



February 21, 2013

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Request for Comment Regarding Proposed Rules for 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
File Code CMS-2334-P

Dear Madam Secretary:

Thank you for the opportunity to provide feedback on the proposed rules. We have appreciated the active, ongoing engagement and consultation between Federal and State officials on Exchange and Medicaid implementation issues and we look forward to continued dialogue as we move closer to full implementation.

We appreciate the clarity regarding premium assistance for non-group health plans that permits states to pay QHP premiums. We also appreciate the flexibility the regulations provide around the implementation of hospital presumptive eligibility. However, we have concerns regarding the proposed rules for implementing the appeals process, the alternative benefit set, and premiums and cost-sharing.

Please see our enclosed comments related to the specific sections of the proposed rules. Again, thank you for the opportunity to provide comments.

Sincerely,

A handwritten signature in black ink that reads "James Schowalter".

James Schowalter
Commissioner
Minnesota Management and Budget

A handwritten signature in black ink that reads "Lucinda Jesson".

Lucinda Jesson, JD
Commissioner
Minnesota Department of Human Services

II.B Proposed Rule

1. Appeals

Appeals process; § 155.505, § 55.520, and § 155.550

Section 155.505(c)(2) provides for administrative review of appeals by HHS upon exhaustion of the state based Exchange appeals process. Minnesota respectfully requests that HHS consider granting states a waiver from administrative review of appeals by HHS upon a showing that the state provides comparable measures for administrative or judicial review at the state level. States have established appeals procedures in place for Medicaid programs. Introducing a new federal level layer of appeals would necessitate significant changes to states' established review and appeals processes to accommodate the federal level of review. It also introduces the potential for differing decisions at the state and federal level. Finally, to the extent that states have significant numbers of Medicaid-eligible individuals whose eligibility determinations are made outside of the Exchange, and considering that HHS does not provide administrative review of appeals for all types of Exchange appeals, this requirement results in inconsistent treatment and potential confusion as to which procedural rights are available.

Minnesota has several procedural questions related to §155.505(c)(2). First, does HHS intend to charge states or state-based Exchanges for the cost of administrative review of appeals by HHS upon exhaustion of the state based appeals process? Second, does HHS plan to require states to transmit the appeal record to HHS exclusively through the HUB? Third, will HHS confirm whether it will provide administrative review for appeals upon exhaustion of the state-based appeals process for the following appeal types: MAGI-based Medicaid and CHIP, employer, and SHOP? Finally, we request that HHS release further details regarding its model for administrative review of appeals upon exhaustion of the state-based appeals process.

Regarding § 155.520(d)(3)(ii), which requires the Exchange to transmit an applicant's "eligibility record" to the appeals entity, Minnesota respectfully requests that HHS clarify which data elements and date ranges are encompassed in an "eligibility record."

Minnesota requests that HHS clarify the application of § 155.550(b). Under current state law Minnesota publishes certain appeals decisions, redacted of any personally identifiable information. To the extent that almost all of the information in an appeal record is information about a Medicaid client or Exchange user, the appeal record is available only to that individual, and is generally not publicly accessible. Section 155.550(b) proposes to add a requirement that all appeals records be publicly available within the confines of other state and federal laws regarding privacy and confidentiality. We request that HHS clarify this section to make clear that generally, the only information contained in the record that will be available to the public is the final appeal decision that is redacted to exclude nonpublic data.

2. Notices

Definitions; § 435.4

The definition of "combined eligibility notice" references § 435.917(b)(1)(iii)(D). There is no item (D) in §435.917(b). Please clarify the source for information that can be excluded from the combined eligibility notice if not known to another insurance affordability program.

Notice content; § 435.917

Subsection (c) of § 435.917 requires that notices to individuals whose eligibility is determined on the basis of MAGI rules be provided a plain language description of: non-MAGI bases of eligibility (disability, long-term care, medically needy coverage), along with the level of benefits and services to someone eligible on such other bases.

The information provided must be sufficient to enable individuals to make an informed decision as to whether or not to seek a determination of eligibility on a MAGI-excepted basis. We note that both individuals who are approved for, as well as those who are denied, Medicaid on the basis of the applicable MAGI standard should be provided the information specified, as eligibility on another basis may better meet the individual's needs. We solicit comments on the level of detail which should be required for inclusion in the notice under § 435.917(c).

