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**VIA ELECTRONIC SUBMISSION**

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
P.O. Box 8016  
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**Attention: CMS-2334-P**  
**Medicaid, Children's Health Insurance Programs,**  
**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**

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 streamlining of eligibility proposed by CMS and proposed provisions regarding notices and appeals. We thus provide additional comments to strengthen these regulations.

Our comments are divided into sections as follows:

- [Part 430 – Grants to States for Medical Assistance Programs](#)
- [Part 431 – State Organization and General Administration](#)
- [Part 435 – Eligibility in the States, D.C., Northern Mariana Islands and American Samoa](#)
- [Part 440 – Services: General Provisions](#)
- [Part 447 – Payments for Services](#)
- [Part 457 – Allotments and Grants to States](#)
- [Part 155 – Exchange Establishment Standards & Other Related Standards](#)
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## **PART 430 – GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS**

### **§ 430.12 Submittal of State plans and plan amendments**

NHeLP thanks HHS for recognizing that the State Plan Amendment (SPA) approval process should be more efficient and transparent. As described in the preamble, HHS is developing an electronic system for submitting SPAs for Medicaid and CHIP and will require states to transition from paper-based state plans to automated, electronic versions. NHeLP agrees that an electronic system will be more efficient. However, as written, the proposed rule does not specifically address the need for greater transparency in SPA development and approval (*cf.* 78 Fed. Reg. 4625 (noting paper-based template are “not transparent”))

States vary widely in the transparency and stakeholder involvement in SPA development and approval. At least four states require legislative approval of SPAs, while several others require notice to the legislature prior to submission of the SPA to HHS.<sup>1</sup> Some states, such as Arizona and New York, dedicate a section of their Medicaid agency’s website to SPAs submitted to HHS, as well as HHS approval letters. By contrast, the District of Columbia’s Department of Health Care Finance declines to publish this information on the agency website, instead providing a list of proposed and pending SPAs to attendees at Medical Care Advisory Committee meetings.

Current federal regulations require information on SPAs to be made available to the public in the event HHS disapproves a SPA (42 C.F.R. § 430.62). In addition, some SPAs may implement “rules of general applicability,” which typically require formal notice and public comment rule making pursuant to the state’s Administrative Procedure Act. However, the need for transparency for all SPAs continues to grow given the trend in Medicaid Act jurisprudence affording SPAs great deference. See *Harris v. Olszewski*,

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<sup>1</sup> See NHeLP’s Role of State Law in Limiting Medicaid Changes, available at <http://www.healthlaw.org/images/stories/issues/RoleofStateLawinLimitingMedicaidChanges.pdf>

442 F.3d 456 (6th Cir. 2006) (finding State plan amendment entitled to *Chevron* deference).

HHS has already taken some steps to increase SPA transparency. It currently posts on Medicaid.gov SPAs approved on and after June 1, 2009. However, post-approval publication of SPAs has limited value for those seeking to provide input on SPAs still in development. Accordingly, HHS should take this opportunity to require adequate notice and a reasonable public comment period for *all* SPAs.

HHS has ample authority to require such procedures, and has done so using its general authority to promulgate rules “as may be necessary” provided under 42 U.S.C. § 1302(a). For instance, HHS imposed a notice and comment requirement for SPAs implementing 42 U.S.C. § 1396u-7, which authorizes states to implement benchmark coverage for certain populations. See 42 C.F.R. § 440.305(d). HHS also cites its 42 U.S.C. § 1302(a) authority when extending public notice and comment procedures for certain alternative benefits plans in proposed § 440.386 (78 Fed. Reg. 4701).

We recommend that HHS model the transparency and public comment provisions for SPAs after the recently enacted transparency regulations enacted for § 1115 demonstrations (see 42 C.F.R. § 431.408). These include adequate public notice, a public comment period of at least 30 days, and a report by the state describing compliance with the requirements, including a report of how the public comments were considered. These procedures allow interested stakeholders a meaningful opportunity to evaluate and participate in the SPA development process prior to submission. These provisions also require at least two public hearings at the state level, as well as a second public comment period once the proposal is submitted to HHS.

Notably, the transparency provisions for § 1115 demonstrations are far more robust than those provided for § 1937 benchmarks (42 C.F.R. § 440.305(d)) and the proposed public notice provisions in § 440.386. For example, § 440.305(d) requires simply a “reasonable opportunity” for public comment.

As explained in NHeLP’s comments on § 440.386, the proposed public notice requirements of § 440.386 are problematic and HHS should not use them as a model for all SPAs. The proposed § 440.386 repeats the language of § 440.305(d) requiring a “reasonable opportunity” for public comment, but then limits the public comment period to just two weeks for certain Alternative Benefits Plans (ABP) which the state Medicaid agency determines provide less coverage or higher cost sharing than existing benchmark plans. No pre-submission notice and comment period would be required for ABPs the state determines are commensurate with, or better than, existing benchmark plans.

First, two weeks is an inadequate amount of time for meaningful stakeholder consideration and input. Second, § 440.386 creates a two tiered process whereby the state’s own evaluation of an ABP determines whether it is subject to public notice and comment. This kind of black box agency determination defeats the very purpose of

transparency and stakeholder input. Finally, there is no compliance provision to help ensure meaningful participation by the public, unlike the reporting requirement in 42 C.F.R. § 431.412(a)(viii) for § 1115 demonstrations.

All SPAs, including those establishing benchmark and ABPs, should be subject to the same transparency and public input procedures modeled upon those governing § 1115 demonstrations. At a minimum, SPAs that materially change a state's Medicaid program should be subject to increased transparency and stakeholder input requirements.

**RECOMMENDATION:** We recommend amending § 430.12 by adding new subsection (d) to read as follows:

- (d) Transparency and stakeholder input. Prior to submitting a State plan amendment to the Centers for Medicare and Medicaid Services for approval, a State must provide the public with advance notice of the amendment and reasonable opportunity to comment with respect to such amendment.***
- (1) Public notice and comment period. Prior to submitting an application for state plan amendment, the State must provide at least a 30-day public notice and comment period followed by a 15-day period for State review of comments received.***
- (2) The public notice shall include the following information:***
- (i) The proposed state plan amendment and a description of the proposed state plan amendment that contains a sufficient level of detail to ensure meaningful input from the public;***
  - (ii) The locations and Internet address where the proposed State plan amendment is available for public review; and***
  - (iii) Postal and Internet email addresses where written comments may be sent and reviewed by the public, and the time period in which comments will be accepted.***
- (2) Publishing the public notice and public input procedures. The State shall publish its public notice and input process, the proposed state plan amendment, and the relevant Medicaid State plan amendment page(s) in a prominent location on either the main page of the public Web site of the State agency responsible for maintaining the Web page or to a Web page that is linked in a readily identifiable way to the main page of the State agency's Web site. The State must keep the public Web site current throughout the public comment and review process.***
- (3) Documentation of Compliance. When submitting a State plan amendment, the State must include written documentation of the State's compliance with the public notice requirements set forth in § 430.12(d)(1)-(2) of this subpart, with a report on the issues raised by the public during the comment period and how the State considered those comments when developing the State plan amendment. The***

***State shall maintain this Documentation of Compliance on the State's agency Web site for continued public reference.***

## **PART 431 – STATE ORGANIZATION AND GENERAL ADMINISTRATION**

### **§ 431.10 Single State Agency**

#### **§ 431.10(c) Delegations**

We strongly believe that HHS must require close supervision and oversight when notice and hearing functions are carried out by a government entity other than the single state agency. We particularly commend HHS' decision to provide that Medicaid agencies may only delegate responsibility to conduct fair hearings to a government agency or public authority that maintains merit personnel standards. Indeed, this is necessary to comply with the requirement in section 1413(d)(2)(B) of the ACA that eligibility determinations be made by public agencies. Given the troubled history of private contractors determining Medicaid and CHIP eligibility in some states (e.g. California, Indiana, Texas), there are serious concerns about the lack of transparency, accountability and accessibility when this authority is delegated away from public agencies. See, e.g., Manju Kulkarni *et al.*, *Public Health and Private Profit: A Witch's Brew*, J. POVERTY LAW & POL. (Jan.-Feb. 2002). At any rate, as we have noted in previous comments and HHS has acknowledged, this is a long-standing feature of the Medicaid program. See, e.g., 76 Fed. Reg. at 51,169. We strongly support this requirement.

We are concerned that some states have implemented § 431.10 in a manner inconsistent with constitutional due process protections. In a number of states that have delegated Medicaid appeals to independent hearing entities, there is a significant problem of Medicaid agencies overturning individual hearing decisions. Reversing decisions made by independent hearing officers, who hear and weigh the evidence, is inconsistent with *Goldberg v. Kelly* and the Fourteenth Amendment of the U.S. Constitution.

We appreciate that the proposed regulations partially protect individuals' due process rights by limiting the single state Medicaid agency's review of delegated appeals to the review of conclusions of law. We believe, however, that this does not go far enough. We recommend that it apply more broadly, to include Medicaid hearing decisions made by any independent agency, and that the Medicaid agency's authority to overturn hearing decisions be eliminated altogether.

**RECOMMENDATION:** We propose revising § 431.10(c) in the following manner:

- (3) The Medicaid agency-
  - (i) ***Subject to the limitation in paragraph (c)(3)(iii) of this section***, must ensure that any agency or public authority to which eligibility determinations or appeals decisions are delegated . . .
  - (ii) ***Subject to the limitation in paragraph (c)(3)(iii) of this section***, must exercise appropriate oversight . . .

(iii) if authority to conduct fair hearings is delegated to ~~another state~~ the Exchange or Exchange Appeals entity under paragraph (c)(1)(ii) of this section, ~~the agency may establish a review process whereby the agency reviews appeals decisions made by the Exchange or Exchange appeals entity, but only with respect to conclusions of law, including interpretations of State or Federal requirements~~ **the agency shall accept as final a hearing decision that is favorable to the applicant or recipient, and shall ensure that prompt corrective action is taken as required by 42 C.F.R. § 431.246.**

#### *§ 431.10(d) Requirement for written agreements*

We support HHS' requirement that the Medicaid agency and Exchange or Exchange appeals entity have written agreements that provide for the relationships and responsibility, quality control, and assurances and procedures to ensure that fair hearings comply with applicable requirements. We recommend that HHS require that the agreement explicitly provide for compliance with the monitoring and reporting requirements and the specific information be reported. We also believe that such agreements must be made available to the public.

**RECOMMENDATION:** Revise § 431.10(d) as follows:

(d) . . . The plan must provide for written agreements between the Medicaid agency and the Exchange . . . and must include provisions for:

. . .

- (2) Quality control and oversight by the Medicaid agency, including any reporting requirements needed to facilitate such control and oversight, ~~including any reporting requirements needed to facilitate such control and oversight~~ **but not limited to the following monitoring and reporting requirements: (i) Total number of appeals received by the Medicaid agency and the Exchange or Exchange appeals entity in the applicable period; (ii) Number and percent of Medicaid or Exchange appeals resolved through the hearing process and the outcomes of cases in the period; (iii) Quality improvement activities related to issues identified through the reports and monitoring.. . .**
- (5) **Making such agreements, and the reported information required by paragraph (d)(2), publicly available upon request and by posting to a dedicated appeals section on a public website.**

#### **§ 431.201 Definitions**

We welcome the expanded definition of an “action” and clarification that actions include determination of medical expenses to establish spend-down liability or of income for the purpose of determining cost sharing amounts. Such determinations have always been “actions,” however, this amended definition will bring welcome clarity to this area.



We note that this definition has been reworded in a way that suggests that termination or suspension of benefits or services is *not* an action. We assume that this is not HHS' intent, because it would be inconsistent with *Goldberg* and its progeny. Accordingly, recommend amending the language.

**RECOMMENDATION:** Revise § 431.201's definition of "Action" in the following manner:

*Action means a termination, suspension, or reduction of Medicaid eligibility or a **termination or suspension of, or** reduction in the level of benefits and services*

...

### **§ 431.205 Provision of hearing system**

We commend HHS for including the requirement that the hearing system be accessible to persons who are limited English proficient and who have disabilities.

We also recommend that HHS include a specific statement in the regulations that the hearing system must not discriminate against any individual on the basis of race, color, national origin, language, sex, sexual orientation, gender identity, age, or disability. Further, the regulation should specifically note that the hearing system must comply with Title VI, the Rehabilitation Act, § 1557 of the ACA and other applicable federal statutes and regulations. So that marketplaces have sufficient time to develop the systems and implement this system upon launch in October, we recommend that HHS issue sub-regulatory guidance quickly.

**RECOMMENDATION:** Amend § 431.205 to add new subparagraph (f) as follows:

***(f) The hearing system must not discriminate against any individual on the basis of race, color, national origin, language, sex, sexual orientation, gender identity, age or disability. The hearing system must comply with Title VI of the Civil Rights Act of 1964, the Rehabilitation Act, the Americans with Disabilities Act, and section 1557 of the Affordable Care Act.***

### **§ 431.206 Informing applicants and beneficiaries**

We strongly support the inclusion of specific language requiring that the information required in this section must be accessible to LEP individuals and individuals with disabilities. This comports with the due process requirements of the U.S. Constitution as well as Title VI, the Rehabilitation Act, and section 1557 of the ACA.

If the agency has information that the individual is LEP or has a disability requiring use of an augmentative or assistive communication device, the agency should be required provide notices to the individual in that language or in an alternative format. If the agency fails to do this, the notice would automatically be deemed ineffective because the notice is insufficient given the individual's language or disability.

Further, since some agencies may not have comprehensive language data on all individuals, we recommend that HHS require taglines in at least 15 languages on all notices. These taglines are an effective and cost-efficient way to inform LEP individuals that the notice is important and how to obtain further information through written translation or oral communication services. As mentioned above, sub-regulatory guidance from HHS would be most helpful.

**RECOMMENDATION:** Amend § 431.206 as follows:

- (e) The information required under this section must be accessible to individuals who are limited English proficient and individuals with disabilities, consistent with § 435.905(b) of this chapter and may be provided in electronic format in accordance with § 435.918 of this chapter. ***The information must also include the following:***
  - (1) for any individual with a disability, information must be provided in an alternative format appropriate for the individual's disability;***
  - (2) for any individual with a visual impairment who is unable to read standard information, the agency must provide information in large print, Braille or other acceptable alternate format appropriate for the individual's disability;***
  - (3) for any individual the agency knows or should reasonably know is LEP, information must be provided in that individual's language; and***
  - (4) for all notices, the agency must provide taglines in at least 15 languages informing individuals of the availability of written translations or oral assistance to understand the information provided and a toll-free telephone number to request assistance.***

#### **§ 431.210 Content of notice**

We enthusiastically support the language indicating that a “clear” statement of “the specific reasons” for an action must be included in notices. Moreover, we commend HHS for clarifying that citing the regulation supporting an action does not satisfy the requirement for a clear statement. 78 Fed. Reg. at 4602. As HHS notes, it is crucial that notices inform individuals of the facts supporting the denial of eligibility, not just the law. This is particularly true because multiple paths to insurance coverage exist, a variety of rules govern them, and more and different types of entities are making determinations. Thus, the likelihood of applicants and beneficiaries having difficulty understanding why they have been denied coverage is significantly greater than it has ever been and clarity and detail more important than ever.

As explained below, in the discussion of the procedural rights of applicants and beneficiaries, we believe that individuals who are entitled to hearings on both Exchange and Medicaid eligibility determinations should have the option of requesting that the



hearing on Medicaid eligibility be conducted first. Accordingly, we recommend that the required content of the notice include this information.

**RECOMMENDATION:** We recommend adding the following language to § 431.210(d)(1):

. . .or State agency hearing, ***and to request that such hearings take place before any hearing on an Exchange determination.***

### **§ 431.220 When a hearing is required**

We suggest an amendment to this section clarifying that, consistent with *Goldberg v. Kelly* and constitutional due process principles, all individuals have the right to a *de novo* hearing.

**RECOMMENDATION:** We recommend that § 431.220(a) be revised in the following manner:

The State agency must grant an opportunity for a ***de novo*** hearing to the following:...

We further note that the description of when a hearing is required at § 431.220(a)(1) is less detailed than the description of matters that may be considered at the hearing. We assume that this is unintentional, given the statement in the Preamble, at 78 Fed. Reg. 4600, that this revision is intended only to clarify. We believe it would be preferable to have the description of the reasons triggering a hearing, and the matters to be considered at a hearing be as similar as possible and recommend that the definition be reworded.

**RECOMMENDATION:** We recommend revising § 431.220(a)(1)(iii) in the following manner:

- (ii) A determination of income for the purposes of imposing any premiums, enrollment fees, ***deductibles, copayments, coinsurance, or other*** cost sharing . . .

### **§ 431.221 Request for a hearing**

We fully support and commend HHS' decision to treat an appeal to the Exchange appeals entity of a decision on eligibility for advanced payment of the premium tax credits or cost sharing reduction as an appeal of any denial of eligibility for Medicaid. As noted in the Preamble, this eliminates the need for two hearing requests and eliminates the very strong possibility of confusion and an applicant or beneficiary missing the deadline to appeal a Medicaid denial. It is one of the most important protections in these new rules.

We are concerned that different timelines for requesting a hearing related to tax credits/cost sharing amounts and Medicaid eligibility may cause difficulties for individuals who need a Medicaid hearing. Existing regulations provide for “a reasonable time not to exceed 90 days” for an applicant or beneficiary to request a Medicaid hearing. 42 C.F.R. § 431.221(d). Accordingly, a number of states allow less than 90 days. In contrast, the proposed regulations allow 90 days to request a hearing of an Exchange eligibility determination. 78 Fed. Reg. 4720 (proposed 45 C.F.R. § 155.520(b)). This creates the possibility that an individual could miss a Medicaid appeal deadline. Consider the example of an individual appealing a determination of an amount of an advanced premium tax credit on the 75th day after the determination is made. If this individual lives in a state that has a 60 day deadline for requesting a Medicaid hearing, despite the fact that a request for an Exchange appeal is treated as a request for a Medicaid hearing, that request does not fall within the Medicaid appeal period and is technically not timely. Accordingly, we recommend that the regulation be modified to ensure that such an individual is not denied the right to a Medicaid hearing.

**RECOMMENDATION:** Add the following language at the end of § 431.221(a)(5):

***Such a request for a Medicaid hearing shall be deemed timely if made within 90 days, regardless of the State’s deadline for requesting a Medicaid hearing.***

We also support HHS’ decision to allow an individual to request a hearing in a variety of ways. We believe, however, that certain safeguards are necessary. While it is simpler for a hearing request to be made by telephone, the possibility that such a request will be misunderstood or lost is much greater than a written request. Accordingly, we recommend that HHS require state agencies and contracting entities to confirm such requests in writing as part of their procedures.

**RECOMMENDATION:** Add the following language after § 431.221(a)(5):

***Such procedures must include a requirement that the agency or other entity receiving the hearing request contemporaneously document all telephonic requests and confirm the hearing request with the individual in writing within one business day of receipt.***

We further suggest that HHS amend this section to harmonize it with § 431.231, which prescribes the time limits for reinstating services. As we discuss below, we welcome HHS’ statement that a notice is considered to be received five days after the date on the notice. The manner of determining when the clock begins to run on a notice of action should be consistent between these two sections to avoid confusion.

**RECOMMENDATION:** Amend § 431.221(d):

The agency must allow the applicant or recipient a reasonable amount of time, not to exceed 90 days from the date that notice of action is **sent**, to request a hearing. ***The date on which a notice is received is considered to be 5 days after the date on the notice, unless the beneficiary shows that he or she did not receive the notice within the 5-day period.***

We also suggest a language clarification. The regulation refers only to appeals “to the Exchange appeals entity” and does not refer to appeal of the denial of eligibility for enrollment in a qualified health plan (QHP). These omissions do not appear to be intentional, because the Preamble indicates that this rule applies more broadly. See 78 Fed. Reg. at 4598.

**RECOMMENDATION:** Amend § 431.221(e) as follows:

. . .the agency must treat an appeal to the **Exchange or** Exchange appeals entity of a determination of the eligibility for **enrollment in a QHP**, advanced payment of premium tax credit, or cost sharing reduction, as a request for hearing under this section.

We also recommend that this regulation contain language specifying that an individual may choose to have a Medicaid hearing before a hearing on Exchange-related issues.

**RECOMMENDATION:** After § 431.221(e), add new subsection:

***(f) The agency must establish procedures that will enable individuals who have the right to an Exchange appeal and a Medicaid fair hearing to elect to have the Medicaid hearing first.***

### **§ 431.223 Denial or Dismissal of a Request for Hearing**

HHS has proposed no changes to this section. We believe, however, that additions are necessary to protect individuals from unintentionally or mistakenly dismissing a Medicaid appeal.

This subsection provides that a request for a hearing may be withdrawn upon the individual’s written request. No other details are provided. In contrast, § 155.530 requires an Exchange appeals entity to provide notice of dismissal, including information about how the dismissal may be vacated. As we noted in our comments on that section, we commend these provisions because they provide crucial protections against inadvertent or erroneous dismissal of an appeal. Such protections are, however, equally important for individuals with hearing requests pending at the Medicaid agency. Particularly individuals who are approved for coverage through the Exchange may not understand that there is a reason to pursue an appeal because they could be eligible for lower premiums or copayments or a better coverage package through Medicaid. We are

particularly concerned for those individuals with disabilities who may qualify for Medicaid in a category to which MAGI does not apply.

Given the inevitable complexity of states' hearing systems, the possibility for confused individuals to erroneously withdraw hearing request is very high. Medicaid eligibility rules will change in every state, and states may be slow to correctly implement the rule changes. Navigators and insurance brokers will be expected to learn a massive amount of information in a short time, increasing the likelihood that they will give erroneous information. Moreover, in many cases, individuals will have both Exchange and Medicaid appeals pending. Such individuals need protection from unintentional or erroneous dismissal even more than individuals who have just one hearing pending at the Exchange. Accordingly, we recommend that the protections of § 155.530(b) be applied to hearing requests pending before the Medicaid agency. We further recommend that the rule provide for dismissals to be vacated with good cause and that dismissals not be allowed for individuals who apparently have a disability and may therefore qualify in a category to which MAGI does not apply.

**RECOMMENDATION:** We propose adding the following subsections to § 431.223:

- (c) *If an appeal is dismissed under paragraph (a) or (b) of this section, the agency must provide timely written notice to the applicant or beneficiary, including –*
  - (1) *the reason for the dismissal;*
  - (2) *an explanation of the dismissal's effect on eligibility; and*
  - (3) *an explanation of how good cause can be shown why the dismissal should be vacated in accordance with paragraph (d) of this section.*
- (d) *The agency may vacate a dismissal if an individual makes a written request within 30 days of the date of the notice of dismissal showing good cause why the dismissal should be vacated.*
- (e) *If an individual with an alleged disability is applying, no dismissals under paragraph (a) may be permitted until there has been a full evaluation for eligibility under categories described in § 435.603(j) of this chapter.*

#### **§ 431.224 Expedited Appeals**

We enthusiastically commend HHS for requiring the provision of expedited hearings for individuals with urgent health needs. As HHS notes, this protection has long existed for Medicaid managed care enrollees. In fairness, beneficiaries not enrolled in managed care should have the same rights. At the same time, it should not be overly burdensome for states to administer, given that the requirement has long applied to managed care systems.

## **§ 431.231 Reinstating services & § 431.232 Adverse decision of local evidentiary hearing**

We welcome HHS' additional specifications in these sections regarding the timing for requesting a hearing. The current versions of the regulations do not allow for the time that it takes for a notice to actually reach an individual. By allowing five days for delivery, and explicitly providing that the individual has the right to attempt to show that she did not receive the notice (or that the notice was ineffective due to language or disability issues per our comments on § 431.206), the revised regulations will help ensure that the right to have the services reinstated is not lost due to delay or other problems with receipt of the notice.

## **§ 431.240 Conducting the hearing**

Eligibility hearings will be conducted in hundreds of locations by individuals with a variety of agencies. We recommend that HHS require additional safeguards to ensure that hearing officers are independent and impartial and that there be consistent ethical standards to which they adhere. Two recognized sources are the National Association of Hearing Officials' Model Code of Ethics and the National Association of Administrative Law Judiciary's Model Code of Judicial Conduct for State Administrative Law Judges.

**RECOMMENDATION:** We propose adding the following language to § 431.240(3):

- (3) By one or more impartial officials or other individuals who have not been directly involved in the initial determination of the action in question ***and who conform to the standards for conduct set forth in the National Association of Hearing Officials' Model Code of Ethics or the National Association of Administrative Law Judiciary's Model Code of Judicial Conduct for State Administrative Law Judges.***

## **§ 431.242 Procedural rights**

As noted above, we believe that individuals who are entitled to hearings on both Exchange and Medicaid eligibility determinations should have the option of requesting that the hearing on Medicaid eligibility be conducted first. This would prevent those who have reason to know that they are likely eligible for Medicaid from having to go through an Exchange eligibility hearing first and delay the time before they qualify for Medicaid. This would conserve administrative resources as well as save trouble for individuals.

**RECOMMENDATION:** We recommend adding a new subsection to § 431.242(d)(1):

- (g) request that a hearing related to Medicaid eligibility based on MAGI take place before any hearing on an appeal of an Exchange determination.***

## § 431.244 Hearing decisions

### § 431.244(f)

The proposed revision presupposes that an appeal of an Exchange determination of eligibility for other state health benefits would precede a hearing on the appellant's Medicaid eligibility. The revision would add to Section 431.244(f) a provision extending the deadline for a Medicaid appeal decision to 45 days from the date of an appeal decision issued by the Exchange appeals entity.

In the Preamble, at 78 Fed. Reg. 4598, you solicited comments on this proposal and on the broader question of how to sequence the Medicaid and Exchange appeals. As discussed above at page \*\*\*, we believe that the choice of which appeal should go first is a right that belongs to the individual and that is inherent in the appeal rights that are at issue. For that reason, we recommend that paragraph (f)(2) be revised consistent with that principle.

As noted above with regard to the proposed revision of Section 431.224, we applaud the establishment of an expedited appeal process and therefore strongly support the timeframe you propose for such appeals in Section 431.244(f)(3).

**RECOMMENDATION:** We recommend revising § 431.244(f)(2):

(f) The agency must take final administrative action as follows:

(1) ...

(2) Within 45 days from the date of the appeal decision issued by the Exchange appeals entity if –

(i) ~~The individual's appeal to the Exchange appeals entity of a determination of~~

~~eligibility for advanced payments of the premium tax credit or cost-sharing reductions is treated as a request for a fair hearing in accordance with §431.221(e) of this part, or the individual otherwise has both requested a fair hearing of an adverse Medicaid determination and appealed a determination of eligibility for advance payment of the premium tax credit or cost-sharing reductions; and~~

(ii) ~~The Exchange appeals entity is not conducting the fair hearing for the individual, in~~

~~accordance with §431.10(c)(1)(ii) of this part.~~ ***the individual has requested that a hearing on his appeal of an Exchange eligibility decision precede the hearing on his Medicaid appeal.***

### § 431.244(g)

We recommend adding clarifying language to strengthen an important requirement that promotes transparency in Medicaid programs. Subsection (g) of this regulation requires that the public have access to all agency hearing decisions. In some states, members of



the public must use public records requests to obtain these documents. Requestors, including applicants, beneficiaries, and non-profit legal assistance organizations, may be charged hundreds of dollars for labor costs (to redact safeguarded information) and copying charges in order to obtain copies. We urge HHS to add clarifying language that redacted versions of these hearing decisions must be made available to the public free of charge, preferably through a free indexed and searchable database posted online.

**RECOMMENDATION:** We recommend adding clarifying language in § 431.244(g):

The public must have **free** access to all hearing decisions, subject to the requirements of subpart F of this part for safeguarding information. ***The agency may satisfy this requirement by making hearing decisions available through a free indexed and searchable database posted online.***

## **PART 435 – ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA**

### **§ 435.4 Definitions and use of terms**

Section 435.4 provides that the term, *non-citizen*, has the same meaning as the term “alien,” as defined in 8 U.S.C. §1101(a)(3). It also provides that the term *qualified non-citizen* has the same meaning as the term “qualified alien” as defined at 8 U.S.C. §1641(b) and (c). And finally, the provision defines *citizenship* as including both citizens of the U.S. and non-citizen nationals of the U.S.

The term “alien,” dating from the nineteenth century and used throughout the Immigration and Nationality Act, 8 U.S.C., denigrates immigrants and has declined in usage. It is particularly inappropriate in a health and public benefits context, where we encourage the wellbeing of all. We support the change to “non-citizen” as well as the inclusion of “nationals” as part of the definition of “citizenship.” The latter may be helpful in ensuring rights when careless drafting confers eligibility on “citizens” but neglects to specifically include “nationals.”

We support the replacement of the term “alien” with the preferable term “non-citizen” which can now be used as a technical term of art in health care, increasing the effectiveness of outreach efforts to enroll immigrant families.

We support including “nationals” within the term “citizenship.”

The definition of the term “lawfully present” will determine which immigrants will be eligible for coverage through the Exchanges, Medicaid and CHIP, and which will be ineligible. Therefore, we support the most inclusive definition possible and do not believe that administrative burden alone should ever be dispositive in deciding whether a given immigration status is included in the definition. The point of departure is the definition included in the July 1, 2010 SHO letter. Compared to the SHO, this provision has expanded the definition in modest ways but also codifies a new restriction which is

harsh and unjustifiable. HHS will apply the same definition of “lawfully present” to Medicaid, CHIP and the Exchanges, which will help to streamline eligibility determinations for immigrants, as well as outreach and education to immigrant communities, and will make the program rules easier to learn and understand. Comments on individual categories in the definition follow.

*§ 435.4—Definition of Lawfully Present at (2), Nonimmigrant visa-holders*

With regard to individuals with nonimmigrant visas, this provision includes all who are “in a valid nonimmigrant status, as defined by 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17).” This wording is inclusive of nonimmigrants such as individuals from the Compacts of Freely Associated States (also known as COFA migrants), and also converts the requirement in the SHO that agencies determine that the applicant has “not violated the terms of the visa,” to a requirement that the agency determine the visa to be “valid.” We support this change as eliminating a need for the agency to determine the terms of the visa and whether or not the terms have been violated. The change will assist states by easing administrative burden and will assist consumers by preventing enrollment delays.

We support the simplification in the definition of “nonimmigrants” considered to be lawfully present.

