(a)(i)) before requiring individuals to provide documentation. Additional comments regarding verification of immigration status if the agency is unable to verify through the hub are provided separately in our comments that focus on issues impacting immigrant families.

We support that the agency must provide a 90-day reasonable opportunity period as described in (§435.956(a(2)) when it is unable to promptly verify citizenship and immigration status, assist the individual in obtaining an SSN, resolving inconsistencies resulting from typographical or other clerical errors, and providing the individual with how to contact the source of electronic data to resolving discrepancy (§435.956(g)). The preamble requests comment on whether states should begin a period of time (such as a few business days) before triggering the reasonable opportunity period and issuing benefits. Given the high level of effectiveness of the electronic match with SSA, we believe that no more than two (2) business days is needed for states to attempt to verify citizenship through the federal data services hub or through an overnight electronic batch process with SSA, giving time for a second pass at a batch verification process after correcting data entry errors. The likelihood that both sources are unavailable at the same time is highly unlikely. Thus, allowing extra time will result in an unnecessary delay in benefits.

We support the requirement that states must maintain a record of having verified citizenship status for each individual, in a case record or electronic database and may not re-verify citizenship at renewal or subsequent application following a break in coverage (§435.956(a)(3)). We suggest that states be required to maintain this information for a period of 10 years.

**CHIP Citizenship Documentation**

**§457.380(b) Eligibility verification**

We support that newborns whose birth is covered by CHIP are exempt from any requirement to verify citizenship. We also strongly support that CHIP must verify citizenship or immigration status in the same manner as required by Medicaid at §435.926(a) and §435.956(g).

# FOSTER CARE CHILDREN

**Section 435.150 Former foster care children**

We are submitting with other colleagues longer comments on this section, and support much of the proposed regulation in this section. However we are very concerned with the regulation's interpretation of eligibility, which unnecessarily narrows Medicaid eligibility to a youth aging out in the state where

s/he was actually in care. We believe Congress intended that Medicaid coverage be available to former foster care youth regardless of where they are living until age 26.

As Sen. Landrieu the chief sponsor of this provision stated on the floor of the Senate on the Senate floor on December 22, 2009:

      “Some of the bill’s most important provisions will benefit the most important population—children. The underlying bill includes a provision allowing children to remain on their parents’ plans up until the age of 26. I have children. I would like to think that by 22 or 23, they will be on their own, they will be gainfully employed and off my payroll. But any of us who have raised children know that sometimes it takes a little more time to launch our children. I see Senator Shaheen, who is nodding. She has done this herself. It takes a little time to launch them. According to the latest data from the Census Bureau, in 2007 there were an estimated 13.2 million uninsured young adults. So the bill includes this important provision to allow kids to stay on their parents’ insurance for a bit longer as they transition into adulthood. But my question was, where do the young people who age out of the foster care system sign up, because they do not have parents? I was proud to work on a provision that Leader Reid included in this bill to *ensure that every young person who ages out of the foster care system will be able to stay on Medicaid until the age of 26 starting in 2014* (italics added). Almost 30,000 young people age out of the foster care system every year, having never been adopted or reunified with their birth parents. The fact that they aged out is our failure as government. We have failed them once and we just can’t fail them twice. We must support their transition to adulthood, and guaranteeing access to quality healthcare will help with that transition.” (*Congressional Record,*Senate Legislative Action, pages S13731 – 13733)

Moreover, we believe that the statutory language of the ACA allows HHS to interpret the foster care provision to apply to all children aging out of care, regardless of whether they continue to reside in the same state in which they were in care. The preamble to the proposed rule (p. 4604) states that it is the language that requires an individual be in foster care under the responsibility of “*the* state” and be enrolled in Medicaid under “*the* state plan” or an 1115 demonstration that led HHS to the decision that the Medicaid mandate only applies to children who remain in *the same* state after they leave foster care rather than in “*a state*.” However, another reading of that same language is possible.  The reference to “under the responsibility of the state” could also be a reference to the fact that the children in foster care who are eligible for Medicaid must have been “under the responsibility of the state” as opposed to under the responsibility of a private child caring agency. In talking about children in care in the custody of a state, the use of the term “under the responsibility of the State” is a familiar term of art.

**Recommendation:** Require states to provide Medicaid to former foster care children up to age 26, regardless of whether they have moved to a new jurisdiction.

# CONSUMER ASSISTANCE

**§435.908(c) Assistance with application and renewal.**  
  
***Certification Program***  
Community-based application assisters have been a successful component of state efforts to connect eligible consumers with coverage, thus, we support the proposed rule to create a certified application counselor program (CAC) for Medicaid and CHIP, consistent with similar provisions in the Exchange. As noted in the NPRM, We note a discrepancy in the use of the term “Certified Application Assister” rather than “Certified Application Counselor” as discussed in the preamble and consistent with the corresponding program in the Exchange.   
  
In 2014, millions of consumers will become eligible for new coverage options and research shows that most will need or want assistance. Medicaid and CHIP agencies have a requirement to provide assistance (§435.908; §457.340) but may lack the resources to effectively meet consumer demand. Moreover, community-based organizations and providers are likely to provide assistance, with or without certification. Thus, state certification programs are needed to ensure that these organizations and individuals have the training and skills, and that there will be oversight, to assure reliable, effective assistance. Given that CACs perform essentially the same functions as navigators, in-person assisters and brokers and agents, states will be able to leverage the training, standards and infrastructure to coordinate the various types of assistance programs.

**Recommendation:** We recommend that the CAC program be required for Medicaid and CHIP agencies.

In addition to the standards set out in §435.908(c)(i)-(iii), we recommend additional minimum standards.

**Recommendation:**CACs must serve in the best interests of clients and are prohibited from receiving compensation for enrollment from a QHP or specific managed care organization (MCOs) that provides coverage in insurance affordability programs. Moreover, we recommend that the regulations be strengthened to explicitly exclude insurance issuers, their subsidiaries and licensed insurance brokers and agents from being certified as CACs given their inherent financial conflict of interest associated with enrollment. While our preference is to exclude these entities, if the final rule does not include this exclusion, there should be stronger monitoring and oversight to ensure the best interests of consumers.

**Recommendation:**Individual assisters or CAC entities, regardless of whether they serve Medicaid/CHIP and/or the Exchange, must disclose any existing relationships with QHPs or insurance affordability programs to consumers. The proposed rule only requires this in the Exchange. Furthermore, if the final rule allows CACs that receive compensation from enrollment in a QHP or MCO, their disclosure to the consumer must describe their relationship and potential conflict of interest, explicitly if they assist with enrollment in less than the full scope of QHPs and MCOs.