CMS has also proposed mandating a combined notice by 2015 to such households. We are concerned about the length and capacity of these notices. In addition, it is not possible to explain Medicaid eligibility in a notice in a manner that would enable an informed decision about whether to apply on another basis. We recommend that states be given the flexibility to provide information through other formats, such as directing individuals to the location of such information on a website, or providing a phone number to request further information on this subject.

Requests for comment on combined notices; pages 4602 - 4603

Newly proposed § 435.918(b) requires that notices be sent by regular mail, unless an individual opts to receive notices through a secure electronic format in lieu of regular mail, which remains the default method of notice delivery. Minnesota strongly supports the option of electronic notices. Additionally, Minnesota requests states be given the discretion to make electronic notices the default delivery method for certain individuals, such as those who have eligibility determined via the Exchange website, while still providing all individuals with the option to receive notices through regular mail. Such discretion will allow states to study the delivery options of its own unique population to determine the most effective default delivery method. Furthermore, if delivery method trends evolve in the next few years, such discretion allows states to dynamically adapt its default delivery method to meet the needs of its population.

CMS requests comments on whether information other than notices should be available electronically. Such other information might include renewal reminders, premium information, changes to covered services, benefit information. We strongly support the use of electronic forms at the option of the client.

With regard to an implementation of the mandatory combined notice in 2015, Minnesota prefers the October 2015 date, with the understanding that when possible the state could implement earlier.

3. Medicaid Eligibility Changes under the Affordable Care Act

Individuals excepted from application of MAGI-based methodologies; § 35.601, § 435.602

Regulations for general financial eligibility methods and financial responsibility of relatives are being amended to limit their application to groups or individuals excepted from the application of MAGI rules.

We are, however, concerned that revisions to § 435.602 on financial responsibility of relatives may be too sweeping without a careful evaluation, and without creating the rules that should apply to the MAGI-based groups. For example, § 435.602 contains a provision about married individuals who cease to live together, which applies when one of the couple is in a nursing facility. What will the policy be for a MAGI-based married individual who enters a nursing facility with coverage under his/her benefit set? Does that person remain a member of the MAGI-household and have the same income eligibility as determined by for that household? And if that is the case, what will be the policy for post-eligibility treatment of income of the person who is institutionalized?

We had hoped for guidance on issues previously raised about long-term care services for MAGI individuals. Specifically, states need to know whether the eligibility factors for payment of long-term care services will apply to MAGI individuals whose benefit set contains long-term care services such as nursing home, intermediate care facility, or institutional care equivalent to a nursing facility. Those factors are: asset transfer rules (federal law has no exceptions); home equity limit; and naming the state as the remainder beneficiary on certain annuities.

4. Medicaid Enrollment Changes under the Affordable Care Act needed to achieve coordination with the Exchange

Authorized representative; § 435.923

We appreciate the effort to create uniform standards around the use of authorized representatives. But we note that the discussion refers to requirements about which states would appreciate clarity.

We note that, before data can be released to an authorized representative, the representative must meet the authentication and data security standards of the releasing entity. For example, information relating to an applicant's modified adjusted gross income from the Internal Revenue Service cannot be requested by or released to an authorized representative unless the representative *meets the authentication and security standards* established by the IRS under section 6103 of the Code.

We urge you to clarify these standards to states as soon as possible so that states can complete their process and systems work.

Authorized representative roles, Medicaid and the Exchange; § 435.923 and § 155.227

The provisions for responsibilities of authorized representatives in Medicaid/CHIP and in the Exchange are not entirely consistent with one another:

435.923(b) Representatives may be authorized to –

- (1) Sign an application on the applicant's behalf;
 - (2) Complete and submit a renewal form;
 - (3) Receive copies of the applicant or beneficiary's notices and other communications from the agency;
 - (4) Act on behalf of the applicant or beneficiary in all other matters with the agency.
- (d) The authorized representative –

- (1) Is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation, as described in paragraph (b)(2) of this section, to the same extent as the individual he or she represents;
- (2) Must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding the applicant or beneficiary provided by the agency.

* * *

§ 155.227

- (c) Duties. The Exchange must permit an individual to authorize their representative to:
- (1) Sign an application on the individual's behalf;
 - (2) Submit an update or respond to a redetermination for the individual in accordance with §155.330 or §155.335;
 - (3) Receive copies of the individual's notices and other communications from the Exchange; and
 - (4) Act on behalf of the individual in all other matters with the Exchange.

We seek clarification on whether the scope of the authorization is defined by the client or whether, once invoked, the representative assumes all of the duties named in the regulations, including "all other matters" with either agency.