*§ 435.4—Definition of Lawfully Present at (4)(ii) & (iii), Work-authorized immigrants*

The provision includes in the definition non-citizens who are “granted employment authorization under 8 C.F.R. 274a.12(c).” This category is inaccurate and restrictive, and places an undue burden on consumers. The definition should include all individuals *whose immigration status makes them eligible* for an Employment Authorization Document (EAD or “work permit”) *regardless of whether they have secured a work permit*. An immigrant’s lawful status does not depend on whether he or she has an EAD in-hand. The EAD requirement imposes particular burdens on low-income children and persons with disabilities who cannot work. Low-income families and individuals cannot easily afford the high fee to apply for and obtain a work permit, particularly if they do not otherwise need it. To obtain the document also entails delay in enrollment for health coverage. The final rule should eliminate this requirement.

**RECOMMENDATION:** Amend §435.4(4)(ii) as follows:

- (ii) “Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. 1254a, and individuals with pending applications for TPS ~~who have been granted employment authorization;~~”

**RECOMMENDATION:** Amend § 435.4(4)(iii) to read as follows:

- (iii) Granted ***an immigration status that confers eligibility for*** employment authorization. . .

*§ 435.4—Definition of Lawfully Present at (4)(vii), Immigrants granted a stay of removal*

The proposed rule includes only immigrants granted an administrative stay of removal under 8 C.F.R. part 241, but should also include administrative stays of removal under the Department of Justice and by a court. These judicially-ordered stays, whether by an Immigration Judge, the Board of Immigration Appeals, or a federal court, also confer lawful presence. The concern expressed in the Preamble that such stays may be granted automatically, is misplaced. Stays issued by courts generally are not automatic, except in unusual circumstances that might provide time necessary for the court to consider the stay request. The possibility of such an unusual circumstance should not undermine the general rule that for all purposes including eligibility for health care and coverage, non-citizens granted a stay of removal are lawfully present in the U.S.

**RECOMMENDATION:** Amend § 435.4(4)(vii) to read as follows:

Granted an ~~administrative~~ stay of removal ***by administrative or court order, statute or regulations*** ~~under 8 CFR part 241;~~

*§ 435.4—Definition of Lawfully Present at (5), Applicants for Asylum*

The NPRM includes in the definition non-citizens who are “granted employment authorization under 8 CFR 274a.12(c).” This is a helpful way of capturing several of the currently eligible categories. However, the list of lawfully present categories fails to include the *individuals whose status makes them eligible to apply for work authorization*, but who have not sought such authorization due to cost or individual circumstances, including children and persons with disabilities who cannot work. The list of lawfully present individuals should include individuals whose immigration status makes them eligible for an Employment Authorization Document (EAD or “work permit”) *regardless of whether they have secured a work permit*. An immigrant’s lawful status does not depend on whether he or she has an EAD in-hand. Low-income families and individuals cannot easily afford the high fee to apply for and obtain a work permit, particularly if they do not otherwise need it. The time that it takes to obtain the document could also result in a delay in enrollment of vital health coverage.

**RECOMMENDATION:** Amend §435.4(5) as follows:

- (5) Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C. 1231, or the Convention Against Torture ~~who—~~ *whose application has been accepted as complete;*
- ~~(i) Has been granted employment authorization; or~~
  - ~~(ii) Is under the age of 14 and has had an application pending for at least 180 days;~~

*§ 435.4—Definition of Lawfully Present at (8), Individuals lawfully present in American Samoa*

Individuals who are lawfully present in American Samoa under the immigration laws of American Samoa were previously eligible for Medicaid and CHIP through the SHO, but lacked explicit inclusion in eligibility for the Exchange. The provision at 45 CFR §155.20, incorporating the same definition for the health insurance Exchanges as is found at 42 CFR §435.4 for Medicaid, ensures the eligibility of these individuals in the Exchange and across the insurance affordability programs.

We support the inclusion in the health insurance Exchanges, through 45 CFR §155.20, of individuals who are lawfully present in American Samoa under the immigration laws of American Samoa.

*§ 435.4—Definition of Lawfully Present at (9), Immigrant victims of trafficking*

This section includes all victims of trafficking in persons under the Victims of Trafficking and Violence Protection Act (TVPA) of 2000. The Department of Homeland Security (DHS) has authority to grant trafficking victims continued presence in the U.S. for the purpose of aiding in the prosecution of traffickers. This category of non-citizens already was eligible for Medicaid and CHIP under separate statute, 22 U.S.C. § 7105(b), and therefore did not appear in the SHO. The provision correctly lists them for purposes of consistent implementation of eligibility for all victims of trafficking under the TVPA across Medicaid, CHIP, and the Exchanges.

We support the inclusion of all victims of trafficking in persons, in accordance with the TVPA, in the definition of individuals who are lawfully present for purposes of eligibility for Medicaid, CHIP, and the Exchanges.

*§ 435.4—Definition of Lawfully Present at (10), Exception for DACA beneficiaries*

For the reasons discussed below, we strongly oppose the exception of individuals granted deferred action by the U.S. Department of Homeland Security under the Deferred Action for Childhood Arrivals (DACA) policy, effective August 15, 2012. The exclusion lacks legal or policy justification and undermines the primary goal of the Affordable Care Act (ACA) - to expand access to affordable health coverage to millions of currently uninsured individuals.

The proposed rule makes arbitrary and capricious distinctions. Under the discretion of the Secretary of DHS, deferred action may be available to a range of individuals in the United States. Individuals granted deferred action have long been considered to be

“lawfully present” by federal agencies as well as Congress.<sup>2</sup> In fact, individuals granted deferred action based on grounds other than DACA remain eligible under the definition of “lawfully present” at § 435.4(4)(vi).

As recently as January 16, 2013, according to the press secretary for U.S. Citizenship and Immigration Services (USCIS), “[t]he relief an individual receives through the Deferred Action for Childhood Arrivals process is the same for immigration purposes as that obtained by any other person who receives deferred action.”<sup>3</sup> And on January 18, 2013, USCIS clarified that “[a]n individual who has received deferred action is authorized by the [DHS] to be present in the United States, and is therefore considered by DHS to be *lawfully present* during the period deferred action is in effect”<sup>4</sup> (emphasis added).

Therefore, it is unreasonable and unfair to distinguish between individuals granted deferred action through the DACA process and individuals granted deferred action for other reasons. Since this population was granted a form of relief already considered by HHS and other agencies to be “lawfully present,” the decision to exclude these particular individuals from eligibility is arbitrary and capricious.

The proposed rule leads to higher health care costs and unintended consequences. Excluding individuals granted deferred action under the DACA process from Medicaid, CHIP, and the health insurance exchanges does not eliminate their need for health care; it only shifts the costs of their care to health care providers and local and state governments. Including DACA recipients, however, would mean allowing a population of generally younger, healthier individuals to pay their fair share for health insurance in the exchanges, spread the risk across a larger pool of covered individuals, and thereby lower the cost of health care for everyone.

In addition, instead of creating a more streamlined eligibility and enrollment system under the ACA, the NPRM will introduce additional complexity in eligibility rules and

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<sup>2</sup> See, e.g., Social Security Administration regulations at 8 C.F.R. §1.3. The Real ID Act similarly defines “approved deferred action status” as one form of “lawful status.” [Pub.L. 109-13](#), § 202(c)(2)(B)(viii)(May 11, 2005), codified at 49 U.S.C. § 30301 note.

<sup>3</sup> Craig LeMoult, NPR All Things Considered, “Some States Put Brakes On Driver’s Licenses For Illegal Immigrants,” *available at* <http://www.npr.org/2013/01/16/169526603/some-states-put-brakes-on-drivers-licenses-for-illegal-immigrants>.

<sup>4</sup> United States Citizenship and Immigration Services, “Frequently Asked Questions, About Deferred Action for Childhood Arrivals,” *available at* <http://www.uscis.gov/portal/site/uscis/menuitem.eb1d4c2a3e5b9ac89243c6a7543f6d1a/?vgnnextoid=3a4dbc4b04499310VgnVCM100000082ca60aRCRD&vgnnextchannel=3a4dbc4b04499310VgnVCM100000082ca60aRCRD>. USCIS also goes on to clarify that deferred action under the DACA process is identical to deferred action granted under other processes (A7: “Deferred action for childhood arrivals is one form of deferred action. The relief an individual receives pursuant to the deferred action for childhood arrivals process is identical for immigration purposes to the relief obtained by any person who receives deferred action as an act of prosecutorial discretion.”). *Id.*

confusion for state agencies, eligibility workers, patient navigators, consumer assistance programs, certified application counselors, health care providers, and other entities that will assist individuals applying for health insurance. The exception will exacerbate the confusion as states reach out to immigrant communities to encourage them to enroll. States will now have to train patient navigators, consumer assistance programs, eligibility workers, and certified application counselors about the distinction between those granted deferred action under the DACA process and those granted deferred action on other grounds.

The proposed rule sends mixed messages to lawfully present immigrants. The proposed rule also contradicts the purposes and goals of the DACA program. One of the motivating factors for the DACA program is to integrate individuals who meet certain requirements into the fabric of their communities, despite their previously undocumented status. As the President stated in his remarks at the Rose Garden on June 15, 2012, “[t]hese are young people who study in our schools, they play in our neighborhoods, they’re friends with our kids, they pledge allegiance to our flag. They are Americans in their heart, in their minds, in every single way but one: on paper.”<sup>5</sup> The President and DHS singled out this group of immigrant children and youth as a particularly compelling group of individuals who do not fit under the administration’s enforcement priority goals and should therefore be granted immigration relief. As the Secretary of DHS stated, “many of these young people have already contributed to our country in significant ways. Prosecutorial discretion, which is used in so many other areas, is especially justified here.”<sup>6</sup>

The DACA program ensures that eligible individuals can live in the United States without fear of deportation, and that they are able to work with authorization so that they might provide for themselves and their families. To ensure that they are healthy and productive at work, these individuals need access to affordable health insurance. Despite the President and DHS’s recognition of these individuals’ circumstances, the proposed rule undermines their ability to participate and contribute fully to the economy and to their communities.

**RECOMMENDATION:** Delete § 435.4(10).

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<sup>5</sup> “Remarks by the President on Immigration,” President Barack Obama, June 15, 2012, available at <http://www.whitehouse.gov/the-press-office/2012/06/15/remarks-president-immigration>.

<sup>6</sup> “Exercising Prosecutorial Discretion with Respect to Individuals Who Came to the United States as Children,” Memorandum from Secretary of Homeland Security, Janet Napolitano, June 15, 2012, available at <http://www.dhs.gov/xlibrary/assets/s1-exercising-prosecutorial-discretion-individuals-who-came-to-us-as-children.pdf>.



### **§ 435.110 Parents and other caretaker relatives**

NHeLP commends HHS for requiring states to convert the statutory minimum for parents and caretaker relatives to a MAGI-equivalent amount. This ensures that the shift to MAGI-based methodology will not lead to a net loss in eligibility in states that refuse expansion and reduce their eligibility limits to the statutory minimum.

### **§ 435.112 Families with Medicaid eligibility extended because of increased earnings or hours of employment & § 435.115 Families with Medicaid eligibility extended because of increased collection of spousal support**

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.

### **§ 435.116 Pregnant Women**

NHeLP commends HHS for requiring states to convert the statutory minimum for pregnant women to a MAGI-equivalent amount. This ensures that the shift to a MAGI-based methodology will not lead to a net loss in eligibility in states that refuse expansion and reduce their eligibility limits to the statutory minimum.

### **§ 435.117 Deemed newborn children**

#### *§ 435.117(b)*

NHeLP recommends that HHS require states to deem eligible all babies born to mothers who qualify as targeted low-income children or who are enrolled in § 1115 demonstration projects. The low-income mothers who would benefit from this suggestion already face numerous obstacles in providing for their newborns, and they should not face the additional burden of filling out a new application for a newborn who will qualify for CHIP or Medicaid.

At the very least, states that take up the option for targeted low-income pregnant women should be required to deem the newborns of all mothers who qualify as targeted low-income children as well. Relatively few states have taken up the option to cover pregnant women to higher income levels through CHIP.

Further, we believe that states must provide deemed newborn status to the child born of a pregnant individual covered under § 1115. This is particularly important in states that operate their entire Medicaid program as a § 1115 waiver, such as Tennessee and Arizona. These states should not be exempt from providing coverage for newborns simply because HHS has allowed them to continue to operate their Medicaid programs under § 1115.

**RECOMMENDATION(S)**: Amend § 435.117(b)(1)(iii) and (iv) as follows:

- (iii) ~~At state option,~~ the State's separate CHIP State plan. . .
- (iv) ~~At state option,~~ the State's demonstration program under section 1115. . .

§ 435.117(c)

The proposed rule expands States' options to cover newborns of mothers who were enrolled under Medicaid in a different state when the child was born. The preamble acknowledges that interpreting the statute as *only* allowing deeming for mothers enrolled in the same state would unnecessarily restrict a woman's right to travel freely between the states (78 Fed. Reg. 4614). However, the regulation does not go far enough. HHS' proposed solution to allow states the option fails to resolve the underlying problem that the woman's right to travel will still be restricted when states do not take up the option. Compare *Duffy v. Meconi*, 508 F Supp. 2d 399 (D. Del. 2007) (holding Medicaid residency regulations violated beneficiary's constitutional right to travel). The only way to resolve the issue, and the fairest policy position, is to *require* states to provide deemed newborn eligibility if the mother was enrolled in Medicaid in another state when the child was born.

**RECOMMENDATION(S)**: HHS should amend § 435.117(c) to read as follows:

- (c) ~~At State option,~~ The agency ~~may~~ **must** provide deemed newborn eligibility under this section to a child if the child's mother was eligible for and receiving Medicaid in another State for the date of the child's birth.

**§ 435.150 Former foster care children**

HHS will require a foster child to be enrolled in Medicaid on the date of attaining 18 years of age (or a higher age elected by the State). However, the statute never links enrollment in Medicaid to a particular age or date. It only requires that an individual was "enrolled in the State plan under this title or under a waiver of the plan while in such foster care." 42 U.S.C. § 1396a(a)(10)(A)(i)(IX)(dd). Enrollment in Medicaid at any point while in foster care qualifies the individual for Medicaid eligibility under this category. There are numerous circumstances where individuals may be eligible but not enrolled in Medicaid on their 18<sup>th</sup> birthday or the day they age out of foster care, and such individuals should not be penalized under the regulation. For example, state administrative error, erroneous termination if a youth has run away from a placement, and termination when a youth becomes an inmate of a public institution could all cause the youth not to be on Medicaid on his 18th birth date.

In addition, HHS included a state option to cover former foster care children who were enrolled in Medicaid in another state when they turned 18 or aged out. For example, an individual who aged out in Maryland would also be Medicaid-eligible in Pennsylvania if

Pennsylvania took up the option. However, leaving this as an option still restricts the rights of individuals to travel freely among the states if they move to a state that does not take up the option, or if no state takes up the option. This would raise serious constitutional issues. Cf. *Duffy v. Meconi*, 508 F Supp. 2d 399 (D. Del. 2007) (holding Medicaid residency regulations violated beneficiary's constitutional right to travel). Furthermore, foster children who are placed out-of-state would be unfairly disqualified from this group unless the state takes up the proposed option. To resolve the issue, HHS should require states to cover former foster care children who were enrolled in a state Medicaid program at some point while in foster care and in foster care on the on the date of attaining 18 years of age (or a higher age elected by the State) or when they aged out.

**RECOMMENDATION(S)**: Amend § 435.150(b)(3) as follows:

- (3) Were in foster care under the responsibility of the ~~any~~ State or Tribe and enrolled in Medicaid under the ~~any~~ State's Medicaid State plan or 1115 demonstration ~~(or at State option were in foster care and Medicaid in any State)~~ upon attaining:...
- (4) Were enrolled in Medicaid under a State's Medicaid plan or 1115 demonstration while in foster care.***

#### **§ 435.170 Pregnant women eligibility for extended or continuous eligibility & § 435.172 Continuous eligibility for hospitalized children**

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.

#### **§ 435.214 Eligibility for family planning services**

NHeLP thanks HHS for this regulation implementing the ACA § 2303 state plan option to provide Medicaid coverage to women and men that is limited to family planning or family planning related services. In particular, we strongly support the inclusion of the income eligibility standards for pregnant women under § 1115 demonstration projects in determining states' highest income standards for the purposes of setting income eligibility for services under this section.

## **§ 435.215 Individuals infected with tuberculosis**

NHeLP agrees that eligibility for individuals with tuberculosis (TB) should be subject to MAGI-based methodologies, provided that states convert their current effective eligibility level to a MAGI-equivalent level according to HHS guidance. This would substantially streamline eligibility determinations and would remove use of asset tests.

NHeLP also points out that HHS should consider continuous eligibility for TB patients throughout the course of their treatment, as losing coverage substantially increases the chance of abandoned or interrupted treatment. This, in turn, can cause recrudescence for the individual and can produce dangerous antibiotic-resistant strains of tuberculosis. Multidrug resistant tuberculosis is much more dangerous and expensive to treat.

## **§ 435.301 General rules**

It is not clear from the description in the preamble why HHS has decided to eliminate paragraph § 435.301(b)(1)(iii), relating to deemed newborns of medically needy mothers, from the current rules. HHS should either leave this rule in place or clarify in the final rule that mothers eligible for Medicaid as medically needy are considered to be covered under the State plan and therefore, their babies would qualify as deemed newborns under § 435.117.

## **§ 435.406 Citizenship and non-citizen eligibility**

The proposed rule provides that when the applicant is a child or is incapacitated, a person acting responsibly for the applicant may declare the applicant's immigration status, provided the responsible person attests to having a reasonable basis to make the declaration. We strongly support this provision as crucial flexibility for enrolling immigrant children and incapacitated individuals in coverage. We question the additional requirement that the application filer attest that he or she has a reasonable basis for making the declaration. If someone is "acting responsibly" for the applicant, then by definition he or she would have a reasonable basis for declaring an applicant's immigration status. To require the attestation places an unnecessary burden on both the application filer and the state agency.

**RECOMMENDATION:** Amend § 435.906 to delete "provided that such individual attests to having a reasonable basis to make a declaration of such status."

*§ 435.406(b) State option to provide Medicaid and CHIP to lawfully residing non-citizen children or pregnant women*

We support the implementation of the Immigrant Children's Health Improvement Act (ICHIA), CHIPRA § 214, which provides states the option to cover lawfully residing immigrant children and/or pregnant women in Medicaid and CHIP with no waiting period. The rule requires that states taking up the option must waive the federal five-year waiting period as well as sponsor deeming and other now-obsolete restrictions

enacted in the welfare law (limits on payments for not-qualified aliens who meet the lawfully present definition, state options to require 40 quarters of work credit). In addition, under § 435.406(b)(2), states that take up the option must provide all the same services to lawfully present immigrants as the state provides to citizens. We appreciate these statements and support inclusion of this provision.

### **§ 435.407 Types of Acceptable Documentation of Citizenship**

We appreciate the streamlining of procedures for the use of documents to prove citizenship. Along with improvements in § 435.406 and § 435.956, this provision would lessen the burden of the citizenship verification process for states and consumers.

The vast majority of applicants will be able to verify their citizenship through the use of electronic data sources. However, for those individuals who will have to provide documentary evidence, we strongly support allowing them to provide copies of documents unless the documentation is questionable or inconsistent with other information. Currently states have to have processes that allow applicants to make in-person visits to the agency offices so that a staff person can view original documents. They have to have procedures to securely return original vital documents such as passports that are mailed with applications. These processes are burdensome for states. States had to train frontline staff to view and process documents that come in and they have to deal with an increased volume of people coming in to state offices, which contributes to long lines and crowded waiting rooms. Consumers are also burdened by having to visit agencies during office hours that often conflict with work schedules or by having to mail in their vital documents that would be difficult and costly to replace if they were to be lost in the process. These burdensome processes will no longer be necessary now that applicants will be able to mail, fax and scan copies of their documents to prove their citizenship status.

The proposed provision also streamlines the acceptance of affidavits for citizenship. The proposed change says that an affidavit can be used when the consumer does not have one of the other documents that can be used to prove citizenship. It also only requires one affidavit; while the existing regulation requires two affidavits and includes a restriction that only allows one of the affidavits to be completed by a relative of the applicant. Moreover, states no longer must obtain a separate affidavit from the applicant/beneficiary or other knowledgeable individual such as a guardian or representative explaining why documentary evidence does not exist or cannot be obtained. We strongly support these changes. Given the primary reliance on electronic verification, we do not anticipate that the affidavits will be needed by many individuals but it is important that the rules and process for the collection of affidavits for those who do need them be streamlined.

The proposed provision also changes the identity affidavit requirements. Currently there is an age restriction on the use of the affidavit for identity. Allowing the affidavit to be used for adults will be very important to help ensure that the application process does not become overly burdensome for the millions of adults that will become newly eligible

for coverage in 2014. Many adults do not have documents such as drivers licenses or passports that will satisfy the identify verification requirement and the affidavit will allow those individuals satisfy this requirement without unneeded extra steps. This proposed change along with increased emphasis on states using electronic verification from data available through other government agencies such as public assistance programs, law enforcement, IRS and others will help to ensure that the verification of identity does not slow down the rapid eligibility determinations expected to occur in 2014 and beyond. We also strongly support lifting the restriction on using affidavits for both citizenship and identify. While we do not believe many individuals will require both affidavits, the affidavits may be the only way some vulnerable individuals such as homeless persons can verify their citizenship and identity.

We appreciate the recognition in the preamble, 78 Fed. Reg. at 4620, that the state must provide assistance to individuals who, though not incapacitated, need assistance in obtaining documentation. The preamble notes this could include individuals who are limited English proficient and individuals with disabilities, among other groups. We strongly support these statements.

Yet the regulatory language of this section fails to reflect the change noted in the preamble. Thus, we recommend that HHS add this language, consistent with the language utilized in § 435.956 to specifically highlight the need to assist LEP individuals and individuals with disabilities.

**RECOMMENDATION:** Amend § 435.407(e) as follows:

*Assistance with obtaining documentation.* States must provide assistance to individuals who need assistance, ***including persons who are limited English proficient and individuals with disabilities***, in securing satisfactory documentary evidence of citizenship in a timely manner.

### **§ 435.603 Application of modified adjusted gross income (MAGI)**

*Including stepparents within the definition of parents.* While we recognize that the technical correction to include “stepparents” within the definition of parents in § 435.603(f)(2)(ii) and to generally include stepparents within the definition of parents is consistent with HHS’ previous policy decision regarding stepparent income deeming, NHeLP reiterates its opposition to this change. We refer back to our previous comments on the Medicaid Eligibility proposed regulations, dated October 31, 2011, at pp. 25-26. We continue to think it is bad policy to deem stepparent income in states where stepparents are not legally responsible for supporting their stepchildren. This policy will result in some children being forced off Medicaid or CHIP and into more expensive alternatives under Exchanges.

*Applying the 5% disregard only to the highest income threshold available.* NHeLP opposes the proposed changes whereby the 5% disregard would not be applied in all MAGI income calculations, but only to the highest threshold available to make the



applicant eligible for Medicaid. While we understand the apparent motivation – to increase the number of persons for whom an enhanced federal match will be available – we do not believe this is necessarily in the best interest of Medicaid beneficiaries. While it may only affect a relatively small group of enrollees, i.e., those parents or caretaker relatives whose MAGI is within 5% of a state's § 1931(b) threshold which is lower than 133% FPL, it could make a difference for such persons. This would be true if a state elects to have an alternative benefit package for the expansion population which is less robust than the state's benefit package for its Medicaid enrollees. For such persons, while the state may receive an enhanced match, the person who would be otherwise eligible for the standard Medicaid benefit package if the 5% disregard were applied to their gross income will be forced to receive lesser coverage. Thus, we urge HHS to reconsider this proposal, and, at a minimum, to require the application of the 5% disregard to MAGI determinations when the application of such a disregard would have an impact on the services available to the enrollee.

We also note that the failure to allow for the 5% disregard whenever MAGI income is implicated could have a significant impact on the level of cost-sharing imposed on Medicaid enrollees. Under the regulation as proposed by HHS, this 5% disregard will only be applied when it may make a difference for MAGI eligibility. So, for example, if a state has a limit of 90% of FPL for 1931 eligibility and the applicant has income at 103% of FPL, the state will not apply a 5% disregard because this parent is under 133% FPL and thus eligible under the new adult category. However, focusing on cost sharing, if states use this same procedure to determine family income, this person does not fall under the 100% limit for nominal, non-mandatory cost sharing, but she would have if the 5% disregard had been applied.

Finally, we believe HHS' original interpretation of § 1902(e)(14)(I) was correct and that the intent of the statute is to apply a 5% disregard whenever the MAGI methodology is being used. We believe it is a strained and unreasonable interpretation of the statute to only apply the 5% disregard in certain situations and believe this is confirmed by HHS' original interpretation. Thus, we ask for the previous interpretation to be reinstated, requiring the 5% disregard to be applied in all MAGI calculations, thus avoiding the problems raised here.

#### § 435.603(j)(4)

We agree with and support the correction that is being made to § 435.603(j)(4) to clarify that an individual who is otherwise eligible under a MAGI-based category is not exempted from the MAGI methodology merely because he or she requests certain long-term care services. We believe that the proposed revision properly clarifies that the exception from MAGI applies when the level-of-care need of the individual is necessary to establish eligibility or where the individual is seeking long term care services that are not available to persons eligible with MAGI-based methods.

#### § 435.831 Income eligibility

The preamble to this rule argues that the explicit exception from MAGI-based methodologies for individuals qualifying as medically needy only forbids HHS from *requiring* states to use MAGI-based methodologies for this category. NHeLP recognizes that such a switch could streamline eligibility determinations for State Medicaid agencies. However, the statute excepts certain very vulnerable populations from MAGI-based methodologies. NHeLP has concerns that the proposed interpretation does not protect medically needy beneficiaries.

First, the proposed rule suggests applying MAGI-based income counting methodologies, but does not explicitly address whether states may continue to apply resource tests. To the contrary, the current medically needy resource rules are not changed (see § 435.840). Because other, less vulnerable populations subject to MAGI-methodologies under the ACA will be exempt from assets tests, the same should apply to medically needy populations. Therefore, if HHS permits states to apply MAGI-based methodologies for income of medically needy individuals, it should require that they eliminate resource tests on such individuals.

Second, the preamble proposes a rather vague methodology to “convert” current effective AFDC income standards to MAGI-equivalent standards in order to comply with SSA § 1902(gg), the maintenance of effort requirement for children through 2019 (78 Fed. Reg at 4612). The proposed method seems analogous to HHS’ guidance for MAGI-conversion using the Average Disregard method, but does not directly refer to that guidance (See [SHO # 12-003](#)). Furthermore, the preamble indicates that “states may” apply this conversion and nothing in the proposed rule indicates that such a conversion be made, let alone how. HHS should clarify in the regulation that states wishing to take up the MAGI-based option *must* convert current effective AFDC income standards according to HHS-approved methodologies. In [prior NHeLP comments](#) to proposed HHS guidance on MAGI-conversion, we have pointed out the insufficiency of the average disregard method to ensure aggregate equivalence in eligibility. Since HHS is perhaps stretching intent a bit to allow for MAGI methodologies to be used for the medically needy, we urge again that it reconsider use of the Average Disregard method and consider a Same Number methodology that would minimize the number of persons who would potentially lose eligibility under a MAGI-based standard.

### **§ 435.905 Availability of program information**

We appreciate the information provided in this section and fully support comprehensive and effective implementation to ensure that all LEP individuals can fully access the benefits of health reform. With an estimated 23% of marketplace applicants expected to be LEP, the importance of this section cannot be underestimated. We specifically recommend including reference to section 1557 of the Affordable Care Act in addition to the citations to the Civil Rights Act and Rehabilitation Act.

We also recommend that HHS include the use of competent bilingual staff in the list of language services. Having access to competent bilingual (and bicultural) staff would be the most effective manner of providing language services. We do support the other

listings (oral interpretation, written translations and taglines) and support continued inclusion of all of these. But as HHS recognizes that states must have flexibility to accommodate differences in populations and languages spoken, it is important to allow – and indeed encourage – the use of competent bilingual staff who can provide services directly to an LEP individual in his/her language – in addition to interpreting.

We also suggest renaming this section as “Accessibility for Individuals who are Limited English Proficient and Individuals with Disabilities”. The section mentions the Rehabilitation Act which addresses assistance to individuals with disabilities and references new section related to individuals with disabilities. Thus it is clear from the narrative that the scope is broader than LEP individuals and we believe the title should match the scope and content.

We strongly recommend that HHS include more details how to implement this requirement in the future sub-regulatory guidance as mentioned in the preamble and the previous Exchange regulations. So that marketplaces have sufficient time to develop the systems and implement this system upon launch in October, HHS must issue this sub-regulatory guidance quickly and this guidance is critical to ensuring their development complies with Title VI as well as section 1557 of the ACA.

We also appreciate the inclusion of subparagraph (b)(3). All individuals must receive information about the available services which is essential to ensuring their utilization.

**RECOMMENDATION:** Rename § 435.905 “Accessibility for Individuals who are Limited English Proficient and Individuals with Disabilities” and amend § 435.905(b)(1) as follows:

Individuals who are limited English proficient through the provision of language services at no cost to the individual including ***competent bilingual staff who provide services directly in a non-English language***, oral interpretation, written translations, and taglines in ***at least 15*** languages indicating the availability of language services. ***The information must also include the following:***

- (i) for any individual with a disability, information must be provided in an alternative format appropriate for the individual’s disability;***
- (ii) for any individual with a visual impairment who is unable to read standard information, the agency must provide information in large print, Braille or other acceptable alternate format appropriate for the individual’s disability;***
- (iii) for any individual the agency knows or should reasonably know is LEP, information must be provided in that individual’s language; and***
- (iv) for all notices, the agency must provide taglines in at least 15 languages informing individuals of the availability of written translations or oral assistance to understand the information provided and a toll-free telephone number to request assistance.***

## § 435.907 Application

We appreciate the recognition in the preamble (78 Fed. Reg. at 4599) of the need to ensure coordination across the entire eligibility, enrollment, and appeals process. The preamble notes that where the Exchange conducts an assessment and finds an individual potentially ineligible for Medicaid and eligible for advance payment of the premium tax credit, the Exchange will provide the individual an opportunity to withdraw the Medicaid application.

When the Exchange conducts such an assessment and an individual chooses to withdraw their Medicaid application, we welcome the addition of paragraph (h) to § 435.907, allowing for automatic reinstatement of the withdrawn application if the individual subsequently files an appeal of their Exchange or advanced premium tax credit or cost-sharing eligibility, or if the Exchange appeals entity assesses the individual potentially eligible for Medicaid.