**Recommendation:** Amend the rule to require that states periodically review the certification for CACs and withdraw certification from those who fail to meet minimum standards.

***Training***  
(c)(1)(ii) and (iii)  Training is critical to the quality and effectiveness of the CAC program, however, the regulations allowing CACs to provide less than the full range of assistance activities is not consistent with the training requirement at (c)(1)(ii). We support certifying CACs to provide a full scope of services through QHP enrollment, as well as deploying CACs to assist with one, some or all of the associated activities.

**Recommendation:** Training should be modular and correspond to a CAC’s scope of activities.

**Recommendation:**Training related to enrollment in a QHP should specifically include advance premium tax credits (APTC), cost-sharing subsidies and tax reconciliation.

**Recommendation:** We also suggest strengthening the regulation by requiring both initial and ongoing training to ensure that CACs remain current on policies and procedures.

It is not sufficient to remind Medicaid and CHIP agencies of their responsibility to ensure that their programs, including CAC programs, provide equal access to individuals with limited English proficiency and individuals with disabilities. These longstanding obligations, however, are often poorly implemented. We strongly urge CMS to provide Medicaid and CHIP agencies specific guidance and examples of how they can effectively meet the needs of LEP individuals and individuals with disabilities. The rule should mandate that the certification process include specific training components that provide information on how to provide culturally and linguistically appropriate services.  These components should address how to knowledgeably and sensitively assist limited-English proficient individuals and immigrant families, especially those of mixed immigration status.

**Recommendation:** Amend the rule to require the state to certify Application Counselors through a process that includes training in how to provide culturally and linguistically appropriate services, especially to vulnerable low-income immigrant families. Additional details regarding the scope of training will be included in our companion comments addressing immigrant and mixed status family issues.

***Scope of Activities***  
**§435.908(c)(2)** We support the types of assistance listed in this section that CACs may provide and the ability of the agency to determine whether CACs will assist with one, some or all of the permitted activities. As noted in the training section above, it will be important to provide training modules that include mandatory baseline competencies such as how to use the IT infrastructure or privacy and security requirements, as well as training that encompasses the different assistance activities for CACs that do not provide the full scope of services.  
  
We note that the preamble of the proposed regulations indicates CACs would not “receive notices” as authorized representatives may. While CACs should not receive notices on behalf or in lieu of applicants, we believe it is helpful to allow applicants and enrollees to opt for their designated CAC to receive copies of notices or to authorize their designated CAC to access electronic notices in the client account.

**Recommendation:** Allow applicants and enrollees to be able to opt to designate their CAC to receive copies of notices (including by authorizing electronic notices in the client account).

***Web Portal***  
**435.908(c)(3)(i)** We support the requirement that states have a designated web portal for use by CACs that has a secure mechanism for granting rights for only those activities the CAC is certified to perform, and only for those activities authorized by the consumer, which is not detailed in the current proposed rule. Such a portal will increase the proportion of applications that are submitted electronically, thereby providing more applicants with access to electronic verification and real-time eligibility while increasing the state’s administrative efficiency.

**Recommendation:** We recommend a clarification that states may use the same portal for navigators and in-person assisters (if the state has an in-person assister program) with proper assignment of rights and functionality. As the current proposed language reads, it indicates the portal must be dedicated to certified application assisters.

***Agency Procedures***  
We agree that applicants and beneficiaries should be informed of the functions and responsibilities of certified application assisters (§435.908(c)(3)(ii)(A)), but it will also be important for consumers to know who is certified and whether there are any limitations on the services each CAC is certified to provide.

**Recommendation:** The agency should be required to maintain a current list of CAC’s on the agency website, which includes any limitations on services they are certified to provided.

Medicaid agencies should have a mechanism in place to evaluate the performance and effectiveness of the CAC program, as well as individual CACs. In particular, it will be important to examine enrollment patterns that suggest steering to specific plans, which may not be in the best interest of consumers.

**Recommendation:** The agency must implement an oversight mechanism to ensure that CACs provide quality services, comply with minimum CAC standards and serve the best interest of consumers.

We support the confidentiality protections against disclosure of applicant or beneficiary information by the certified application counselor without authorization, §435.908(3)(ii)(B) and (C).  
  
***Prohibition on Charges to Consumers***  
**§435.908(c)(4)** We strongly support protecting consumers by prohibiting application assisters from imposing any charges on applicants or beneficiaries. However, we believe that CACs provide a valuable service to Medicaid and CHIP agencies and states should not be restricted from providing these organizations with resources to extend consumer assistance.

**Recommendation:** It would be extremely helpful for HHS to provide states with sub-regulatory guidance on the availability of federal funding to help support grants or payments to CACs. In particular, information about how Medicaid administrative claiming can be used to match community-based investments in application assistance would be very helpful.

**§457.340 Application for and enrollment in CHIP.**

We support that application and renewal assistance, including §435.908 relating to CACs, the availability of program information and Internet Website requirements apply equally to CHIP (§457.340(a), including the comments noted above.

**§155.205 Consumer assistance tools and programs of an Exchange.**  
  
(d) We support the strengthening of the consumer assistance requirements of the Exchange to ensure that any individual providing consumer assistance must be trained regarding QHP options, insurance affordability programs, eligibility and benefit rules and regulations regarding all insurance affordability programs.

**Recommendation:** We suggest strengthening the rule by adding, “including advanced premium tax credits (APTCs), cost-sharing subsidies and tax reconciliation.”

**§155.225 Certified Application Counselors.**  
  
***General Rule***  
We support the requirement at §155.225(a) that the Exchange must have a CAC program and that the Exchange must accept CACs trained and authorized by Medicaid. However, Medicaid CAC’s may not be trained or experienced in all activities, given that the Medicaid rule allows the state to authorize CACs to do one, some or all of the activities, including facilitating enrollment in a QHP. The exchange must only certify those Medicaid CACs that are authorized to provide the full scope of activities or require the Medicaid CAC to receive additional training to be certified in the Exchange.  
  
The preamble to the regulations indicates that CACs will serve the same core application assistance services available directly through the Exchange, or through Navigators or licensed insurance agents and brokers. The proposed rule at §155.225(a)(3) authorized application counselors to help to facilitate enrollment of eligible individuals in QHPs. We believe this requires further clarification of what “facilitate enrollment” entails. Specifically, it should include assisting consumers through plan selection to avoid handoffs and delays in enrollment.