5. Medicaid Eligibility Requirements and Coverage Options established by other Federal Statutes
Medicaid pregnant women, extended and continuous eligibility; § 435.170

This section implements subsections 1902(e)(5) and (6) on extended and continuous eligibility for pregnant women, as follows:

- (b) Extended eligibility for pregnant women. For a pregnant woman who was eligible and enrolled under subpart B, C, or D of this part on the date her pregnancy ends, the agency must provide coverage for pregnancy-related services in accordance with § 435.116(d)(3) of this part through the last day of the month in which the 60-day post-partum period ends.
- (c) Continuous eligibility for pregnant women. For a pregnant woman who was eligible and enrolled under subpart B, C, or D of this part and who, because of a change in household income, would not otherwise remain eligible, the agency must provide coverage for pregnancy related services in accordance with § 435.116(d)(3) of this part through the last day of the month in which the 60-day post-partum period ends.

Extended eligibility under § 435.170(b), otherwise known as post-partum coverage, does not align with either § 1902(e)(5), which provides that the woman "shall continue to be eligible under the plan, as though she were pregnant, for all pregnancy and post-partum medical assistance under the plan," nor does it align with the newly consolidated pregnant women group under of the final rule. Section 435.116(d)(1) for the consolidated pregnant woman eligibility group mandates full Medicaid coverage as described in paragraph § 435.116(d)(2). The authority used by CMS to consolidate pregnant women categories into one group with a mandatory full Medicaid benefit set should also be applied to the benefits available in the post-partum period.

The provision for continuous eligibility under § 435.170(c), in limiting coverage to pregnancy related services in accordance with § 435.116(d)(3), is also in conflict with the required benefit set for pregnant women under § 435.116(d)(1) and (2), and should be corrected. As written, states would be expected to conduct an eligibility review during pregnancy or post-partum periods to determine if benefits should subsequently be limited to pregnancy-related services, defeating the entire purpose of continuous eligibility.

Reasonable classifications of children; § 435.222

The proposed rule to revise this section of the regulations is intended to comply with the requirement to convert AFDC-related income standards to equivalent standards using MAGI rules. We have no objection to the revision that states using an AFDC-related standard convert that standard to a MAGI-equivalent income level. Because you are touching this regulation, we ask that you make complete corrections to this provision consistent with federal law. Nothing in § 1902(a)(10)(A)(ii)(I) and (IV) of the Social Security Act would limit reasonable classifications of children to the AFDC-related cash program. The revision should indicate that it applies when a state has elected an AFDC-related income standard but should also convey that a state may elect an SSI-related income standard and methodologies.

7. Verification Procedures for Individuals Attesting to Citizenship or Satisfactory Immigration Status Citizenship documentation; § 435.407 and § 435.956

In making changes to citizenship documentation, CMS notes that verification is a one-time event. In re-establishing this requirement in § 435.956(a)(3), the regulation provides: “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 at a renewal of eligibility or subsequent application following a break in coverage.” CMS discusses this and invites comments.

CMS’ policy indicates that states must not submit a citizenship documentation request through the HUB more than once for an individual. We are assuming that HUB verifications occur at the time the application is being submitted. Given the requirement of an online, streamlined application and the expectation of real-time eligibility determinations for most applicants, will states be expected to check their records to ascertain whether citizenship has already been verified and block the citizenship verification request to the HUB for any individual for whom this factor has been previously verified?

CMS requests comments regarding the appropriate verification procedures for qualified non-citizens who are veterans with a discharge characterized as an honorable discharge or are in active duty, as these individuals and their spouses and dependents are exempt from the five-year waiting period applicable to certain qualified noncitizens. We recommend that self-attestation of veteran or active duty status for such noncitizens be accepted, unless the State has information that is not reasonably compatible with such attestation, subject to the requirements of § 435.952.

9. Coordinated Medicaid/CHIP Open Enrollment Process

Coordinated Medicaid/CHIP Open Enrollment Process; § 435.1205

CMS seeks comments on whether states should notify only a subset of applicants about the process to apply for coverage with an effective date in 2013 (i.e., only those applicants who appear to be potentially eligible under 2013 rules based on the available information provided on the single streamlined application).

We believe it would be desirable to target such notification to applicants who appear to qualify under 2013 rules, and that states should be given the option to target such notification. We are doubtful that a rigorous systematic screening to determine potential 2013 eligibility will be possible given other systems changes needed to implement the ACA.