The preamble states that the appeals entity will conduct an assessment of Medicaid eligibility that is as comprehensive as that performed by the Exchange in making the underlying assessment of Medicaid eligibility. We are concerned that this may be more likely to result in an assessment of ineligibility for Medicaid by the Exchange appeals entity and thus fail to trigger the automatic reinstatement of the individual's Medicaid application, particularly as the appeals entity assessment review may be no more in depth than that conducted by the Exchange. If an individual files an appeal related to their determination of eligibility for enrollment in a QHP or for advance payment of the premium tax credit or cost-sharing reductions, this should trigger automatic reinstatement of their Medicaid application. An assessment of eligibility for Medicaid, conducted by either the Exchange or Exchange appeals entity, is not a full evaluation of Medicaid eligibility. To be sure that individuals are appropriately evaluated for all insurance programs, we strongly urge HHS to institute automatic reinstatement of withdrawn applications where an individual has previously withdrawn their Medicaid application and is seeking appeal of an Exchange determination.

**RECOMMENDATION:** Amend § 435.907(h)(2) to read as follows:

Individuals described in this paragraph are individuals who --

- (i) Submitted an application described in paragraph (b) of this section to the Exchange;
- (ii) Withdrew their application for Medicaid in accordance with 45 C.F.R. § 155.305(b)(4)(A);
- (iii) Are assessed as potentially eligible for Medicaid by the Exchange appeals entity ***and/or are seeking an appeal related to their determination of eligibility for enrollment in a QHP or for advance payment of the premium tax credit or cost-sharing reductions.***

## **§ 435.908 Assistance with application and renewal**

We commend HHS for recognizing in the preamble (78 Fed. Reg. at 4606) that application assisters should not be required to complete two different certification processes for the Exchange and Medicaid. Creating a single certification process by which assisters can navigate and provide assistance with eligibility and enrollment in all insurance programs will ensure that individuals are seamlessly and efficiently guided to the most appropriate coverage program. States should be encouraged to create such a single certification process, and we encourage HHS to facilitate this process and provide technical assistance to states as needed.

We appreciate the recognition by HHS that assistance in the application process must be provided to all individuals needing it. As noted throughout these comments, the application process can be daunting, particularly for those with disabilities or language barriers. We also appreciate the safeguards included in proposed § 435.908(c) to protect the confidentiality of information provided to application assisters and the requirement to establish consumer protections on how private information can be shared.

We appreciate that HHS has reiterated the responsibility of Medicaid and CHIP agencies to ensure that their programs provide equal access to individuals with LEP and individuals with disabilities. Our experience with Medicaid and CHIP programs, however, is that these longstanding obligations for equal access are often poorly implemented. We strongly urge HHS to provide specific guidance and urge HHS to apply these requirements to navigators and assisters.

We recommend that the certification process for application counselors (as well as navigators and assisters) include specific training components that provide information on how to provide accessible services to individuals with disabilities and culturally and linguistically appropriate services. Training should also include components on how to access and work with interpreters (if competent bilingual staff is unavailable) and how to access and use augmentative and assistive communication devices to assist individuals with disabilities.

Further, application counselors should have access to population-level data to help determine the needs of the population(s) served. These needs can be based on demographic characteristics such as age, sex, disability, language(s), race/ethnicity, religion, socioeconomic status, education level, sexual orientation, and gender identity. Data sources may include census figures, voter registration data, and school enrollment profiles.

Additionally, many immigrants may apply for assistance for themselves or their family members as part of mixed-status families (with citizen and non-citizen members).



Parents in mixed-status households can be afraid to apply for and enroll their family members in health coverage. Mixed-status families can also confront confusing eligibility rules due to language barriers and concerns about adverse “public charge” determinations. Counselors should receive effective training to avoid creating obstacles to their participation. In general, to ensure that counselors comply with civil rights and privacy laws, training should address what questions are, and more importantly are not, required of immigrants and/or non-applicants.

We strongly recommend that the discussion in the preamble about requirements to comply with equal access also appear in the regulatory text.

Due to confidentiality and privacy concerns of immigrant families, we support that Certified Application Assistors must be “trained in and subject to regulations relating to the safeguarding and confidentiality of information” at § 435.908(c)(1)(iii). We also 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).

These protections will help allow immigrant families to feel assured that their personal information will not be shared without their clear and explicit permission and that they will know where and for what purpose their information is being shared. In addition, these protections will help prevent individuals from fraudulently acting as application assistors, especially those who specifically target immigrant communities. We support that these Medicaid confidentiality requirements apply to certified application assistors enrolling individuals in CHIP (at § 457.340(a)) as well as in the Exchange (at § 155.225(a)).

**RECOMMENDATION:** Amend § 435.908(c) to delete “and” at the end of (ii), add “and at the end of (iii) and add new (iv) as follows:

***(iv) Effectively trained in providing enrollee-centered services in a culturally and linguistically appropriate manner. The training must include, at a minimum: the requirements of Title VI of the Civil Rights Act of 1964, the Rehabilitation Act, the Americans with Disabilities Act, and section 1557 of the Affordable Care Act; how to access and provide language services; how to access and utilize augmentative and assistive communication devices; how to provide culturally competent services; eligibility requirements for immigrants; and what information is not required for non-applicants, including the Policy Guidance Regarding Inquiries into Citizenship, Immigration Status and Social Security Numbers in State Applications for Medicaid, CHIP, TANF, and Food Stamp Benefits.***

We also appreciate that HHS notes that application counselors must act “in the best interest of the applicants assisted.” However, we believe that the standard for application counselors should be the same as for navigators which are required to be



fair and impartial. Given that applicants likely will not understand the differences between certified application counselors, assisters and navigators, we believe it is important to hold all of them to the highest standard. Further, we do not believe that issuers should be permitted to be certified application counselors. Due to the financial benefit they would reap if an applicant selects the issuer's plan, it is unlikely they could act in a fair and impartial manner.

**RECOMMENDATION:** Amend § 435.908(c) to add new (v) as follows:

- (v) Held accountable to act ***in a fair, accurate and impartial manner*** in the best interest of the applicants assisted;

**RECOMMENDATION:** Amend § 435.908(c) to add new subsection (5) as follows:

- (5) ***Issuers shall not be permitted to serve as application assisters***

### **§ 435.910 Use of Social Security Number**

The proposed rule requires that “the agency must verify the SSN furnished by an applicant or beneficiary with SSA to ensure the SSN was issued to that individual, and to determine whether any other SSNs were issued to that individual.”

We have the following concerns with this imposing this requirement as currently written:

- (1) The purpose of this verification is unclear as currently described.
- (2) There is no procedure instructing how the agency must conduct this verification of SSN.
- (3) There is no procedure instructing the agency what procedures it must follow in the event that another SSN is found to have been issued to the individual.
- (4) There is no requirement that the agency must provide clear notice to the applicant or beneficiary if there is a problem during this verification.
- (5) There is no requirement that the applicant or beneficiary be given a reasonable opportunity period to correct a non-verification of his/her SSN.
- (6) There is no requirement that the state must provide clear instructions as well as assistance to the applicant or beneficiary as to how to correct his or her SSA records in the event of non-verification.

**RECOMMENDATION:** Delete § 435.910(g) and HHS should conduct future rulemaking that fully address the requirements for verification of SSN, in particular what protections and procedures the state is required to provide an applicant or beneficiary in the event of a problem with his or her SSN verification.

## **§ 435.911 Determination of Eligibility**

We agree with and support both proposed changes to § 435.911:

- (1) to clarify the income standard for parents and caretaker relatives to be the higher of 133% FPL or the income standard established by the state for mandatory coverage of parents and caretaker relatives, and
- (2) to allow for eligibility determinations under MAGI rules for persons over 65 who are parents or caretaker relatives, or persons on Medicare who are pregnant or are parents or caretaker relatives, and who would otherwise be exempted from the MAGI rules.

We reiterate our earlier comments regarding the inconsistency in the application of timeliness and performance standards in subsection (c). This subsection identifies rules for determining eligibility for three different groups of individuals, yet timeliness and performance standards are cross-referenced only for the MAGI-based determination group (defined at (c)(1)). HHS has not clearly indicated that states must comply with the timeliness and performance standards in § 435.912 for individuals undergoing non-MAGI-based Medicaid eligibility determinations. NHeLP is concerned that states could view inconsistent references to § 435.912 in this section as an indication of an intent to apply different standards to different groups of individuals.

**RECOMMENDATION:** We urge HHS to add a cross-reference to § 435.912 in paragraph (c)(2) for determinations based other than MAGI.

We appreciate the recognition by HHS that some states may establish income eligibility standards that are higher for pregnant women, children, and in some states, parents and caretaker relatives. We commend HHS for proposing that the applicable MAGI standard for parents and caretaker relatives should be the highest income standard which can be applied for a parent or caretaker relative under any MAGI-based eligibility group. The revisions on this issue are consistent with the goal of supporting states that have chosen to expand coverage to parents and caretaker relatives at higher income levels through adoption of an optional group for parents and caretakers.

We also recommend that HHS issue sub-regulatory guidance to state Medicaid agencies affirming this long-standing requirement and clarifying the agencies' notice and timeliness obligations to non-citizen applicants.

## **§ 435.917 Notice of agency's decision concerning eligibility**

We appreciate the recognition by HHS that the state agency is responsible for communicating specific content in a clear and timely manner to applicants and beneficiaries when issuing either a notice of approval or notice of denial or other adverse action. We welcome the language at § 435.917 requiring that notices be written in plain language and be accessible to individuals with disabilities and who are limited English proficient.

We urge HHS to clarify in the content of notice for an eligibility approval that the level of benefits and services approved also include clear explanation of any restrictions on the availability of medical treatment that may be in place if the individual will be enrolled in a managed care plan, including utilization control mechanisms and whether the plan has stated any moral or religious exceptions under 42 U.S.C. § 1396u-2(b)(2)(B). This existing requirement (at 42 U.S.C. § 1396u-2(a)(5)) requires not only that the state agency make this information available to the individual in a written and prominent manner, but the Medicaid managed care entity must also inform beneficiaries in writing of its policies before and during enrollment. States remain responsible for assuring access to all covered services, and this regulation should make clear that the state is responsible for notifying all potential enrollees of these limits and providing adequate information for accessing covered services. We urge HHS to issue guidance in an *FAQ* or *Dear State Medicaid Director* letter describing these ongoing requirements.

We commend HHS for requiring that notice content for approvals, denials, or terminations of eligibility include information regarding bases of eligibility other than the applicable MAGI standard, and the benefits and services afforded to individuals eligible on such other bases and how to request a determination on such bases. This provision is consistent with current Medicaid law requiring that beneficiaries be given the opportunity to choose which basis of eligibility they would like to be considered. Eligibility determinations must adhere to this requirement to consider individuals on all bases of eligibility, and requiring notice content to include this information, whether approved or denied, and in a clear and accessible manner is an important aspect of meeting this requirement.

HHS requests specific comment on the level of detail which should be required for inclusion in the notice under subsection (c). We recommend that the notice include, at minimum, information on the level of benefits and services which may be available to the individual on a basis other than MAGI, *specifying how such availability differs from the MAGI-based eligibility*, as well as information regarding any premiums, enrollment fees or cost-sharing associated with eligibility on a basis other than MAGI. Allowing individuals to understand the differences in benefits as specifically as possible so that they may consider their personal health needs, as well as variations in affordability, will best facilitate informed decision-making by the individual.

It is imperative that HHS require states to provide all of the information needed by an individual in weighing the advantages or disadvantages of a certain coverage group. We urge HHS to clearly describe minimum standards for such notice content consistent with this recommendation. Further, information regarding eligibility on bases other than MAGI should be required even if the state is using a combined eligibility notice as defined in § 435.4. We urge HHS to require that if the information described in subsection (c) is not included in such combined eligibility notice, the agency must also provide that information in a supplemental notice, consistent with this section.

**RECOMMENDATION:** We recommend revising § 435.917(d) to require a supplemental notice if the information described in subsection (c) is not included in the combined eligibility notice.

We greatly appreciate the recognition in the preamble that eligibility notices must be written in plain language and are accessible to individuals who are limited English proficient and individuals with disabilities. We believe that in situations where notices are not accessible that the notice must be found invalid and any actions taken in response to that notice must be voided. Only when the state provides the notice in accessible manner – that is in an LEP individual’s preferred written language or in an alternative format for an individual with a disability who cannot read regular print – would the notice, and any actions taken pursuant to the notice, be valid.

We would suggest additional language that if an individual notes a language preference on his/her application that the eligibility notice must be provided in that language. This is particularly important if eligibility is denied but also for approval since approval may require the individual take additional steps to actually enroll in a qualified health plan. Otherwise, it is unclear how the information would be accessible.

**RECOMMENDATION:** Amend § 435.917(a)(2) as follows:

Be accessible to persons who are limited English proficient and individuals with disabilities, consistent with § 435.905 of this subpart, ***including the following:***

- (A) for any individual with a visual impairment who is unable to read a standard notice, the agency must provide a notice in a large print, Braille or alternate format appropriate to the individual’s disability;***
- (B) for any individual the agency knows or should reasonably know is LEP, the notice must be provided in that individual’s language; and***
- (C) for all notices, the agency must provide taglines in at least 15 languages informing individuals of the availability of written translations or oral assistance to understand the information provided and a toll-free telephone number to request assistance, and***

#### **§ 435.918 Use of electronic notices**

We appreciate the requirement that states give individuals the option to receive secure electronic notices related to their application for Medicaid eligibility. Many individuals may benefit from increased flexibility in receiving and responding to electronic notifications, and the time savings can mean that individuals are able to help facilitate speedier eligibility determinations. If an individual elects to receive electronic notices, however, this should simply add electronic notifications as an additional means by which the agency can communicate important notices to the individual. Paper-based written notifications should continue unless and until the individual clearly and unambiguously expresses intent that they no longer wish to receive them. To prioritize consumer protection, the individual should be required to state, in writing, that they no

longer wish to receive such notices by regular mail, and they prefer to receive all eligibility notices electronically.

**RECOMMENDATION:** We urge HHS to clarify that paper-based written notifications will continue even if an individual elects to receive electronic notifications. Written notifications should cease only after clear and unambiguous expression by the individual that they no longer wish to receive paper-based notifications.

HHS seeks comment on whether other communications between the Medicaid or CHIP agency could be provided electronically. These communications include, among other things, notices of adverse actions. We strongly urge HHS to require that all notices conveying any adverse action taken by the agency ALWAYS be sent by written mail, even if the individual receives all other communications by electronic notification only. Dual electronic and paper-based notification in general, and specifically in regards to adverse actions, should add little administrative burden to the agency. Notices conveying an adverse action are of the utmost importance for individuals, triggering additional rights to an appeal and other fair hearing rights, and the agency should always be required to maintain additional protections that guard against delivery errors of these notices.

We also recommend HHS include specific language noting the importance of ensuring that the notice must be accessible to LEP individuals and individuals with disabilities. As we have specified above, we recommend that HHS provide additional requirements to ensure states effectively implement this provision.

**RECOMMENDATION:** Amend § 435.918 to add new subsection (c) as follows:

- (c) The notices required under this section must be accessible to individuals who are limited English proficient and individuals with disabilities, consistent with § 435.905(b) of this chapter and may be provided in electronic format in accordance with § 435.918 of this chapter. ***The information must also include the following:***
  - (1) for any individual with a disability, information must be provided in an alternative format appropriate for the individual's disability;***
  - (2) for any individual with a visual impairment who is unable to read standard information, the agency must provide information in large print, Braille or other acceptable alternate format appropriate for the individual's disability;***
  - (3) for any individual the agency knows or should reasonably know is LEP, information must be provided in that individual's language; and***
  - (4) for all notices, the agency must provide taglines in at least 15 languages informing individuals of the availability of written translations or oral assistance to understand the information provided and a toll-free telephone number to request assistance.***

## § 435.923 Authorized Representatives

We appreciate the additional guidance from HHS regarding authorized representatives. It is important to clearly define the scope and limits of authority vested in these individuals, and this proposed rule goes a long way in helping Medicaid agencies better understand the role of authorized representatives.

We urge HHS to require agencies to include detailed information to both the applicant and potential authorized representatives clearly describing the scope and requirements associated with this relationship. While we support broad authority for authorized representatives, this must go hand-in-hand with full and complete informed consent to authorize a representative by the applicant. Authorized representatives should also be clearly instructed on the requirements on them to maintain confidentiality of the applicant's personal information, as well as the scope of their authority to act on behalf of the applicant.

We also urge HHS to clarify how the authorized representatives' authority relates to the applicants' ongoing authority regarding their application. It is possible that some individuals may designate an authorized representative only as a precaution in case they are later unable to receive communications or make decisions regarding their applications. Is this type of precautionary designation allowed by these proposed rules? And if so, where the individual seeks to retain authority of their application unless and until the authorized representative is needed, how can they notify the agency when such need arises? We ask that HHS issue clear guidance to states on these issues. We recommend that individuals be able to maintain complete control over their application and related notices and communications, that they be permitted to designate partial authority to authorized representatives if preferred, and that the representation may, if preferred, be triggered only in the event of the individual's inability to represent herself. This last situation could also be communicated to the agency by evidence of subsequent creation of legal authority under state law to establish such authority for decision-making (subsequent designation of a legal guardian or power of attorney).

According to these comments, we therefore make the following recommendations.

**RECOMMENDATION:** Clarify that the Medicaid agency must make clear to both the consumer and the authorized representative the powers and duties of the authorized representative as well as all other requirements of § 435.923 in a manner that is understood by both parties. The current proposed rule, while requiring that the agency ensure that the authorized representative complies with applicable state and federal law, does not require that the agency ensure that both the consumer and the authorized representative understand the requirements of § 435.923 regarding timing, scope of representation, or duration.

**RECOMMENDATION:** Clarify that the authorized representative may, but need not, be authorized to have full capacity to act on behalf of the consumer in dealings with Medicaid agency. There are many instances in which the consumer may wish the



authorized representative to have authority over some but not all aspects of interaction with the agency, or may seek such representation only if they are unable to provide or authorize it.

**RECOMMENDATION:** Modify proposed § 435.923 to specify that, where an authorized representative is appointed by legal documentation to act on behalf of an individual under state law as set out in proposed § 435.923(a), the authorized representative shall have an affirmative duty to notify the Medicaid agency and the individual on whose behalf he or she is acting of any revocation or material change in that separate legal authority and that such a material change or revocation shall result in revocation of the authorized representative's authority to act on behalf of the consumer.

### **§ 435.926 Continuous eligibility for children**

We appreciate the codification of the state option to provide continuous eligibility for children regardless of a change in income or other circumstances rendering the child ineligible for Medicaid. Providing this continuous eligibility not only allows continuous treatment without interruption, but it allows care to continue as the agency, along with the beneficiary and/or the beneficiary's family, determine whether the child may be eligible on another basis and if not, if there are alternative programs that may be able to assist.

### **§ 435.952 Use of information and requests of additional information from individuals**

We strongly commend HHS for requiring states to establish an exception at § 435.952(c) to permit self-attestation for all eligibility criteria where documentation does not exist or is not reasonably available. This exception process is critical to reducing the unreasonable burden often placed on both beneficiaries and agencies. We believe rules that maximize and prioritize the use of self-attestation where appropriate, as it is the least administratively burdensome process, are most responsive to many of these concerns.

Under § 435.952(c)(2)(ii), not amended in this proposed rule, if electronic data is not available to verify immigration status, states may require documentary evidence. However, if electronic data is not available to verify citizenship, § 435.407(f) removes the requirement that only an original document can be used, and proposes that the state must accept a photocopy, facsimile, scanned or other copy of a document. There should be a similar provision for demonstrating satisfactory immigration status.

**RECOMMENDATION:** Amend the final rule to provide that to verify immigration status, the state must accept a photocopy, facsimile, scanned or other copy of a document.

### *§ 435.952(c)(3) Exception for special circumstances*

This provision requires states to permit self-attestation for all eligibility criteria when documentation does not exist, such as for homelessness, domestic violence, or natural disaster. However, the proposal carves out an exception to require documentation of citizenship and immigration status, with the rationale that documentation is specifically required under Title XIX. Immigrants caught in a natural disaster, such as a devastating hurricane or escape from domestic violence, may have to present themselves for health coverage and care without documentation of their immigration status. HHS should permit them to attest to their status and obtain benefits until such time as HHS can verify the status. The requirement of documentation is harsh and inconsistent with the ACA's policy of administrative streamlining that permits applicants to declare immigration status by entering an identifying number into a web portal. Even when an applicant in special circumstances cannot provide an identifying immigration status number, the rules should allow attestation in an emergency and prohibit delaying or denying benefits pending later verification of income and other eligibility criteria. To address concern about fraud, the rule could require the state to spot-check verification of attestations as is provided in § 155.320(d), which permits spot-check verification of attestations for enrollment in employer-sponsored insurance. At a minimum, the special circumstance of major disaster should be designated by HHS rules as an event triggering an automatic waiver of other statutory verification requirements, as is provided for by the Stafford Act of 1988 and implemented through federal and state disaster assistance and emergency preparedness plans.

**RECOMMENDATION:** Amend § 435.952(c)(3) to delete the exception that requires states to collect documentary evidence of eligible immigration status under special circumstances such as natural disaster, domestic violence, and homelessness.

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

We support the clear explanation of the verification process that the state must comply with to verify citizenship and immigration status. In particular, we support the specific reference to the requirement that the state must comply with § 1137(d) of the Social Security Act. We also support the requirements that:

- (1) a state must provide an applicant or beneficiary a reasonable opportunity period to provide proof of immigration status if electronic verification is unsuccessful through the “electronic service” (§435.956(a)(2)(i)) and;
- (2) a state may not “delay, deny, reduce or terminate benefits” for an individual who is otherwise eligible for Medicaid during the reasonable opportunity period.” (§435.956(a)(3)).

Furthermore, we support the requirement that the Medicaid agency “may not re-verify or require an individual to re-verify citizenship at renewal.” §435.956(a)(3). However, we recommend adding the requirement that a state may not re-verify immigration status at renewal as well. Like citizenship, immigration status for most lawfully present immigrants does not change from year to year; nor does a non-citizen have to renew his

or her status every year with the Department of Homeland Security nor does she lose her status from year to year. Furthermore, a beneficiary whose immigration status changes is already obligated to report that change in status to the Medicaid agency under existing change reporting requirements that apply to every beneficiary.

Allowing the Medicaid agency to re-verify immigration status of a non-citizen beneficiary at renewal will likely cause unnecessary delay or wrongful denial of benefits and likely gaps in coverage. This disparate impact on non-citizens at the time of renewal could also deter other immigrant families from applying as they see families like themselves having challenges in keeping their Medicaid coverage when those families are clearly eligible.

**RECOMMENDATION:** Amend § 435.956(a)(3) as follows

- (3) The agency must maintain a record of having verified citizenship or immigration status for each individual, in a case record or electronic database. The agency may not re-verify or require an individual to re-verify citizenship ***or immigration status*** at a renewal of eligibility or subsequent application following a break in coverage.

§ 435.956(g)(i)

We support reaffirming the existing Medicaid requirement that a state must “assist the individual in obtaining an SSN, in accordance with § 435.910” during the reasonable opportunity period. In particular we support ensuring the state provide this assistance if the SSN is “relevant to the verification of the individual’s status.”

However, there may be Medicaid eligible individuals who are lawfully present but are not eligible for an SSN. If these individuals have other documentation of their lawful status, the state should be required to accept this documentation to verify immigration status. The state should then assist the individual to obtain a non-work SSN for the purposes of applying for benefits as is already required by 45 C.F.R. § 435.910 and not “delay, deny reduce or terminate” an individual who is lawfully present and is awaiting a non-work SSN from SSA.

We also support and commend HHS for including specific language noting the importance of ensuring that the notice must be accessible to LEP individuals and individuals with disabilities. As we have specified above, we recommend that HHS provide additional requirements to ensure states effectively implement this provision.

**RECOMMENDATION:** Amend § 435.956(g) to add new (v) as follows:

- (v) Assist individuals who are limited English proficient and individuals with disabilities by undertaking the following:
  - (A) for any individual with a visual impairment who is unable to read a standard notice, the agency must provide the notice in large print,***

- Braille or other acceptable alternate format appropriate for the individual's disability;***  
***(C) for any individual the agency knows or should reasonably know is LEP, the agency must provide the notice in that individual's language; and***  
***(D) for all notices, the agency must provide taglines in at least 15 languages informing individuals of the availability of written translations or oral assistance to understand the information provided and a toll-free telephone number to request assistance.***

*§ 435.956(a)(1) Verification of immigration status*

States must verify immigration status through the federal data services hub if available, and adds that if the hub is not available, states may verify directly with DHS in accordance with §1137d of the Act. It is helpful to non-citizen applicants that in the event of an interruption in federal hub service, a state has the option to verify immigration status directly with DHS. If the federal hub function is not available at all times, consumers could encounter undue delay in their ability to enroll in coverage. When States need to verify directly with DHS, final rules must condition direct verification on the existence of an agreement (MOU) that provides the applicant with the due process and privacy protections found in §1137d of the Act.

**RECOMMENDATION:** We support § 435.956(a)(1)(ii) to permit States to verify an applicant's immigration status directly with DHS in the event the federal hub is not available, and we suggest amending the rule to require States, before directly verifying information through DHS, to have MOUs with DHS in place that protect applicants' due process and privacy rights under § 1137d of the Act.

*§ 435.956(a)(2)(i) Reasonable opportunity period*

If an agency cannot promptly verify an applicant's non-financial information, or if there are inconsistencies in the verification, the agency must then provide a reasonable opportunity to establish eligibility. The Preamble, 78 Fed. Reg. at 4616, seeks comment on two options for the level of promptness in verification that should be required: (1) "promptly and without undue delay," resulting in eligibility at the same level of 'real time' standard applied to applicants generally; and (2) promptness defined as a given number of business days. Enrollment in health coverage is too vital to allow the agency to delay several days. Therefore, we do not support allowing a number of business days to define the concept of "promptly."

We support finalizing the proposal that the reasonable opportunity period is triggered if verification of citizenship or immigration status cannot be concluded "promptly."

*§ 435.956(a)(2)(ii) Provision of benefits during reasonable opportunity period*

This provision strengthens the language of the rule requiring provision of benefits during a reasonable opportunity period, making that consistent with § 1137d of the Act, which mandates that the agency “may not delay, deny, reduce or terminate benefits . . . during the reasonable opportunity period. . . .” In addition, § 435.1008(c) makes FFP available to the state for this purpose. These statutory rights have long been critical to meeting the health care needs of non-citizens who sometimes encounter delays in verification due to inaccurate databases, changes in status, and lost documents.

We support revised language of § 435.956(a)(2)(ii) that is now consistent with longstanding statutory rights. We support § 435.1008(c) providing FFP for this purpose.

*§ 435.956(g)(2)(i) Reasonable opportunity period is 90 days*

This provision provides a consistent 90-day period for resolving inconsistencies in verification of both citizenship and immigration status. Consistency will be simpler for states to administer, resulting in greater fairness for immigrant applicants. We support the consistent timeframe of 90 days for resolving inconsistencies in verifying both citizenship and immigration status.

**§ 435.1001 FFP for administration**

NHeLP commends this amendment which authorizes FFP for administering presumptive eligibility for all applicable populations.

**§ 435.1002 FFP for services**

NHeLP supports this amendment which authorizes FFP for presumptive eligibility services for all applicable populations, regardless of whether they are ultimately found eligible. We also specifically commend the addition of the language “file an application for a full eligibility determination or,” which ensures FFP for services in the circumstances where a final application is not filed.

**§ 435.1008 FFP in expenditures for medical assistance for individuals who have declared citizenship or nationality or satisfactory immigration status**

NHeLP commends the inclusion of regulatory language at § 435.1008 to ensure FFP is available during a time period for reasonable opportunity to verify citizenship. This policy is essential because GAO studies have shown that the most significant impact of the citizenship verification process is to prevent U.S. citizens from enrolling in Medicaid.<sup>7</sup>

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<sup>7</sup> See *Summary of GAO and Staff Findings: Medicaid Citizenship Documentation Requirements Deny Coverage to Citizens and Cost Taxpayers Millions* (Majority Staff, U.S. House of Representatives Committee on Oversight and Government Reform, July 24, 2007), <http://oversight-archive.waxman.house.gov/documents/20070724110341.pdf> (last accessed Feb. 1, 2013) and *Medicaid: States Reported That Citizenship Documentation Requirement*

NHeLP recommends that HHS maintain and expand this reasonable opportunity period to ensure that states receive FFP for covering this population of U.S. citizens being harmed by an ill-advised and onerous verification system.

### **§ 435.1015 FFP for premium assistance for plans in the individual market**

NHeLP recommends that HHS eliminate the proposed policy to allow premium assistance for plans in the *individual* market, or otherwise tightly circumscribe it. The policy has limited value and may be wasteful. While states may face pressure – from industry and politics – to implement premium assistance programs, the reality is that Medicaid has been and remains the most efficient health care spending vehicle in the country. It will rarely be a thrifty use of scarce programmatic dollars to allow states to spend Medicaid dollars subsidizing *private* insurance. Far more often the result will be bloated Medicaid spending as the state subsidizes expensive private market services, pays for all of the services that the private product does not cover, *and* administers the whole system. And, while we are sympathetic to the objectives of coordinated systems and simplifying things for families, we do not believe “wrap around” benefits will effectively accomplish that goal either. Wrap around benefits create another layer of confusion for consumers as they deal with two different insurance systems. This is precisely the problem dually eligible individuals have faced for years, and HHS has launched a major effort to integrate their coverage into one plan.

In addition to our policy concerns, we question the legality of this proposal. We do not believe the authorizing language that HHS relies upon in § 1905(a)(29) unambiguously creates the needed authority. Moreover, if this authority had already existed, then it is not clear why Congress would have needed to create authority in § 1906 and § 1906A for premium assistance. And the fact that § 1906 specifically refers to *group* coverage indicates that Congress intended premium assistance for just that—*group* coverage. This logic is furthered by § 10203 of the ACA which aligns premium assistance definitions in § 1906 and elsewhere, but ignores the purported premium assistance authority of § 1905.

If, against our recommendation, HHS allows premium assistance for individual plans, the regulations should include a strong and detailed standard guaranteeing the premium assistance scheme will be budget neutral. Moreover, it would be essential for the regulation to retain its language requiring that individuals have access to the full range of covered services and that all cost-sharing limits be obeyed.

