MEDICARE RIGHTS CENTER

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October 31, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–2349–P
P.O. Box 8016,
Baltimore, MD 21244–8016

RE: CMS-2349-P (Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010)

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 new modified Medicaid adjusted gross income (MAGI) budgeting, including those eligible for Medicare, in the proposed Medicaid enrollment and eligibility regulations. However, final regulations should provide further guidance and instruction to states with regard to these non-MAGI populations.

To avoid creating two separate state Medicaid eligibility and enrollment systems, the regulations should require states to use the newly created eligibility and enrollment systems for Medicaid, Medicare Savings Programs (MSPs), and the Part D Low-Income Subsidy (LIS) to 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 will be essential for facilitating seamless transitions to Medicare from Medicaid, as well as mitigating gaps in coverage and financial hurdles that will prevent access to care.

A failure to provide such guidance could result in states creating bifurcated Medicaid systems and disadvantaging non-MAGI beneficiaries. For these reasons we respectfully request that CMS consider and incorporate our comments.

Sincerely,

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§435.907(c)—Alternative application for non-MAGI insurance affordability programs

We understand that some non-MAGI populations, such as the long term care population may need to submit information beyond what must be submitted by the MAGI population and therefore alternative applications may need to be developed.

For non-MAGI populations who will need to submit information beyond what must be submitted by the MAGI population, CMS has outlined two pathways: create a separate streamlined non-MAGI application or require supplemental forms be submitted along with the MAGI application. We request that if an alternative form is created by a state Medicaid agency that the Secretary must approve the application using similar criteria for approving the MAGI application. If a state Medicaid agency decides to require additional forms be submitted along with the streamlined MAGI application, we ask that those forms be reviewed and approved by the Secretary to ensure that the forms are not duplicative or unduly burdensome. Any additional forms should be provided with the initial MAGI application. Sending additional forms to the applicant after the initial application risks creating delay in the eligibility determination and, if determined eligible, receipt of the benefit. Moreover, for populations that can be easily identified as non-MAGIs, the MAGI application should instruct the applicant to go to the appropriate additional forms. The applicant should not be required to fill in information that is unnecessary.

Non-MAGI applicants should have a variety of submission pathways including paper submission. However, all non-MAGI applications should be provided online and allow for online submission in a manner similar to the MAGI application. Additionally, the regulations must emphasize that regardless of the application pathway, translation and interpretation services are available through the state Medicaid agency.

§435.911(c)1—Eligibility for mandatory coverage on the basis of modified adjusted gross income

We are pleased that this provision will allow an applicant who may be Medicaid eligible as disabled or medically needy to immediately enroll into the newly created adult group so long as the applicant meets the non-financial and financial MAGI eligibility criteria. We are, however, concerned that as currently written the regulation does not require further screening of these individuals for non-MAGI programs for which they may qualify unless the individual affirmatively asks for further screening. If these individuals are not also screened for non-MAGI categories of Medicaid eligibility they may end up with a less generous Medicaid benefit. Given that the proposed guidance on benefits has not been released, we ask that unless the benefit is equal to the benefits under non-MAGI Medicaid these individuals must be screened for and enrolled into the non-MAGI programs for which they might qualify. The individual, who is unlikely to be aware of the various categories of eligibility, should not bear the burden of asking for such screening.

§435.911(c)2—Eligibility on basis other than applicable modified adjusted gross income standard

We are pleased that the guidance instructs state Medicaid agencies to collect additional information needed to make an eligibility determination for non-MAGI applicants. The regulations should require states to work to extend the enrollment and data sharing benefits for the MAGI applicants to the non-MAGI applicants. State Medicaid agencies could, for example, utilize state income tax data or asset verification systems to verify information submitted by non-MAGI applicants, rather than requesting additional proof from applicants. This is particularly useful for non-MAGI benefits such as the Medicare Savings Programs (MSPs), which in many states already require only minimal proof of income and assets. Such benefits could easily be folded into the data sharing eligibility and enrollment improvements extended to MAGI applicants. Additionally, the regulations should require states to explore other alternatives such as self-attestation of income and/or assets.

CMS has already clarified that states may use the increased 90%/10% Federal Medical Assistance Percentage (FMAP) to improve eligibility and enrollment systems for the non-MAGIs. CMS should encourage states to carve in the non-MAGI populations before 2015 when these funds will no longer be available. CMS should require states to guard against bifurcating Medicaid eligibility and enrollment systems. This comment should not be read to suggest that contracting out both MAGI and non-MAGI Medicaid eligibility and enrollment to 3rd parties would guard against such bifurcation. Instead, it should be read to require state Medicaid agencies to develop a single enrollment and eligibility process for the MAGI and non-MAGI populations.

The preamble makes clear that the term 'as needed' refers to collecting information that is needed to make an eligibility determination, however, that is not immediately clear in the text of the regulation. We ask that CMS clarify that the term 'as needed' refers to the information needed to make an eligibility determination and not that the state may simply elect not to collect information.

