October 31, 2011

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

Re: Request for Comments Regarding Proposed Rules Regarding Standards Related to Reinsurance, Risk Corridors and Risk Adjustment; the Establishment of Exchanges and Qualified Health Plans; Exchange Functions in the Individual Market: Eligibility Determinations and Exchange Standards for Employers; Medicaid Program: Eligibility Changes under the Affordable Care Act of 2010; and Health Insurance Premium Tax Credits

Dear Madame 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 dialog as these activities progress. We are pleased that the proposed rules acknowledge the diversity of health care markets across the country and provide States with the flexibility needed to meet the unique needs of their residents and health care system.

However, there are components that should be improved to simplify processes for consumers and reduce administrative burden, create more competitive health care markets, improve access to affordable and high quality health care, contain health care costs, and improve the health of the public. We are specifically concerned with the proposed rules that contain significant variation between Medicaid and premium tax credit eligibility. The variations in eligibility, particularly related to household size and calculation of income, will create the need for additional data collection from applicants and discourage people from obtaining coverage. We strongly urge further simplification of the eligibility determination process to achieve greater consistency across Medicaid and premium tax credits.

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

Sincerely,

Mike Rothman, JD Commissioner Department of Commerce	Lucinda Jesson, JD Commissioner Department of Human Services	Edward P. Ehlinger, MD, MSPH Commissioner Department of Health

MINNESOTA COMMENTS ON PROPOSED RULES REGARDING:

- **STANDARDS RELATED TO REINSURANCE, RISK CORRIDORS AND RISK ADJUSTMENT;**
- **THE ESTABLISHMENT OF EXCHANGES AND QUALIFIED HEALTH PLANS;**
- **EXCHANGE FUNCTIONS IN THE INDIVIDUAL MARKET: ELIGIBILITY DETERMINATIONS AND EXCHANGE STANDARDS FOR EMPLOYERS;**
- **MEDICAID PROGRAM: ELIGIBILITY CHANGES UNDER THE AFFORDABLE CARE ACT OF 2010; AND**
- **HEALTH INSURANCE PREMIUM TAX CREDITS**

Risk Adjustment – § 153.300 through § 153.350 and § 153.600 through § 153.620

In general, we support the approach and process for risk adjustment that the U.S. Department of Health and Human Services (HHS) has proposed. Risk adjustment will be critical to protect the individual and small group markets from adverse selection, particularly inside versus outside the exchange. The proposed rule provides reasonable flexibility for States and attempts to build on existing State efforts (e.g., the use of State-based all payer claims databases). However, although we support the general approach in the proposed rule, there are some details that warrant special attention.

We strongly support the requirements in § 153.340 that "the State, or HHS on behalf of the State, must collect risk-related data to determine individual risk scores that form the basis for risk adjustment" and also § 153.610 that "all issuers that offer risk adjustment covered plans must submit all required risk adjustment data for those risk adjustment covered plans in the manner and timeframes established by the State, or by HHS on behalf of the State." We agree with the analysis in the Preamble regarding the risks of using a distributed approach to risk adjustment data. Minnesota's efforts with insurers to submit uniform, standardized claims data from their data warehouses to Minnesota's all payer claims database has demonstrated that there is significant variation in the type, definition, and format of data maintained by insurers. We do not believe that it is practical or cost-effective to use a distributed data model. In addition, there is a significant value from a methodological perspective to having a full patient claims history for risk adjustment that is not possible from a distributed model when individuals change insurers.

We strongly disagree with the data formats proposed in § 153.340(b) to collect the enrollment, claims and encounter data. The regulation proposes to use the ASC X12N 837 Health Care Claims transaction. This transaction set was designed to submit health care claim billing information and encounter information from providers of health care services to payers. It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where there is a need for coordination of benefits. However, the ASC X12N 837 is not ideal for collecting data associated with the adjudication and payment of claims, because the ASC X12N 835 Health Care Claim Payment/Advice is the transaction designed for reporting on the payment of claims. For the collection of medical claims data, we request that HHS use the Uniform Medical Claims Payer Reporting Standard currently under development by ASC X12 and the APCD Council. For the collection of pharmacy claims data, we request that HHS use the Uniform Healthcare Payer Data Standard Implementation Guide being developed by National Council for Prescription Drug Programs (NCPDP) and the APCD Council. For the collection of enrollment data, we request that HHS use the eligibility formats currently supported by the APCD Council.

