

January 7, 2010

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2346-P
P.O. Box 8016,
Baltimore, MD 21244-8016

RE: CMS-2346-P (Medicaid: Federal Funding for Medicaid Eligibility Determination and Enrollment Activities)

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

To Whom It May Concern,

The undersigned organizations would like to thank the Centers for Medicare & Medicaid Services (CMS) for providing enhanced matching funds to states to develop and modernize their Medicaid and related enrollment systems. We are pleased that CMS recognizes that this funding is essential to improving enrollment processes and preventing bureaucratic disentanglements and delays in benefit administration as a result of technological errors. Many states have had a desire to reform their systems, but their ability to do so has been limited by a lack of adequate capital for modernizing eligibility and enrollment systems. The availability of increased matching funds makes these reforms possible.

While the proposed rule focuses primarily on enrollment systems for people who will be eligible for coverage through an Exchange plan or Medicaid under the Affordable Care Act (ACA), CMS and states must also incorporate the Medicare population into new systems to ensure that older adults and people with disabilities will benefit from system modernization and streamlined enrollment processes. For that reason, our comments are focused on individuals eligible for and enrolled in Medicare, toward ensuring that this population will be part of the new modernized systems that many states may develop for non-Medicare populations as a result of the ACA. These systems are likely to include innovations that will advance the goal of seamless enrollment into benefits. Use of such enrollment systems for Medicaid, Medicare Savings Programs (MSPs), and the Part D Low-Income Subsidy (LIS) will help ensure that people with Medicare who have limited incomes will have access to benefits that they deserve and that could help improve their financial outlook. In addition, including individuals dually eligible for Medicare and Medicaid in new systems—as well as other special populations—will be essential for facilitating seamless transitions to Medicare from Medicaid and exchange plans, as well as mitigating gaps in coverage and financial hurdles that will prevent access to care.

Therefore, the language of the rule should make clear that the enhanced matching funds are fully available to be used to incorporate into new or improved eligibility and enrollment systems components that would determine eligibility and facilitate enrollment for populations that are still subject to traditional Medicaid eligibility criteria, such as the

Medicare population. Furthermore, CMS should release guidance to states to encourage state-based policymakers to incorporate this population into new systems or, at the very least, to demonstrate in development plans that these populations will be incorporated into systems in the future if not immediately, and that systems will be built in a manner that allows for effective expansion to other populations.

Modernization of enrollment systems is necessary to facilitate enrollment of Medicare-eligible individuals into an array of programs that help consumers with fixed incomes afford and access care, by helping to fix ongoing technological issues that prevent enrollment or cause long delays in enrollment. According to recent articles in *Health Affairs*, anywhere from one-third to one-half of eligible consumers are not enrolled in MSPs.¹ Unfortunately, complicated enrollment processes and outdated systems are one reason for this grave under-enrollment. The limitations of current data systems are further demonstrated by recent problems with data exchanges between the federal government and the states to facilitate enrollment into MSPs and Part A and B Buy-In. State and federal systems are frequently not compatible, preventing data files from being effectively matched so that an enrollment can occur. When data files do not match, they are sent back and forth between state and federal systems until the discrepancy is resolved. This process can take months, and it is often difficult to determine which data element is causing the problem. In the meantime, individuals go without much-needed benefits, straining state-based and emergency health systems.² Furthermore, many old systems lack the capacity for integration, meaning information cannot be shared across programs to streamline eligibility determinations to promote “Express-Lane Eligibility.” While the rule states that Express-Lane Eligibility is a potential goal for states as they develop new systems, the Medicare population would be unable to benefit from this streamlined enrollment process if the population remains siloed in older systems lacking the capacity to exchange data effectively.

