June 3, 2013

VIA ELECTRONIC SUBMISSION

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

Attention: CMS-2327-FC

Medicaid Program; Increased Federal Medical Assistance Percentage Changes Under the Affordable Care Act of 2010

Dear Sir/Madam:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. We appreciate the opportunity to provide comments to HHS' proposed rule on federal matching assistance percentage.

General Comments

NHeLP believes HHS' proposed rule is well designed to ensure states are able to receive the enhanced matching funds required by the ACA for newly eligible enrollees. We commend HHS for ensuring that enhanced FMAP funding is available, as required by the ACA, for a wide array of individuals who, despite having income below the MAGI converted thresholds, would not have been enrolled in full benefits coverage due to enrollment caps, waiting lists, or enrollment in only partial benefit coverage. However, we have several recommendations to improve the regulation for vulnerable individuals.

We strongly commend HHS for reiterating at various points in the regulation that the process to determine FMAP should not create additional burdens for consumers. We support this policy and believe that there is no need to burden consumers to estimate matching rate populations. Put simply, we believe this means that consumers should not be asked to provide anything more than the bare minimum information needed to make an eligibility

determination. We believe that HHS should create clearer protections to ensure this policy is followed in practice.

In particular, we are unclear as to how the "threshold methodology" that HHS has selected can achieve this goal without creating problematic incentives. Since determining categorical eligibility for traditional Medicaid programs requires more information than the basic "streamlined" application or "assessment" process may glean, we do not see how states will avoid asking additional questions in an individualized threshold methodology process. We are also not clear as to how this avoids the other stated goal of having states avoid operating dual eligibility systems. We *might* be supportive of the threshold methodology approach (see next paragraph) if the scope of the FMAP determination is limited to only the information included on the streamlined application. (We understand this to be HHS' approach). We believe HHS should clarify this policy because any additional information requests would not comply with the stated goal of not burdening consumers. We are otherwise strongly supportive of HHS' decision to utilize one consistent methodology for all states, as opposed to having different states choose between two or three methodologies.

However, we note that even if states limit the threshold methodology to information readily available on the streamlined application, this may create a problematic incentive for states. In this scenario, a state that lowers its categorical eligibility limits would capture more individuals at the enhanced matching rate, because there would be some individuals who could not be determined traditional-Medicaid eligible based on "assessment" alone but who would have been determined traditional Medicaid eligible if the state hadn't lowered its income limits. (See hypothetical example). We believe the simple solution to this incentive problem is a proxy that adjusts to account for individuals who would have been categorically eligible at the old income limit. (Also described in hypothetical.)

> *Hypothetical example:*
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> *In State the income limit for disability based Medicaid in 2009 was 120% FPL. In 2014, State adopts the Medicaid Expansion, and the disability based category continues to use the 120%FPL income limit (or, a converted limit of say 122%). In 2015, Applicant A with 110% of FPL income and a disability applies, and is enrolled in disability based Medicaid at traditional matching rates. In 2016, State drops the disability category income limit from 120/122% to 100%. In 2017, Applicant B with 110% of FPL income and a disability applies. For assessment eligibility purposes, Applicant B's disability status is irrelevant, since she is over the income limit for that category. She is enrolled in the Medicaid Expansion as newly eligible at enhanced matching rates. Her disability was relevant for FMAP purposes, but it was never determined. State has effectively increased its matching rate for Applicant B (and all other disabled applicants between 100-120/122% FPL) by reducing its categorical*

income limits. State has an incentive to further reduce the income limit since the same logic would apply with every reduction.

Solution to hypothetical problem:

HHS uses a "categorical eligibility proxy." Under this proxy, State calculates how many applicants without a disability determination between 100-120/122% FPL ended up with a disability determination based on historical data. The proxy result is 3%. For 3% of the applicant population in that income range, State receives only the traditional matching rate. Although State regrettably receives less matching rates, the result is optimally equitable and counteracts the incentive to reduce categorical income limits.

We recognize that many individuals have a wider range of reasons to pursue disability determinations than Medicaid alone. However, for many other individuals Medicaid is the gateway to the disability process and/or in fact the only program they are interested in. Without a disability proxy, HHS' policy not only forecloses the outcomes for these individuals, it in fact creates an incentive for the state to foreclose the outcome.

Whether in the context of information requests related to the threshold methodology (which we have recommended against) or those related to proxies, such as the resource proxy, we believe HHS must develop clear policies that will protect consumers:

(1) During the eligibility process, consumers should only be provided questions directly tied to eligibility and necessary for an eligibility (as opposed to FMAP) determination.
(2) Any extra FMAP-related contacts should occur *after* eligibility and enrollment is completed and should have no eligibility or enrollment consequences for the applicant. (For example, the additional information should not delay or stop the application process.)
(3) All such post-enrollment FMAP-related contacts should be conducted in strict compliance with HHS-approved scripts that clearly explain that providing information is voluntary and has no impact on the eligibility and enrollment process which has been finalized nor any future eligibility process.
(4) Failure of a consumer to provide information – whether by failure to respond or refusal – should not have any negative consequences.
(5) Presumably, HHS is already requiring states to gather as much of the missing information as possible through data matching, but this should also be explicitly required to ensure states only contact consumers for FMAP-related information where information is truly unavailable.