Minnesota is pleased that the proposed rule allows States with all payer claims databases the ability to propose an alternative State-based risk adjustment approach. However, we request that HHS be more specific about the validation requirements described in § 153.350(a). The additional specificity is necessary to ensure that States currently collecting an all payer claims database have adequate time to incorporate the validation requirements into their data collection process. The specificity will also help to assure insurers and consumers that the risk adjustment process is sufficient to mitigate concerns associated with adverse selection. We also request that HHS consider providing even greater flexibility in forming a State and Federal partnership in the implementation of risk adjustment. HHS should consider a model where HHS collects the data being proposed in § 153.340, but allows the State to use the data and develop an alternate risk adjustment methodology under § 153.330. This model would allow a State to develop a risk adjustment methodology that is tailored to its individual and small group market, but would avoid some of the challenges and costs of developing a full data collection process. This model would also allow States to consider using this data with State Medicaid claims data to establish a risk adjustment strategy that incorporates Medicaid. Individuals eligible for Medicaid or Exchange tax credits are likely to move between the two coverage types over time and thus a risk adjustment method that incorporates that movement may provide a more robust methodology. Lastly, this type of model would also provide data to the States that could be used for quality measurement and monitoring health care markets inside and outside the Exchange.

We recommend that HHS develop a prospective risk adjustment model. A prospective model provides a strong incentive for insurers to assist enrollees with chronic conditions in managing and coordinating their care. A concurrent risk adjustment model can inappropriately reward issuers that have higher costs and sicker patients resulting from the insurer's failure to manage and coordinate care. While limited claims experience and a lack of claims data for the uninsured will be a potential barrier to prospective risk adjustment in 2014, we request that HHS consider other methods of assessing risk, such as a self-reported, enrollee questionnaire. If limited claims experience or interactions with the transitional reinsurance program makes prospective risk adjustment impractical in 2014, we recommend that HHS create a transitional plan that allows for prospective risk adjustment by 2017.

From a methodology perspective, we also suggest that HHS consider specific risk adjustment processes for the Native American population. Under the ACA, Native Americans are not subject to the requirement to maintain minimum essential coverage, they are not subject to cost-sharing, and insurers should include I/T/U providers in their networks to serve Native Americans. These provisions may result in adverse selection and discourage insurers from wanting to enroll and manage the care of these populations. We encourage HHS to consider risk adjustment mechanisms to address this potential for adverse selection.

Exchange Plan Amendment Process – § 155.105

In § 155.105(e), the proposed regulation suggests utilizing the State Plan Amendment process in place for Medicaid and CHIP as a model for evaluating and approving or disapproving Exchange Plan Amendments. The proposed regulation requires States to notify HHS before making any significant changes to an approved Exchange Plan and requires that changes must be approved in writing by HHS before they may go into effect. A dialog between HHS and States is important; however, the timelines in the State Plan Amendment Process that can exceed 180 days are too cumbersome for Exchange Plan Amendments. This timeframe would severely restrict the ability of an Exchange and a State to adapt to changing market conditions, evolving technology and a dynamic

area of law. In keeping with the proposed rule's intent to afford States substantial flexibility, we strongly recommend that a more streamlined approach be considered to allow the Exchange and States to implement changes more quickly and that an expedited review of HHS determinations is included in this process. We support the National Association of Insurance Commissioner's (NAIC) suggestion of a 30-day advance notice requirement in lieu of a filing for approval, which would give HHS the opportunity to raise concerns if it believes a change is not consistent with Federal law.