13. Changes to Modified Adjusted Gross Income and MAGI Screen

Five percent disregard; § 435.603(d)

A proposal to change the application of the five percent disregard to MAGI eligibility determinations is described as follows:

Instead of applying the five percent disregard to determine eligibility for a particular eligibility category, we are proposing a policy under which the five percent disregard should be applied when its application affects eligibility on the basis of MAGI. Thus the five percent disregard would be applied not when eligibility for any Medicaid eligibility group is being determined but, rather, when an applicant or beneficiary would otherwise be ineligible for any medical assistance (under any MAGI-based eligibility category in the program). The impact of this change would be that the five percent disregard would apply only to the highest income threshold under a MAGI-based group available for that person.

Given the variations in state Medicaid programs and eligibility groups, we do not believe this limitation in the application of the five percent disregard is administratively possible, nor is it enforceable as written in the proposed regulation. The regulation denies the five percent disregard to an individual's income determination, as provided in federal law. A change in the interpretation of federal law provides people with a basis to challenge a more restrictive application of the disregard, particularly when it affects one's cost sharing or benefit set in a transition from one eligibility group to another group. Additionally, the proposed policy is an unnecessary complication to the previous characterization of a simple across the board disregard and is counterintuitive to the premise of a streamlined simplified eligibility determination. This concept would be quite difficult to explain to consumers. We recommend no change to this regulation.

Exceptions to MAGI; § 435.603(j)(4).

CMS is proposing changes to a final regulation, explained as follows:

Revisions to § 435.603(j)(4) therefore are proposed to clarify that the exception from application of MAGI-based methods applies only in the case of individuals who request coverage for long-term care services and supports for the purpose of being evaluated for an eligibility group for which meeting a level-of-care need is a condition of eligibility or under which long-term care services not covered for individuals determined eligible using MAGI based financial methods are

covered. The exception does not apply to someone eligible using MAGI-based methodologies under a MAGI-based eligibility group which covers the needed long-term care services, simply because the individual requests such services.

We appreciate the clarification but we continue to have concerns about the clarity of this provision, which provides:

§ 435.603(j) . . . (4) Individuals who request coverage for long-term care services and supports for the purpose of being evaluated for an eligibility group for which meeting a level-of-care need is a condition of eligibility or under which long-term care services not covered for individuals determined eligible using MAGI-based financial methods are covered. “Long-term care services” include nursing facility services, a level of care in any institution equivalent to nursing facility services; home and community-based services furnished under a waiver or State plan under sections 1915 or 1115 of the Act; home health services as described in sections 1905(a)(7) of the Act and personal care services described in sections 1905(a)(24) of the Act.

We do not find the additional language or the explanation about this provision helpful to states in resolving how to determine eligibility under § 1915(k) or § 1915(i) state plan options or the interaction of the spousal anti-impoverishment requirements in § 2404 of the ACA, which is also effective January 1, 2014.

Relative to the definition of “long-term care services,” we are confused by the use of different references than the one found in federal law. This exception is described in § 1902(e)(14) of the Social Security Act as:

(D)(iv) Subparagraphs (A), (B), and (C) shall not apply to any determination of eligibility of individuals for purposes of medical assistance for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, home or community-based services furnished under a waiver or State plan amendment under section 1915 or a waiver under section 1115, and *services described in section 1917(c)(1)(C)(ii)*.

The last citation in italics is a state option to elect *other* long-term care services, among them home care and personal care assistance. The limitation in the regulation to two specific items from this cited provision does not appear consistent with the federal statute, and could result in differing interpretations. To avoid confusion, we ask that you use the reference in federal law of section 1917(c)(1)(C)(ii), or explain the rationale for limiting the meaning of those services.

II. Essential Health Benefits in Alternative Benefit Plans

Essential health benefits in Medicaid; § 440.335 and § 440.347

In general, we are supportive of the requirement that Alternative Benefit Sets meet essential health benefits (EHB) requirements; however, we are concerned that the process CMS proposes to demonstrate EHB compliance is too burdensome. Requiring that states begin by using one of the ten commercial benchmark plans as a baseline and build from there is not useful for states that choose to provide the full

Medicaid benefit set under the option for secretary-approved coverage. Beyond providing a comprehensive benefit set, one of the advantages of offering the full Medicaid benefit set to the new adult group is that all Medicaid clients receive the same benefit set. Therefore, states would not have to operationalize a post-eligibility review process to screen for people who may be entitled to opt-out of the alternative benefit set and elect to receive full state plan benefits instead. Given the number of changes that states must implement in 2014, maintaining a single benefit set reduces administrative burden and confusion for clients, and reduces the number of systems changes required. It is essential that whatever process is put in place ensure the ability to maintain a benefit set for the new adult group that is *exactly* the same as the full state plan benefit set.