### **§ 435.1102 Children covered under presumptive eligibility**

We commend HHS for recognizing that, even when there is a shift towards a streamlined application process to provide real-time eligibility determinations,

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*Resulted in Enrollment Declines for Eligible Citizens and Posed Administrative Burdens* (U.S. Govt. Accountability Office, GAO-07-889, June 2007), [www.gao.gov/new.items/d07889.pdf](http://www.gao.gov/new.items/d07889.pdf) (last accessed Feb. 1, 2013).



presumptive eligibility (PE) will continue to play an important role in ensuring Medicaid applicants receive immediate health care coverage.

§ 435.1102(d)(1)

We are concerned this section allows a State agency, for purposes of making a PE determination, to require attestation (by the applicant or another person with reasonable knowledge) that the individual is (1) a citizen or national of the United States or in satisfactory immigration status; or (2) a resident of the state. HHS is seeking comment on whether this should be a state option or a requirement. We believe it should be neither. Neither the statute nor previous CMS guidance on presumptive eligibility include an attestation of immigration status. Sections 1920(b)(1)(A) and 1920A(b)(2)(A) provide 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, adding new § 1920(e), extends PE to other groups “in the same manner as the State provides for such a period under this section or section 1920A.”

Any requirement that a PE application include an attestation of immigration status will only serve to deter potentially eligible individuals from successfully applying. Further, the purpose of PE is to get individuals into care quickly while further determinations are made. Given the complexity of determining immigration status, neither the “qualified entity” staff nor the applicant is necessarily knowledgeable about the immigration eligibility rules, and we are concerned that a qualified entity may wrongly turn eligible applicants from PE or deter them from applying. Immigration status is appropriately addressed when an individual submits a complete application.

**RECOMMENDATION:** Strike § 435.1102(d)(1).

§ 435.1102(d)(2)

We commend HHS for prohibiting states from imposing requirements for PE not specified in this section and for not requiring verification of the conditions for PE. This will ensure applicants receive needed health care services immediately based on preliminary information as Congress intends.

**§ 435.1103 Presumptive eligibility for other individuals**

We thank HHS for this regulation extending PE to other groups of individuals including caretaker relatives and parents, individuals ages 19 and older and under age 65, former foster care children, pregnant women, persons eligible for family planning benefits, and persons eligible for coverage for the treatment of breast or cervical cancer.

We are concerned that the terms of § 435.1102 (d)(1) will apply to pregnant women and other individuals eligible for PE as well. Please see our comments to that section above recommending to strike § 435.1102(d)(1).

In addition, we are concerned with the proposed requirement that pregnant women be limited to one presumptive eligibility period per pregnancy. Such a limit does not exist in the regulations or other sub-regulatory guidance for other groups that may be presumptively eligible. Further, the statutory language at 42 U.S.C. § 1396r-1 for pregnant women mirrors the language used for other presumptive eligibility groups, suggesting that the rules for all group should be closely aligned. Therefore, there should be no separate and additional rule requiring a limit of one presumptive eligibility period per pregnancy for pregnant women.

There are many circumstances under which a woman may need more than one presumptive eligibility period. Some women may experience great difficulty in completing an application for Medicaid during their pregnancy. For example, homeless women or women living in shelters following circumstances of interpersonal violence may face added barriers in providing the information needed to complete a Medicaid application within the time required. We recognize that HHS may seek to avoid inappropriate use of PE, and we support this important goal. However, we urge HHS to utilize alternative mechanisms to monitor and respond to these concerns. We urge HHS to remove this proposed addition to the rule as it is likely to create an additional and harmful barrier to care for potentially Medicaid-eligible pregnant women.

We are also concerned about circumstances in which a pregnant woman who is determined presumptively eligible for Medicaid may need hospitalization due the pregnancy or other unexpected situation. As one example, a pregnant woman may experience a miscarriage that requires hospitalization. Services received in this situation may not qualify as “ambulatory prenatal care,” meaning that these services are only eligible for coverage if the woman is actually determined Medicaid eligible and can request retroactive coverage. This situation happens frequently, and in most cases the woman, who is no longer pregnant, fails to complete the full Medicaid application because she is no longer potentially eligible. The result is that these women often face extraordinary medical bills to cover the costs of the inpatient miscarriage management services. We urge CMS to clarify that presumptive eligibility for ambulatory prenatal care does not preclude separate and additional presumptive eligibility for hospital care. We have provided recommended regulatory language to that effect below.

**RECOMMENDATION:** Amend § 435.1103(a) as follows:

- (a) The terms of § 435.1101 and § 435.1102 of this subpart apply to pregnant women such that the agency may provide Medicaid to pregnant women during a presumptive eligibility period following a determination by a qualified entity that the pregnant woman has income at or below the income standard established by the State under § 435.116(c), except that coverage of services provided to such women are limited to ambulatory prenatal care ~~and the~~

~~number of presumptive eligibility periods that may be authorized for pregnant women is one per pregnancy~~ **and do not preclude a separate period of presumptive eligibility for hospital services as allowable** under § 435.1110.

#### **§ 435.1110 Presumptive eligibility determined by hospitals**

We appreciate the additional guidance to states and hospitals regarding presumptive eligibility determinations for pregnant women covering ambulatory prenatal care as well as inpatient pregnancy care during the presumptive eligibility period. Many hospitals offer a range of routine and specialized ambulatory prenatal care for pregnant women through clinics. We urge HHS to provide ongoing support and technical assistance to hospitals seeking to make presumptive eligibility determinations for pregnant women.

#### **§ 435.1200 Medicaid agency responsibilities for a coordinated eligibility and enrollment process with other insurance affordability programs**

We strongly support the requirement for a coordinated system of notices across insurance affordability programs. Please see our comments on the definitions of *combined eligibility notice* and *coordinated content* at § 435.4 and § 435.917.

We understand that time is needed to allow for systems to build, but given the importance in providing a combined eligibility notice, we believe the single notice should be in place as soon as possible and no later than January 1, 2015.

We commend HHS for amending § 435.1200(b)(3), which requires an agreement between the agency and the Exchange and other insurance affordability programs, to include a delineation of the responsibilities of each program. These safeguards will help ensure coordination between insurance affordability programs.

#### **§ 435.1205 Alignment with exchange initial open enrollment period**

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, 2013, 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 the 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.

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, 2013 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.

## **PART 440 – SERVICES**

### **§ 440.130**

NHeLP commends HHS for conforming the regulatory definition relating to who can provide preventive services with the statutory provision at 1905(a)(13) of the Social Security Act that defines “services . . . recommended by a physician or other licensed practitioner of healing arts within the scope of their practice under State law.” This is a critically important amendment.

### **§ 440.305 Scope**

NHeLP commends the addition of language in § 440.305(a) prohibiting states targeting Medicaid Expansion populations solely on the basis of the applicable matching rate.

### **§ 440.315 Exempt Individuals**

We strongly commend HHS for clarifying at subparagraph (f) the definition of “medically frail” and individuals with “special medical needs” to ensure it includes adults with serious mental illness, individuals with intellectual or developmental disabilities that impair the ability to perform one or more activities of daily living, and those with a disability determination based on Social Security or state plan criteria (in states that apply more restrictive criteria than the Supplemental Security Income program), in addition to the other important populations already described in regulation.

We strongly support HHS’ suggestion that individuals with a substance use disorder are included in the definition of medically frail or special medical needs and, thus, exempt from mandatory enrollment in Alternative Benefit Plans (ABPs). The regulation themselves should be clear on this point.

We strongly recommend that HHS also include “individuals with chronic health conditions” within the definition of medically frail or special medical needs. Individuals with chronic illness should not be forced into a benchmark package that will not meet their predictable needs and may lead to higher long-term costs associated with poorly managed chronic conditions.

We commend HHS for adding language at subparagraph (h) confirming that the new former foster care children group is exempt from mandatory enrollment in ABPs.

We note that our suggested benchmark exempt populations are vulnerable individuals who will often be best served by traditional Medicaid state plan benefits, and we encourage HHS to develop a systemic plan for how these individuals (who may be enrolled into a Medicaid ABP based on a streamlined application collecting minimal

information about disability or function) will be identified for exemptions. HHS must develop requirements and supports for states to identify exemption eligibility.

**RECOMMENDATION:** Amend § 440.315(f) to read as follows:

- (f) The individual is medically frail or otherwise an individual with special medical needs. For these purposes, the State's definition of individuals who are medically frail or otherwise have special medical needs must at least include those individuals described in § 438.50(d)(3) of this chapter, individuals with disabling mental disorders (including children with serious emotional disturbances and adults with serious mental illness), individuals with serious, ~~and complex,~~ **or chronic** medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living, **individuals with substance abuse disorders**, or individuals with a disability determination based on Social Security criteria or in States that apply more restrictive criteria than the Supplemental Security Income program, the State plan criteria.

#### **§ 440.330 Benchmark health benefits coverage**

We commend HHS for clarifying the authority at subparagraph (d) for states to provide a wide range of benefits in developing Secretary-approved coverage. We believe this promotes multiple high priority goals including facilitating state flexibility, helping states design specialized benefits packages, and most importantly, providing states with the authority to align traditional and benchmark benefits. In particular, we applaud HHS' inclusion of various options for LTSS and care coordination support. We urge HHS to clarify that these benefits are available for inclusion through the Secretary-approved process irrespective of whether they have otherwise been implemented in the a particular state Medicaid program. For example, a state may want to design a Medicaid benchmark to target a vulnerable population (e.g., individuals with dementia) and include a particularly relevant home support service that is not otherwise available in the state's Medicaid program (which may not have a § 1915(i) or similar program offering the service).

While we support HHS' proposed policy, we note that many consumer stakeholders have misunderstood the allowance for inclusion of benefits under Secretary-approved coverage due to the general prohibition on adding services to Medicaid benchmarks. HHS should clarify that benefits can be added, but only through the Secretary-approved process.

NHeLP appreciates that HHS has maintained two critical provisions developed in 2010 regulations which require that Secretary-approved coverage (1) provide appropriate coverage to meet the needs of the covered population and (2) be fully described and compared to another benchmark or the state plan. While these requirements will help promote quality and transparency in coverage, we believe HHS should *additionally* require that the final Secretary-approved benefits package be at least actuarially



equivalent to one of the first three benchmark options. This will ensure that states use the Secretary-approved option to provide a benefit that is *innovative*, but not solely to provide a benefit that is *lesser*.

**RECOMMENDATION:** Amend § 440.330(d) to read as follows:

- (d) *Secretary-approved coverage.* Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage to meet the needs of the population provided that coverage, **and is at least actuarially equivalent to one of the benchmark options in paragraphs (a), (b), or (c).** Secretarial coverage may include benefits of the type that are available under 1 or more of the standard benchmark coverage packages defined in § 440.330(a) through (c) of this chapter, State plan benefits described in sections 1905(a), 1915(i), 1915(j), 1915(k), **and of** ~~section 1945 of the Act~~ **(whether actually covered in the state plan or not)**, any other Medicaid State plan benefits enacted under title XIX, or benefits available under base benchmark plans described in 45 CFR 156.100.

#### **§ 440.335 Benchmark-equivalent health benefits coverage**

We are supportive of subparagraphs (b)(7) and (b)(8) implementing the statutory requirements for benchmark equivalents to cover prescription drugs and mental health benefits. We believe HHS should clarify subparagraph (c)(1). It appears that HHS is suggesting that it will use a similar policy for benchmark equivalent coverage as it does for Secretary-approved coverage and, thus, allow addition of benefits through the benchmark equivalent coverage process. We see no legal impediment to this approach. We support it and urge HHS to confirm it. We also commend the broad list of services included, for the same reasons described in our comments to § 440.330(d).

We are confused, however, by the language in § 440.335(c)(1) allowing addition of services available in “2 or more” benchmark options, as opposed to the language of “1 or more” which appears in § 440.330 and in current regulation. We believe this may be a clerical error and recommend the “1 or more” language to maximize state flexibility.

**RECOMMENDATION:** Amend § 440.335(c)(1) to read as follows:

- (c)(1) *Additional Coverage.* In addition to the types of benefits of this section, benchmark-equivalent coverage may include coverage for any additional benefits of the type which are covered in **1** 2 or more. . .

#### **§ 440.345 EPSDT and other required benefits**

We commend HHS for clarifying that ABPs must include coverage of family planning services and supplies at subparagraph (b) and mental health parity at subparagraph (c). We recommend that HHS clarify the family planning provision to specify coverage of 1905(a)(4)(C) services and supplies and require states to assure compliance with

1902(a)(23) freedom of choice for family planning services and supplies. We consider it likely that many states contract with managed care organizations, some of which may have no Medicaid experience, and that this will increase the likelihood that they will run afoul of the (a)(23) requirements.

We support HHS' language in subparagraph (d) requiring that ABPs to include EHBs and all updates or modifications made thereafter by the Secretary to the definition of EHBs.

HHS indicates that, once initially approved, states are not required to update ABPs until December 31, 2015. While we support the intent of this policy as a general rule, we recommend that HHS reserve some exceptional authority to resolve significant problems with the benefits package during this time period. We also urge HHS to ensure that (1) adequate data is collected for ABPs in 2014 and 2015 to inform updating prior to 2016; and (2) consumer stakeholders are included in all aspects of these processes. (Please see our comments to § 440.386 for additional recommendations on stakeholder input.)

We agree with HHS' legal conclusion, stated at 78 Fed. Reg. 4631, that § 1927 of the Act (prescription drug requirements in Medicaid) applies to ABPs. This is a critical protection requiring coverage of a range of drugs necessary to meet the needs of the Medicaid population. We recommend that HHS explicitly state this requirement in the regulation. However, we have serious concerns regarding the flexibility afforded to states to apply quantitative limits on drug coverage, particularly given that these limits are not common practice in the private insurance market. Allowing limits such as "hard caps" in ABPs threatens access to lifesaving care and treatment, undermines the letter and spirit of the ACA's EHB requirement, and will violate the nondiscrimination requirements as applied to numerous populations of persons with conditions, illnesses, and disabilities. We recommend that HHS apply the § 1927 requirement with respect to the range of covered medications, but prohibit additional authority for quantitative limits or other limits except as legally applicable based on the underlying ABP and EHB benchmarks.

**RECOMMENDATIONS:** Amend § 440.345(b) and (e) and add (f) to read as follows:

(b) *Family planning.* Alternative Benefit Plans must include coverage for family planning services and supplies ***described in § 1905(a)(4)(C) of the Act and must comply with the freedom of choice provisions of § 1902(a)(23).***

...

(e) *Updating of benefits.* States are not required to update Alternative Benefit Plans that have been determined to include essential health benefits as of January 1, 2014, until December 31, 2015, ***unless the Secretary determines that there are exceptional circumstances to update a plan.*** States will adhere to future guidance for updating benefits beyond that date, as described by the Secretary.

***(f) Outpatient drug coverage. Alternative Benefit Plans must include coverage for outpatient drugs as required by § 1927 of the Act, except that § 1927(d) and other authority for utilization management or coverage limits under § 1927 shall not apply.***

#### **§ 440.347 Essential health benefits**

##### *§ 440.347(a), (b), and (c)*

We support HHS' intent to effectuate the statutory requirement to make ABP coverage include, at a minimum, EHB level of coverage. However, we recommend that HHS modify the regulation in two fundamental ways to better implement the EHB requirement and meet the needs of the more vulnerable Medicaid population.

First, we recommend that HHS require that ABP plans be required to provide appropriate coverage to meet the needs of the population in all ten statutory EHB categories, as per the general requirement for ABPs in § 440.330. We believe that the failure to specify minimum standards in each of the ten categories is a flaw in the Exchange EHB standard, but this shortcoming has even graver consequences for the vulnerable enrollees in Medicaid. HHS should ensure that the EHB requirement is a strong floor for ABPs, and provide states with ample flexibility to add to that floor.

Second, while we understand that HHS may have created flexibility in the selection of EHBs at subparagraphs (b) and (c) to facilitate state ABP targeting of vulnerable populations, we believe this flexibility causes more harm than good. States *already* have extensive flexibility to target ABPs through the Secretary-approved process, so the flexibility for EHB adds very little. At the same time, this flexibility for EHB creates confusion because, for example, a state with three ABPs could ultimately have four EHB standards in place (one for each ABP and one for the Exchange). Administrative simplicity, oversight, and consumer understanding are all better served if the state has one EHB standard applicable for the Exchange and ABPs. We recommend HHS require states to use the state-selected Exchange EHB standard for ABPs.

NHeLP strongly commends HHS for including in ABPs the full range of preventive services required in the EHB, including all of the PHSA § 2713 services. This is a critical provision for vulnerable populations and will help achieve the ACA objective of shifting health care emphasis from expensive interventions to cost-effective prevention. We urge HHS to explicitly state this requirement (currently in the preamble at 78 Fed. Reg. 4631) in the regulation itself. Please also see our comments to § 447.56(a)(2) below, recommending that HHS also apply the PHSA § 2713 cost-sharing protections to the § 2713 services in ABPs. This is essential to providing meaningful coverage to vulnerable populations and avoiding the unfair outcome of *greater* cost-sharing for *poorer* individuals.

**RECOMMENDATIONS:** Amend § 440.347(a)-(c) as follows:

- (a) Alternative benefit plans must contain essential health benefits coverage, including benefits ***appropriate coverage to meet the needs of the population*** in each of the following ten categories, ***and otherwise*** consistent with the requirements set forth in 45 CFR Part 156:
- ...
- (b) Alternative benefit plans must include at least the essential health benefits included in ~~one of the state options for establishing~~ essential health benefits ***package*** described in 45 CFR part 156.
- (c) ~~States may select more than one option for establishing essential health benefits in keeping with the flexibility for States to implement more than one alternative benefit plan for targeted populations~~ ***Preventive and wellness services under paragraph (a)(9) must include the services described in § 2713 of the Public Health Services Act.***

§ 440.347(d)

HHS has reserved subparagraph (d) to later incorporate an approach for covering habilitative services in Medicaid ABPs after it reviews comments to this proposed rule. By requiring coverage of habilitative services and devices in the ten mandatory EHB categories, Congress clearly indicated its intent to meet the health needs of individuals with functional limitations following illness, injury, disability, or due to a chronic condition. Our recommendations for implementing Congressional intent are:

- We recommend that HHS develop an objective minimum national standard for habilitative services based on “appropriate coverage to meet the needs of the population,” and allow states flexibility to add to this minimum for purposes of innovation. We note, for illustrative purposes, the extensive difficulty HHS has had to go through over the past years to develop a functional definition of “integrated settings” after years of non-aligned localized definitions created serious problems across programs and states. HHS should avoid similar problems now by setting a clear, uniform standard for habilitative services.
- If HHS does not follow our recommendation for a national standard for habilitative services, then we support HHS’ suggestion of a state-defined standard to be used for Medicaid ABPs with the following requirements:
  - States should be required to base their definitions on documented and evidenced-based criteria, such as those endorsed by a relevant national academy of providers or national disease group.
  - States should not automatically be allowed to use their Exchange habilitative services definition unless it independently meets the criteria in the bullet above.
- We strongly recommend against HHS allowing any of the potential flexibility, authorized in the Exchange, for issuers to define the habilitative benefit.

- States should not be allowed to define habilitative services through parity with rehabilitative services since the two services can address distinct, but sometimes overlapping, purposes and impact different sets of individuals. Furthermore, parity is a poor standard because there is no certainty that the rehabilitative services level is itself adequate to begin with. Specifically, with regard to EPSDT beneficiaries who have been prescribed a treatment for the purpose of restoring the child to his/her best possible functional level, states should not be allowed to use any definition of “habilitative” as the authority for denying, terminating or reducing coverage of the treatment.
- HHS should require coverage of habilitative services without age restrictions – a pediatric only habilitative benefit is inadequate, especially as the new eligibility category is for adults only.
- HHS should require coverage of habilitative devices without arbitrary restrictions and caps that limit the effectiveness of the benefit.
- HHS should prohibit the exclusion of specific conditions or diagnosis from accessing the benefit.

#### § 440.347(e)

We commend HHS for adding language stating that EHB benefit design cannot discriminate on the basis of an individual’s age, expected length of life, or an individual’s present or predicted disability, degree of medical dependency, or quality of life or other health conditions. We believe these non-discrimination provisions will require vigorous monitoring and strong enforcement.

While the proposed rule does recognize the importance of non-discriminatory plan design, Section 440.347(e) fails to state the full range of nondiscrimination protections applicable to the EHB.<sup>8</sup> The EHB aims to address a number of deficiencies in the current insurance market including discriminatory benefit design and inadequate or absent coverage for important health services. These goals apply to all aspects of the Medicaid program available to individuals newly eligible for comprehensive coverage through the Medicaid eligibility expansion.<sup>9</sup>

HHS must consider four provisions of the ACA as it uses its authority to ensure that the EHB and plans offering the EHB do not discriminate:

- § 1557 prohibits discrimination on the basis of race, color, national origin, sex, age and disability in health programs or activities that receive federal financial

<sup>8</sup> Medicaid, Children’s Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, 78 Fed. Reg. 4,594, 4,701 (proposed Jan. 22, 2013) (to be codified at 45 C.F.R. pt. 440).

<sup>9</sup> As required under the statute, the essential health benefits cannot use benefit designs that discriminate. This means that neither the state itself as it manages fee-for-service payments nor a plan that contracts with the state to deliver the EHB can use medical management techniques in a way that discriminates against protected groups..

assistance, are administered by an Executive agency, or were established by Title I of the ACA.<sup>10</sup>

- § 1302(b)(4)(B) requires that the Secretary “not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life.”<sup>11</sup>
- § 1302(b)(4)(C) requires the Secretary to “take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups.”<sup>12</sup>
- § 1302(b)(4)(D) requires the Secretary to ensure “that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals’ age or expected length of life or the individuals’ present or predicted disability, degree of medical dependency, or quality of life.”<sup>13</sup>

The preamble references only § 1302(b)(4)<sup>14</sup> and the rule states only the protections available under that provision; it therefore reflects an incomplete and insufficient standard. Because the protections under § 1557 also apply, the final rule must expressly state a comprehensive and consistent nondiscrimination standard. We recommend the language used in the nondiscrimination standard set out in the proposed EHB rule.<sup>15</sup> This has the added benefit of making these rules consistent.

As one issue that could arise, if a state allows a benefit design that excludes a set of services critical for individuals with disabilities, this would discriminate against those

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<sup>10</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1557 (2010), *amended by* Health Care and Education Affordability and Reconciliation Act, Pub. L. No. 111-152 (2010) (to be codified at 42 U.S.C. § 18116).

<sup>11</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1302(b)(2)(B) (2010), *amended by* Health Care and Education Affordability and Reconciliation Act, Pub. L. No. 111-152 (2010) (to be codified at 42 U.S.C. § 18022).

<sup>12</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1302(b)(4)(C) (2010), *amended by* Health Care and Education Affordability and Reconciliation Act, Pub. L. No. 111-152 (2010) (to be codified at 42 U.S.C. § 18022).

<sup>13</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1302(b)(4)(D) (2010), *amended by* Health Care and Education Affordability and Reconciliation Act, Pub. L. No. 111-152 (2010) (to be codified at 42 U.S.C. § 18022).

<sup>14</sup> Medicaid, Children’s Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, 78 Fed. Reg. 4,594, 4,630 (proposed Jan. 22, 2013).

<sup>15</sup> Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 77 Fed. Reg. 70,644, 70,670 (proposed Nov. 26, 2012) (to be codified at 45 C.F.R. part 156) (referring to 45 C.F.R. § 156.200(e) (2012), which prohibits a Qualified Health Plan from discriminating based on race, color, national origin, sex, age, disability, gender identity, or sexual orientation). The Center pointed out in its comments on the proposed EHB rule that the EHB rule itself explicitly state the full nondiscrimination standard. Likewise, the Medicaid EHB rule should expressly state the full range of applicable nondiscrimination protections.



individuals subject to the benefit design. While HHS recognizes this basis, it fails to recognize discrimination on the basis of other factors which it must include.

Further, HHS indicates benefit design non-discrimination policies do not prevent states from exercising § 1937 targeting criteria. While we understand that § 1937 allows states the flexibility to amend Medicaid state plans to provide certain populations (as defined by the state) with benefits packages other than those offered in the standard Medicaid state plan, HHS must closely monitor this and ensure there is no discrimination in benefit design for certain populations.

**RECOMMENDATIONS:** Amend § 440.347(e) as follows:

- (e) Essential health benefits cannot be based on a benefit design or implementation of a benefit design that discriminates on the basis of an individual's age, expected length of life, ~~or of~~ an individual's present or predicted disability, degree of medical dependency, or quality of life or other health conditions, ***race, color, national origin, language, sex, sexual orientation or gender identity.***

#### **§ 440.360**

Please see our comments to § 440.330 above, commending the flexibility for states to include a wide-range of services through the Secretary-approved option, but also suggesting that HHS further clarify confusion about the intended policy.

#### **§ 440.386 Public Notice**

According to the preamble, HHS added § 440.386 to modify the public notice requirement for ABPs currently found at § 440.305(d) to allow states “greater flexibility” when required to publish notice. However, we disagree with HHS’s proposed two-tracked approach that exempts those ABPs that the state contends will provide “more benefits” from public comment. An ABP may quantitatively provide more benefits than another, but may fail to meet consumers’ needs in specific areas. The two-tracked approach proposed by HHS would provide pre-submission transparency and public input for some ABPs, and allow states to decide which ABPs would be exempt from the public process. Accordingly, we believe consumers and other stakeholders should have full opportunity to evaluate and comment on all ABPs, and indeed, all amendments to a state’s Medicaid plan (see NHeLP’s comments on § 430.12 and § 457.60)

We recommend that HHS improve the current notice and comment requirement. HHS’ current proposal suggesting two weeks of notice prior to *submission* is problematic because two weeks is not sufficient time for stakeholders to provide meaningful input, and there is no time built in for state review of and response to the comments. We recommend that HHS:

- Require an advance notice and comment period of no less than 30 days. This aligns with other comment periods (such as the state comment period for § 1115 waivers) and is particularly important because of the time and effort required to conduct the benefit-by-benefit comparisons between non-aligned Medicaid state plans, ABP proposals, and EHBs which will be necessary to provide meaningful input.
- Require a mandatory 15-day period (sometimes referred to as a “cool down” period) for states to review comments received and incorporate suggestions into the final ABP submission.
- Include specific requirements for adequate public posting of the proposal, including that it be posted on an internet website, and including a clear description of the process and timeline for comment submission.
- Include a reporting requirement, like the one at 42 C.F.R. § 431.412(a)(viii) for § 1115 demonstrations, to help ensure meaningful participation by the public and that HHS understands the issues raised at the state level when making the SPA approval decision.

**RECOMMENDATION:** We recommend amending § 440.386 by deleting proposed sub sections (a) and (b), designating the proposed introductory paragraph as subsection (a), and adding a new subsection (b) as follows:

- (a) States submitting a State plan amendment to establish an alternative benefit plan, or an amendment to modify an existing alternative benefit plan, must provide the public with notification of such an amendment, ***including by posting of such amendment, with a timeline and instructions for filing comments to an internet website***, and reasonable opportunity to comment with respect to such amendment, have included in the notice a description of the method of assuring compliance with § 440.345 of this part related to full access to EPSDT services and the method for complying with the provisions of section 5006(e) of the American Recovery and Reinvestment Act of 2009.
- (b) ***Transparency and stakeholder input. Prior to submitting a State plan amendment to the Centers for Medicare and Medicaid Services for approval, a State must provide the public with advance notice of the amendment and reasonable opportunity to comment with respect to such amendment.***
- (1) ***Public notice and comment period. Prior to submitting an application to HHS for state plan amendment, the State must provide at least a 30-day public notice and comment period followed by a 15-day period for State review of comments received, and the public notice shall include all of the following information:***
- (i) ***The proposed state plan amendment and a comprehensive description of state plan amendment to be submitted to HHS that contains a sufficient level of detail to ensure meaningful input from the public, including:***

- (ii) The locations and Internet address where copies of the state plan amendment are available for public review and comment.*
- (iii) Postal and Internet email addresses where written comments may be sent and reviewed by the public, and the minimum 30-day time period in which comments will be accepted.*
- (2) Statement of public notice and public input procedures. The State shall publish its public notice process, public input process, the proposed state plan amendment, and a link to the relevant Medicaid state plan amendment page(s) on the state's agency Web site in a prominent location on either the main page of the public Web site of the State agency responsible for maintaining and amending the Web page that is linked in a readily identifiable way to the main page of the State agency's Web site. The State must maintain and keep current the public Web site throughout the entire public comment and review process.*
- (3) Documentation of compliance. When submitting a state plan amendment under paragraph (a), the state must include written documentation of the State's compliance with the public notice requirements set forth in § 440.386(b)(1)(2) of this subparagraph, with a report of the issues raised by the public during the comment period and how the State considered those comments when developing the state plan amendment. The State shall publish all documentation of compliance submitted to the Centers for Medicare and Medicaid Services, including the report of issues raised by the public during the comment period, on the state's agency Web site for continued public reference.*

## **PART 447 – PAYMENTS FOR SERVICES**

HHS has “streamlined and simplified” the cost sharing regulations to “increase state flexibility.” 78 Fed. Reg. at 4658. In the Deficit Reduction Act, Congress gave states increased flexibility to impose copayments on outpatient prescription drugs, non-emergency use of the emergency department, and on individuals with family incomes above 100% FPL, see 42 U.S.C. § 1396o-1. The proposed regulations reflect this.

By contrast, Congress has preserved requirements of “nominality” and introduced additional consumer protections for individuals with family incomes at or below 100% FPL. See *Id.* at §§ 1396o, 1396o-1. Thus, our comments focus on this population group. Given the statutory exclusions of some populations and services from copayments, our comments focus further on the subgroups most likely to be affected by copayments: aged, disabled and chronically ill adults living in the community (who are not on Medicare and are not in hospice) and childless, non-disabled, non-elderly adults.

As promulgated, these proposed regulations bring to mind a concern voiced on multiple occasions by multiple researchers—that copayments all too often act as a “blunt tool” that discourages essential and appropriate care and create barriers to care for those in

need. See Leighton Ku & Victoria Wachino, Center on Budget and Policy Priorities, *The Effect of Increased Cost-Sharing in Medicaid* 8 (July 7, 2005), <http://www.cbpp.org/cms/?fa=view&id=321>; Matthew D. Solomon et al., *Cost Sharing and the Initiation of Drug Therapy for the Chronically Ill*, 169 ARCH. INTERN. MED 740, 746 (Apr. 27, 2009) (finding copayments caused delays in initiation of drug therapy for patients with chronic diseases and expressing concern with the use of copayments as a “blunt tool”). We urge HHS to modify the regulations so that copayments are imposed in a more nuanced way that recognizes the reality of living life below the poverty level (in many cases, well below that level). There are a number of reasons why now is the time to update the approach and to replace blunt rules with nuanced policies.