Functions of an Exchange – § 155.200

The Preamble of the proposed rule states that Exchanges will have a central role in the process of determining an individual's eligibility for enrollment in a Qualified Health Plan (QHP), advance payments of the premium tax credit, cost-sharing reductions, Medicaid, CHIP and a Basic Health Plan (BHP), if a BHP is operating in the service area. Further, it is stated that it is the intent of the Affordable Care Act (ACA) to require the establishment of a system with streamlined and coordinated eligibility and enrollment through which an individual may apply for enrollment in a QHP, advance payments of the premium tax credit, cost-sharing reductions, Medicaid, CHIP, and a BHP and receive a determination of eligibility for any such program. We fully support these provisions of the proposed rule as a streamlined process for eligibility and enrollment broadly will provide a more consumer-orientated approach by simplifying our complex health care system and reducing administrative burdens and unnecessary paperwork and processes. We understand that HHS considered establishing a Federal system for eligibility determination for tax credits. We support the decision that HHS has incorporated into the proposed rules to refrain from isolating this one component of eligibility, as it could create administrative burdens for States to reconcile eligibility determinations for different programs by different entities and would pose challenges for creating a seamless experience for consumers.

The Preamble also notes that the Exchange must implement enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes, information disclosures, and data reporting pursuant to the ACA. It is also noted that future rulemaking is anticipated on these topics and that those rules will include requirements for quality data collection, standards for assessing a QHP's quality improvement strategies, and details on how Exchanges can assess and calculate ratings of health care quality and outcomes using methodologies made available by HHS or alternatives. States vary in regard to the type of information available on quality, cost, and enrollee satisfaction for health insurers and health care providers. In 2008, Minnesota enacted bipartisan nation-leading reforms based on significant prior work by Minnesota's health care industry to improve quality and reduce cost through measurement, transparency, care redesign, and payment reform. These reforms provide market incentives for providers to improve the value of care and for health plans to include and incent consumer use of the most valuable providers in their network. Key components of this reform include new and enhanced measurement activities and transparency of cost and quality information for health care providers. We recommend that future HHS rulemaking acknowledge the efforts of States like Minnesota that have made significant strides in this area and as indicated in the Preamble, allow for State alternatives to HHS methodologies. We stress that HHS should refrain from establishing data collection and assessment standards and methodologies that would prevent States like Minnesota from incorporating our nation-leading reforms into the Exchange to help consumers make more informed health care decisions.

Required Consumer Assistance Tools and Programs of an Exchange – § 155.205

In § 155.205, the proposed rule lists a number of required consumer assistance tools and programs required of an Exchange. One component of this section requires an Exchange to make available the provider directories of QHPs. We strongly support provision of easily comparable provider

information through an Exchange. Information about providers drives consumer decisions and consumers would greatly benefit from one easy, streamlined place to find not only up to date provider availability information, but also apples to apples comparisons of the cost and quality of those providers. This information will help drive market competition by health insurers and health care providers to improve the value of our health care system. One part of Minnesota's 2008 health reforms included the development of a Provider Peer Grouping System to promote quality and transparency in the health care market. This system will provide transparent and apples to apples comparison information about health care value - both cost and quality - for all physician clinics and hospitals based on a composite measure of risk-adjusted cost and quality. This information will start to become available to the public by the end of 2011 and we are pleased that HHS awarded funding as requested in our Level 1 grant application for the inclusion and presentation of this information in connection with QHPs available through the Exchange.

Navigator Program Standards – § 155.210

The Preamble notes that Exchanges must award grant funds to public or private entities to serve as Navigators. We encourage HHS to interpret "grants" to include compensation on a per capita basis for the enrollment and service of individuals (including those enrolling in Medicaid), employees, and employers. To avoid adverse selection with the market outside the Exchange, it will be important that Exchanges have the flexibility to structure Navigator compensation mechanisms in a similar fashion to those that exist outside the Exchange.