**Recommendation:** We strongly recommend that the final rule explicitly add the requirement that CACs facilitate enrollment “in QHPs and insurance affordability programs including assistance with advanced premium tax credits (APTCs), cost-sharing subsidies and tax reconciliation.” Thus, appropriate training must include these activities. Additionally, since Medicaid and CHIP CACs must be accepted by the Exchange, it may be necessary for the Exchange to supplement their training, if Medicaid does not provide training on QHP selection, APTCs, etc.

***Standards of Certification***  
As written, the proposed rule at §155.225(b) requires the Exchange to certify any individual or organization that registers, gets trained, discloses to consumers and the exchange any relationships, and signs an agreement requiring compliance with privacy and security standards, as well as applicable authentication and data security standards. We do not believe that “taking all comers” is in the best interest of consumers as required under §155.225(b)(5), which we otherwise support. Rather than rely on an after-the-fact monitoring and decertification, the exchange should exercise more scrutiny in selection of CACs.

**Recommendation:** Consistent with our recommendations for the Medicaid CAC program, we strongly urge HHS to explicitly prohibit insurance issuers, their subsidiaries and licensed insurance agents and brokers from being certified as CACs. While our preference is to exclude these entities, if the final rule does not include this exclusion, there should be stronger monitoring and oversight to ensure the best interests of consumers.

Notwithstanding the recommendation above, we agree that CACs must disclose (§155.225(b)(3)) to the Exchange and applicants any relationships the application counselor or sponsoring agency has with QHPs or insurance affordability programs, as well as any potential conflicts of interest.

**Recommendation:** We recommend that Exchanges be required to develop standards for the types of relationships and potential conflicts of interest that must be disclosed (e.g., health care providers that participate in a QHP network), as well as the format for disclosing such relationships or conflicts. Such information should be disclosed as part of the process through which the consumer will authorize a CAC. This information will be important not only to consumers, but also to the Exchange in identifying patterns of enrollment that suggest steering to a plan .

We support that CACs be required to provide reasonable accommodations for those with disabilities consistent with the ADA. However, the rule should also mandate that the certification process include specific training components that provide information on how to provide culturally and linguistically appropriate and accessible services.  These components should address how to knowledgeably and sensitively assist limited-English proficient individuals and immigrant families, especially those of mixed immigration status.

**Recommendation:** Amend the rule to require the Exchange to certify Application Counselors through a process that includes training in how to provide culturally and linguistically appropriate services, especially to vulnerable low-income immigrant families. Additional details regarding the scope of training will be included in our companion comments addressing immigrant and mixed status family issues.

We support that the Exchange should withdraw certification of any CAC that is noncompliant (§155.225(c)).

**Recommendation:** To ensure CAC compliance, as well as the quality and effectiveness of the CAC programs, we recommend that the final rules require routine performance monitoring of CACs. Performance metrics should include examining enrollment patterns to detect any steering of consumers to a specific plan, which is not in the best interest of consumers.

***Availability of Information***  
We agree that the Exchange must establish procedures to ensure that applicants are informed of the functions and responsibilities of certified application counselors but it will also be important for consumers to know who is certified and whether there are any limitations on the services each CAC is certified to provide.

**Recommendation:** The Exchange should be required to maintain a current list of CAC’s on its website.

We support the confidentiality protections against disclosure of applicant or beneficiary information by the certified application counselor without authorization, §155.225(d)(2).  
  
***Fees***  
We strongly support protecting consumers by disallowing application assisters from imposing any charges on applications or beneficiaries (§155.225(e)). However, we are concerned about the language in the preamble, which states that CACs are not funded through the Exchange, through grants or directly. We believe that CACs provide a valuable service to Exchanges and states should not be restricted from providing these organizations with resources to extend consumer assistance.

**Recommendation:** It would be helpful for HHS to clarify that Exchanges are not prohibited from providing financial resources to CACs.

***Other Comments***  
We recommend that Exchanges must have a designated web portal for use by CACs that has a secure mechanism with proper assignment of rights and functionality, and which should be available to navigators and in-person assisters (if authorized by the state). Such a portal will increase the proportion of applications that are submitted electronically, thereby providing more applicants with access to electronic verification and real-time eligibility while increasing the state’s administrative efficiency.

**Recommendation:** We recommend that Exchanges be required to provide a portal through which CACs will facilitate the application and enrollment process.

The NPRM also requests comments on whether the Exchange should have the authority to create additional standards for certification or otherwise limit eligibility of certified application counselors beyond what is proposed. We believe the Exchange should have the flexibility to set higher consumer protection standards than is proposed in the rule. For example, an Exchange should be able to go beyond requiring that CACs act in the best interest of consumers and prohibit conflicts of interest. However, such standards should be consistent with other types of assistance (i.e. navigators) and disallow a state from requiring that CACs be licensed insurance brokers and agents or that they be required to carry errors and omissions insurance.  
  
As proposed in draft legislation, a number of states prompted by insurance industry interests are seeking to restrict navigators from fulfilling their duties. We believe these proposals are in conflict with federal law and regulations. Likewise, we do not believe states should not have the flexibility to stop a CAC from assisting consumers through the entire process, which includes plan selection and enrollment.

# COORDINATED MEDICAID/CHIP OPEN ENROLLMENT PROCESS

**§435.1205 and §457.370**

**Adopt a contingency plan for states not ready to Implement the single, streamlined application by October 1, 2013**. The public will be hearing about new coverage options throughout the summer and fall of 2013, and it would only result in mass confusion if when people went to apply for coverage and were found eligible for Medicaid (or their children eligible for Medicaid or CHIP), they were told to return several months later and submit a new application. As a result, we strongly support the proposal in &435.1205(c)(1) requiring that state Medicaid agencies be prepared to accept the single, streamlined application (HHS’s or an approved alternative), as well as an electronic account data from an agency administering another insurance affordability program.

However, we are deeply concerned that a number of states simply will not be ready to accept and process the data that they receive from the FFE, beginning October 1, 2103, that indicates someone is eligible for Medicaid or CHIP. In these states, we anticipate that people will apply for coverage through the FFE, find out that they are eligible for Medicaid or CHIP, and basically have nowhere to go to secure coverage effective January 1, 2014. We realize that your proposed rule says that states must have the capacity to process the FFE’s assessment of Medicaid and CHIP, but believe it would be prudent to recognize and address the reality that not all states will be ready to do so. Specifically, we recommend adding a provision that says states that cannot demonstrate that they have the capacity to accept and process assessments beginning October 1, 2013 may satisfy the legal requirements of the ACA by treating the FFE’s assessment of Medicaid or CHIP eligibility as final and enrolling the individual in Medicaid/CHIP coverage, effective January 1, 2014. If and when the state develops the capacity to comply with the ACA requirements for processing Medicaid and CHIP applications, it would have the option to revert to treating the FFE’s finding as an assessment. In the absence of such a provision, we see it as quite possible that numerous people will apply for coverage and emerge without insurance even though they are clearly eligible for Medicaid or CHIP.