First, over three decades of research overwhelmingly establishes that copayments—even small ones by middle class standards—make it harder for low income people to afford medical services and force them into difficult choices between needed health care and other basic necessities. See NHeLP, *Researchers Repeatedly Find Cost sharing Harms Medicaid Beneficiaries Access to Care and Health Status* (2011), at [http://www.healthlaw.org/images/stories/NHeLP\\_Cost\\_Sharing\\_Summary\\_8.5.11.pdf](http://www.healthlaw.org/images/stories/NHeLP_Cost_Sharing_Summary_8.5.11.pdf) (summarizing 14 of these studies); Leighton Ku, *The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings* (May 31, 2005). The research establishes particularly adverse consequences for people with chronic conditions. Their conditions require more medical care and, thus, more copayments. *Id.*

Second, many people assume that, without copayments, Medicaid beneficiaries will not have financial responsibility for their care. However, the amounts that Medicaid beneficiaries pay out-of-pocket for medical care are already substantial and are growing faster than their incomes. See Matt Broaddus and Leighton Ku, Ctr. on Budget & Pol. Priorities, *Out-of-pocket Medicaid Expenses for Medicaid Beneficiaries are Substantial and Growing*, 1 (May 31, 2005) (noting out-of-pocket expenses for disabled Medicaid beneficiaries are particularly high), <http://www.cbpp.org/cms/?fa=view&id=320>. Adjusted annually, as the statute requires, Medicaid copayments will become ever more demanding for lower income Americans whose incomes do not keep pace with the “medical care component of the consumer price index for all urban consumers” (rounded up). 42 U.S.C. § 1396o-1(h).

Third, across all Medicaid eligibility groups, individuals are increasingly being enrolled in managed care arrangements, be they MCOs or primary care case management. The Medicaid Act includes provisions that require states and Medicaid-participating managed care entities to select providers who are well qualified to render care and to subject patient care and services to ongoing monitoring and utilization controls designed to prevent unnecessary utilization. In such an environment, there is less of a need for cost sharing. In the words of a previous Medicaid director in Arizona:

Cost sharing works against the notion of managed care. Cost sharing is imposed to change beneficiary behavior or to make the beneficiary financially responsible for the service choices “they” make (like overuse the emergency room). . . . If you are going

to put co-payments and co-insurance on AHCCCS MCO members it will work against the health plans' medical management programs.

Fourth, while some states have stressed the need for “personal responsibility,” that concept is not simply financial. It is also a responsibility to obtain timely care and adhere to treatment regimens. The most recently published study on cost sharing finds that midlife and older adults understand the potential consequences of delaying care or non-adherence to treatment. Yet, despite actively learning about and attempting to manage their insurance coverage, cost sharing can leave them with no alternative but to forego necessary care. See David Grande et al., *Life Disruptions for Midlife and Older Adults with High Out-of-Pocket Health Expenditures*, 11 ANNALS OF FAM. MED. 37, 40-41 (Jan./Feb. 2013). Reduced access to care due to cost sharing has also been associated with increases in hospitalizations and other expensive forms of care. See Amitabh Chandra et al., *Patient Cost-Sharing and Hospitalization Offsets in the Elderly*, 100 AM. ECON. REV. 193 (2010), and John Hsu et al., *Unintended Consequences of Caps on Medicare Drug Benefits*, 354 NEW ENG. J. MED. 2349 (2006).

Thus, while we understand the governments' desire to increase state flexibility and/or patient responsibility, the overwhelming and redundant research surrounding the imposition of copayments on low income people and the changing reality of Medicaid delivery systems make it penny wise and pound foolish to impose blunt copayments on very low income people. Because they will cause these individuals to forego needed care, despite knowledge of potential negative consequences, HHS's cost sharing proposals will simply encourage the very kind of delayed attention and resulting (expensive) interventions which the ACA is intended to address. We urge HHS to use these regulations to update Medicaid copayment policies so that they enable low income individuals to contribute to the cost of their care *without* creating barriers to care.

#### **§ 447.51 Definitions**

HHS should revise the definition of *alternative non-emergency service provider* applicable to proposed regulation § 447.54. It is important for the regulation to require these providers to be actually available and able to provide the necessary diagnostic and/or treatment services for which the Medicaid beneficiary has gone to the emergency department (ED) to obtain. Otherwise, individuals are being penalized for making a medical choice which really was no choice at all. We recommend using the definition contained in *Dear State Medicaid Director* (Aug. 15, 2007) (SMDL #07-010) as a guide.

HHS should revise the definition of *cost sharing* to track the definition Congress has provided in the Medicaid statute, 42 U.S.C. § 1396o-1(a)(3). The word “co-insurance” does not appear in the statute and while the existing regulations use the term, they have always focused on copayments. This will not only bring the regulations into line with the statute but will also further the goal of simplification.



**RECOMMENDATION:** Amend the definitional section, § 447.51, as follows:

*Alternative non-emergency services provider* means a Medicaid-**participating** provider, such as a physician's office, health care clinic, community health center, hospital outpatient department, or similar provider that ***is actually available and accessible*** to ~~can~~ provide clinically appropriate services ***for the diagnosis or treatment of a non-emergency condition*** in a timely manner.

*Cost sharing* means any copayment, ~~coinsurance~~, deductible, or ~~other~~-similar charge.

### **§ 447.52 Cost Sharing**

The proposed regulations omit the term, “nominal,” instead referring only to the “maximum allowable cost sharing.” However, the Medicaid Act specifically limits cost sharing to “nominal” amounts and commands the Secretary to determine the “nominal” amounts in each year. “Nominal” is the substantive standard in 42 U.S.C. §§ 1396o and 1396o-1 for cost sharing responsibilities for individuals with household income at or below 100% FPL, who are not exempt from cost sharing, and where the alternative authority of section o-1 is not invoked in the state plan, it forms the standard for all recipients. See 42 U.S.C. § 1396a(a)(3). This term conveys the statutory requirement that cost sharing burdens on Medicaid recipients not be onerous.

**RECOMMENDATION:** CMS should restore the use of the term “nominal,” as that term is used in the existing regulations. See 42 C.F.R. § 447.53(a).

#### **§ 447.52(b)(1)**

The proposed regulations for outpatient services replace the current tiered copayments with a single copayment based on the individual's income. HHS proposes to set the copayment for the below poverty population at \$4.00—ten cents above the current FY 2013 maximum copayment amount. This is simply too high. Although the 5% aggregate cap does ameliorate the burden for some of beneficiaries, that is not enough. To give examples from our client files:

FW fractured his spine and has constant back pain and numbness in his legs. It is difficult to work, but he collects aluminum cans and scrap metal to make money. He needs to see his doctors routinely and has been prescribed a number of medications to treat his conditions. Medicaid copayments are about \$60 per month. He has no family or friends who can help him pay for his care. He can go days and sometimes weeks without care.

PS suffers from a number of problems, including gout, diabetes, high cholesterol, asthma, acid reflux, and depression. Like FW, he should see his doctors routinely and has been prescribed a number of medications. Medicaid copayments are about \$80 per month. He has no money so these payments are impossible for him and he



goes without care. Over the last year, he was hospitalized on multiple occasions; he has been coughing up blood; he became so ill that he tried to commit suicide.

Moreover, the cost of the service to the agency is not the relevant factor. Rather, HHS should determine nominality in relation to the income and health status of the paying population. This is what HHS is doing for Medicare populations living below the federal poverty level (FPL) by limiting Part D copayments to \$1.10 for preferred/generic drugs and \$3.30 for other medications for individuals with incomes at or below the FPL and \$2.50 and \$6.30, respectively, for individuals with incomes over the FPL. See <https://secure.ssa.gov/poms.nsf/lnx/0603001005>.

We propose these amounts as benchmarks for Medicaid as well. And while our recommendations below reflect this, if HHS is not going to treat all poor people equally, then we urge you to lower the Medicaid copayment maximum significantly, to \$2.10, which is the approximate average of the FY 2013 maximum copayment amounts.

**RECOMMENDATION:** Amend the table at § 447.52(b)(1) by setting the maximum copayment for outpatient services for individuals with family income at or below 100% FPL at \$1.10.

The proposed regulations for an inpatient stay copayment for individuals with incomes at or below 100% FPL is 50% of the cost the agency pays for the first day of care. This is unchanged from the current regulations. However, there are a number of reasons why this is problematic. Assuming a per diem inpatient rate of \$854.00 (modeled on 2012 Florida rates), the below poverty individual would be responsible for a \$427.00 copayment. The monthly income for someone earning at the poverty level is only \$930. It is unreasonable to expect that any poor person can afford this kind of copayment. The individual has qualified for Medicaid precisely because she does not have sufficient income to meet the expenses of daily living (food, shelter, clothing) and also pay for health care. Moreover, some states pay hospitals different per diem rates, with higher payments going to the hospitals with the sickest patients. This means that the sicker the patient, the higher that patient's copayment. Still other states are using diagnosis related payment models that pay hospitals a set payment based on the patient's condition and severity, so in these states a copayment based on the first day of care is a fiction. In addition, the rationale for copayments are lacking here. In general, people do not admit themselves into the hospital but rather are admitted by their doctors and there is, thus, little or no care reduction incentive to be gained by the inpatient stay copayment. As CMS notes in the preamble to the proposed regulations, the 50% cost sharing 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.

**RECOMMENDATION:** We recommend that HHS determine nominality in relation to the income and health status of the below poverty Medicaid populations and amend the table at § 447.52(b)(1) by setting the maximum copayment for an inpatient stay as follows: individuals with incomes at or below 100% FPL: \$10.00 (to be adjusted annually by the statutory COLA). This \$10.00 copayment should also be the base copayment for

individuals with higher incomes whose copayment responsibilities have been set by Congress.

## **§ 447.53 Cost sharing for drugs**

### *§ 447.53(b)*

This section allows states to establish cost sharing for preferred and non-preferred drugs. Individuals with incomes at or below 150% FPL could be charged up to \$4 copays for “preferred” drugs and \$8 copays for “non-preferred” drugs. By contrast, researchers have repeatedly concluded that even low prescription drug copayments cause very low income people not to fill the prescriptions their doctors have given them to treat their health conditions. In Oregon, after \$2 generic and \$3 brand name copayments were imposed, utilization of necessary prescription drugs declined by 17%, with reductions across every therapeutic category studied and with the greatest reductions occurring for drugs treating depression and respiratory diseases. 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). A study in Minnesota found that when the State imposed tiered copayments of \$1 for generic drugs and \$3 for brand name drugs—far below those in the proposed regulations—slightly more than half of Medicaid patients using a public hospital reported being unable to fill prescriptions because of cost sharing. About one-third of those who went without prescription drugs had more serious health problems, like strokes, diabetes problems or asthma attacks, and required expensive emergency room care or hospital admission. Melody Mendiola et al. “Medicaid Patients Perceive Copays as a Barrier to Medication Compliance,” Hennepin County Medical Center, Minneapolis, MN, presented at the Society of General Internal Medicine national conference, May 2005 and American College of Physicians Minnesota chapter conference, Nov. 2004.

The proposed \$4 preferred drug/\$8 non-preferred drug copayment ignores reality: Individuals cannot be incentivized to simply “prefer” the preferred drug, as is accomplished with some success with middle class consumers. At these income levels and with those high co-pay differentials, Medicaid enrollees are not really given any meaningful choice – they simply will go without the “non-preferred” drug even if it really is necessary and would work far more effectively than a preferred drug.

As already noted, the experience with copays under Medicare Part D is instructive. The Low Income Subsidy available under Part D includes limits for copayments: \$1.10 for preferred/generic drugs and \$3.30 for other medications for individuals with incomes at or below 100% of FPL and \$2.50 and \$6.30, respectively, for individuals with incomes over 100% of FPL. (Even these copayments have caused barriers to treatment for Medicare beneficiaries who also qualify for Medicaid—to the extent that some states have stepped in to help cover the costs.)

**RECOMMENDATION:** We recommend that HHS determine the nominal copayment in relation to the income and health status of the Medicaid population and amend the table at § 447.53(b) by setting the maximum copayments for 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; Non-preferred drugs: \$4.20.

#### § 447.53(e)

The Medicaid Act says that states “shall” provide for cost sharing at the preferred drug level in the case of a drug that is not preferred if the prescribing physician determines that the preferred drug is needed. Given the clear understanding from the numerous studies that conclude prescription drug copayments cause dangerous reductions in prescription use, the regulations need to establish a process for states to implement this critical Medicaid Act requirement and do so in a way that recognizes how pharmacies and pharmacists work with electronic claims processing.

The process needs reliable and to be easy for the prescriber to invoke, and it should be described in the state plan and provider manuals. Otherwise, the process will be unworkable because clinicians will not know about it and be unwilling or uncertain about invoking it for each individual--for what, to the provider, will probably seem like a tiny sum of money not worth his or her effort. We suggest that the regulations require states to establish a process that will allow the prescribing practitioner to easily designate that the prescribed drug is necessary and require pharmacists to apply that designation in all cases to limit the copays to the preferred drug through the availability of a simple electronic communication from the pharmacist confirming receipt of such a designation and an automated response acknowledging payment premised on the preferred drug rate.

The system must also allow a physician to invoke the preferred drug copayments if he or she determines that the non-preferred drug is otherwise in the patient’s best interest. This basis is particularly important for occasions where a drug the patient was stabilized on is removed from the preferred drug list, and the patient has been difficult to stabilize and/or takes a number of other drugs. This situation is not unusual where anti-psychotic drugs are involved. The prescribing physician cannot attest that the preferred drug would be less effective or have adverse effects, but in these circumstances it would not be considered good medical practice to change regimen abruptly. We have proposed language below.

Finally, the regulation should recognize that some states’ laws extend prescribing authority to practitioners who are not physicians

**RECOMMENDATION:** Amend § 447.53(e) as follows:

- (1) In the case of a drug that is identified by the agency **or MCO** as a non-preferred drug within a therapeutically equivalent or therapeutically similar class of drugs, the agency must have a process in place ~~so~~ **to ensure** that ***the individual's*** cost sharing ***will be*** is limited to the amount imposed for a preferred drug ***if the individual's prescribing health care practitioner determines that the non-preferred drug for treatment of the same condition would be less effective for the individual, would have adverse effects for the individual, or is otherwise not in the best medical interests of the individual.*** ~~In such cases the agency must ensure that reimbursement to the pharmacy is based on the appropriate cost sharing amount.~~
- (2) ***The process shall be set forth in the state plan and the same process shall be required in MCO contracts with network prescribing practitioners.***
- (3) ***The process must (i) allow the prescribing practitioner, after making the determination that a preferred drug is necessary, to prescribe the non-preferred drug at the preferred drug copayment rate using a simple designation on the prescription indicating "prescribed drug medically necessary;" (ii) enable providers to use the same electronic process for dispensing non-preferred drugs that is used for prescribing and dispensing preferred drugs; and (iii) describe how prescribing practitioner and pharmacy providers will be informed of the process.***
- (4) ***The agency or MCO must ensure that reimbursement to the pharmacy is based on the appropriate cost sharing amount, through a system of electronic confirmation at the pharmacy that such a prescription and designation has been presented and automated response from the payor with the correct copayment amount applied. In all cases, states or MCOs must bar pharmacies from charging other than the preferred copayment rate whenever a prescription has been completed by the prescribing practitioner in accordance with the approved process.***

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

**§ 447.54(b)**

The proposed regulation allows states to impose up to an \$8 copayment on individuals with incomes at or below 150% FPL (i.e. twice the currently proposed \$4 copayment) and unlimited copays on individuals with incomes above 150% of FPL. This section should be revised because parts of it are inconsistent with the Medicaid Act, 42 U.S.C. § 1396o-1(e)(2)(B), which provides that: (1) with respect to individuals with incomes at or below 100% FPL or who are exempted from cost sharing, the state can impose a nominal copayment so long as no cost sharing is imposed to receive such care through an outpatient department or other alternative health care provider in the geographic area of the hospital emergency department involved, and (2) with respect to individuals

with incomes between 100-150% of FPL, the cost sharing can be twice the nominal amount.

In addition, the section should be revised to reduce the copay amount. It does not reflect the reality of ED use by Medicaid beneficiaries. Many Medicaid beneficiaries resort to EDs because they lack access to a regular source of primary care. Those enrolled in MCOs with weak provider networks go to EDs to obtain access to specialty care that is unavailable through FQHCs or other alternative primary care sites. Primary care providers tell their patients, when in doubt, go to the ED, with many leaving a message to that effect on their office voice mails during off hours. The prudent layperson responds to all these situations by going to the ED to obtain care.

### **RECOMMENDATION:**

Amend the table at § 447.54(b) by setting the maximum copayment for individuals with family income at or below 100% FPL at \$3.30; the maximum copayment for individuals with family income from 101-150% FPL at \$6.30; and the maximum copayment for individuals with family income above 150% of FPL at \$12.00.

**RECOMMENDATION:** Amend § 447.54 to add a new section (d) and re-designate the subsequent sections of the regulations, as follows:

***(d) For individuals with family income not exceeding 100 percent of the FPL, the state may impose cost sharing for non-emergency use of the emergency department, not to exceed the amount established in paragraph (b) of this section so long as no cost sharing is imposed to receive such care through an outpatient department or other alternative health care provider in the geographic area of the hospital emergency department involved.***

§ 447.54(c) and (d)

These subsections contain a typographical error that should be corrected.

### **RECOMMENDATIONS:**

Amend § 447.54(c) as follows: "... not to exceed the maximum amount established in paragraph ~~(a)~~**(b)** of this section...."

Amend § 446.54(d) as follows: "... to impose cost sharing under paragraph ~~(a)~~**(b)** or (c) of this section of non-emergency...."

HHS noted in the preamble to the Proposed Rule that "[a]ny cost sharing included in the state plan would be applied equally to services provided under fee-for-service, managed care, or benchmark coverage." 78 Fed. Reg. at 4661. However, the Proposed Rule

omits (without explanation) the present 42 C.F.R. § 447.60, which applies the requirements set forth in Part 447 to services provided under managed care: “Contracts with MCOs must provide that any cost sharing charges the MCO imposes on Medicaid enrollees are in accordance with the requirements set forth in §§ 447.50 and 447.53 through 447.58 for cost sharing charges imposed by the State agency.”

**RECOMMENDATION:** Restore current § 447.60. If CMS deleted the provision solely because CMS considers this requirement to be imposed independently in 42 C.F.R. Part 438, we request that CMS clarify that point in its Final Rule.

## **§ 447.55 Premiums**

The statute allows premiums to be imposed on qualified individuals with disabilities and working individuals whose incomes exceed 150 percent of FPL. The regulations need to include this income limitation. In addition, the proposed rule § 447.55(a)(2) does not reflect statutory requirements at 42 U.S.C. § 1396o(g)(1)(B) that limit aggregate premium expenses to no more than 7.5% of the individual’s family income up to 450% FPL.

**RECOMMENDATIONS:** Amend § 447.55(a)(2) by adding the following at the end of the paragraph:

***“...on a sliding scale based on income, **except that in the case of individuals who have annual income that does not exceed 450% of the federal poverty line, such premiums do not exceed 7.5% of such income.**”***

Amend § 447.55(a)(4) as follows:

**Qualified disabled and working individuals described in section 1905(s) of the Act *whose income exceeds 150 percent of FPL*, may be charged premiums....**

Medically needy income levels are capped at 133 percent of the AFDC levels in effect on July 16, 1996. As a result, many people who qualify for Medicaid as medically needy have very low incomes. While they are not mandatory categorically needy, their income status can be equally or more dire than a categorically needy person. They will not be able to afford premiums. This section of the regulation should be amended to reflect Congress’ overriding concern that very low income people not be shut out of health care due to enrollment fees or cost sharing.

The provision should also be clear that the premiums can be charged only after the individual has met their spend down amount and is receiving Medicaid (and cannot be included as part of the spend down).



**RECOMMENDATION:** Amend § 447.55(a)(5) as follows:

Medically needy individuals, as defined in §§ 435.4 and 436.3 of this subchapter ***whose family incomes exceed 150 percent of FPL and who have met their spend down liability, if any, as set forth in § 435.831***, may be charged ***premiums*** on a sliding scale....

The regulations provide for a process for waiving premiums in cases of undue hardship. This process should be set forth in the state plan and reflected in state law and other public documents.

**RECOMMENDATION:** Add a sentence at the end of § 447.55(c)(4) as follows:

***This process should be summarized in the state plan.***

### **§ 447.56 Limitations on premiums and cost sharing**

#### **§ 447.56(a)**

Medicaid cost sharing protections related to preventive services must harmonize with the PHSA § 2713 cost sharing prohibitions. We urge HHS to amend Title XIX cost-sharing provisions to clarify that the preventive services included in the essential health benefits are exempt from cost sharing. Otherwise, low income individuals enrolled in Medicaid alternative benefit plans may be responsible for cost sharing for some of the preventive services that are available to higher income individuals in the private market with no cost sharing..

In addition, NHeLP urges HHS to ensure that services provided to pregnant women are comprehensive. In the preamble to previously issued Medicaid eligibility rules, HHS states that it would require states to obtain HHS approval before providing pregnant women more restricted services than offered non-pregnant adults. We urge HHS to include this requirement in the proposed rule.

**RECOMMENDATION:** Amend § 447.56(a)(2) as follows:

- (iii) Preventive services, at a minimum the services specified at § 457.520, provided to children under 18 years of age regardless of family income, ... American Academy of Pediatrics; ~~and~~
- (iv) Preventive services provided in accordance with § 440.347; and***
- (iv) Pregnancy-related services, including those defined at §§ 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered as pregnancy-related, except those services specifically identified in the state plan, and justified to and approved by HHS, as not being related to the pregnancy.***

We also ask HHS to exempt individuals who are receiving Medicaid-covered home and community based long term care services and supports pursuant to a waiver or plan of care. Care and services for these individuals are already adequately, increasingly heavily, vetted during the process used to establish the plan of care. Cost sharing can create significant challenges to the proper execution of the plan of care. Cost sharing, rather than individual need, could drive its development. Take, for example, an individual on SSI (\$716/month) who is enrolled in a Medicaid home and community-based waiver program. The person-centered care team has determined that the plan of care should include physical therapy twice a week. Under HHS' current proposal, this individual would be responsible for payment for \$48.00 in copayment for just the first six weeks for just one service in the plan of care. Under these circumstances, copayments can drive plan development rather than patient need (even with a 5% aggregate cap).

When the substantive cost sharing provisions were first added to the Medicaid Act in the early 1980s, Medicaid coverage of long term community-based care was in its infancy. Now, however, state Medicaid programs across the country have home and community based care options for the elderly, individuals with disabilities, and children with HIV/drug dependence. In many instances, the community setting is a small residential setting where the beneficiary is paying the landlord for room and board, etc. Indeed, many individuals in home and community settings have already been determined to be eligible to retain only limited funds, such as a personal needs allowance or a spousal allowance. For practical purposes, these individuals are financially situated similarly to those in institutional settings. The cost sharing provisions should not raise *Olmstead* issues because they lead individuals into more restrictive settings. See *Fisher v. Oklahoma Health Care Auth.*, 335 F.3d 1175 (10th Cir. 2003). Medicare has recognized this problem by removing Part D copays for home and community based services. See ACA § 3309 (eff. Jan. 1, 2012) (providing that dually eligible individuals who receive Medicaid home and community based services (HCBS), will no longer have a Medicare Part D copayment for their prescription medications). Medicaid should do the same.

Furthermore, states should have the express option to exclude medically frail individuals from cost sharing.

**RECOMMENDATION:** Amend § 447.56(a)(1)(v) as follows:

- (v) Any individual who, as a condition of receiving services in an institution is required to spend all but a minimal amount of the individual's income required for personal needs. ~~At state option, this exemption may be applied to~~ **or** receiving services in a home and community-based setting if they are required to contribute to the cost of their care **or through a Medicaid home and community based services plan of care. If application of cost sharing increases the risk that individuals will be subject to institutional care, the exemption will also be applied to individuals who are medically frail or otherwise individuals with special medical needs as described in § 438.50(d)(3) of this chapter, individuals with serious, complex, or chronic medical conditions, individuals with a physical, intellectual or**

***developmental disability that significantly impairs their ability to perform 1 or more activities of daily living, and individuals with substance abuse disorders.***

Further, the cost sharing requirements need to exempt beneficiaries from cost sharing when their care is the result of a “never event.”

**RECOMMENDATION:** Amend § 447.56(a)(2) by adding new subsection (v) at the end:

- (a)(2) The agency shall not impose cost sharing for the following services: ...  
**(v) *Health care and services associated with “never events” as announced by HHS, including as a result of pressure ulcer stages III and IV during an institutional stay; falls or trauma during an institutional stay; infection after a surgical procedure; administration of incompatible blood; air embolism; and foreign object unintentionally retained after surgery.***

§ 447.56(f)

NHeLP is deeply troubled by new limitations on the application of a 5% aggregate cap on cost-sharing for Medicaid beneficiaries. Whereas current rules at § 447.78(a) and (b) apply this cap broadly, the proposed rule selectively applies this cap. The omission of a 5% aggregate cap for Medicaid beneficiaries below 100% of FPL violates statutory requirements at 42 U.S.C. § 1396o-1(a)(2)(B). The May 2010 final rule that implemented the § 447.78 notes that §§ 1396o and 1396o-1 should not be read in isolation, for to do so “would frustrate the statutory purpose and permit a State to effectively impose aggregate cost sharing far in excess of 5 percent of family income by using the two statutory cost sharing options cumulatively.” (75 Fed. Reg. 30253). This is exactly what the proposed rule would do for any group not listed in § 447.56(f)(2). In HHS’ own words:

Such a result would be an inadequate beneficiary protection and would not achieve the statutory purpose of the aggregate limit. The clear statutory purpose is to limit family cost sharing obligations to 5 percent of family income and that purpose can be achieved only if the aggregate limit applies to all cost sharing imposed under the State plan for all family members, including cost sharing imposed under section 1916. (75 Fed. Reg. 30253)

Such changes significantly erode one of the most critical beneficiary protections and *add* administrative complexity because states will have to employ more complex tracking systems. HHS also pledges in the preamble that the proposed rules will “greatly simplify and streamline the cost sharing regulation ‘in a manner that is consistent with simplicity of administration and the best interests of the recipients,’ in accordance with section 1902(a)(19) of the Act.” (78 Fed. Reg. 4595.) The changes proposed here are most certainly not consistent with § 1902(a)(19), which was *correctly* invoked to explain

the implementation of § 447.78. HHS has provided no rationale to explain this major regulatory change.

Even if HHS elects to continue with a selective application of the 5% aggregate cap, it is imperative for the regulations to apply the cap to all individuals below 100% of FPL. This omission clearly violates 42 U.S.C. § 1396o-1(a)(2)(B), which applies the cap to all individuals covered under § 1396o. We see no alternative interpretation, certainly not one in the best interests of the beneficiary, that would permit a State to apply cost sharing to the very poorest of the poor – individuals below 100% of FPL – without subjecting that cost-sharing to a 5% aggregate cap. As a matter of policy, that the copayment may not be mandatory for them to pay is irrelevant to the effect that unlimited copayments will actually have on these poor who are trying to pay the copay charge.

**RECOMMENDATION:** Delete proposed § 447.56(f)(1) & (2); redesignate paragraphs (3)-(6) as (2)-(5), respectively; and add new § 447.56(f)(1) as follows:

***(f)(1) The total aggregate amount of premiums and cost sharing imposed under sections 1916 and 1916A of the Act for all individuals in a family enrolled in Medicaid may not exceed 5 percent of the family's income for the monthly or quarterly period, as specified by the state.***

If HHS refuses to maintain the current universal cap, it should at the very least amend § 447.56(f)(2), by adding a new subsection (i) and re-designating the subsequent subsections as follows:

***(i) Individuals whose family income does not exceed 100 percent of the poverty line applicable to a family of the size involved minus the MAGI disregard; . . .***

The proposed regulation allows states to “indicate” a process in their state plans for tracking beneficiary premiums or cost sharing that could place beneficiaries at risk of reaching the aggregate limit. This instruction is too vague and will mean that, in many states, there will be no state plans, yet beneficiaries will be approaching and exceeding the aggregate cap. The regulation needs to close the loop by establishing a clear requirement.

**RECOMMENDATION:** Amend § 447.56(f)(3) as follows:

~~If the state adopts premiums or cost sharing rules that could place beneficiaries at risk of reaching the aggregate family limit,~~ ***The state plan must indicate set forth a process to track . . . that does not rely solely on beneficiary documentation. Beneficiaries must be informed of the process and how to obtain ongoing access to it.***

## **§ 447.57 Beneficiary and public notice requirements**

If cost sharing is substantially modified during the SPA review process, the state agency should provide for additional public notice and seek comments on the approach, as modified. Not only is this in the best interests of recipients but it also is consistent with the requirements of the Administrative Procedure Act for proper rule making.

**RECOMMENDATION:** Amend § 447.57(c) by adding a sentence at the end of the paragraph as follows:

***If the proposed SPA is substantially modified as a result of the process described above, the state agency will provide the public with a reasonable opportunity, no less than 30 days, to comment on the revised SPA using the process set forth in this paragraph.***

## **Proposed § 447.58: Use of section 1115 authority**

Rather than remove current § 447.58 and reserve it, we suggest this regulation be used to address to implement long-standing Medicaid Act limitations on waivers to implement copayments that are not consistent with the congressional plan. Since the 1980s, Congress has repeatedly told HHS and the states that it intends the statutory cost sharing rules to apply broadly. In other words, Congress does not expect the cost sharing provisions to be waived very often. The copayment regulations should finally recognize the Congressional directive.