The proposed rule includes a number of standards for the Navigator program. In § 155.210(b)(1)(iii), States and Exchanges are permitted to create specific licensing, certification or other standards for Navigators, as long as they are consistent with the ACA. We appreciate the flexibility given to States to develop a Navigator program that is tailored to meet their unique needs. In § 155.210(b)(1)(iv), it is stated that any entity that serves as a Navigator may not have a conflict of interest - receive compensation from an insurer for a QHP - during the term as a Navigator. We support this position and the uniform application of conflict of interest standards to both the individual and SHOP Exchange. Conflict of interest provisions are essential to ensure that consumers of the Exchange receive impartial information.

In § 155.210 (e), the proposed rule prohibits an Exchange from using Federal funds to support the Navigator program, but also considers requiring Exchanges to have their Navigator program operational prior to the initial open enrollment period (October 2013) and before the Exchange begins to generate revenue to support its operations. Minnesota recognizes that the training and deployment of Navigators in 2013 is important to the success of the Exchange and we encourage HHS to work with States on funding issues and mechanisms for this program prior to 2015.

Notices – § 155.230

In § 155.230(a), the proposed rule requires that any notice sent by an Exchange to applicants be in writing. We request that HHS clarify that any notice required of an Exchange may be provided in an electronic written format. The Exchange provides applicants, qualified individuals, qualified employees, qualified employers, and enrollees with new, innovative, and increasingly electronic ways of obtaining health care coverage. In receiving communications about this health care coverage, many individuals will prefer email and short message text notifications to other more traditional forms of communications. The Exchange should be unambiguously permitted to use any of these forms of communication, particularly when requested by an individual. While an Exchange should be required to make reasonable efforts to protect the security and privacy of its communications, individuals should ultimately be able to choose their preferred means of

communication and receiving information. We further request that HHS consider allowing individuals to choose that any Medicaid-related communication that is sent through the Exchange be transmitted in an electronic format that matches the communication preference of the individual. Allowing Exchange consumers to choose their preferred method of communication would provide an enhanced customer service experience, is supported by the Government Paperwork Elimination Act (Pub. L. 105–277), and could also lead to cost savings for the Exchange.

The proposed rule also requires that the Exchange annually re-evaluate the appropriateness and usability of the applications, forms, and notices and in consultation with HHS in instances when changes are made. In the interest of clarity and in keeping with the stated desire to provide States with flexibility in administering Exchanges, we request that the requirement to consult HHS be limited to those changes in applications, forms, and notices which are substantive to the underlying document.

Payment of Premiums – § 155.240
Enrollment of Qualified Individuals Into QHPs – § 155.400
In § 155.240, the proposed rule states that an Exchange may facilitate through electronic means the collection and payment of premiums. The rules also specify that consumers must be able to make premium payments directly to insurers. We appreciate the flexibility to allow the Exchange to act as a pass-through or to collect and distribute premiums to insurers. The benefit of providing premium billing and collection services to the consumer is ease of enrollment, real-time enrollment, and online bill pay. Operationally, premium billing and collection allows the Exchange to determine the effective date of coverage in real-time and provides the Exchange the streamlined ability to track an individual's ongoing coverage status and ensure compliance with Exchange enrollment regulations. Given the advantages of online premium collection and billing, Exchanges should have the ability set this as the default payment mechanism, but also provide consumers the option to pay an insurer directly.

In the area of premium payment, health insurers in Minnesota have expressed concerns about receiving payments from multiple sources. We recommend that an Exchange or a contractor facilitating premium aggregation and payment for the Exchange, with the designation of an insurer, be able to receive premium tax credits from the IRS on the insurer's behalf and aggregate and reconcile individual, Federal, and potentially other sources of premium payment for an individual and subsequently make one complete premium payment to the insurer. This mechanism would simplify the premium payment and reconciliation process, support program integrity by reducing the potential for payment error, facilitate faster real-time enrollment, and make it easier for Exchanges to ensure compliance with Exchange enrollment regulations.