**Retain and strengthen the procedures for securing coverage for people who qualify under 2013 rules (§435.1205).**

In general, we support the requirements in §435.1205 requiring states to 1) evaluate the eligibility of people using the single, streamlined application beginning October 1, 2103 for eligibility under 2013 rules, or 2) alert people who apply using the single, streamlined application beginning October 1, 2013 that they might qualify for coverage under 2013 rules. These provisions are particularly important for children. Given that the median income threshold for children’s coverage is 230 percent of the FPL, many of the people seeking Exchange coverage beginning October 1, 2013 are likely to have children who already are Medicaid or CHIP eligible. We encourage you to retain and strengthen these provisions by adopting the following changes:

* **Create a specific option for states to use the MAGI household composition and income counting rules, beginning October 1, 2013**. In the absence of such an option, states that find someone has income below a 2013 Medicaid threshold based on MAGI methodologies might feel compelled to ask additional questions to ensure that they are below the threshold when pre-MAGI methodologies are used. Given that there are few, if any instances, in which the differences in methodologies would affect the outcome of an eligibility determination, we encourage you to explicitly allow states to determine someone’s Medicaid eligibility under the 2013 Medicaid and CHIP categories based on the findings from processing of the single, streamlined application.
* **Require states to specifically alert families if they have children or other members who appear eligible under 2013 rules**. Along with a generic alert to people that they might qualify for Medicaid or CHIP right away, we encourage you to require states to provide a more meaningful and effective alert to families with children who appear eligible for Medicaid or CHIP. In particular, states should be required to inform people when it appears that their children qualify for coverage under 2013 Medicaid and CHIP rules. We know that families are more likely to pursue applications if they have reason to believe that their children will be found eligible for coverage. Similarly, other individuals who appear to be clearly eligible for Medicaid and CHIP should receive a tailored alert that they appear eligible, rather than a generic notice that they might qualify under 2013 rules.

# CHIP CHANGES

**§457.110 Enrollment assistance and information requirements.**  
  
We support the plain language and accessibility requirements of this provision.  
  
**§457.340** **Application for and enrollment in CHIP.**  
  
(a) We support consistency in application and renewal assistance, availability of program information and Internet Website between CHIP and Medicaid.  
  
**§457.342 Continuous eligibility for children**  
  
(a) Continuous eligibility is a critical strategy to eliminate gaps in coverage, reduce administrative burden on families and states and enable states to better measure the quality of health care. We strongly support the decision to use the proposed rule to clarify and codify current HHS policy with respect to continuous eligibility, including the proposed clarifications on how continuous eligibility applies in Medicaid and its availability as a state option in CHIP. One area where additional clarification is needed is with respect to what happens to a child’s coverage when a family temporarily is unable to pay premiums. We recommend that while continuous eligibility may be terminated for failure to pay premiums (§457.342(b)), that the state may only do so after complying with §457.570.

**Recommendation:** We recommend that states be required to reinstate a child’s 12-month continuous eligibility period if the family pays their premium between the end of their payment grace period and the end of the 90-day lockout.

**457.350(h) Waiting lists, enrollment caps and closed enrollment.**  
We support the requirement that CHIP agencies must inform families that if their circumstances change, the child may be eligible for other insurance affordability programs, as is currently required regarding Medicaid.

**§457.355 Presumptive eligibility for children**  
We support the requirement that presumptive eligibility for children in CHIP be consistent with the determination process in Medicaid. See detailed comments at §435.1100-1110.  
  
**§457.360 Deemed newborn children**  
The clarification of policy regarding deemed newborns in CHIP, consistent with Medicaid, is extremely useful. We support that children born to mothers covered by CHIP as a low-income targeted pregnant woman or low-income targeted child be enrolled in Medicaid if they are eligible based on the mother’s eligibility at the time of enrollment. In other words, if a state covers children under the age of 1 up to 300% of the federal poverty level (FPL) but the mother was covered under CHIP with income at 195% of FPL, the child should be deemed continuously eligible for Medicaid until their first birthday.  
  
Deemed newborns (in Medicaid or CHIP) is an eligibility category where significant churn is noted because some states do not offer a specific renewal process for deemed newborns given the specificity of the group’s eligibility ending at one (1) year of age. By explicitly stating in the proposed rule (§457.360(b)(2)) that the child is deemed to have applied for and been determined eligible under the State’s separate CHIP State plan, and remains continuous eligible until their first birthday, the rules provide clarity regarding the child’s coverage category. It would provide further guidance for CMS to specifically state in the proposed rule or in sub-regulatory guidance that deemed newborns are subject to same renewal processes as required of other separate CHIP program beneficiaries.

**Recommendation:** Ideally, deemed newborns should be eligible for Medicaid or CHIP coverage regardless of their state residency. The proposed rule at §457.360(c) gives states the option to provide ongoing coverage to a deemed child born in another state. We recommend that states be required to offer this coverage.

**§457.380 Eligibility Verification**  
We support the clarification that citizenship or immigration status in regard to CHIP must be verified through the federal data services hub and otherwise follow the standards set out for Medicaid in §435.926.   
  
**§457.570 Disenrollment**  
We support the proposed rules requiring reasonable notice of nonpayment, limiting the lockout period to 90 days, and disallowing states from requiring payment of outstanding premiums at the end of the lockout period before re-enrollment. In particular, we strongly support that the agency **must** review the family’s circumstances (§435.570(b)) to determine if their income has declined, making the child eligible for Medicaid or a lower cost-sharing category.  
  
We believe the proposed rule should be strengthened to capture the intent noted in the preamble that “prohibiting a child from enrollment after the family pays the unpaid premium or enrollment fee is counter to promoting enrollment in and continual coverage.”

**Recommendation:** We recommend that the final rule specifically state that if a family pays its outstanding premium before the end of the lockout period, the child will be reinstated back to the effective end date with no gap in coverage. Additionally, in states that have approved state plans providing continuous eligibility, there should be no disruption to the continuous eligibility period.

**Recommendation:** Providing multiple ways to pay premiums and sending multiple, non-threatening payment due reminders are helpful in encouraging payment. We suggest that CMS consider future sub-regulatory guidance to States to promote best practices in premium payments.