It is particularly important for states to incorporate the Medicare population into new enrollment systems in light of the ACA. Allowing the Medicare population to enroll in low-income programs through the enrollment systems used for the Exchange and Medicaid or a similar system (“no wrong door enrollment”) would also help to smooth the transition from Qualified Health Plans (QHPs) and Medicaid to Medicare, which occurs when people turn 65 or become eligible owing to disability. The rules governing the transition from a QHP with a premium subsidy or expanded Medicaid to Medicare (e.g., what notice must occur, how and if coverage will end, etc.) are not yet clear. Further, individuals who had been using the Exchange and then become Medicare-eligible would need to familiarize themselves with more complicated Medicare systems, which could lead to disenrollment and low enrollment in programs that could help cover

¹ Eichner, J. and Vladeck B.C. “Medicare as a Catalyst for Reducing Health Disparities,” *Health Affairs* (March/April 2005); 24(2): 365-375.; Federman, A.D., Vladeck, B.C., and Siu, A.L. “Avoidance of Health Care Services Because of Cost: Impact of the Medicare Savings Program,” *Health Affairs* (January/February 2005)24(1): 263-270.;

² Goggin-Callahan, D. *Warning Signs: Preliminary Report Highlights Problems with State Implementation of MIPPA Low-Income Reforms*, Medicare Rights Center, February 2010. Available at www.medicarerights.org/pdf/Warning-Signs-MIPPA.pdf.

Medicare costs and ease the financial burden of transitioning from more heavily subsidized coverage to Medicare. This is especially of concern for certain low-income individuals—for example, those with incomes between 100 and 138 percent of the Federal Poverty Level, who will be covered under expanded Medicaid.

Individuals who will be eligible for Medicaid before and after becoming eligible for Medicare will also face significant transition issues. Because the Medicaid eligibility criteria and calculations that are applied to income will be different for people once they become Medicare-eligible, there will need to be a new determination of eligibility for Medicaid. People who become Medicare-eligible may have to provide documentation and attest to income and assets, essentially requiring them to submit a new application for Medicaid coverage. If low-income Medicare populations are not included in new systems, streamlining this enrollment and transition process may be difficult or impossible. Whereas the non-Medicare population will enjoy simpler, more automated enrollment systems, the low-income Medicare population may face an increase in complications. We question the feasibility of exchanging data between new and old systems given the technological limitations of many existing systems. If people are simply dropped from new systems upon becoming Medicare eligible, then there is a chance they will fall through the cracks, leading low-income Medicare consumers to be uninsured if they do not enroll in Medicare on time, or underinsured because they lose Medicaid and have Medicare alone.³

Furthermore, the rule states that new systems should be able to capture and report data on populations and enrollment trends. CMS, for instance, has recently increased efforts to collect data on dually eligible consumers. Yet as the rule attests, many current systems are ill-equipped to capture such data, and if Medicare consumers are relegated to outdated, inefficient systems, states and CMS will continue to face the same data collection hurdles. Sadly, a lack of accurate, up-to-date data on vulnerable populations could lead to even more disparities in the coverage and care that these individuals are receiving.

For the above reasons, it is essential that CMS works with states as it provides increased matching funds to ensure that funds are used not only to improve systems for the non-Medicare population who are subject to new rules but for the Medicare population as well.

In addition, though the rule only extends 90 percent matching rates to December 31, 2015, because CMS believes that by that time implementation of core aspects of the Exchanges must be completed, we ask that 90 percent matching rates be available beyond 2015 to assure that states continue to work to incorporate all populations, including the Medicare population, into new or improved systems. While we believe that Medicare populations should be included immediately in new Exchanges and Medicaid systems wherever possible, we acknowledge that states may prioritize non-Medicare populations

³ While Medicaid pays secondary to Medicare, in our experience if people have Medicaid when they become eligible for Medicare and do not enroll in Medicare immediately, they are able to retain Medicaid coverage as primary for a period of time, protecting them from gaps in coverage.

in order to meet the timeframes set forth in the ACA. Incorporation of dually eligible and other low-income Medicare consumers may thus be a longer-term goal, and states will require an extension of increased matching funds to achieve objectives related to these populations.

Thank you again for the opportunity to comment and for making funding available to states so that they can reform their insurance and subsidy enrollment systems. This support is essential to ensuring that as many eligible Americans as possible can access and afford good health care.

Sincerely,

California Health Advocates
Center for Health Care Rights
Center for Independence of the Disabled of New York
Center for Medicare Advocacy
Center on Budget and Policy Priorities
Empire Justice Center
Families USA
Medicare Rights Center
National Association of Area Agencies on Aging
National Association of Social Workers
National Consumer Voice for Quality Long-Term Care
National Council on the Aging
National Senior Citizens Law Center
New Yorkers for Accessible Health Coverage
Pennsylvania Health Law Project