In § 155.240(b), the proposed rule permits Indian tribes, tribal organizations and urban Indian organizations to pay premiums on behalf of individuals. We support this provision and stress that our comments on premium aggregation and reconciliation above are more important in this instance where portions of a premium payment may come from a tribe, individual, and the IRS.

Annual Open Enrollment Periods – § 155.410
Under § 155.410, annual open enrollment periods are specified for enrollment into QHPs for the Exchange. As currently described, it appears that an individual not enrolling during the open enrollment period for the Exchange could get coverage outside the Exchange outside of the open enrollment period and would not have access to premium tax credits or cost-sharing reductions. If a State decides to apply the same open enrollment period to the Exchange and the outside market to

prevent adverse selection, it is unclear whether and what type of coverage could be available to individuals seeking coverage outside of the open enrollment period. Rather than deny coverage to individuals outside of the open enrollment period, States should have the ability to apply rating rules or allow enrollment into a State plan of last resort mechanism that has a premium add on or penalty (such as an existing high risk pool product or the mechanism used for Medicare). We ask that HHS engage in further discussions on this topic with the States, including its relationship to the transitional reinsurance program.

Special Enrollment Periods – § 155.420

In § 155.420, requirements regarding special enrollment periods are specified for individuals to enroll or change enrollment in a QHP. We support the provision in the proposed rule that would limit the special enrollment period due to a loss of coverage only to those with a loss of minimum essential coverage. We agree that there is a risk of adverse selection if individuals who maintained less than minimum essential coverage were granted a special enrollment period based on termination of that coverage; those individuals may wait until experiencing a significant health care need to enroll in a QHP through the Exchange.

Under § 155.420 (d), individuals are allowed to enroll or change enrollment in a QHP as a result of a list of qualifying special events. To prevent adverse selection, we recommend that individuals with a special enrollment period due to a change in dependents or premium tax credits be able to enroll in, but not change their QHP during a special enrollment period. This mirrors standard practice in the market today. For example, individuals are generally not able to change enrollment to a different plan when they get married or have a child; they may add dependents to their current coverage and then change their plan during the next enrollment period. Individuals with a special enrollment period due to a change in cost-sharing reductions should be able to enroll or change enrollment in a QHP as the cost-sharing reductions may warrant a different actuarial plan level, but enrollees should maintain the same insurer to minimize mid-year changes in risk pools and reduce administrative burdens for insurers and Exchanges.

Eligibility for Premium Tax Credit – § 1.36B-2(c)
Functions of a SHOP – § 155.705

Under § 155.705(b)(8), employees of small employers participating in an Exchange may only enroll in QHPs in the small group market, unless a State merges its individual and small group market risk pools. In the Preamble, it is stated that the reason for this provision is to avoid adverse selection. While we are supportive in general of the proposed regulations related to SHOP, this provision was not specifically incorporated into the ACA and it unnecessarily limits the flexibility of States and the health plan choices of small employers and their employees in an unmerged market. Adverse selection is a concern with various provisions of the ACA, but States should have the flexibility to address these concerns as allowed under the law.

Under various Federal laws including HIPAA and ERISA, employers are currently limited in their ability to provide a defined contribution towards individual coverage in markets like Minnesota that do not currently have guarantee issue and modified community rating. The reason for this is that an employer's contribution and/or sponsorship of coverage regardless of whether it is a "group" or "individual" health plan, is considered a group health plan under these Federal laws and group health plans are prohibited from restricting access to or varying premiums based on various health factors including health status. The ACAs provisions requiring individual guarantee issue and modified community rating for individual health plans allow employees of small employers to choose and

utilize tax-preferred employer defined contributions to purchase individual market coverage. The regulations must also provide this flexibility.