**§457.805 State plan requirement: Procedures to address substitution under group health plans.**   
We very strongly disagree with the continuation of any waiting period in CHIP for children who have been recently enrolled in a group health insurance plan. In practice, the proposed policy to allow families to be required to wait up to 90 days to enroll their children in CHIP may result in many of them remaining uninsured. While the proposed rule suggests that these uninsured children could temporarily enrolled in APTC-funded coverage while awaiting CHIP, we see no evidence that either the federal government or states have the capacity to smoothly implement such a plan. To the contrary, the policy represents an administrative mess of red tape for families that could result in many children falling through the cracks and remaining uninsured. Moreover, even if some children are able to temporarily secure coverage via the Exchange while awaiting CHIP, it is deeply problematic to design a system of coverage for CHIP-eligible children that actually promotes disruptions in the continuity of their care. The proposed policy is entirely inconsistent with the vision of universal coverage under the ACA and makes little or no policy sense, as explained in more detail below:

* Promoting churn between the Exchange and CHIP for children is administratively burdensome and costly at a time when the readiness of state IT systems is tenuous. It is likely that some state systems will not have the capacity to track children who are locked out during their waiting period, as required by the proposed regulations, and thus these children may slip through the cracks.
* Twenty-five (25) of the 38 states with CHIP waiting periods will have a federally-facilitated exchange (FFE). In these states, the FFE will not be able to fully assess or determine eligibility for CHIP. The FFE will need to send the electronic account to CHIP to determine whether the child qualifies for any good cause exceptions to the waiting period. If the child is determined not eligible to enroll, the CHIP agency will need to send the electronic record back to the Exchange for enrollment in a QHP with or without financial assistance. At the end of the waiting period, the CHIP agency will have to notify the Exchange that the child is now eligible for CHIP and the Exchange will have to disenroll while CHIP enrolls the child. These are only the transactions between the agencies; the subsequent enrollment and disenrollment in a QHP and subsequent enrollment in CHIP plan adds to the administrative effort required to maintain the CHIP waiting period. This is not simple, streamlined eligibility and enrollment as required by the ACA.
* Some CHIP-eligible children are likely to go uninsured during the waiting period. As already noted, the red tape associated with administering the proposed policy can be expected to result in children remaining uninsured. In addition, the proposed policy allows for gaps in coverage that will remain even if it could be administered flawlessly. Specifically, there are scenarios where the child cannot get financial assistance in the Exchange because a parent has access to self-only coverage that is less than 9.5% of household income. However, the cost of covering the family is greater than 8% of family income (which excludes the family from qualifying for an exemption from the individual mandate) but family coverage is not greater than 9.5% of household income (or the child’s portion is not greater than 5% of household income), so the child does not qualify for an exception to the CHIP waiting period. And even if the cost of family coverage is less than 8% of family income subjecting the family to the penalty, the penalty will be far less than the cost of family coverage, so the child could go uninsured.
* The lack of continuous coverage impacts the health status of children who are left uninsured or may have to change providers, disrupting continuity of care, when they move from one plan to another.
* Movement between plans inhibits the ability to measure the quality of care and hold plans accountable for improvements in quality outcomes over time.

**Recommendation:** In the final rule, disallow the use of waiting periods in CHIP.

If these regulations must stand, we believe the proposed limitation on the length of waiting period and the mandated exceptions improve current policy. Furthermore, we believe it is imperative that CHIP agencies track when these children would be eligible and initiate action to enroll in CHIP. We do not believe the regulations as proposed make clear the expectation for coordination.  
  
**Recommendation:** We strongly recommend that the final rule include a requirement that states coordinate eligibility after the child has met the waiting period requirements as noted in this statement in the preamble: “For individuals subject to a waiting period, under proposed revisions at §457.350(i)(3), states also would need to notify such program of the date on which such period ends and the individual is eligible to enroll in CHIP.”

In addition, we are concerned that current federal regulations allow states to adopt other anti-substitution provisions that are inconsistent with the new post-ACA universe, such as requirements that children not have access to employer-based coverage on a prospective basis. If such coverage is unaffordable, it would result in children not having any routes to coverage.

**Recommendation:**  We recommend that HHS review states’ other anti-substitution policies to determine whether there are issues – beyond waiting periods – that would inappropriately keep children out of health insurance, including any policies that deny coverage based on access to employer-based coverage that may be unaffordable.

# PREMIUM ASSISTANCE

***Comments on* §*435.1015 premium assistance CMS File Code-2334-P***  
  
This section clarifies the applicability of pre-existing federal options to do premium assistance in the individual market, including going forward, for the purchase of QHP’s in the new health exchanges.  
**General comments**: In the CHIPRA law of 2009 Congress moved away from the use of Medicaid and CHIP funding to subsidize individual market coverage because it is rarely cost-effective and coverage is often substandard in the individual market. Passage of the ACA and creation of exchanges with premium tax credits change this equation, hence we understand the addition of this section and the importance of examining the intersection of public coverage and the new exchange based coverage options especially.  
  
However, to ensure that premium assistance is utilized by states only in cases where it is truly cost-effective and not a waste of taxpayer dollars, as well as to ensure that children and adults do not lose any of the benefit and/or cost-sharing protections that attend to their Medicaid and CHIP eligibility we offer the following suggestions. Some of these suggestions are specific to the proposed regulatory language and some reflect considerations of the role of premium assistance post passage of ACA.  
  
***General comments:***  
  
*Cost-effectiveness:* CMS should issue long-awaited guidance on the cost-effectiveness test for Medicaid and CHIP premium assistance options that were updated in CHIPRA and standardized in ACA subject to the comments below. Section 435.1015 includes a description of the test, and we urge you to modify that test as described below, and then issue guidance to apply a similar test to all of the premium assistance options that states have.   
  
A clear explanation of and ongoing enforcement by CMS of the cost-effectiveness test is essential to ensuring that taxpayer dollars are used wisely and that premium assistance is a sound policy option for states to pursue for children and families.  
  
*CHIPRA required premium assistance notice requirements for employers should be dropped:* P.L. 111-3 at Section 311(b) included a conforming amendment requiring employers who provided group health coverage in a state that offered premium assistance to send a notice to their employees about their possible eligibility. Post passage of the Affordable Care Act, and the creation of advanced premium tax credits, which will be far more widespread, there is substantial potential for confusion between the two and this requirement on employers should be rescinded. This may require a statutory change, we urge you to consider the best path forward.   
  
Specific comments on §435.1015

* *Wraparound benefits and cost-sharing protections:* We very much support these paragraphs (a)(2) and (3) that ensure that beneficiaries are provided with wraparound benefits and do not incur any additional cost-sharing charges in excess of amounts that would be imposed in Medicaid or CHIP.