**RECOMMENDATION:** Add a new regulation, as follows:

### ***§ 447.58: Use of waiver authority***

- (1) For populations described in section 1902(a)(10)(A) of the Medicaid Act, deductions, cost sharing or similar charges imposed under any waiver authority of the Secretary, including section 1115 of the Social Security Act, shall be consistent with those prescribed in section 1916 and/or 1916A of the Social Security and part 447 of these regulations, unless the state obtains a waiver for a copayment demonstration project.***
- (2) To be approvable by the Secretary, each such copayment demonstration waiver project must:***
  - (a) Test a unique and previously untested use of copayments;***
  - (b) Be limited to no more than two years;***
  - (c) Provide benefits to affected Medicaid beneficiaries which can reasonably be expected to be equivalent to the risk to such beneficiaries;***
  - (d) Be based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including through use of control groups of similar Medicaid beneficiaries in the geographic area;***

- (e) Be voluntary for Medicaid beneficiaries, unless the state makes provision for assumption of liability for preventable damage to the health of beneficiaries resulting from involuntary participation in the demonstration; and*
- (f) Include an evaluation plan that delineates how and when data will be collected, analyzed and reported. Reports must be posted on a publicly available website.*
- (3) Each state must develop and implement a process for public notice and opportunity for public comment prior to submitting a copayment demonstration waiver project to the Secretary for approval that is consistent with the requirements governing notice and comment for all proposed section 1115 demonstration projects.**

## **PART 457 – ALLOTMENTS AND GRANTS TO STATES**

### **§ 457.60 Amendments**

NHeLP agrees with HHS that the CHIP State Plan Amendment (SPA) approval process should be more efficient and transparent. However, as written, the proposed rule does not specifically address the need for greater transparency.

States vary widely in the transparency and stakeholder involvement in SPA development. At least four states have provisions requiring legislative approval of SPAs, while several others the legislature to be notified before the SPA is submitted to CMS.<sup>16</sup> Some states (e.g. AZ, NY) dedicate a section of their Medicaid agency's website to SPAs submitted to HHS, as well as HHS approval letters. By contrast, the District of Columbia's Department of Health Care Finance declines to publish this information on the agency website, instead providing a list of proposed and pending SPAs to attendees at Medical Care Advisory Committee meetings.

Current federal regulations require information on SPAs be made available to the public in the event HHS disapproves a SPA (42 C.F.R. § 430.62). In addition, some SPAs may also create "rules of general applicability," which typically require formal notice and comment rulemaking, pursuant to a state's Administrative Procedure Act.

HHS has already taken steps to post some approved SPAs on Medicaid.gov. However, post-approval publication has limited value for individuals seeking to provide input on SPAs still in development. The need for transparency is even greater given the trend in Medicaid Act jurisprudence affording SPAs great deference. See *Harris v. Olszewski*, 442 F.3d 456 (6th Cir. 2006). Accordingly, HHS should take this opportunity to require adequate notice and a reasonable public comment period for *all* SPAs.

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<sup>16</sup> See NHeLP's Role of State Law in Limiting Medicaid Changes, available at <http://www.healthlaw.org/images/stories/issues/RoleofStateLawinLimitingMedicaidChanges.pdf>



HHS has ample authority to require such procedures, and has done so using its general authority to promulgate rules “as may be necessary” provided under 42 U.S.C. § 1302(a). For instance, HHS imposed a notice and comment requirement for SPAs implementing 42 U.S.C. § 1396u-7, which authorizes states to implement benchmark coverage for certain populations. See 42 C.F.R. § 440.305(d). Moreover, HHS cites to this same general authority in 42 U.S.C. § 1302(a) when extending public notice and comment procedures for certain alternative benefits plans in proposed § 440.386 (78 Fed. Reg. 4701).

HHS should model the transparency and public comment provisions for SPAs after the recently enacted transparency regulations enacted for § 1115 demonstrations (see 42 C.F.R. § 431.408). These include adequate public notice, a public comment period of at least 30 days, and a report by the state describing compliance with the requirements, including a report of how the state considered public comments. These procedures allow interested stakeholders a meaningful opportunity to evaluate and participate in the SPA development process prior to submission. They also require at least two public hearings at the state level, as well as a second public comment period once the proposal is submitted to HHS.

Notably, the transparency provisions for § 1115 demonstrations are far more robust than those provided for § 1937 benchmark (42 C.F.R. § 440.305(d)) and the proposed public notice provisions in § 440.386. As already explained, proposed § 440.386 is problematic and should not be used as a model for all SPAs. The proposed § 440.386 repeats the language of § 440.305(d) requiring a “reasonable opportunity” for public comment, but then limits the public comment period to just two weeks for certain ABPs which the state Medicaid agency determines provide less coverage or higher cost sharing than existing benchmark plans. No pre-submission notice and comment period would be required for ABPs the state determines are commensurate with, or better than, existing benchmark plans.

First, two weeks is an inadequate amount of time for meaningful stakeholder consideration and input. Second, § 440.386 creates a two tiered process whereby the state’s own evaluation of an ABP determines whether it is subject to public notice and comment. This kind of black box agency determination defeats the very purpose of transparency. Finally, there is no compliance provision to help ensure meaningful participation by the public, unlike the reporting requirement in 42 C.F.R. § 431.412(a)(viii) for § 1115 demonstrations.

All SPAs should be subject to the same transparency and public input procedures, which should be based upon those governing § 1115 demonstrations. At the very least, SPAs that materially change state’s Medicaid program should be subject to increased transparency and stakeholder input requirements.

**RECOMMENDATION:** We recommend amending § 457.60 by designating the introductory paragraph as subsection (a) and adding new subsection (b) to read as follows:

- (b) Transparency and stakeholder input. Prior to submitting a State plan amendment to the Centers for Medicare and Medicaid Services for approval, a State must provide the public with advance notice of the amendment and reasonable opportunity to comment with respect to such amendment.***
- (1) Public notice and comment period. Prior to submitting an application for state plan amendment, the State must provide at least a 30-day public notice and comment period followed by a 15-day period for State review of comments received.***
- (2) The public notice shall include the following information:***
- (i) The proposed state plan amendment and a description of the proposed state plan amendment that contains a sufficient level of detail to ensure meaningful input from the public;***
  - (ii) The locations and Internet address where the proposed State plan amendment is available for public review; and***
  - (iii) Postal and Internet email addresses where written comments may be sent and reviewed by the public, and the time period in which comments will be accepted.***
- (2) Publishing the public notice and public input procedures. The State shall publish its public notice and input process, the proposed state plan amendment, and the relevant Medicaid State plan amendment page(s) in a prominent location on either the main page of the public Web site of the State agency responsible for maintaining the Web page or to a Web page that is linked in a readily identifiable way to the main page of the State agency's Web site. The State must keep the public Web site current throughout the public comment and review process.***
- (3) Documentation of Compliance. When submitting a State plan amendment, the State must include written documentation of the State's compliance with the public notice requirements set forth in § 430.12(d)(1)-(2) of this subpart, with a report on the issues raised by the public during the comment period and how the State considered those comments when developing the State plan amendment. The State shall maintain this Documentation of Compliance on the State's agency Web site for continued public reference.***

#### **§ 457.110 Enrollment assistance and information requirements**

We support the requirements that information must be provided in plain language and accessible to LEP individuals and individuals with disabilities. We recommend adding in additional language to provide more details on the requirements.

**RECOMMENDATION:** Amend § 457.110(a) as follows and renumber proposed (1) and (2) as (5) and (6)

- (a) . . . This information shall be provided in plain language and is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this part ***including the following:***
- (1) for any individual with a disability, information must be provided in an alternative format appropriate for the individual's disability;***
  - (2) for any individual with a visual impairment who is unable to read a standard notice, the agency must provide a notice in a large print, Braille or alternate format appropriate to the individual's disability;***
  - (3) for any individual the agency knows or should reasonably know is LEP, information must be provided in that individual's language; and***
  - (4) for all information, the agency must provide taglines in at least 15 languages informing individuals of the availability of written translations or oral assistance to understand the information provided and a toll-free telephone number to request assistance;***

#### **§ 457.310 Targeted low-income child**

NHeLP strongly supports the amendment to § 457.310(b)(2)(i) indicating that eligibility for limited coverage of family planning under § 435.214 does not preclude an individual from being eligible for CHIP and that an individual can be eligible for both.

#### **§ 457.320 Other eligibility requirements**

The proposed rule provides that when the applicant is a child or is incapacitated, a person acting responsibly for the applicant may declare the applicant's immigration status, provided the responsible person attests to having a reasonable basis to make the declaration. We strongly support this provision as crucial flexibility for enrolling immigrant children and incapacitated individuals in coverage. We question the additional requirement that the application filer attest that he or she has a reasonable basis for making the declaration. If someone is "acting responsibly" for the applicant, then by definition he or she would have a reasonable basis for declaring an applicant's immigration status. To require the attestation places an unnecessary burden on both the application filer and the state agency.

**RECOMMENDATION:** Amend § 457.320(d) to delete the following "provided that such individual attests to having a reasonable basis to make a declaration of such status."

*§ 457.320(c) State option to provide Medicaid and CHIP to lawfully residing non-citizen children or pregnant women*

We support the implementation of the Immigrant Children's Health Improvement Act (ICHIA), CHIPRA § 214, which provides states the option to cover lawfully residing immigrant children and/or pregnant women in Medicaid and CHIP with no waiting

period. The rule requires that states taking up the option must waive the federal five-year waiting period as well as sponsor deeming and other now-obsolete restrictions enacted in the welfare law (limits on payments for not-qualified aliens who meet the lawfully present definition, state options to require 40 quarters of work credit). In addition, under § 435.406(b)(2), states that take up the option must provide all the same services to lawfully present immigrants as the state provides to citizens. We appreciate these statements and support inclusion of this provision.

### **§ 457.330**

We request that this section, regarding certified application counselors in CHIP, be amended consistent with our recommendations for certified application in Medicaid and the marketplaces. The preamble referred to § 457.330 but we did not see any proposed regulatory language. It may be that the cross-reference was to § 457.340 but it is unclear.

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

We support the requirements that information must be provided in plain language and accessible to LEP individuals and individuals with disabilities. We recommend adding in additional language to provide more details on the requirements.

**RECOMMENDATION:** Amend § 457.340(e) by renumbering (1) as (2) and adding as follows:

- (e) . . . The notice must be written in plain language; and accessible to persons who are limited English proficient and individuals with disabilities, consistent with § 435.905(b) of this chapter and § 457.110 of this part ***including the following:***
  - (1) for any individual with a visual impairment who is unable to read a standard notice, the agency must provide a notice in a large print, Braille or alternate format appropriate to the individual's disability;***
  - (2) for any individual the agency knows or should reasonably know is LEP, the notice must be provided in that individual's language; and***
  - (3) for all notices, the agency must provide taglines in at least 15 languages informing individuals of the availability of written translations or oral assistance to understand the information provided and a toll-free telephone number to request assistance;***

### **§ 457.342 Continuous eligibility for children**

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 Eligibility screening and enrollment in other insurance affordability programs**

We support the requirement in subparagraph (h) 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**

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.

### **§ 457.380 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).

### **§ 457.570 Disenrollment protections**

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 enroll 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.

## **PART 155 – EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT**

### **I. General Comments**

We enthusiastically commend HHS for requiring that Exchanges and Exchange Appeals Entities comply with Medicaid's notice and hearing requirements when conducting hearings regarding eligibility for QHPs and premium tax credits and cost sharing reductions. Because the Exchange and Exchange Appeals Entities will be conducting Medicaid hearings, it makes no sense to have two different sets of hearing procedures for different coverage options. It would be unmanageable to administer such a system. Moreover, it would be incredibly confusing to applicants and beneficiaries and conflict with the ACA requirements that there be "no wrong door" and a single, streamlined application process.

Using the Medicaid rules for all hearings also provides necessary protection for applicants and beneficiaries. As HHS has long recognized, the due process protections described in *Goldberg v. Kelly*, particularly the right to a pre-termination hearing, are crucial to ensuring that Medicaid applicants and beneficiaries have the full opportunity to demonstrate that they are entitled to Medicaid and, if they already have coverage, that they are not deprived of necessary medical care while going through the hearing process. The Supreme Court has held that providing continued coverage pending a hearing is necessary because Medicaid beneficiaries will suffer serious harm without the services that they need and, by definition, lack the means to pay for care. *Goldberg v. Kelly*, 397 U.S. 254, 264 (1970). It is likely that many individuals appealing determinations that they are not eligible for QHPs or of the amount of premium tax credits and cost sharing will also have low incomes and will be at risk of harm without the coverage they need. Thus, they will need the *Goldberg* protections just as Medicaid beneficiaries do.

We also strongly support HHS' decision to explicitly require that the hearing system be accessible to persons with LEP and with disabilities.

## **II. Comments on the Proposed Regulations**

### **§ 155.20 Definitions**

Section 155.20 provides that the term, *non-citizen*, has the same meaning as the term “alien,” as defined in 8 U.S.C. §1101(a)(3). It also provides that the term *qualified non-citizen* has the same meaning as the term “qualified alien” as defined at 8 U.S.C. §1641(b) and (c). Finally, the provision defines *citizenship* as including both citizens of the U.S. and non-citizen nationals of the U.S.

The term “alien,” dating from the nineteenth century and used throughout the Immigration and Nationality Act, 8 U.S.C., denigrates immigrants and has declined in usage. It is particularly inappropriate in a health and public benefits context, where governments must strive to overcome barriers to immigrant participation in the programs for which they are eligible.

We support the change to “non-citizen” as well as the inclusion of “nationals” as part of the definition of “citizenship.” We support the replacement of the term “alien” with the preferable term “non-citizen” which can now be used as a technical term of art in health care, increasing the effectiveness of outreach efforts to enroll immigrant families.

We support including “nationals” within the term “citizenship” and the reference to § 435.4 for the definition of “lawfully present.”

Further, immigrants to American Samoa, who are lawfully present under the laws of American Samoa, were previously eligible for Medicaid and CHIP through the SHO, but lacked explicit inclusion in eligibility for the Exchange. The provision at 45 C.F.R. § 155.20, incorporating the same definition for the health insurance Exchanges as is found at 42 C.F.R. §435.4 for Medicaid, ensures the eligibility of individuals who are lawfully present in American Samoa under the laws of American Samoa, in the implementation of the Exchange.

### **§ 155.200 Functions of an Exchange**

NHeLP supports HHS’ proposal to require that Exchanges perform the minimum functions described in subpart F (proposed §§ 155.500-.555). Comments on those proposed sections can be found under the appropriate headings in this letter.

### **§ 155.205 Consumer assistance tools and programs of an Exchange**

We appreciate that HHS recognizes that consumer assistance functions must meet certain standards. We want to ensure that all individuals providing consumer assistance provide equal access to individuals with LEP and individuals with disabilities. Our experience with Medicaid and CHIP programs, however, is that these longstanding obligations for equal access are often poorly implemented. We strongly urge HHS to provide Exchanges with specific guidance and strengthen the training requirements for

navigators and assisters as well as certified application counselors (see our comments to § 155.225).

We recommend that the training process for navigators (as well as assisters and certified application counselors) include specific training components that provide information on how to provide accessible services to individuals with disabilities and culturally and linguistically appropriate services. Training should also include components on how to access and work with interpreters (if competent bilingual staff is unavailable) and how to access and use augmentative and assistive communication devices to assist individuals with disabilities.

And since individuals providing consumer assistance will ultimately assist enrollees with selecting a qualified health plan, we believe HHS should ensure these individuals receive the necessary training to assist enrollees in making effective choices.

**RECOMMENDATION:** Amend § 155.205(d) by adding to subparagraph (1):

- (1) . . . Any individual providing such consumer assistance must be trained regarding:
- (i) QHP options, insurance affordability programs, eligibility ***and retention***, and benefits rules and regulations governing all insurance affordability programs operated in the state, as implemented in the state;
  - (ii) ***How to compare QHPs to find the best plan for the consumers specific needs;***
  - (iii) ***Premiums, cost-sharing, and quality ratings associated with QHPs offered;***
  - (iv) ***How to interpret quality data and cost considerations when comparing plans;***
  - (v) ***How to calculate the actual cost of coverage after credits are applied;***
  - (vi) ***Appeals rights and processes regarding eligibility benefits, insurance affordability programs, tax credits, and exceptions from the mandate penalty;***
  - (vii) ***Complaint rights and process regarding Exchange services;***
  - (viii) ***Referral processes to the HHS Office for Civil Rights of oral or written complaints of discrimination on the basis of race, color, national origin, disability, age, sex, sexual orientation and gender identity;***
  - (ix) ***How to provide applicant- and enrollee-centered services in a culturally and linguistically appropriate manner. The training must include, at a minimum: the requirements of Title VI of the Civil Rights Act of 1964, the Rehabilitation Act, the Americans with Disabilities Act, and section 1557 of the Affordable Care Act; how to access and provide language services; how to access and utilize augmentative and assistive communication devices; how to provide culturally competent services; eligibility requirements for immigrants; and what information is not required for non-applicants, including the***

***Policy Guidance Regarding Inquiries into Citizenship, Immigration Status and Social Security Numbers in State Applications for Medicaid, CHIP, TANF, and Food Stamp Benefits.***

- (x) Referral processes to other programs that aid consumers through the process of acquiring and using health insurance, when the Exchange consumer assistance program cannot help the consumer with their particular need.***

**§ 155.225 Certified Application Counselors**

We appreciate that HHS has reiterated the responsibility of Exchanges to certify application assisters to ensure that their programs provide equal access to individuals with LEP and individuals with disabilities. Our experience with Medicaid and CHIP programs, however, is that these longstanding obligations for equal access are often poorly implemented. We strongly urge HHS to provide Exchanges with specific guidance and urge HHS to apply these requirements to navigators and assisters.

We recommend that the certification process for application counselors (as well as navigators and assisters) include specific training components that provide information on how to provide accessible services to individuals with disabilities and culturally and linguistically appropriate services. Training should also include components on how to access and work with interpreters (if competent bilingual staff is unavailable) and how to access and use augmentative and assistive communication devices to assist individuals with disabilities.

Further, application counselors should have access to population-level data to help determine the needs of the population(s) served. These needs can be based on demographic characteristics such as age, sex, disability, language(s), race/ethnicity, religion, socioeconomic status, education level, sexual orientation, and gender identity. Data sources may include census figures, voter registration data, and school enrollment profiles.

Additionally, many immigrants may apply for assistance for themselves or their family members as part of mixed-status families (with citizen and non-citizen members). Parents in mixed-status households can be afraid to apply for and enroll their family members in health coverage. Mixed-status families can also confront confusing eligibility rules due to language barriers and concerns about adverse “public charge” determinations. Counselors should receive effective training to avoid creating obstacles to their participation. In general, to ensure that counselors comply with civil rights and privacy laws, training should address what questions are, and more importantly are not, required of immigrants and/or non-applicants.

And since the certified application counselors will likely assist enrollees with selecting a qualified health plan, we believe HHS should ensure these individuals receive the necessary training to assist enrollees in making effective choices.

We strongly recommend that the discussion in the preamble about requirements to comply with equal access also appear in the regulatory text.

We also believe that the Exchange requirements in § 155.225 and Medicaid requirements for certifying Certified application counselors and the provisions for CAC assistance in § 435.908 (c)(1) and (2) should be consistent. The current inconsistencies and omissions will create confusion for the entities seeking to serve as CACs, and they may undermine the overall efficacy of CACs' efforts.

**RECOMMENDATION:** Amend § 155.225(b)(2) to read as follows:

- (b) *Standards of certification.* The Exchange must certify an individual to become an application counselor if he or she. . .
  - (2) Is trained regarding:
    - (i) QHP options, insurance affordability programs, eligibility ***and retention***, and benefits rules and regulations governing all insurance affordability programs operated in the state, as implemented in the state;
    - (ii) ***How to compare QHPs to find the best plan for the consumers specific needs;***
    - (iii) ***Premiums, cost-sharing, and quality ratings associated with QHPs offered;***
    - (iv) ***How to interpret quality data and cost considerations when comparing plans;***
    - (v) ***How to calculate the actual cost of coverage after credits are applied;***
    - (vi) ***Appeals rights and processes regarding eligibility benefits, insurance affordability programs, tax credits, and exceptions from the mandate penalty;***
    - (vii) ***Complaint rights and process regarding Exchange services;***
    - (viii) ***Referral processes to the HHS Office for Civil Rights of oral or written complaints of discrimination on the basis of race, color, national origin, disability, age, sex, sexual orientation and gender identity;***
    - (ix) ***How to provide applicant- and enrollee-centered services in a culturally and linguistically appropriate manner. The training must include, at a minimum: the requirements of Title VI of the Civil Rights Act of 1964, the Rehabilitation Act, the Americans with Disabilities Act, and section 1557 of the Affordable Care Act; how to access and provide language services; how to access and utilize augmentative and assistive communication devices; how to provide culturally competent services; eligibility requirements for immigrants; and what information is not required for non-applicants, including the Policy Guidance Regarding Inquiries into Citizenship, Immigration Status and Social Security Numbers in State Applications for Medicaid, CHIP, TANF, and Food Stamp Benefits.***
    - (x) ***Referral processes to other programs that aid consumers through the process of acquiring and using health insurance, when the***



***Exchange consumer assistance program cannot help the consumer with their particular need.***

We also appreciate that HHS notes that application counselors must act “in the best interest of the applicants assisted”. However, we believe that the standard for application counselors should be the same as for navigators which are required to be fair and impartial. Given that applicants likely will not understand the differences between certified application counselors, assisters and navigators, we believe it is important to hold all of them to the highest standard. Further, we do not believe that issuers should be permitted to be certified application counselors. Due to the financial benefit they would reap if an applicant selects the issuer’s plan, it is unlikely they could act in a fair and impartial manner.

**RECOMMENDATION:** Amend § 155.225(b)(5) as follows:

- (5) Agrees to act ***in a fair, accurate and impartial manner*** in the best interest of the applicants assisted;

**RECOMMENDATION:** Amend § 155.225 to add new subsection (f) as follows:

- (f) Issuers shall not be permitted to serve as certified application counselors.***

We also ask HHS to develop a cost estimate for certified application counselors for the Exchange. HHS provided an ICR for Application Assisters in §§ 435.908 and 457.340 (78 Fed. Reg. at 4664; the preamble refers to 435.909 but we believe that is a typographical error as § 435.909 is reserved and § 435.908 address application counselors) but there is no corresponding ICR for § 155.225.

### **§ 155.227 Authorized representatives**

We commend HHS for defining the important term “authorized representative.” We support HHS’s proposal to permit authorized representatives to have full capacity to act on behalf of the consumer, if the consumer so wishes. We support the proposed requirement that the designation of an authorized representative be in writing including a signature or other legally binding format, and that the required representation be accepted through all the modalities described in 45 C.F.R. § 155.405(c). We further support the requirements in proposed paragraph (a)(4) that the Exchange require that the authorized representative comply with all applicable federal and state laws concerning conflicts of interest and confidentiality of information, and that the Exchange ensure that the authorized representative be responsible for fulfilling all responsibilities within the scope of his or her representation to the same extent as the individual he or she represents. We also support HHS’s proposal to ensure that the Exchange rules closely track those for Medicaid.

While the proposed regulation improves on the current regulation, we make the following suggestions for improvements. First, we recommend that the Exchange be required to make clear to both the consumer and the authorized representative the powers and duties of the authorized representative, as well as all other requirements of § 155.227 in a manner that is easily understandable by both parties. The current proposed rule does not require that the Exchange ensure that both the consumer and the authorized representative understand the requirements of § 155.227 regarding timing, scope of representation, or duration.

We also recommend that the regulations clarify that the authorized representative may, but need not, be authorized to have full capacity to act on behalf of the consumer in dealings with Exchanges. There are many instances in which the consumer may wish the authorized representative to have authority over some but not all aspects of interaction with Exchanges. Finally, we recommend that the requirement in proposed § 155.227(d)(2) that the applicant or enrollee notify both the Exchange and the representative that the representative is no longer authorized to act on his or her behalf be removed. There are many reasons that this requirement may be impractical or impossible, including instances where contacting the authorized representative may put the applicant or enrollee at risk of physical or other violence or where the authorized representative is unreachable. The duty to notify the former authorized representative should fall on Exchanges, not consumers.

We further recommend that HHS modify proposed § 155.227 to specify that, where an authorized representative is appointed by legal documentation to act on behalf of an individual under state law as set out in proposed § 155.227(a)(2), the authorized representative shall have an affirmative duty to notify the Exchange and the individual on whose behalf he or she is acting of any revocation or material change in that separate legal authority and that such a material change or revocation shall result in revocation of the authorized representative's authority to act on behalf of the consumer. Finally, we suggest that HHS clarify the circumstances in which legal documentation may serve in the place of an affirmative representation, supported by the signature of the enrollee or applicant, to appoint an authorized representative. There are many types of powers of attorney and not all provide the holder with the authority envisioned by proposed § 155.227.

**RECOMMENDATION:** Amend § 155.227(a)(2) to read as follows:

- (2) Designation of an authorized representative must be in writing, including a signature or through another legally binding format subject to applicable authentication and data security standards. ~~If submitted, legal~~ Legal documentation of authority to act on behalf of an individual under state law, such as a court order establishing legal guardianship or a power of attorney ***authorizing the holder to act on behalf of the consumer in the types of activities permitted under § 155.227(c),*** ~~for,~~ shall serve in the place of the applicant's signature. ***An authorized representative designated pursuant to this paragraph shall notify the Exchange and the individual on whose***

***behalf he or she is acting of any revocation or material change in the underlying legal authority to act on the represented individual's behalf. Such a revocation shall result in revocation of the authorized representative's authority to act on behalf of the consumer for purposes of this section.***

**RECOMMENDATION:** Add new section § 155.227(a)(5) to read as follows:

***(5) The Exchange ensures that both the authorized representative and the represented individual understand the powers and duties of the authorized representative, the time periods in which and manner by which a representative may be designated, and the methods by which the representation may be terminated.***

**RECOMMENDATION:** Amend § 155.227(c) to read as follows:

(c) *Duties.* The Exchange must permit an individual to authorize their representative to ***engage in one or more of the following activities, separately or together.***

...

**RECOMMENDATION:** Amend § 155.227(d) to read as follows:

- (d) *Duration.* The Exchange must consider an authorized representative valid until the applicant or enrollee:
- (1) Modifies the authorization;
  - (2) Notifies the Exchange ~~and the representative~~ that the representative is no longer authorized to act on his or her behalf using one of the methods available for the submission of an application as described in 45 CFR 155.405(c); or
  - (3) The authorized representative informs the Exchange and the individual that he or she is no longer acting in such capacity.

### **§ 155.230 General standards for Exchange notices**

“Plain language” is necessary not only to clearly notify enrollees of their rights, but to properly explain the various health insurance options that may be available to consumers. Communications geared toward LEP persons and persons with disabilities are not only desirable, but required by various laws, including § 2001 of the ACA (enacting Public Health Service Act § 2719, which requires group health plans and health insurance issuers to provide notice of appeal processes in a “culturally and linguistically appropriate manner”); Title VI -- 42 U.S.C. § 2000d, *et seq.*; ACA, § 1557 (42 U.S.C. § 18116, nondiscrimination), and § 504 of the Rehabilitation Act.

## § 155.230(a)

NHeLP supports HHS's proposal to clarify in paragraph (a) that the general standards for notices apply to all notices sent by the Exchange to individuals or employers. We also support HHS' proposal to add new paragraph (a)(1) to require that notices sent by the Exchange must be written and include an explanation of the action reflected in the notice, including the effective date of the action. We further support HHS' proposal to add paragraph (a)(2) to require the notice to include any factual findings relevant to the action, and to revise paragraph (a)(3) to clarify that the notice must include the citation to, or identification of, the relevant regulations supporting the action. 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. Finally, we appreciate HHS' recognition that notices must be provided in plain language and be accessible to LEP individuals and persons with disabilities as civil rights laws demand.

While the proposed regulation improves on the current regulation, we make the following suggestions for improvements. Proposed revised regulatory language is also provided.

**RECOMMENDATION:** Amend § 155.230(a) to read as follows:

- (a) *General requirement.* Any notice required to be sent by the Exchange to individuals or employers must be written and include:
  - (1) An explanation of the action reflected in the notice, including the effective date of the action.
  - (2) Any factual findings relevant to the action.
  - (3) Citations to, or identification of, the relevant **law or** regulation(s) supporting the action.
  - (4) Contact information for available customer service **and consumer assistance** resources.
  - (5) An explanation of appeal rights, if applicable.
  - (6) A clear statement identifying, by name, all persons to whom the notice applies**

## § 155.300 Definitions and general standards for eligibility determinations

In the definition of "Qualifying coverage in an eligible employer-sponsored plan," we recommend against the reference to the affordability standard in 26 C.F.R. 1.36B-2(c)(3). This affordability standard is based on individual coverage when, in many cases, the individual may actually be purchasing family coverage. blocks access to premium tax credits for many families who do not in fact have an affordable insurance available, and worst of all, will lead to uninsurance in families including children. Insurance is an affordability concern at the individual and *family* level, and NHeLP recommends that HHS amend all affordability standards to apply the requirement to both individuals and families.

## **§ 155.302 Options for conducting eligibility determinations**

### **§ 155.302(a)(1)**

We commend the clarification that contracting arrangements must comply with the delegation rules at 42 C.F.R. § 431.10(c)(2).

### **§ 155.302(b)(4)**

NHeLP continues to oppose the policy whereby the Exchange provides individuals with the opportunity to withdraw any appeal of a Medicaid denial. Given that the exchange assessment will not be a determination, and that it will be generally conducted on the basis of a streamlined application that does not obtain the information necessary to make a non-MAGI Medicaid eligibility determination, we believe this policy will lead to Exchanges encouraging Medicaid-eligible individuals to withdraw applications. NHeLP recommends that HHS eliminate the withdrawal opportunity, or in the alternative, limit it to individuals above a certain income threshold that would make them unlikely to be Medicaid eligible (for example, 300% FPL).

If HHS nevertheless retains the withdrawal provision, then NHeLP supports the inclusion of the new language in the proposed regulation:

- Prohibiting the withdrawal if the individuals has been assessed potentially eligible; and
- Requiring that a withdrawn appeal is automatically reinstated if there is a subsequent review of potential Medicaid or CHIP eligibility. We recommend, however, that the subsequent review be defined to include any type of subsequent review, not only the appeals entity suggested in the regulation. We also recommend that the regulation include the language currently contained in the preamble which preserves the original date of application as the date of record.

### **§ 155.302(b)(5)**

NHeLP supports the additional language in §155.302(b)(5) requiring the Exchange to adhere to state Medicaid or CHIP agency appeals decisions.

## **§ 155.305 Eligibility standards**

In the Preamble, 78 Fed. Reg. at 4636, HHS announces that eligibility standards for exemptions under § 5000A of the IRC will be discussed in future regulations. We ask that HHS clarify in forthcoming regulations that the Exchange will not issue certificates of exemption from the shared responsibility payment for exempt noncitizens, consistent with 26 C.F.R. §1.5000A-3(k), which provides that such claims will be available exclusively from the Internal Revenue Service through the tax-filing process.