As mentioned we ask that state Medicaid agencies utilize data available from other state agencies such as tax returns and that states utilize electronic asset verification systems. However, we recognize that additional information and documentation may be required from the applicant. If a state has elected to use a single non-MAGI application with additional forms, we ask that only those forms that are needed to make an eligibility determination be sent to the applicant. The regulations should make clear that the request should be tailored to that particular applicant. Similarly, if the state has elected to use a modified application for the non-MAGI population, the applicant should be sent a modified application with the already submitted information pre-populated into the application.

The Low Income Subsidy, or Extra Help, is the program that helps eligible Medicare beneficiaries pay for Medicare Part D prescriptions. Although it is not currently defined as an insurance affordability program, we ask that CMS include the Low Income Subsidy in the insurance affordability program definition and that state Medicaid agencies be required to screen for this benefit.

§435.916—Periodic redetermination of Medicaid eligibility

The proposed regulations sought comment on whether to extend the MAGI renewal rules and processes to non-MAGI beneficiaries. We strongly support the principles set out in §435.916(a). As with the initial application we believe the state Medicaid agency should first look to data already available to the state before requesting that the beneficiary proactively provide the information. We support the preamble's assertion that requesting this information may result in eligible beneficiaries losing the benefit. Therefore, we encourage CMS to extend the MAGI renewal benefits to the non-MAGI populations.

The redetermination process is an opportunity for state Medicaid agencies to determine if there has been a change in the beneficiary's health status, for example if the beneficiary has become disabled or medically needy. However, the onus must not be placed on the beneficiary to proactively identify the potential change in status or eligibility. We believe that the state, rather than the beneficiary, is in the best place to gather needed information and assess any potential change in status. Therefore, the Medicaid agency should do outreach to consumers, requesting that they voluntarily provide health status updates and, in the course of periodic redeterminations, should be required to screen for eligibility for non-MAGI programs.

As individuals transition from MAGI beneficiaries to non-MAGI status, for example approaching their 65th birthday, state Medicaid agencies must do beneficiary outreach and education regarding the need to enroll into other insurance affordability programs and must screen applicants for eligibility for non-MAGI Medicaid categories. These individuals may continue to qualify for Medicaid under another category of Medicaid eligibility if they lose eligibility for MAGI-based programs. Like the redetermination process, this transition process provides the state with an opportunity to identify a change in Medicaid status and facilitate enrollment into the new eligibility category. The regulations should make clear that states continue to be subject to the

current requirement that Medicaid agencies must screen any individual who loses Medicaid coverage for eligibility under any other categories. States should also be required to provide outreach to facilitate these eligibility screenings and transitions. Moreover, for individuals transitioning out of MAGI program eligibility, the state should be required to continue Medicaid coverage during the pendency of a Medicaid application for a non-MAGI Medicaid benefit. This will help to ensure continuous insurance coverage and avoid unnecessary gaps in insurance due to application processing delay.

§435.1200(d)—Internet Website

We support the preamble's acknowledgement that the website will serve as a mechanism through which individuals will communicate with the agency and therefore must be accessible to people with disabilities and those who are limited English proficient. While we understand that the agency's intention is to address accessibility in other regulations, we wish to emphasize the importance of making translated materials available on state websites so that limited English proficient individuals can fully participate in these programs and the requirements of Title VI of the Civil Rights Act can be met. Similarly, access for persons with disabilities is critical. We urge that the regulations governing accessibility be specific and thorough. We also ask the agency to work with the states to develop model forms, uniform vocabulary and other materials so that the states can avoid expensive duplicative efforts and so that a uniformly high quality of translation can be achieved.

We understand the preamble to permit state websites to be either: a single website for information about and enrollment into all insurance affordability programs or a broad health care website that includes information about health insurance coverage and health services. We encourage any state Medicaid website to include information about all coverage and services. However, we ask that the regulations do not permit states to create sites that are merely health care information clearinghouse portals. Instead applicants should be able to fill out and submit applications for all insurance affordability programs from a single site. A webpage that does not allow for online application submission should not satisfy the text of the regulation.

Online applications (as well as telephone screenings and paper applications) should be designed with questions at the start that seek to immediately identify non-MAGI applicants, for example individuals over the age of 65. By identifying these populations early in the application process, the applicant can be directed only to provide information needed for these non-MAGI categories and will not have to provide unnecessary or duplicative information to the state.

§435.1200(f)—Transfer of applications from other insurance affordability programs to the state Medicaid agency

We are pleased that the proposed regulations do not allow the state Medicaid agency to request information or documentation from the applicant that is already contained in the transferred application. Similarly, and echoing our comments regarding §435.911(c)2, we ask that state Medicaid agencies consider verifying information already known to other state entities or utilizing data sharing technologies such as asset verification systems before requesting additional information from the applicant.

§435.1200(g)—Evaluation of eligibility for the Exchanges and other insurance affordability programs

We applaud CMS for allowing individuals who are eligible for other insurance affordability program to immediately enroll into these programs during the pendency of a Medicaid determination regarding eligibility on the basis of being blind or disabled.