We remain concerned that these “wraparound” protections are not always well implemented. There is little evidence that children, for example, are able to access the full EPSDT benefit when they are enrolled in premium assistance arrangements. States should be required to inform families of their rights in this regard. Since states will need to track the cost of providing wraparound coverage to ensure cost-effectiveness, this information should be used to provide evidence as to whether children and adults are receiving the full package of services. Similarly beneficiaries must be aware of the limits on the cost-sharing they may be charged and should not incur any additional costs upfront for which they have to seek reimbursement.

* *Cost-effectiveness test:* Paragraph(a)(4) should be clarified to ensure that the cost of the cost-sharing wraparound is included in the cost effectiveness test. The current language which reads “The cost of purchasing such coverage, including administrative expenditures and the costs of providing wraparound benefits for items and services covered…” could be interpreted to mean the cost of premiums to purchase coverage only and not include in the test the costs associated with covering copayments, deductibles and other cost-sharing requirements.

The statutory definition of cost-effectiveness in CHIPRA says “the amount of expenditures under the State child health plan, including administrative expenditures, that the State would have made to provide *comparable coverage* of the targeted low-income child involved or the family involved.” It is our view that “comparable coverage” clearly incorporates the provision of cost-sharing limits into the cost-effectiveness test, and we are concerned that the regulatory language does not clearly do so. Cost-sharing standards are generally far more protective for children and their families in Medicaid and CHIP than in private insurance, and as such states should be considering their value when calculating whether it is cost-effective to purchase private insurance for a beneficiary.

# ELECTRONIC SUBMISSION OF THE MEDICAID AND CHIP STATE PLAN

**Electronic Submission of the Medicaid and CHIP State Plan (§§430.12, 457.50, 457.60)**  
We strongly encourage HHS to add a provision to the final rule specifying that Medicaid and CHIP state plans, including amendments, will be made available to the public at the time that they are submitted. Consumers and advocates acting on their behalf, as well as researchers and policy analysts, should have access to the basic, descriptive information contained in state plans and amendments as soon as they become available.

# ESSENTIAL HEALTH BENEFITS IN ALTERNATIVE BENEFITS PLANS

**§440.315 Exempt individuals.** We support the clarification of the definition of medically frail to include all those with disabling conditions. Because the reference plans that may serve as the model for benefits in alternative benefit plans are employer-sponsored insurance plans, they may not adequately serve the needs of those who are too medically frail to work. Medicaid should provide more comprehensive benefits for such individuals and this language will allow it to do so. Employer-sponsored plans also often inadequately cover substance use disorders, so we support adding individuals with substance use disorders to the definition of medically frail.

**§440.347 Essential health benefits.** Paragraph (c) allows states to select more than one EHB option for alternative benefit plans. We urge CMS to instead limit states to choosing a single EHB option for Medicaid. The EHBs are intended to be a consistent floor for benefits—Congress indicated its desire to extend this consistency to alternative benefits plans in Medicaid by applying EHB requirements to them. Further, selecting multiple EHB options will pose unnecessary administrative burdens on state Medicaid programs. To maintain consistency and ease of administration in Medicaid, there should be only one EHB benchmark for alternative benefit plans. States would retain flexibility to provide different sets of benefits for different populations, but they should all have, at a minimum, the same set of EHBs. Because Medicaid serves a different population than private health plans, this single EHB benchmark need not be the same benchmark chosen for the state’s individual and small group markets.

The preamble seeks comment on defining habilitation services as part of the Medicaid EHB. States should be required to develop a definition of habilitation services for use in Medicaid. First, not all states may choose to define habilitation services for their private market EHBs. Second, Medicaid enrollees are low income individuals who need greater protection from health costs than individual who purchase private market coverage. Further, state Medicaid programs have more experience in providing habilitation benefits than do private insurers, so they can be expected to fulfill this responsibility without necessarily relying on simplifications like parity with rehabilitation benefits.

**§§440.330, 440.335, and 440.360.** Each of these sections contains requirements for adding additional services or coverage to alternative benefit plans. We urge CMS to consolidate these sections and clarify that states have the flexibility to offer additional benefits by choosing the Secretary-approved coverage option. It should clarify that this flexibility extends to all those enrolled in alternative benefit plans, including those eligible under section 1902(a)(10)(A)(i)(VIII) of the Act, and that the federal match otherwise available for these populations is available for the additional benefits when they are approved by the Secretary.

# ELIGIBILITY APPEALS AND OTHER PROVISIONS RELATED TO ELIGIBILITY AND ENROLLMENT FOR EXCHANGES

**§ 155.230(a)**

Since an Exchange notice can apply to one or more members of a household, we strongly recommend that the notice be required to clearly state whether it applies to all members of the household or only certain identified individuals.

**§ 155.420 Special enrollment periods**

In § 155.420(a)(2) the proposed regulation sets a new definition for “dependent” to align it with other sections and only creates a special enrollment period for individuals ultimately eligible to enroll in a plan. Implementing a plan-specific definition of special enrollment period may confuse individuals who do not realize that they may or may not have a special enrollment period depending on who they are, the plan they apply for, and the terms of that plan. We urge HHS to consider an alternative approach that will allow families to understand more easily when their members qualify for a special enrollment period.

We support the suggestion in the preamble, at 78 Fed. Reg. 4646 to include foster children within the special enrollment period populations.

**§ 155.500 Definitions**

HHS should modify the final regulation to ensure that all actions that an applicant or enrollee shall have a right to appeal are included in the definition of an “appeal request” by an “appeal entity.” The appeal request should not be limited by the requirement that a notice have been issued and should not be narrowly written to apply only to determinations and redeterminations of eligibility, as there additional actions that can be appealed (e.g. Exchange’s failure to provide timely notice). Cross referencing only specific notices in the definition substantially narrows the scope of what could be defined as an “appeal request.” While § 155.355 is not open for review, we recommend making changes there to conform with changes recommended below.

**Recommendation**: Amend the definitions in § 155.500 as follows:

*Appeal request* means a clear expression, either orally or in writing, by an applicant, enrollee, employer, or small business employer or employee to have any ***action where there is a right to appeal, as provided in accordance with §*** ***155.355 and 155.505(b)(1)-(3),*** eligibility determination or redetermination contained in a notice issued in accordance with § 155.310(g), § 155.330(e)(1)(ii), § 55.335(h)(1)(ii), § 155.715(e) or (f), or pursuant to future guidance on section 1311(d)(4)(H) of the Affordable Care Act, reviewed by an appeals entity.