Finally, we urge HHS to include more transparency in the FMAP determination process. Small variations in FMAP formulas or proxies may have large financial repercussions for HHS and states, and consequently, create financial incentives which may negatively impact consumers in certain circumstances. It is important for this process to be as

transparent as possible to avoid problematic policies or the appearance thereof. State methods and calculations, including proxies, as well as HHS approvals of them, should be publicly posted on the HHS website for viewing.

Specific comments

§ 433.10(c)(8)

Based on the discussion in the regulation preamble at 78 Fed. Reg. 19922, and the reference to § 1902(k)(1) of the Social Security Act, we understand HHS to be interpreting the term "benchmark coverage" in (c)(8) to refer to both benchmark-exempt coverage and coverage through benchmarks for the Medicaid Expansion population. In this way, statutory language providing expansion state FMAP match only for benchmark coverage would be available for both populations. We support this interpretation of the statute and believe it gives effect to the legislative intent. However, we do not believe there is any good reason to repeat the statutory language creating the confusion in the regulation, particularly since the clarifying language in the preamble does not appear in the regulation itself. Consequently, we recommend removing the confusing language from the regulation, or adding the clarifying language to the regulation text.

§ 433.206(c)(4)

We recognize the challenge, addressed in § 433.206(c)(4), of determining the appropriate FMAP corresponding to an individual for whom a disability determination is necessary. While we understand the logic of HHS' approach, we are concerned that it may create an incentive for states to slow the disability determination process and extend the timeframe for which enhanced matching rates are available. We believe this would harm many consumers who will depend on the benefits package corresponding to a disability based category, and that it will disrupt HHS' intended goal of fast enrollment. We suggest the following considerations:

- It is our understanding that HHS does not intend to reconcile matching rates based on the date of application. For example, if an individual applies and the disability review takes 60 days during which time the state receives "newly eligible" FMAP, but the individual is ultimately determined disabled and non-newly eligible, the state match for the 60 days will not subsequently be reduced. While we recognize that such a reconciliation would be undesirable for states, we believe it would reduce any incentive for delay and would result in the most accurate final matching rate determinations. We recommend HHS adopt a reconciliation.
- If HHS maintains the current policy, including the incentives for state delays we noted above, without a reconciliation process, then we recommend HHS review the timeframes around the disability process and work to bring it as close to "real time" eligibility as is feasibly possible. Please see our recommendations submitted in previous comments (to CMS-2349-F) suggesting the disability determination

application time limit be reduced to 60 days, with additional protections and the long-term goal of achieving disability determinations as close to real time as possible. HHS should additionally develop protections to make sure states are not slowing the disability process, and in fact are proactively working to accelerate it.

§ 433.206(d)

We support the establishment of a resource criteria proxy adjustment – states should receive fully enhanced matching rates for the estimated population who will be traditionally-eligible on the basis of their income yet would have been "newly eligible" if assets were considered under traditional rules. We are most strongly supportive, however, of the requirement in section (d)(1) requiring that "the use of a resource proxy methodology must not delay or interfere with the eligibility determination for an individual." States should only be permitted to conduct proxy surveying once the eligibility and enrollment process is complete, and only then if there is no consequence for consumer non-participation in the surveying. We recommend HHS include in regulation the five protections we have listed above in the General Comments section.

§ 433.206(e)

We support the development of an adjustment to newly eligible FMAP to account for state enrollment caps, waiting lists, and other limits. States should receive enhanced match for the population of individuals who would have been subject to such limits and would not have been enrolled in the state's traditional Medicaid program.

§ 433.206(f)

We support HHS' policy that states should not count "potential spend-down amounts" in making determinations of "newly eligible" individuals. (See 78 Fed Reg 19938). We agree there is simply no way to properly assume any individual would have otherwise spent-down.

§ 433.206(g)

We are supportive of the creation of authority for special circumstances allowing adjustments to methodologies or new proxies. However, given how broad and vague this regulatory language is, we believe that HHS should include language requiring that any such special circumstance exception must (1) not require consumers to provide any information beyond the minimum necessary to make eligibility determinations as a condition of enrollment, or otherwise burden consumers, and (2) must be made publicly available by posting on the HHS website.

Conclusion

In summary, we are supportive of HHS' regulation but urge that it be improved to reinforce consumer protections and promote transparency. If you have questions about these comments, please contact Leonardo Cuello at (202) 289-7661 or cuello@healthlaw.org. Thank you for consideration of our comments.

Sincerely,

Emily Spitzer,
Executive Director