We are concerned that the process CMS has proposed for states to use the secretary-approved option might actually end up requiring states to have two benefit sets even if the desired outcome is full state plan benefits for everyone. If states must begin building coverage by starting with a “base” benchmark plan and are not given the option to discard elements of the base benchmark plan that are not included in the full state plan benefit set, the result will always be differing Medicaid benefit sets whenever the base benchmark plans include benefits that are not covered in the state plan benefit set. A cursory look through Minnesota’s ten base benchmark plans revealed several services included in the benchmarks but not covered under the full state plan benefit including, diagnosis of infertility (ambulatory patient services - physician services), and detoxification in a non-hospital setting (substance use disorder services).

Applying the current EHB definition, which is based on small group health plans and that HHS developed for commercial products in the private market, needlessly complicates the process of complying with the section 1937 benchmark requirement. The section 1937 benchmark requirement is limited to Medicaid clients and is clearly distinct from the benchmark requirements applied to private market health plans. CMS regulations recognize this distinction as evidenced by the requirement to include Medicaid-specific benefits such as non-emergency transportation and EPSDT benefits. Therefore, it makes sense that mandatory Medicaid benefit set requirements should be an option to serve as the basis for demonstrating EHB compliance under the Secretary-Approved option when such coverage is a variant of a state’s Medicaid state plan benefit set.

We recommend that HHS use its authority to create a second definition of EHB compliance that would be based on the Medicaid mandatory benefit set, limit that definition to the alternative benefit set in Medicaid programs, and allow states to use this benefit set as the basis to build a coverage option for secretary-approved coverage.

III. Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges
B. Proposed Regulations Part 155 – Exchange Establishment Standards and Other Related Standards
Under the Affordable Care Act

Eligibility verification process for insurance affordability programs; § 155.320

Verification rules regarding access to or enrollment in an eligible employer-sponsored plan are consolidated into subsection (d). For states that do not have electronic data sources for this information, and that then rely on the attestation of the filer, CMS is proposing to require such states to conduct checks on a statistically significant random sample of those applicants who attest to lack of access to or

enrollment in an employer-sponsored plan. Rather than a random sample, states should use whatever information they have at their disposal to identify individuals who are likely to have employer-sponsored insurance and to conduct a minimum number of follow-up investigations. Random sampling is not likely to yield important information, and the goal should be to detect and assist individuals who have access to affordable employer-sponsored insurance. States need flexibility to employ more accurate methods of finding individuals with access to employer-sponsored insurance as more information becomes available and as consumers become more familiar with insurance affordability programs and insurance options.

Section IV.B.2

Medicaid Premiums and cost sharing; § 447.55

Subsection (c) of § 447.55 is titled, “Consequences of nonpayment” of premiums. Subsection (c)(3) deals with limitations on charging premiums and should perhaps be moved to another subsection.

There appears to be a typographical error in § 447.55(c)(3). It begins: “With respect to premiums imposed under paragraph (a)(3) . . .” However, the text in (c)(3) describes the rules for charging premiums for the TWWIIA basic coverage group under § 1902(a)(10)(A)(ii)(XV) of the Social Security Act. Therefore, we believe the intended reference is to § 447.55(a)(2).

Requests for comment; page 4658

CMS states that it is considering separate cost sharing for a set of services called “community-based long-term services and supports.” These services might include: personal care, home health, rehabilitative services furnished over an “extended” period of time pursuant to a coordinated plan of care.

. . . [W]e are considering whether it may be more appropriate to define nominal cost sharing differently for community-based long-term care services and supports, or perhaps to refine the treatment of nominal cost sharing generally for a continuous coordinated course of care. We seek comment on these approaches, including how we would define long-term services and supports and the unit of service for which separate cost sharing could be charged.

Given the amount of flexibility in the type of services that might form a “coordinated plan of care” and the fact that no plan of care remains constant for an extended period of time, our impression would be that this proposal would be extremely difficult to administer. Two of the potential services mentioned, home care and rehabilitative services are not necessarily provided for extended periods of time. No mention is made of benefits under a section 1915(i) or 1915(k) state plan option, or the more well-known long-term care community-based services under section 1915(c) or (d) – all benefit packages that may be offered over a longer period than a few months. Perhaps these defined packages are the more appropriate starting place for consideration of separate cost-sharing. Such a proposal would need to take into account the fact that some individuals under these plans contribute to the cost of care.