### § 155.305(a)(3)

We commend the provision of continued eligibility during temporary absence. Continuity of care favors allowing individuals to maintain coverage in their state of residency during such temporary absences. However, we recommend deleting the final clause of the provision (or at least modifying it). We believe states should have generous residency options, and if they do, the final clause would completely undercut the temporary absence rule.

**RECOMMENDATION:** Amend § 155.305(a)(3)(v) as follows:

- (v) *Temporary absence.* The Exchange may not deny or terminate an individual's eligibility for enrollment in a QHP through the Exchange if the individual meets the standards in paragraph (a)(3) of this section but for a temporary absence from the service area of the Exchange and intends to return when the purpose of the absence has been accomplished, ~~unless another Exchange verifies that the individual meets the residency standard of such Exchange.~~

### § 155.305(h)

We support the clarification limiting enrollments into catastrophic plans to QHPs inside the Exchange, as opposed to plans outside the Exchange. Catastrophic plans are a poor coverage option for individuals, and HHS should diminish their use to the extent permissible by the ACA. We recommend that the word “must” in §155.305(h) be changed to “may.”

**RECOMMENDATION:** Amend § 155.305(h) as follows:

- (h) *Eligibility for enrollment through the Exchange in a QHP that is a catastrophic plan.* The Exchange ~~must~~ **may** determine an applicant eligible for enrollment in a QHP through the Exchange in a QHP that is a catastrophic plan as defined by section 1302(e) of the Affordable Care Act, if he or she

## § 155.310 Eligibility process

### §155.310(j)

We understand and accept the need to align § 155.310(j) with the annual redetermination period outlined in § 155.335. However, we do not believe that an individual enrolling prior to their effective annual redetermination date should need to re-attest to their information. If the same individual had been enrolled at the point of their initial determination, they would not have needed review prior to annual redetermination. So the fact that they did not enroll at their initial determination (for example, they may not have had a special enrollment period at the time of that initial application) should not force them through a superfluous attestation.



## **§ 155.315 Verification process related to eligibility for enrollment in a QHP through the Exchange**

If an agency cannot promptly verify an applicant's non-financial information, or if there are inconsistencies in the verification, the agency must then provide a reasonable opportunity to establish eligibility. The Preamble, 78 Fed. Reg. at 4616, seeks comment on two options for the level of promptness in verification that should be required: (1) "promptly and without undue delay," resulting in eligibility at the same level of 'real time' standard applied to applicants generally; and (2) promptness defined as a given number of business days. Enrollment in health coverage is too vital to allow the agency to delay several days. Therefore, we do not support allowing a number of business days to define the concept of "promptly."

### **§ 155.315(b)**

We commend the allowance of 90 days for an individual to resolve inconsistencies with the Social Security Administration. However, we recommend that the provision should allow for additional periods of 90 days when the individual demonstrates good faith effort to resolve the inconsistency, as many of the steps an individual could take may necessitate paperwork and waiting periods outside of the individual's control which may exceed 90 days.

We support the provision defining date of notice as five days after the date of notice, or a later effective date as demonstrated by the individual.

### **§ 155.315(f)**

While we appreciate the additional two day period provided by this provision, we believe the policy is still problematic. The policy allows Exchanges to seek information from individuals when they do not "reasonably expect" to get needed data in two days, but reasonable expectation is difficult to define in this context and the two day period is too important to be skipped at Exchange discretion. NHeLP recommends that the two day period should be required, and extended to five days prior to seeking information from individuals. NHeLP recommends that the burden of resolving inconsistencies should fall first on the Exchanges and only reach individuals when the Exchanges have exhausted all of their means to resolve the inconsistency.

## **§ 155.320 Verification process related to eligibility for insurance affordability programs**

### **§ 155.320(c)**

Subsection 155.320(c) proposes a complex system for verifying income using a combination of data sources and attestations. While we appreciate that HHS has made

significant efforts to emphasize attestations, which we believe will result in a simpler system, we believe system should be improved as follows:

- HHS should ease eligibility rules for individuals who have complied in good faith with the information requests (including attestations), but for whom “data” is unavailable. Vulnerable consumers should not be punished because data systems are inadequate, have occasional glitches, or “the system is down.” Many of these consumers simply will have not alternate ways to prove their income. We note this is additionally important because § 155.315(f)(3) states that Exchanges *may* extend periods for good-faith compliance, but does not *require* them to do so. If consumers fully comply but are denied because “there was no data,” they will rank the system as a failure.
- This is particularly true where an individual, in good faith, has attested to an *increase* in their income. Such an individual should not face additional delays or barriers based on data limitations.
- We understand the purpose of HHS’ “ten percent” and “significant amount” standards. We support an unambiguous standard. Therefore, we recommend that “significant amount” be abandoned in favor of a percentage. However, we believe that HHS should consistently use a standard higher than “ten percent.” We recommend this threshold should be increased to “twenty percent or more” because many individuals may have fluctuating income and be better predictors of their income (for example, they may know work hours are being reduced or there will be a seasonal decrease in income) than a data source. More importantly, these individuals are complying with the process in good faith, many attesting to increases in income, and therefore implementing a narrower standard creates additional administrative burden with little purpose.
- We are aware that raising the acceptable percentage for discrepancy runs the risk of a greater reconciliation for some individuals. However, we believe this should be cured through better up-front notice, if not more lenient reconciliation rules.
- We recommend that HHS adjust the reasonable compatibility standard to create a standard which is more lenient and which never interferes with eligibility due to minor data discrepancies which do not impact the outcome. We suggest replacing “reasonably compatible” with “significantly and materially incompatible.” Materially incompatible must be specified to mean “making an important change to the outcome.”

**RECOMMENDATIONS:** Amend § 155.320(c)(iii) and (iv) as follows:

(iii) . . .

(B) If data available to the Exchange in accordance with paragraph (c)(1)(ii) of this section indicate that a tax filer’s projected annual household income is in excess of his or her attestation by ***twenty percent or more*** ~~a significant~~

amount, the Exchange must proceed in accordance with § 155.315(f)(1) through (4) of this part.

- (C) If other information provided by the application filer indicates that a tax filer's projected annual household income is in excess of his or her attestation by a **twenty percent or more** ~~a significant amount~~, the Exchange must utilize data available to the Exchange in accordance with paragraph (c)(1)(ii) of this section to verify the attestation. If such data ~~is~~ **are** unavailable or are ~~not~~ **significantly and materially incompatible** ~~reasonably compatible~~ with the applicant's attestation, the Exchange must proceed in accordance with § 155.315(f)(1) through (4) of this part.

- (vi) *Alternate verification process for decreases in annual household income and situations in which tax return data is unavailable.* If a tax filer qualifies for an alternate verification process based on the requirements specified in paragraph (c)(3)(iv) of this section and the applicant's attestation to projected annual household income, as described in paragraph (c)(3)(ii)(B) of this section, is greater than **twenty** ~~ten~~ percent below the annual household income computed in accordance with paragraph (c)(3)(ii)(A), or if data described in paragraph (c)(1)(i) of this section is unavailable, the Exchange must attempt to verify the applicant's attestation of the tax filer's projected annual household income by following the procedures specified in paragraph (c)(3)(vi)(A) through (G).

...

- (C) *Increases in annual household income.* If an applicant's attestation, in accordance with paragraph (c)(3)(ii)(B) of this section, indicates that a tax filer's annual household income has increased or is reasonably expected to increase from the data described in paragraph (c)(3)(vi)(A) of this section to the benefit year for which the applicant(s) in the tax filer's family are requesting coverage and the Exchange has not verified the applicant's MAGI-based income through the process specified in paragraph (c)(2)(ii) of this section to be within the applicable Medicaid or CHIP MAGI based income standard, the Exchange must accept the applicant's attestation for the tax filer's family without further verification, unless the Exchange finds that an applicant's attestation of a tax filer's annual household income is ~~not~~ **significantly and materially incompatible** ~~reasonably compatible~~ with other information provided by the application filer or available to the Exchange in accordance with paragraph (c)(1)(ii) of this section, in which case the Exchange must request additional documentation using the procedures specified in § 155.315(f).

- (D) *Decreases in annual household income and situations in which electronic data is unavailable.* If electronic data are unavailable or an applicant's attestation to projected annual household income, as described in paragraph (c)(3)(ii)(B) of this section, is more than **twenty** ~~ten~~ percent below the annual household income as computed using data sources described in paragraphs (c)(3)(vi)(A) of this section, the Exchange must follow the procedures specified in § 155.315(f)(1) through (4).

(E) If, following the 90-day period described in paragraph (c)(3)(vi)(D) of this section, an applicant has not responded to a request for additional information from the Exchange and the data sources specified in paragraph (c)(1) of this section indicate that an applicant in the tax filer's family is eligible for Medicaid or CHIP, the Exchange must not provide the applicant with eligibility for advance payments of the premium tax credit, ~~or cost-sharing reductions, Medicaid, CHIP or the BHP, if a BHP is operating in the service area of the Exchange.~~ **The Exchange must inform the applicant they appear eligible for Medicaid or CHIP, and offer to transmit their file to the appropriate agency.**

...  
(G) If, at the conclusion of the period specified in paragraph (c)(3)(vi)(D) of this section, the Exchange remains unable to verify the applicant's attestation for the tax filer and the information described in paragraph (c)(3)(ii)(A) of this section is unavailable, the Exchange must **reinitiate verification until the information is verified or the Exchange can demonstrate bad-faith non-cooperation by the applicant** ~~determine the tax filer ineligible for advance payments of the premium tax credit and cost-sharing reductions, notify the applicant of such determination in accordance with the notice requirement specified in § 155.310(g), and discontinue any advance payments of the premium tax credit and cost-sharing reductions in accordance with the effective dates specified in § 155.330(f).~~

#### § 155.320(d)

We are generally supportive of HHS' approach to verifying employer-sponsored insurance. We believe the framework of attestation and data matching is workable. However, we have a few concerns:

- As per our recommendation at § 155.320(c), we suggest that HHS use the term "significantly and materially incompatible" instead of "reasonably compatible."
- More importantly, we disagree with the provision at (d)(3)(iii) for random sampling where an individual has attested and the Exchange simply lacks viable data. Contacts to employers are highly intrusive (there may be confidentiality concerns with provisions such as subpart (G)) and create risks for employees who may have very weak position or status with employers. In this circumstance, where there is no reason to doubt the attestation (and the individual has no way of knowing there will be no viable data source), contacting employers creates an unnecessary administrative step and may create problems for individuals. HHS should eliminate the random sampling process, and instead focus on developing data sources. HHS could create a framework where individuals are offered the choice of having their employer contacted. Individuals who chose not have their employer contacted would be provided notice about, and subject to reconciliation, as addressed by subpart (C).

- Notwithstanding our above suggestion, we are supportive of the approach in subpart (F), relying upon the attestation to trigger eligibility. However, we are concerned with the length of delay involved and recommend the 90-day period be shortened.

**RECOMMENDATIONS:** Amend § 155.320(d)(3) as follows:

(d)(3) *Verification procedures.*

...

- (ii) If an applicant's attestation is ~~not~~ ***significantly and materially incompatible*** ~~reasonably compatible~~ with the information specified in paragraphs (d)(2)(i) through (d)(2)(iii) of this section, other information provided by the application filer, or other information in the records of the Exchange, the Exchange must follow the procedures specified in § 155.315(f) of this subpart.
- (iii) If the Exchange does not have any of the information specified in paragraphs (d)(2)(i) through (d)(2)(iii) for an applicant, and either does not have the information specified in paragraph (d)(2)(iv) for an applicant or an applicant's attestation is ~~not~~ ***significantly and materially incompatible*** ~~reasonably compatible~~ with the information specified in (d)(2)(iv) of this section, the Exchange must ~~select a statistically significant random sample of such applicants and~~ ***offer the applicant the choice of having their employer contacted or proceeding without employer contact. If the applicant chooses to not have the employer contacted, they will be provided notice that they are subject to reconciliation. The Exchange must also –***

- (A) ***If the applicant chooses to have his or her employer contacted,***  
~~Provide~~ provide notice to the applicant indicating that the Exchange will be contacting any employer identified on the application for the applicant and the members of his or her household, as defined in 26 CFR 1.36B–1(d), to verify whether the applicant is enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested;

...

- (F) If, after a period of ~~30~~ **90** days from the date on which the notice described in paragraph (d)(3)(iii)(A) of this section is sent to the applicant, the Exchange is unable to obtain the necessary information from an employer, the Exchange must determine the applicant's eligibility based on his or her attestation regarding that employer.

## § 155.330 Eligibility redetermination during a benefit year

### § 155.330(e)

NHeLP strongly supports the suggestion, in the preamble at 78 Fed. Reg. 4642, to add information about cost-sharing changes to notices sent to consumers. We note that the notice should also include information about the special enrollment period and the deadline to make a decision.

### § 155.330(f)

We support the requirement decisions be in effect as soon as possible (for example, on the first day of following month). While we understand the difficulties related to QHP billing cycles, we believe the HHS framework should prioritize two considerations:

- Decisions which may lead to an individual accessing care should always be resolved in real time (or as soon as possible). For example, a decision which may lead to an enrollment or is based on a reported *decrease* in income should be highest priority.
- For decisions which may lead to disenrollments or which are based on reported *increases* in income, Exchanges should have flexibility to implement changes in administratively convenient timeframes. For example, an individual who is covered and being redetermined suffers no loss if there is a delay in a decision regarding their reported increase in income (provided they are informed of any potential reconciliation).

The HHS rules should emphasize continuity of coverage and would do a disservice to consumers if redetermination led to gaps in coverage. This is particularly true since most—and eventually all—of these decisions should happen in real time.

In § 155.330(f)(2)(ii) we recommend clarifying that an appeal decision pursuant to § 155.545(c)(1) would trump the option based on notice date (i.e., It should not be notice “or” appeal decision.)

We support the standard in subpart (f)(3). However, the same policy should not apply in (f)(4), since this would harm continuity of care, as per our description above.

We support the suggestion, in the preamble at 78 Fed. Reg. 4643 that the rule should address effective dates for children in foster care. We emphasize the need to preserve this vulnerable population’s access to benefits in a timely manner.

We are supportive of the approach in subpart (f)(6), although we recommend the regulation more explicitly state that the purpose of the “flexibility” is to allow Exchanges to comply with the need to redress errors or special problems (such as those described in § 155.420(d)(4)) and should be used only for that purpose.



### **§ 155.335 Annual eligibility redetermination**

We commend the use of the term “qualified individual” instead of “enrollee” throughout this provision, so that individuals who are found eligible but do not actually get enrolled do not have to resubmit information when they may later be considered for enrollment.

We do not support HHS’ new subsection § 155.335(m). We understand the concerns about the administrative costs associated with conducting redeterminations. However, many individuals are likely to be confused about annual enrollment periods and the application process. HHS should err on the side of repeated follow-up with individuals who have tried to apply for benefits. We recommend subsection (m) should be deleted, or at least modified to only allow a state exchange to stop redetermining a qualified individual after three annual redeterminations without an enrollment.

**RECOMMENDATION:** Delete § 155.335(m).

### **§ 155.345 Coordination with Medicaid, CHIP, the basic Health Program, and the Preexisting Condition Insurance Plan**

We support the minor changes to subparts (a)(1) and (a)(2) and commend the emphasis on clearly delineated responsibilities and transparency with HHS. However, we strongly recommend that HHS require all such agreements to be publicly available, including by posting to an internet website.

We are generally supportive of the combined eligibility content and notice process proposed in the regulation, including the phased-in approach. We make a few recommendations:

- While we recognize that a phased-in approach may be necessary for coordinated notices, HHS should clarify that this does not diminish the ACA’s general requirement for coordination between the Exchange and Medicaid from the first day of open enrollment in October 2013.
- We strongly recommend that HHS ensure that, whichever agency is issuing the combined content and notice, the notice must include complete information about full Medicaid appeal rights.
- We remain particularly concerned that individuals eligible for Medicaid on a non-MAGI basis will not be appropriately screened and enrolled in the coverage that best meets their needs. We recommend that HHS ensure that, whichever agency is issuing the combined content and notice, it contain a clear statement that the individual might be eligible for additional benefits and more affordable coverage, and specify how the individual can be screened.

We support the new provisions requiring notice of information receipt (subparagraph (g)(2)), a streamlined process (subparagraph (g)(6)) and combined eligibility notice (subparagraph (g)(7)), subject to our recommendations above.

### § 155.345(f)

This provision requires the Exchange to have procedures for enrolling, with APTC and cost sharing reductions, immigrants below 100% of FPL who are ineligible for Medicaid or CHIP due to the federal five-year bar. Under § 155.345(g), when an individual applies directly to a Medicaid-, CHIP-, and/or BHP-administering agency, the Exchange enrollment procedures must include notice to that agency, must not duplicate any eligibility and verification findings already made by the transmitting agency, must not request information or documentation already provided to another agency, must determine eligibility without undue delay, and must follow a streamlined process.

We support the requirement at § 155.345(f) for specific Exchange enrollment procedures for very low income immigrants barred from Medicaid by the federal five year waiting period. We also support the following rule at § 155.345(g) proscribing detailed due process rights for Exchange-eligible individuals, such as these vulnerable low-income noncitizens, who apply first at an agency administering Medicaid, CHIP or BHP.

### **§ 155.400 Enrollment of qualified individuals into QHPs**

We commend the addition of the requirement at § 155.400(b)(3) for Exchanges to send updated enrollment and eligibility information without delay.

### **§ 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. While we understand these interests, implementing a plan-specific definition of special enrollment period will be confusing to individuals who will not realize that they may or may not have a special enrollment period depending on who they are and which plan they apply for. We urge HHS to consider an approach that will allow individuals to understand when they can enroll in a plan.

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

In § 155.420(b)(2) we are concerned about the removal of language about APTC and cost-sharing effective dates. While we understand that HHS has a great challenge in aligning timeframes, and doing so in consideration of QHP billing cycles, we recommend against implementing potentially different effective dates for an individual’s enrollment as compared to APTC increases and cost-sharing reductions. Increases in premium and cost-sharing assistance should be contemporaneous with enrollment.

As per our comments above at § 155.330(f)(6), we are supportive of the provision of special effective dates at subpart § 155.420 (b)(2)(iii) for individuals whose enrollments are erroneously handled. However, we believe the flexibility should be explicitly provided only to correct the unfair outcome. Furthermore, we recommend that the effective date should be based on what it would have been without the error, and (b)(1) should only be used when there is no such ascertainable effective date. (i.e., it should not be (b)(1) “or” the date of the triggering event.)

Our comments to subparagraph (b)(4) match our comments to subparagraph (b)(2) above. We recommend that increases in premium and cost-sharing support must have the same effective dates as enrollment.

We support the new proposed references to dependents throughout subparagraph (d).

In subparagraph (d)(1) we support the additional specificity on triggering events regarding minimum essential coverage. We appreciate that the triggering events include the granting of an eligible immigration status or becoming a naturalized U.S. citizen. This rule helps to ensure the immediate enrollment of a previously-ineligible and uninsured immigrants in health coverage as soon as lawful presence is acquired. We thus support §155.420, protecting uninsured immigrants against undue delay in health insurance enrollment once they acquire a lawfully present immigration status.

We commend the new provisions at subparagraph (d)(6)(ii) including a trigger for changes to dependent tax credits or cost-sharing and subparagraph (d)(6)(iii) including a trigger for individuals losing employer sponsored coverage. In particular, we strongly support the provision to allow the process to begin in advance of the end of employer coverage, thereby minimizing gaps in coverage.

We strongly support the new provision at subparagraph (d)(10) for the same reasons described above for subparagraph (d)(6).

We support the requirement that the Exchange must allow a qualified individual to enroll or change from QHP to another if the “qualified individual who was previously not a citizen, national, or lawfully present individual gains such status” and that change in immigration status is listed among the triggering events for a special enrollment period.

Because an individual may become newly lawfully present under immigration law as determined by the U.S. Department of Homeland Security or court order at any time during the year, it is important that such an individual, if otherwise eligible for the Exchange and applicable tax credits, be able to apply and enroll for affordable health care at the time he or she becomes newly eligible rather than requiring that he or she remain uninsured and wait until the open enrollment period.

We appreciate that (d)(9) acknowledges that there are special circumstances under which an enrollee may need to disenroll outside of the regular enrollment period. In our 2011 comments to CMS, we emphasized that a person may need to disenroll if her plan

either does not cover services she needs or if there are no providers willing to offer those services due to religious objections. We urge CMS to issue guidance pertaining to § 155.420(9) to clarify that provider religious objections can be the basis for a special enrollment period.

### **§ 155.430 Termination of Coverage**

NHeLP is concerned with existing and proposed rules regarding termination of coverage as they apply to pregnant women. Specifically, under HHS' proposal a woman could lose eligibility for advance payments of premium tax credits and cost-sharing reductions if she becomes pregnant and is at or below 133% of the FPL (or up to 185% of the FPL, depending on the state), because she would become eligible for Medicaid through the pregnancy-related category of eligibility. While final and proposed regulations purport to require an Exchange to provide a QHP enrollee with the opportunity to stay in her QHP, they do not ensure that a woman will be able to afford to do so. HHS' proposal could force a pregnant woman to either transition to Medicaid or lose or later repay her advanced payment of premium tax credits and cost-sharing reductions. Although Medicaid may be the best option for many women, especially if HHS ensures that states provide comprehensive pregnancy-related services, it will not always be so. HHS' rules should not force a pregnant woman to choose between continuity of care with her current providers and affordability of care under Medicaid (since coverage in the Exchange would be unaffordable without tax credits and cost-sharing reductions).

Further, HHS should work with states to develop new models of integration and coordination that ensure that a woman who becomes eligible for Medicaid on the basis of pregnancy is offered a seamless transition between the Exchange and Medicaid.

### **§ 155.500 Definitions**

We support the regulations providing definitions of the terms “appeal record”, “appeal request”, “appeal entity”, “appellant”, “de novo review” and “evidentiary hearing” as part of the proposed regulations. We are pleased that an appeal request is defined to include any oral or written expression to have an eligibility determination or redetermination reviewed by an appeals entity.

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), § 155.335(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 §§ 155.310(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).~~

## **§ 155.505 General eligibility appeals requirements**

### **§ 155.505(a)**

NHeLP strongly supports the general eligibility appeal requirements in this section and the requirement in subparagraph (a) that they apply to both the HHS and state-based Exchange appeal entities. It is critical that applicants/enrollees have the same due process rights whether they are in the federal or state-based Exchange, or use one or the other appeal system in their state.

We strongly support the proposal to require that Exchange appeals entities meet the fair hearing standards that apply to Medicaid appeals. 78 Federal Register 4648. We believe that your approach not only supports sound and efficient program administration but is constitutionally mandated. To conform to the Medicaid rules and to make explicit the constitutional underpinnings of the Exchange appeals process, we recommend that you cite *Goldberg*, as the Medicaid rules do in 42 CFR § 431.205(d). This is important as an aid to the construction and implementation of the Exchange appeals rules. The Medicaid rules have been interpreted and applied in light of *Goldberg* and its progeny, and Medicaid appeal processes have therefore been shaped not just by the rules but by constitutional case law. If HHS wants the Exchange appeals process to closely track the Medicaid process, the rules should make clear that the same constitutional principles control both types of appeals.

**RECOMMENDATION:** Revise § 155.05(a) as follows:

- (a) *General requirements.*
  - (1) Unless otherwise specified, ...
  - (2) ***The exchange eligibility system must meet the due process standards set forth in Goldberg v. Kelly, 397 U.S. 254 (1970), and any additional standards specified in this subpart.***

§ 155.505(b)

Again we are very supportive of the issues that applicants and enrollees have the right to appeal under the proposed regulations. As stated above, we want to ensure that the issues they can appeal are broadly stated to encompass all actions taken by the Exchange, Medicaid, or other relevant agencies. As written, § 155.505(b) may be read too narrowly to limit the issues or actions that can be appealed. Consistent with those concerns, we have offered some minor edits below.

**RECOMMENDATION:** Amend § 155.505(b) as follows:

- (b) *Right to appeal.* ~~In accordance with § 155.355 and future guidance on section 1311(d)(4)(H) of the Affordable Care Act, an applicant or~~ ***An*** enrollee must have the right to appeal—
  - (1) ...

§ 155.505(c)

We support the options for Exchange appeals to be conducted by either the state-based Exchange or HHS, or both. Having both will give applicants additional appeal rights and a more “local” process to resolve eligibility and related concerns.

The regulations should include the preamble specification, 78 Fed. Reg. at 4648, which provides that the state-based Exchange may authorize an eligible state entity to carry out the appeals function. For example, states that decide to contract with the Medicaid agency appeal entity to consolidate the appeals hearings of Medicaid and the Exchange (e.g. APTCs, CSRs) should have that option in addition to the option the Medicaid agency has to delegate Medicaid appeals to the state-based Exchange entity.

**RECOMMENDATION:** Amend § 155.505(b) as follows:

- (c) *Options for Exchange appeals.* Exchange eligibility appeals may be conducted by—
  - (1) The Exchange, ***or an eligible state entity authorized by the Exchange,*** if the Exchange establishes an appeals process in accordance with the requirements of this subpart; or
  - (2) ...



§ 155.505(d) – (f)

We support the provisions in the paragraphs (d), (e), (f) and (g) addressing “eligible entities,” “authorized representatives,” “accessibility requirements,” and “judicial review.” These are all critical to ensure minimum standards for an appeals entity and effective and meaningful due process.

§ 155.505(f)

The preamble (78 Fed. Reg. at 4649) requests comment on paragraph (f) of the proposed regulation that the appeals processes must be accessible to individuals who are LEP or living with disabilities. We strongly support these requirements. Without such accessibility, the Exchanges will offer substandard assistance to groups of individuals who have a high potential of losing assistance.

In situations where the appeals processes are not accessible – whether due to provision of a notice in a language the individual does not understand or the failure to provide augmentative or assistive communication assistance to an individual with a disability – the appeals process must cease until cured. Further, any actions undertaken during the process must be voided. Only when the state provides a meaningful notice – in an LEP individual’s preferred written language or in an alternative format for an individual with a disability who cannot read regular print – would the notice, and any actions taken pursuant to it, be valid. These requirements apply pursuant to the Title VI of the Civil Rights Act, the Rehabilitation Act, the Americans with Disabilities Act and section 1557 of the ACA. For more information on section 1557, see NHeLP’s [Short Paper 6: The ACA and Application of § 1557 and Title VI of the Civil Rights Act of 1964 to the Health Insurance Exchanges](#). Moreover, courts have recognized that providing information in English to a poorly educated, non-English speaking individual without proper translation or oral interpretation results in “procedural unconscionability.” *Cisneros v. American Gen. Finan. Servs.*, No. C 11-02869 CRB (N.D. Cal. July 24, 2012) (regarding an arbitration provision); see generally, e.g., *Cruz v. Califano*, No 77-2234 (E.D. Penn. 1979) (settlement agreement to provide Spanish-language notices and other assistance in a case challenging Social Security Administration’s English-only appeals process). These and other case examples are on file with NHeLP.

**RECOMMENDATION:** Amend § 155.505(f) as follows:

*Accessibility Requirements.* Appeals processes established under this subpart must comply with the accessibility requirements in § 155.205(c) ***including the following:***

- (1) for any individual with a disability, information must be provided in an alternative format appropriate for the individual’s disability;***
- (2) for any individual with a visual impairment who is unable to read a standard notice, the agency must provide a notice in a large print, Braille or alternate format appropriate to the individual’s disability;***

- (3) for any individual the agency knows or should reasonably know is LEP, information must be provided in that individual's language; and**  
**(4) for all information, the agency must provide taglines in at least 15 languages informing individuals of the availability of written translations or oral assistance to understand the information provided and a toll-free telephone number to request assistance.**

## **§ 155.510 Appeals Coordination**

### **§ 155.510(a)**

We support the provisions in the proposed regulations to require agreements between the appeals entity and the agencies administering the affordability programs regarding appeals processes, including a clear delineation of responsibilities for each entity to support the process. This is critical to ensure that this process works with so many partners involved. It would be important for the agreement delineating the various agencies' responsibilities to be public, so the process and accountability remains transparent. The proposed provision also importantly includes a requirement that the appellants are not burdened by the appeals coordination, including not being asked to provide information that has already been provided once. This is a critical provision to include and we strongly support it. Requiring a prompt issuance of the appeals decision, consistent with the timeliness standards, is also critically important. Finally, requiring compliance with the single state agency provision governing the Medicaid agency coordination of responsibilities in § 431.10(d) is another important part of this paragraph and will help ensure coordination on appeals.

### **§ 155.510(b)**

NHeLP strongly supports this provision. We also strongly support requiring all notices regarding Medicaid or CHIP determinations to conform with Medicaid and CHIP laws and requiring information about the appellant's eligibility determination and information provided be electronically transferred to the appeal entity via secure interface, as applicable. Finally, we endorse, in paragraph (b)(4), the requirement that the Exchange treat any determination by the Exchange appeal entity as potentially ineligible for Medicaid or CHIP as a determination of ineligibility for Medicaid or CHIP. We want it to be made clear that that determination must be included in the relevant written notices that must be provided under the Medicaid /CHIP regulations with the requisite specificity of those notice provisions.

Some questions arise from this paragraph:

- It assumes that the Medicaid eligibility determination has been made by the Exchange, but is it not true that the delegation of Medicaid appeals to the Exchange appeal entity does not necessarily mean the initial determination of eligibility is made by the Exchange?

- Could the Medicaid agency determine eligibility but still delegate the appeals decisions to the Exchange appeals entity, even if a less likely scenario?

In the preamble, 78 Fed. Reg. at 4649, HHS seeks comment on an alternative more specific requirement in paragraph (b)(1) to align with the preamble proposed by Medicaid in which the individual would be informed at the time of the eligibility determination made by the Exchange of his/her right to opt into an appeal of the denial of Medicaid or CHIP eligibility with the Medicaid or CHIP agency. We strongly endorse this approach as it provides more protection for individuals who will need to know about this option at the time of the determination in every case where there is a Medicaid appeal. Information about the right to this opt-in option should also be provided in writing at the time of the determination.

We also recommend that the requirements for agreements include specific mention that the entities must comply with the accessibility requirements for LEP individuals and individuals with disabilities. We thus make the following recommendation.

**RECOMMENDATION:** Amend § 155.510(a) to delete “and” after subsection (2), add “and” after subsection (3) and add new subsection (4):

***(4) Comply with the accessibility requirements as outlined in § 155.205(c) and § 155.505(f).***

## **§ 155.515 Notice of appeal procedures**

### **§ 155.515(a)**

NHeLP commends HHS for requiring that applicants and enrollees receive a notice of appeal at the time of application and again upon determination of eligibility. It is critical to protect the applicant/enrollees’ rights by informing them at multiple points in the process. HHS should modify the final regulation to ensure that written notices are sent out in all circumstances where an applicant or enrollee shall have a right to an appeal pursuant to § 155.505(b).

