MEDICARE RIGHTS CENTER

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October 31, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9974–P
Mail Stop C4-26-05, 7500 Security Boulevard
Baltimore, MD 21244–1850

RE: CMS-9974-P (Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market; Eligibility Determinations; Exchange Standards for Employers)

Submitted electronically at: http://www.regulations.gov

To Whom It May Concern:

We the undersigned applaud the Center for Medicare and Medicaid Services (CMS) for its efforts to consider populations excluded from the newly created Exchange premium tax credit, including those eligible for Medicare, in the proposed Exchange enrollment and eligibility regulations. However, final regulations should provide further guidance and instruction to states with regard to these non-MAGI populations. To that end we ask that CMS consider the comments that follow.

Sincerely,

The Medicare Rights Center

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§155.335—Annual Eligibility Redetermination

One of the purposes of the annual redetermination, as stated in the preamble, is to ensure the eligibility process for the Exchange, Medicaid and CHIP is streamlined and seamless. Seamlessness is equally important as QHP enrollees become eligible for other insurance affordability programs, including Medicare. Like the redetermination process, this transition process provides the Exchange with an opportunity to identify a change in eligibility status and facilitate enrollment into the new benefit. In many instances the Exchange can easily identify these transitions because of the data points collected by the Exchanges, such as date of birth.

At minimum the Exchange should include proactive outreach to enrollees about the end of the premium tax credit and Medicare eligibility and enrollment. A failure to provide outreach may result in enrollees facing gaps in coverage. For example, although the Medicare initial enrollment period includes the three months following the month of a beneficiary's birth month, an enrollee who delays Medicare enrollment until that 3rd month would have Medicare coverage beginning the 3rd month after the month in which they enrolled. Thus, there would be a 6 month period during which the enrollee would be without Medicare, many of those months without a premium tax credit.

§155.345—Coordination with Medicaid, CHIP, the Basic Health Program and Pre-existing Condition Insurance Program

We want to ensure that the regulations reflect that there is no wrong door for entering Medicaid and Exchange determinations. Although we appreciate that state Medicaid agency and Exchanges agreements do not require the Exchange to make Medicaid eligibility determinations, we ask that the regulations make clear that any individual who presents an application to the Exchange receive the same basis screening, including individuals who are ineligible for subsidies such as applicants over the age of 65.

We understand the regulation to require the Exchange to conduct a basic screening for Medicaid and other insurance affordability programs for individuals who have submitted a Medicaid or premium subsidy application to the Exchange. The regulations should clarify that the presentation or submission of an application, complete or incomplete, to the Exchange meets the definition of a ‘request for an eligibility determination for insurance affordability programs’. The application submission should trigger the basic screening. Additionally, the regulations should require the state Medicaid agency to treat the submission of that initial application to the Exchange as the protected filing date.

The advantages of the data sharing outlined in the proposed regulations should allow state Medicaid agencies to make relatively expeditious eligibility determinations. We therefore request that a Medicaid eligibility determination be made no more than 30 days after the application was presented to the Exchange. This deadline would be consistent with SNAP requirements and, with the efficiencies brought about by enhanced and expedited data exchange envisioned under the ACA, would be reasonable to impose on state Medicaid programs. We recognize that Medicaid eligibility determinations for Medicaid eligibility due to disability could require an exception, and that the current deadline for disability review is 90 days. However, in no event should the fact that an individual chose to make an initial application submission to the Exchange be allowed to extend these timeframes. The individual’s choice of the Exchange or a Medicaid agency as the point of entry to the application process should not affect in any way rights to prompt processing of the application.

We ask that CMS clarify what a basic screening by the Exchange entails. Regardless of what the process entails, the regulations must require that an applicant be told that such a screening is merely a preliminary collection of information and that no eligibility determination has been made. Furthermore, the regulations must clearly instruct the Exchange to transfer the screening information to the Medicaid agency even if the information provided during the screening appears to make the applicant ineligible for the benefit.