*Appeals entity* means a body designated to hear appeals of ***any*** ***action where there is a right to appeal, as provided in accordance with §§*** ***155.355 and 155.505(b)(1)-(3),*** eligibility determinations or redeterminations contained in notices issued in accordance with §§ 55.310(g),155.330(e)(1)(ii), 155.335(h)(1)(ii), 155.715(e) and (f), or notices issued in accordance with future guidance on exemptions pursuant to section 1311(d)(4)(H).

**§ 155.520(b)**

We strongly support and endorse the provision requiring that an applicant/enrollee have 90 days from the date of the eligibility determination to request an appeal. This tracks the Medicaid timeline and will simplify and align the process if a notice includes both a Medicaid determination and determination of eligibility for Exchange coverage or for APTCs or CSRs.

As stated above in the discussion related to § 155.500, we want to ensure that the issues an applicant/enrollee can appeal are broadly stated to encompass all actions taken by the Exchange, Medicaid, or other relevant agencies. As written, § 155.520(b) may be read too narrowly to limit the issues or actions that can be appealed only to a notice of an eligibility determination. Consistent with those concerns, we have offered some minor edits below.

**Recommendation**: Amend § 155.520(b) as follows:

(b) *Appeals request*. The Exchange and the appeals entity must allow an applicant or enrollee to request an appeal within 90 days of the date of the notice of ***any action where there is a right to appeal, as provided in accordance with §*** ***155.355 and 155.505(b)(1)-(3),*** eligibility determination.

**§ 155.535 Informal resolution and hearing requirements**

*§ 155.535(a)*

We support the requirement that the HHS appeals process provide an opportunity for informal resolution prior to a hearing. We also support the provision allowing for a state-based entity to have the option to provide an informal resolution process as it is important for a appellant to have the opportunity to resolve the dispute over adverse actions taken by the Exchange, Medicaid or CHIP at the lowest (least formal) level and to avoid unnecessary hearings. Even where the state-based entity provides such an option, we believe it should be only at the election of the individual in any individual case. We also strongly support the requirement in (a)(2) that the appellant’s right to a hearing is preserved in any case where the individual remains dissatisfied with the outcome of the informal resolution. We support the requirement in paragraph (a)(3) that the appellant not be asked to provide duplicative information or documentation previously provided during the application or informal resolution process. This is critical to place no additional burden on the appellant simply because they have chosen to appeal the adverse action or the informal resolution is unsuccessful. We also support the requirement that the informal resolution be considered final and binding if the appellant does not elect to take the informal decision to a hearing. This is especially important to ensure that agencies (Exchange, Medicaid and CHIP) are bound to follow a determination at the informal level that reverses a determination by that agency.

As the preamble states at 78 Fed. Reg. 4651, participation in the informal resolution process must not impair the appellant’s right to a hearing where the appellant remains dissatisfied with the outcome. While the intention in the preamble is clear, HHS should clarify the language in the proposed regulation to ensure that: (1) the informal review process timeline runs concurrently with the hearing timeline unless there is a conditional withdrawal of the hearing by the appellant to “stop the clock,” and (2) the informal review does not cause the applicant to lose any rights to timely request a separate Medicaid appeal if the appeal involves APTCs or CSRs (which outcome may impact any separate Medicaid appeal). These protections are critical to ensure that the informal process does not indefinitely delay (or infringe upon) the appellant’s due process right to a hearing or to cause an appellant to drop or not pursue the hearing altogether. Further, the right to proceed to a hearing should not be impaired with the appellant having to make a new hearing request if dissatisfied with the informal review should they elect it. This option should also not delay the appellant’s right to a hearing decision in accordance with § 155.545(b)(1).

**Recommendation**: Amend § 155.535(a) as follows:

(a) *Informal resolution.* The HHS appeals process will provide an opportunity for informal resolution and a hearing in accordance with the requirements of this section. A state-based Exchange appeals entity may also provide ***an opportunity for*** an informal resolution process prior to a hearing, provided that—

(1) The process complies with the scope of review specified in paragraph (e) of this section;

(2) The appellant’s right to a hearing***, in accordance with §*** ***155.355 and 155.505(b)(1)-(3), is not impaired and any hearing request*** is preserved ***while such informal review occurs, including*** in any case in which the appellant remains dissatisfied with the outcome of the informal resolution process;

(3) If the appeal advances to hearing, the appellant is not asked to ***make a new appeal request or*** provide duplicative information or documentation that he or she previously provided during the application or informal resolution process; and

(4) If the appeal does not advance to hearing, the informal resolution decision is final and binding.

*§ 155.535(b)*

We do *not* concur with the preamble discussion that states HHS does not expect a hearing to be scheduled until the appellant has indicated that he or she is dissatisfied with the outcome of the informal resolution process. As discussed above, this informal review time should run concurrently with the hearing so as not to impair the appellant’s right to a timely hearing and decision. An appeal request must be treated as a request for a hearing in all cases but can be resolved (i.e. the appellant can withdraw the request) if an appellant is satisfied with any informal review process that is offered and he elects to utilize. This is common practice in Medicaid appeal requests today.

**§ 155.555 Employer appeals process**

The preamble seeks comment on whether employees should have the ability to appeal an Exchange redetermination that results from an employer appeal. We recommend an approach that would give employees and other individuals affected by such a redetermination the right to appeal the redetermination. While employees have the right to participate in the employer appeal, families may not recognize the importance of the appeal until they receive notice of a redetermination or experience a change in eligibility. Further, even if an employee has the opportunity to participate, other family members may be affected by the employer appeal. Therefore, an addition right of appeal should be extended to all affected individuals.

# COST-SHARING AND PREMIUMS

**Part 447—Payments for Services**

Although most children in Medicaid are exempt from most cost sharing, having their parents face unaffordable cost sharing can lead to negative consequences for children, as children are more likely to receive care if their parents have care, and benefit from having healthy parents.

**§447.50. Premiums and cost sharing: Basis and purpose**

We generally support the streamlining and simplifying of Medicaid premium and cost sharing rules. Making the current rules consistent and removing redundant provisions between section 1916 and section 1916A of the Act will make it easier for stakeholders and policymakers to navigate. Nevertheless, there has been an extensive body of research indicating that when low-income families face higher cost sharing and premium charges, enrollment and the use of necessary services decreases. The preamble mentions this research, but it is disappointing that these proposed rules offer states the option to impose higher cost sharing on low-income families. More effective and targeted strategies such as turning to disease management programs or ensuring that all Medicaid beneficiaries have a primary care provider who helps them manage and coordinate their health care would serve the goals of the program better than cost sharing.