**RECOMMENDATION:** Amend § 155.515(a) as follows:

- (a) Requirement to providing notice of appeal procedures. The Exchange must provide notice of the appeals procedures ***in writing*** at the time that the –
  - (1)...
  - (2) Notice of eligibility determination is sent under § 155.310(g), § 155.330(e)(1)(ii), § 55.335(h)(1)(ii), or future guidance on exemptions pursuant to section 1311(d)(4)(H) of the Affordable Care Act, ***or upon any action where there is a right to appeal, as provided in accordance with § 155.355 and 155.505(b)(1)-(3).***

§ 155.515(b)

We also strongly support the provision requiring that the notices include an explanation of the applicant/enrollees' appeal rights, procedures for requesting an appeal, the right to representation by legal counsel or an authorized representative, and an explanation of the circumstances under which eligibility may be maintained or reinstated pending appeal, and an explanation that the outcome of the appeal for one household member may result in a change of eligibility for another member and result in a redetermination of eligibility for that other member in accordance with § 155.305. All of these elements of the content of the notice are critical.

It is unclear what HHS meant by "may be handled as a redetermination." Is there another option to this? Would it result in a determination or not? Choosing clearer language, such as "will result in", would be preferable. It is unclear how this provision concerning notice of right to appeal and appeals procedures interacts with the general standards for Exchange notices in § 155.230. Is it contemplated that the notices outlined here would include that content or is this notice in addition to that one?

**RECOMMENDATION:** Include a cross reference to § 155.230 or clarify that these notice content requirements are in addition to those requirements.

We strongly support the inclusion of parameters for notices for appeals. We recommend that the section also specifically require information is accessible to LEP individuals and individuals with disabilities. As we have discussed earlier, this is required to comply with due process requirements of the U.S. Constitution as well as Title VI, the Rehabilitation Act, and section 1557 of the ACA.

**RECOMMENDATION:** Amend § 155.515(b) to delete "and" after subsection (4), add "and" after subsection (5) and add new subsection (6):

- (5) Information in a culturally and linguistically appropriate manner including the following:**
  - (A) for any individual with a visual impairment who is unable to read a standard notice, the agency must provide notice in a large print, Braille or alternate format appropriate to the individual's disability;**
  - (B) for any individual the agency knows or should reasonably know is LEP, the notice must be provided in that individual's language; and**
  - (C) for all notices, the agency must provide taglines in at least 15 languages informing individuals of the availability of written translations or oral assistance to understand the information provided and a toll-free telephone number to request assistance.**

## § 155.520 Appeals requests

### § 155.520(a)

We strongly endorse the provision requiring that the Exchange and appeals entity accept appeal requests by phone, mail, in person or via internet. It is critical to allow people as many avenues as possible to request an appeal. We are also pleased that the Exchange and appeals entity may assist the applicant/enrollee in filing an appeal, must not interfere with the applicant/enrollee's right to make an appeal and must consider it to be a valid appeal if submitted in accordance with the relevant appeal request provisions. It is unclear why an appeal by email, facsimile or other commonly available electronic system would not also be allowed. These should be added to the options for submission to make it consistent with the Medicaid notice provision (see § 431.221).

**RECOMMENDATION:** Amend § 155.520(a) as follows:

- (a) *General standards for appeal requests.* The Exchange and the appeals entity—
  - (1) Must accept appeal requests submitted—
    - (i) By telephone;
    - (ii) By mail;
    - (iii) In person, if the Exchange or the appeals entity, as applicable, is capable of receiving in-person appeal requests; ~~or~~
    - (iv) Via the Internet ***or other electronic means;*** ~~or~~
    - (v) ***Via facsimile.***

### § 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 § 155.505(b), 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.

§ 155.520(c)

We strongly support and endorse the provision requiring that an applicant or enrollee receive 30 days from the date of the state-based Exchange appeals entity's notice of an appeal decision (through any methods listed in (a)(1)) to file an appeal to HHS. This is consistent with the requirements of the ACA and provides an additional avenue for recourse if the person is dissatisfied with the state-based appeal decision.

§ 155.520(d)

We strongly support this provision requiring the appeals entity to send a timely acknowledgment of receipt of the valid appeal request and that the notice contain the information regarding what the appellant is eligible for pending the appeal, including Exchange coverage, APTCs or CSRs or Medicaid. We also strongly endorse the requirement that the appeal entity (both state-based and federal HHS) send timely notice via secure interface of the appeals request and instructions to provide eligibility pending appeal (if applicable) to the Exchange and the Medicaid or CHIP agency. It is critical that this information is shared in a timely way with all impacted agencies and entities so that all agencies are clear of the person's eligibility and that coverage for the appropriate affordability program is in place. We also support the requirement that the appeals entity confirms receipt of records from the Exchange or from the appeals entity to HHS.

We strongly support the provision in subparagraph (d)(2) to require the appeals entity to promptly to provide written notice to an applicant or enrollee of the fact that an appeal request is "invalid" and therefore has not been accepted and why (to inform the applicant/enrollee what was defective), as well as the requirement that the appeals entity accept the amended notice once the defect is cured and it is still submitted timely.

We strongly support the provision in subparagraph (d)(3) to require the Exchange to transmit to the appeals entity (via secure electronic interface) a valid appeal request along with appellant's eligibility records when the Exchange receives such an appeal. We also support the similar provision in subparagraph (d)(4) that requires the state-based appeals entity to transmit the appellant's appeal record and eligibility record to HHS in cases of an appeal request to HHS.

There is not specificity or clarity regarding what is meant by "timely acknowledgement" or "promptly provide" or "promptly confirm" or "without undue delay." This should have a very short time limit of one or two days, especially because this acknowledgment could



be done electronically in most cases. Finally, a requirement in subparagraph (d)(2)(i) regarding the written notice of the “invalid” appeal request should inform the applicant or enrollee that they can cure the defect and resubmit the appeal again as long as it meets the timeliness requirement in this section.

**RECOMMENDATION:** Amend § 155.520(d)(i) as follows:

- (i) Promptly and without undue delay, ***and no longer than one day***, send written notice to the applicant or enrollee that the appeal request has not been accepted, and of the nature of the defect in the appeal request, ***and that the applicant or enrollee can cure the defect and resubmit the appeal again as long as it meets the timeliness requirement***, and

We also recommend that HHS specify that an acknowledgement of an appeal request be provided in a culturally and linguistically appropriate manner, depending on the individual.

**RECOMMENDATION:** Amend § 155.520 to delete “and” after subsection (iii), add “and” at the end of subsection (iv) and add new subsection (a)(i)(v):

***(v) In a non-English language from an LEP individual.***

**RECOMMENDATION:** Amend § 155.520(d)(1) to add “and” at the end of subsection (iv) and add new subsection (d)(1)(v):

- (v) Must provide the timely acknowledgement in a culturally and linguistically appropriate manner including the following:***
  - (A) for any individual with a visual impairment who is unable to read a standard acknowledgement, the agency must provide the acknowledgement in a large print, Braille or alternate format appropriate to the individual’s disability;***
  - (B) for any individual the agency knows or should reasonably know is LEP, the acknowledgement must be provided in that individual’s language; and***
  - (C) for all acknowledgements, the agency must provide taglines in at least 15 languages informing individuals of the availability of written translations or oral assistance to understand the information provided and a toll-free telephone number to request assistance.***

**RECOMMENDATION:** Amend § 155.520(d)(2) to delete “and” after (i), add “and” after (ii) and add new subsection (d)(2)(iii):

- (iii) provide the notice in a culturally and linguistically appropriate manner including the following:***

- (B) for any individual with a visual impairment who is unable to read a standard notice, the agency must provide the notice in a large print, Braille or alternate format appropriate to the individual's disability;**  
**(B) for any individual the agency knows or should reasonably know is LEP, the notice must be provided in that individual's language; and**  
**(C) for all notices, the agency must provide taglines in at least 15 languages informing individuals of the availability of written translations or oral assistance to understand the information provided and a toll-free telephone number to request assistance.**

## **§ 155.525 Eligibility pending appeal**

NHeLP is extremely supportive of this provision concerning continuing eligibility pending appeal, requiring that upon receipt of a valid appeal request or notice of appeal concerning a mid-year or annual redetermination, the Exchange or Medicaid or CHIP, as applicable, must continue to consider the applicant/enrollee eligible while the appeal is pending, consistent with this new provision or the applicable Medicaid /CHIP regulations. Where the applicant is receiving coverage through the Exchange, the Exchange must continue eligibility for enrollment in the QHP, APTC or CSRs, as applicable, at the same level of eligibility as was in place immediately before the redetermination. This requirement is absolutely critical to prevent breaks in health coverage or access to care while an applicant or enrollee appeals a decision they believe to be erroneous and protects the enrollee's status quo while that appeal is being addressed/resolved.

HHS seeks comments at 78 Fed. Reg. 4651 on its decision not to provide benefits pending an appeal for new applicants denied eligibility. This will certainly disadvantage new applicants who will not get coverage while their appeal is pending a final resolution, including those applicants who may receive coverage during an inconsistency period under § 155.315(f)(4) while the Exchange provides an opportunity for the applicant to resolve the inconsistency. However, certainly this situation is different than one where eligibility was already established, and the person was re-determined ineligible. Because of this different standard, there may be justification for not pending the benefits. However, it should be made clear that once the eligibility is determined, after the inconsistency coverage period has ended, that the person should no longer be considered a "new" applicant, and the continuing eligibility pending appeal provision should apply upon an appeal.

## **§ 155.530 Dismissals**

### **§ 155.530(a)**

We believe that paragraph (a) should be revised slightly in the interests of fairness and administrative efficiency. Specifically, we recommend that the appeals entity be permitted, rather than required to dismiss an appeal in the circumstances listed in the paragraph. We propose that paragraph (a)(2), which authorizes dismissal if the

appellant fails to appear at a scheduled hearing, be revised to add the qualifier, “without good cause.” Paragraph (d) already permits a dismissal, including a dismissal for failure to appear, to be vacated upon written request within 30 days and a showing of good cause.

Applied literally, the present language would require the appeals entity to dismiss an appeal, even if it knows that the appellant missed the hearing for good cause, and require the appellant to file a written request to vacate the dismissal. In the experience of Tennessee advocates, low-income appellants often intend to be at a hearing but fail to appear due to illness, car trouble, last minute child care problems, being required to stay at their jobs, etc. They call, or have a friend, as soon as possible after missing the hearing, or just before it is scheduled to start, and explain the circumstances. The hearing entity should not be required to dismiss their appeal and force them to submit a written request to vacate. Such a requirement adds an unnecessary administrative burden on the parties and is especially onerous for people with disabilities or LEP.

Revising this provision as we request would also conform the rule for Exchange appeals with the longstanding rule for Medicaid appeals. See 42 CFR 431.223.

**RECOMMENDATION:** Amend § 155.530(a) as follows:

- (a) *Dismissal of appeal.* The appeals entity ~~must~~ **may** dismiss an appeal if the appellant –  
...  
(2) fails to appear at a scheduled hearing ***without good cause***;

§ 155.530(b) & (d)

We support the provision that the appeals entity must dismiss an appeal if the appeal is withdrawn in writing, the appellant fails to appear at the scheduled hearing (or send counsel or an authored representative), fails to submit a valid appeal request or dies while an appeal is pending, as long as there are adequate protections (including notice, and a good cause exception, as provided in paragraph (b)). We strongly support the requirement in paragraph (b) that the state-based appeal entity provide timely notice to appellant of the reasons for the dismissal, an explanation of the dismissal’s effect on eligibility, and an explanation of how the appellant may show good cause why the dismissal should be vacated (in accordance with paragraph (d)). This notice is critical to protect the rights of an appellant who may not have been aware of the hearing date, or the lack of validity of an appeal, and offers an additional procedural protection against unwarranted dismissals of appropriate appeals. We also strongly support the “good cause” exception language in paragraph (d), which allows a dismissal to be vacated if the appellant makes a written request within 30 days of the notice of dismissal and shows good cause why it should be vacated. Finally, we support the requirement that notice of the dismissal be provided to the Exchange and Medicaid or CHIP agency, as appropriate. This sharing of information is critical in all directions.

We are concerned that the timely notice of dismissal to the applicant not be required to be in writing to ensure such notice is provided. We also believe additional clarity is needed concerning what timely notice means. Finally, we are concerned that the time to vacate a dismissal may be too short, especially in order to provide more time for an individual to seek such a remedy where they may be incapacitated, did not receive notice of the hearing, or some other reason that may justify more time. This seems especially important if this is their only opportunity to appeal and get pending benefits, which is very important. It is also important for the notice to be understood by individuals with disabilities or who are LEP.

**RECOMMENDATION:** Amend § 155.530(b) and (d) as follows:

(b) *Notice of dismissal to the appellant.* If an appeal is dismissed under paragraph (a) of this section, the appeals entity must provide timely **written** notice to the appellant, including—

(d) *Vacating a dismissal.* The appeals entity may vacate a dismissal if the appellant makes a written request within ~~30~~ **90** days of the date of the notice of dismissal showing good cause why the dismissal should be vacated.

**RECOMMENDATION:** Amend § 155.530(b) to delete “and” after subsection (2), add “and” after subsection (3) and add new subsection (b)(4):

**(4) *The information is provided in a culturally and linguistically appropriate manner including the following:***

**(A) *for any individual with a visual impairment who is unable to read a standard notice, the agency must provide the notice in a large print, Braille or alternate format appropriate to the individual’s disability;***

**(B) *for any individual the agency knows or should reasonably know is LEP, the notice must be provided in that individual’s language; and***

**(C) *for all notices, the agency must provide taglines in at least 15 languages informing individuals of the availability of written translations or oral assistance to understand the information provided and a toll-free telephone number to request assistance.***

## **§ 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.

We also recommend that the requirements for informal resolution include specific mention that the entities must comply with the accessibility requirements for LEP individuals and individuals with disabilities. To comply with due process requirements, all individuals must have the ability to participate in the appeals hearing. For LEP individuals and individuals with disabilities, this may require the appeals entity to provide competent interpreters, translated materials, or augmentative and assistive communication devices. If an entity fails to provide needed assistance, the hearing must be postponed (with provision of benefits continuing) or any decision rendered from it must be invalidated.

**RECOMMENDATION:** Amend § 155.535(a) to delete “and” after subsection (3), add “and” after subsection (4) and add new subsection (a)(5):

- (5) The process complies with the accessibility requirements as outlined in § 155.205(c) and § 155.505(f).***

§ 155.535(b)

We support the requirement in paragraph (b) that the appeals entity send written notice to the appellant of the date, time and location or format of the hearing no later than 15 days prior to the date of hearing. We concur with the discussion in the preamble, 78 Fed. Reg. at 4652, that this should provide the appellant with enough time to contact the appeals entity to change the date and time if it is prohibitive of participation for some reason and that the appeals entity should work with the appellant to set a reasonable and mutually convenient date and time. We also concur with the discussion in the preamble that the format of the hearing encompasses telephonic hearings and hearings by video conference. 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.

In addition, HHS should include the language from the preamble that requires the appeals entity to change the date and time if it is prohibitive of participation for some reason and to work with the appellant to set a reasonable and mutually convenient date and time in the regulation itself. Finally, the language from the preamble that requires the hearings be offered in multiple formats and that the hearing may be held in person, if requested by the appellant is necessary to add to the regulation.



**RECOMMENDATION:** Amend § 155.535(b) as follows:

(b) *Notice of hearing.*

**(1)** When a hearing is scheduled, the appeals entity must send written notice to the appellant of the date, time, and location or format of the hearing no later than 15 days prior to the hearing date.

**(2)** *The notice shall inform the appellant that they may request a change of date and time if the hearing date and time are prohibitive or participation and may request the hearing be held in person, if in-person hearings are not held as a routine format.*

We also recommend that the requirements for informal resolution include specific mention that the entities must comply with the accessibility requirements for LEP individuals and individuals with disabilities.

**RECOMMENDATION:** Amend § 155.535(b) to add (3) after “Notice of Hearing” and add new subsection (b)(3):

**(3)** *The notice must be provided in a culturally and linguistically appropriate manner including the following:*

**(A)** *for any individual with a visual impairment who is unable to read a standard notice, the agency must provide the notice in a large print, Braille or alternate format appropriate to the individual’s disability;*

**(B)** *for any individual the agency knows or should reasonably know is LEP, the notice must be provided in that individual’s language; and*

**(C)** *for all notices, the agency must provide taglines in at least 15 languages informing individuals of the availability of written translations or oral assistance to understand the information provided and a toll-free telephone number to request assistance.*

§ 155.535(c)

We strongly endorse the requirements in paragraph (c) about conducting hearings. In particular, we believe that the requirement that the hearings be conducted by impartial hearing officials (or officers) who have not been involved in the eligibility determination or prior appeal decision in the matter is critical to an effective and meaningful consumer protection scheme. Modeling this on Medicaid is very important and will further assist states with aligning their Exchange and Medicaid appeals and hearing process.

We also recommend that the requirements for informal resolution include specific mention that the entities must comply with the accessibility requirements for LEP individuals and individuals with disabilities.

**RECOMMENDATION:** Amend § 155.535(c) to delete “and” after subsection (3) and add new subsection (c)(5) and (6):

- (5) with appropriate language services for LEP individuals including competent interpretation and translated materials at no cost; and**
- (6) with appropriate augmentative or assistive communication devices for individuals with disabilities at no cost.**

§ 155.535(d), (e) & (f)

NHeLP strongly commends and endorses the requirements in paragraphs (d), (e) and (f) of this provision related to the procedural rights of appellant at the hearing, the information and evidence that must be considered, and the standards of review at the hearing. Again, modeling these requirements on Medicaid fair hearing requirements is critical to ensuring a consumer protection scheme that is meaningful and effective. Without the right to review the entire record (including the initial determination and basis for it), present evidence, bring witnesses and cross-examine adverse witnesses, an appeals hearing process would hold little value and legitimacy, as it would not afford the necessary protections for an appellant to make an effective case for him or herself or to understand the basis for the underlying adverse determination or action.

NHeLP also strongly supports the requirements of paragraphs (e) and (f) of this proposed regulation. Requiring the appeals entity to consider the entire record, including any and all additional relevant evidence provided or presented during the appeal and at the hearing, is also critical to ensure a full and meaningful review and impartial process. Similarly, utilizing and requiring a *de novo* standard of review is critical to allow the appellant an opportunity to present their entire case, with all necessary facts and evidence, and affords the hearing officials the necessary ability to review the entire case, including all aspects of the initial determination or other action adverse to the appellant. Including all of these requirements will further make feasible an alignment or consolidation of the Medicaid and Exchange due process systems, both the notice and appeals/hearing process, placing fewer burdens on applicants and enrollees, while creating greater efficiencies and cost-savings for states.

### **§ 155.540 Expedited appeals**

We are extremely supportive of this new regulation which requires that the appeals entity establish and maintain an expedited appeal process for appellants to request in circumstances where there is an immediate need for health services because a standard appeal could seriously jeopardize the appellant’s life or health or ability to attain, maintain, or regain maximum function, as explained by HHS in the preamble, 78 Fed. Reg. at 4652. This provision and the option it provides is critical for applicants who cannot afford to pay out of pocket for urgent health care services and/or do not yet have coverage under any of the affordability programs while they are awaiting resolution of an appeal. This provision is particularly critical in light of HHS’ decision in § 155.525 not to provide eligibility pending appeal for new applicants. It is also important that this

provision parallel those contained in the proposed Medicaid regulations in § 431.224 and § 431.244. We also strongly support the requirement proposed in paragraph (b) that the denial of a request for an expedited appeal be handled under the standard process and that the appeals entity make reasonable efforts to notify the appellant orally or electronically of the denial of the expedited appeal and must provide written notice (electronically or in hard copy) within 2 days of the denial. Knowing the status of that request is critical for appellants and having written notice of the denial within 2 days will ensure it is acted upon promptly. The proposed regulation (paragraph (b)(2)) that requires the notice of the denial of the request for an expedited appeal should include information regarding the reason for the denial, the fact that the appeal will be heard on the standard appeal timeline, and any options appellant may have if she disagrees with the decision (e.g. potentially an informal review process).

**RECOMMENDATION:** Amend § 155.540(b)(2) as follows:

- (2) Make reasonable efforts to inform the appellant through electronic or oral notification of the denial and, if notified orally, follow up with the appellant by written notice within 2 days of the denial, ***including information in the notice stating the reason for the denial, the fact that the appeal will be heard on the standard appeal timeline, and any options the appellant may have if he or she disagrees with the decision.***

We also recommend that the requirements for expedited appeals include specific mention that the entities must comply with the accessibility requirements for LEP individuals and individuals with disabilities. To comply with due process requirements, all individuals must have the ability to participate in the appeals hearing, including an expedited one if the individual's circumstances require it. For LEP individuals and individuals with disabilities, this may require the appeals entity to provide competent interpreters, translated materials, or augmentative and assistive communication devices. If an entity fails to provide needed assistance, the hearing must be postponed (with provision of benefits continuing) or any decision rendered from it must be invalidated.

**RECOMMENDATION:** Amend § 155.540(a) to add at the end

***. . .The process complies with the accessibility requirements as outlined in § 155.205(c) and § 155.505(f).***

**RECOMMENDATION:** Amend § 155.540(b) to add new (3) after "Notice of Hearing":

- (3) ***The notice must be provided in a culturally and linguistically appropriate manner including the following:***
  - (A) ***for any individual with a visual impairment who is unable to read a standard notice, the agency must provide the notice in a large print, Braille or alternate format appropriate to the individual's disability;***

- (B) for any individual the agency knows or should reasonably know is LEP, the notice must be provided in that individual's language; and**  
**(C) for all notices, the agency must provide taglines in at least 15 languages informing individuals of the availability of written translations or oral assistance to understand the information provided and a toll-free telephone number to request assistance.**

**RECOMMENDATION:** Amend § 155.540(a) to add new subsection (a)(1) and (2):

- (1) The expedited appeal must provide with appropriate language services for LEP individuals including competent interpretation and translated materials at no cost; and**  
**(2) The expedited appeal must provide appropriate augmentative or assistive communication devices for individuals with disabilities at no cost.**

### **§ 155.545 Appeal decisions**

#### **§ 155.545(a)**

NHeLP strongly supports the proposed language in paragraph (a) requiring that the appeals decision be based exclusively on information and evidence used to determine eligibility as well as any additional evidence presented during the course of an appeal (including informal review or at the hearing) and the eligibility requirements under Subpart D (Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability Programs) and future guidance on § 1311(d)(4)(H) of the ACA (concerning exemptions). We also strongly support the requirements that the notice of the decision must include a plain language description of the effect of the decision on eligibility, a summary of the facts relevant to the appeal, the legal basis for the decision, and the effective date of the decision. These are all based on the Medicaid fair hearing standards and are critically important elements to ensure an appellant understands how the eligibility rules apply to the facts in the appellant's case, and what the basis for the decision was.

We are also very supportive of the requirement contained in paragraph (a)(6) that requires the state-based Exchange appeals entity to include an explanation of the appellant's right to pursue an appeal at HHS if the appellant is dissatisfied with the hearing decision. This is critical information for any appellant to understanding his/her rights and any options that appellant will continue to have, and so that appellant does not miss any subsequent appeal timeframes.

**RECOMMENDATION:** Add language in the proposed regulation (paragraph (a)(6)) that requires the explanation include the time limits to appeal at HHS.

§ 155.545(b)

We strongly support the requirements in this paragraph that notice of the decision be provided in writing within 90 days of the date an appeal request is received. That said, it is critical that the language “as administratively feasible” be removed as it eliminates all of the gain that the deadline provides, essentially creating a major loophole allowing the standard to be ignored by states if they don’t find it feasible. This is particularly a concern if the exchange appeal entity hears the Medicaid appeal, or if the final proposed Medicaid regulation at 431.244 retains the proposed language requiring issuance of the Medicaid decision by the Medicaid agency 45 days after the exchange appeals entity decision. This could create a serious problem in getting a timely Medicaid hearing decision. It should also be made clear that the Exchange appeal decision timeline does not alter any legal time frames that apply to issuing a Medicaid decision.

We also strongly support the requirement that in cases of an expedited appeal, the appeals entity must issue notice of the decision as expeditiously as possible, but no later than three working days after the appeals entity receives the request for an expedited appeal. We also support the requirement that the appeals entity provide notice to the Exchange or Medicaid or CHIP agency, as applicable.

**RECOMMENDATION:** Amend paragraph (b)(1) as follows:

- (1) Must issue written notice of the appeal decision to the appellant within 90 days of the date an appeal request under § 155.520(b) or (c) is received, ~~as administratively feasible.~~

We also recommend that the requirements for appeals decisions also include specific mention that the entities must comply with the accessibility requirements for LEP individuals and individuals with disabilities.

**RECOMMENDATION:** Amend § 155.545(b) to add new subsection (4):

- (4) Must provide the written notice in a culturally and linguistically appropriate manner including the following:***
  - (A) for any individual with a visual impairment who is unable to read a standard notice, the agency must provide the notice in a large print, Braille or alternate format appropriate to the individual’s disability;***
  - (B) for any individual the agency knows or should reasonably know is LEP, the notice must be provided in that individual’s language.***

§ 155.545(c)

NHeLP strongly supports the requirement that the Exchange or Medicaid/CHIP agency, upon receiving notice of the appeals decision, implement the decision retroactive to the date that the incorrect eligibility determination was made, or at a time determined under timeframes established under § 155.330(f), or in accordance with applicable Medicaid

or CHIP standards (in 42 C.F.R. parts 435 or 457); Yet it is difficult to determine from proposed paragraph (c)(1) exactly when the decision effective date is given different situations described here. NHeLP further supports the requirement that the Exchange or Medicaid re-determine eligibility of family members of appellant's household who have not appealed their own eligibility but whose eligibility may be affected by the appeals decision. While we would normally oppose any more frequent than annual redeterminations, this could help to prevent a family member from having to later pay back APTCs or CSRs if the family member turns out not to be eligible.

The language in (c)(1) should require that the effective date of the appeals decision be the date that the incorrect eligibility determination or other adverse action was taken so as to preserve that date when the appellant should be made whole (to remedy the error). Retroactive coverage to the date of the initial adverse determination is really important so that appellants are not harmed by the delay in getting through the entire appeals process.

**RECOMMENDATION:** Amend § 155.545(c)(1) as follows:

- (1) Implement the appeal decision retroactive to the date the incorrect eligibility determination was made ***other adverse action was taken***, or at a time determined under § 155.330(f), as applicable, or in accordance with the applicable Medicaid or CHIP standards in 42 CFR parts 435 or 457; and . . .

NHeLP also recommends that the appellant be allowed to choose if they want to “opt out” of retroactive coverage to the effective date of the appeal. This would allow an appellant who does not want to be exposed to potential premium payments to opt out of the retro period and just obtain prospective coverage.

### **§ 155.550 Appeal record**

We strongly support this provision requiring that the appeals record be made accessible to appellants at a convenient place and time, subject to privacy and confidentiality laws. We also strongly support the requirement that these appeal records be made publicly accessible. This requirement mirrors that of the Medicaid regulations and is important to give appellants access to their appeals record so appellants can understand what decisions were being made and the facts and law relied on. In addition, requiring that the Medicaid hearing decisions be made public provides transparency that is important to ensure accountability regarding decisions being made by the various agencies and the appeals entities.

### **§ 155.555 Employer appeals process**

As to paragraph (I) of the proposed regulation, concerning implementation of the appeals decision, the preamble seeks comment on two separate options concerning whether employees should have the ability to appeal an Exchange redetermination that results from an employer appeal. We strongly recommend that option one be adopted to



permit employees (and other individuals affected by such a redetermination) with the right to appeal a change in eligibility reflected in the redetermination notice generated by the employer appeal. While employees have the right to participate in the employer appeal, the employee (and other effected family members) may not fully understand or recognize the importance of the provider 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 and they may not understand the impact on their eligibility until they later get notice of the redetermined eligibility as well. It is therefore imperative that an additional right of appeal should be extended to the employee (and all other affected individuals) to protect the due process rights of the employee, even if this may cause an employer to go without an additional appeal if the employee appeal is successful in gaining eligibility for APTCs or CSRs. Given the likely more advanced sophistication of an employer versus a low-income employee, this balancing of interests seems appropriate and fair, while still protecting the interests of both the employer and employee.

## **Collection of Information Requirements**

### **B. ICRs Regarding Medicaid Eligibility and Enrollment**

#### **2. ICRs Regarding Fair Hearing Processes**

As detailed above, we fully support the proposal to require that the hearing system and information must be accessible to LEP individuals and persons with disabilities. And since both Title VI and the Rehabilitation Act have been in force for decades, we agree that the costs of complying with this requirement are exempt from the PRA because states should have been doing this since the 1960's as a usual and customary business practice. While section 1557 of the ACA provides another legal basis to ensure these requirements are met, the underlying responsibilities remain.

#### **5. ICRs Regarding the Availability of Program Information for Individuals who are Limited English Proficient**

As just noted, we believe it was HHS' intent that this section apply to both LEP individuals and individuals with disabilities and are thus basing our comment on that conclusion. We agree that the costs of complying with this requirement are exempt from the PRA because states should have been doing this since the 1960's and 1970's as a usual and customary business practice. While section 1557 of the ACA provides another legal basis to ensure these requirements are met, the underlying responsibilities remain.

## Additional ICR Request

We also ask HHS to develop a cost estimate for certified application counselors for the Exchange. HHS provided an ICR for Application Assistants in §§ 435.908 and 457.340 (78 Fed. Reg. at 4664; the preamble refers to 435.909 but we believe that is a typographical error as § 435.909 is reserved and § 435.908 address application counselors) but there is no corresponding ICR for § 155.225.

## Conclusion

In sum, we are encouraged that elements of the Proposed Rule will enhance and streamline Exchange operations, and particularly vis-à-vis Medicaid and CHIP eligibility and appeals. We hope that you will consider the improvements we have suggested. If you have questions about these comments, please contact Mara Youdelman, [youdelman@healthlaw.org](mailto:youdelman@healthlaw.org), or Leonardo Cuello, [cuello@healthlaw.org](mailto:cuello@healthlaw.org), (202) 289-7661. Thank you for consideration.

Sincerely,



Emily Spitzer  
Executive Director