Additionally, most states operate Medicaid Managed Care programs. The purpose of managed care is to do exactly what cost sharing intends to do, which is to limit inappropriate utilization of health care. Thus, in this environment, it is unnecessary to impose cost sharing and premiums to low-income families*.*

**§447.51. Definitions**

We support the definitions of alternative non-emergency services provider, cost sharing, premiums, emergency and non-emergency services, and preferred drugs.

**§447.52(b) Maximum Allowable Cost Sharing.**

While we agree that cost sharing for outpatient services being tied to what a state agency pays can be burdensome for states, a $4 cost sharing payment is too high for individuals below poverty. The preamble states that*,* “Because the majority of state services are reimbursed at more than $50, we believe that a flat $4 cost sharing maximum is reasonable.” We believe a better approach to take regarding a maximum nominal amount would be based on the income of those in Medicaid, not on what a state is paying. If low-income individuals can’t afford the cost sharing, the amount that a state agency pays makes no difference. For Medicare beneficiaries below poverty, HHS follows this approach by limiting Part D cost sharing to $1.10 for preferred/generic drugs and $3.30 for other medications for individuals with incomes at or below the poverty level and $2.50 and $6.30, respectively, for individuals with incomes over the poverty level. *See* [*https://secure.ssa.gov/poms.nsf/lnx/0603001005*](https://secure.ssa.gov/poms.nsf/lnx/0603001005)*.* We recommend that this should be the same benchmark used for Medicaid beneficiaries as well. If HHS will not use this method, we would recommend that the maximum cost sharing amount for those below poverty would be $2.10, which is the approximate average of FY 2013 maximum nominal amounts of: $0.65, $1.30, $2.60, and $3.90.

**Recommendation:** HHS should base “nominal” on the income of Medicaid beneficiaries and set a maximum nominal amount of $1.10 for outpatient services.

Regarding cost sharing for inpatient stay, we strongly disagree that states should have the option to allow cost sharing of up to 50% of cost for the first day of care, as this is exceptionally high and certainly unaffordable for individuals below poverty. In the preamble it is noted that cost sharing at 50% of the cost for inpatient care is “a relatively high cost for very low-income people and not a service that consumers have the ability to avoid or prevent.” 78 Fed. Reg. at 4658. Most likely this will become bad debt for hospitals. Based on 2012 Florida rates, the per diem inpatient rate was $854 and an individual below poverty would have to pay a cost sharing amount of $427. Considering that the monthly income for an individual at the poverty level is $930, this is truly unaffordable. Thus, we recommend that a maximum nominal amount for inpatient stays should be based on the income of those in Medicaid. If HHS will only consider cost sharing amounts of: $4, $50, or $100 described in the preamble, we strongly recommend a $4 maximum allowable cost sharing amount for those below poverty.

**Recommendation:** HHS should base “nominal” on the income of Medicaid beneficiaries and set a maximum nominal amount of $4 for inpatient stay.

**§447.53. Cost sharing for drugs.**

The statute allows states to set higher cost sharing for non-preferred drugs than they do for preferred drugs, which these proposed rules enact. While this is a reasonable tool for states seeking to contain prescription drugs costs, $8 for non-preferred drugs and $4 for preferred drugs for individuals at or below 150% FPL is high. Research indicates that imposing even modest drug cost sharing causes low-income individuals to not fill their prescriptions. A study found that after $2 generic and $3 brand name copayments were imposed in Oregon, utilization of necessary prescription drugs declined by 17 percent. *See* Daniel Hartung et al., *Impact of a Medicaid Copayment Policy on Prescription Drug and Health Services Utilization in a Fee-for-Service Medicaid Population*, 46 Med. Care 565 (2008). This can in turn drive up inpatient and other costs.

Low-income individuals cannot be incentivized to simply “prefer” the preferred drug. At these income levels and with those high cost sharing differentials, individuals enrolled in Medicaid are not really given any meaningful choice and likely will go without the “non-preferred” drug, even if it is necessary and would work far more effectively than a preferred drug. This is critically important, as this is one of the few areas where children are not exempt from cost sharing.

As previously mentioned, the Medicare Part D limits for cost sharing are: $1.10 for preferred/generic drugs and $3.30 for other medications for individuals with incomes at or below the poverty level and $2.50 and $6.30,respectively, for individuals with incomes over the poverty level; and we recommend these benchmarks for Medicaid beneficiaries.

**Recommendation:** HHS should base “nominal” on the income of Medicaid beneficiaries and set the maximum nominal cost sharing for drugs as follows: Individuals with family income at or below 150% FPL: Preferred drugs: $1.10; Non-preferred drugs: $3.30; Individuals with family income exceeding 151% FPL: Preferred drugs: $1.10; and Non-preferred drugs: $4.20.

**§447.54. Cost sharing for services furnished in a hospital emergency department.**

Research indicates that Medicaid beneficiaries often use the emergency room because there are no available and accessible non-emergency services providers near. Although we understand that the intent is to encourage more appropriate use of the emergency room, $8 is more than double the current FY 2013 maximum nominal amount ($3.90) for families below 150% FPL and is unaffordable for low-income individuals. Again, nominal cost should be based on the income of Medicaid beneficiaries. For families at or below 150% FPL, we recommend a $4maximum nominal amount. As this is one of the few areas where an agency may impose cost sharing on children, we think it’s particularly important for HHS to ensure that the safeguards at §447.54(d) are observed. We also strongly support §447.52(f)(5) that requires states to specify the process by which non-emergency services are identified.

**Recommendation:** HHS should base “nominal” on the income of Medicaid beneficiaries and set the maximum nominal amount of $4 for non-emergency use of the emergency room.

**Recommendation:** HHS should ensure that the safeguards at §447.54(d) are observed by states that impose cost sharing for non-emergency use of the emergency room.

**§447.56(a)(2)(iv)**

We strongly support the proposal to have all pregnancy-related services exempt from cost sharing and premiums, unless specifically identified in the state plan as non-pregnancy related. We also strongly support HHS codifying the requirement in the ACA to exempt counseling and drugs for cessation of tobacco use. This is vital from the children’s perspective as the health and well-being of a mother during pregnancy can significantly impact the health of both the woman and her child. This proposed rule will help protect pregnant women from high levels of cost-sharing that might present a barrier to necessary care.

**§447.56(f)(3)**

Some states have not truly had a process to track family’s cost sharing and premiums, placing the burden on families and having them rely on the “shoebox” method. Therefore, we strongly support HHS clarifying that the state plan must include an automated mechanism to track each beneficiary’s cost sharing and premiums to ensure that beneficiaries will not exceed the aggregate limit of five percent of family income. States can track their cost sharing and premiums through their Medicaid Management Information Systems (MMIS), and would have an incentive to improve their systems through enhanced Federal funding.