ACA § 1515 also supports the proposition that employees of small employers be allowed to purchase health plans outside of the small group risk pool. This section prohibits individuals from using Section 125 plans for the purchase of coverage through the Exchange, likely to prevent the ability to get both the individual premium tax credits under the ACA and also utilize tax preferred individual contributions to a Section 125 plan to pay for Exchange QHP premiums. However, employees of employers offering a group health plan – which includes an employer defined contribution and/or sponsorship of coverage regardless of whether it is a "group" or "individual" health plan - through an Exchange may use a Section 125 Plan to purchase a QHP through the Exchange. Under the ACA, individuals enrolled in a group health plan or eligible for an affordable group health plan with minimal essential coverage are not eligible for the individual premium tax credits. Under defined contribution, eligibility for affordable minimal essential coverage through a group health plan could be determined by assessing whether the employer defined contribution for the lowest cost bronze plan limits employee premium contributions to less than 9.5% of income.

We ask that § 155.705(b)(8) be removed from the proposed rules in order to maximize portability of coverage and provide part-time employees and families with more than one worker the ability to aggregate contributions from multiple employers to purchase one health plan. Portability would allow individuals and families to choose and keep the individual health plan they like if they change jobs, lose their job, or become self employed. If an individual loses their job or becomes self employed and thus does not have an employer contribution, they would potentially be eligible for a premium tax credit and could apply it to the cost of their existing health plan. It also encourages long term relationships with insurers and associated health care providers that provide incentives for care coordination and health improvement. Contribution aggregation could assist part-time workers in affording coverage and may encourage more employers to contribute towards coverage for part-time workers. The aggregation of contributions could also help simplify health care coverage for families with more than one worker and allow for a more cost-effective use of health care resources for these families.

Certification Standards for Qualified Health Plans – § 155.1000

Under § 155.1000(a), a "Multi-State Plan" is defined as a health plan offered by a health insurance issuer under contract with the U.S. Office of Personnel Management (OPM), which must meet all requirements for QHPs. We strongly support this requirement. Applying different standards to Multi-State Plans risks creating a potential for adverse selection and giving some of the largest insurers regulatory advantages over smaller competitors.

Establishment of Exchange Network Adequacy Standards – § 155.1050

In § 155.1050, the proposed rule requires an Exchange to ensure that the provider network of each QHP offers a sufficient choice of providers for enrollees. Network adequacy requirements are an important protection to ensure that consumers have access to critical care when they need it. However, the availability of affordable choices depends on the ability of insurers to offer consumers a choice of different provider networks within an array of QHPs. Limiting network variation may stifle innovation in the private market and prevent the ability to reduce health care costs by encouraging the use of high quality, low cost providers – driving value and improved outcomes. States differ in local health care delivery systems, market conditions, and geographical characteristics. Thus, a national standard would not be sufficiently broad or flexible to address these

differences. We support the State flexibility provided in the proposed regulations on network adequacy.

Marketing of QHPs – §156.225
In §156.225 the proposed rule requires that QHPs comply with existing state laws regarding marketing. We appreciate the deference given to states on the marketing requirements for QHPs. Given that QHPs may be sold both inside and outside the Exchange this flexibility will allow a state to set marketing requirements that are suitable for the entire private market. We also support codification of section 1311(c)(1)(A) prohibiting QHP issuers from employing marketing practices that have the effect of discouraging enrollment of individuals with significant health needs. We would also support a prohibition against unfair or deceptive marketing practices by QHP issuers.

Essential Community Providers – § 156.235
The proposed regulation requires that, "A QHP issuer must include within the provider network of the QHP a sufficient number of essential community providers, where available, that serve predominantly low-income, medically underserved individuals." We are concerned that the regulation limits the requirement to a sufficient number of essential community providers rather than all essential community providers. We believe that this limitation is inconsistent with the requirements in §1311(c)(1)(C) of the ACA. We believe that §1311(c)(1)(C) requires a QHP to contract with all essential community providers that serve predominantly low income and medically underserved individuals where the essential community provider is available in a QHP service area.

We also note that there is no explicit authority in the ACA to limit essential community providers to a sufficient number. Section 1311(c)(2) explicitly states, "Nothing in paragraph (1)(C) shall be construed to require a qualified health plan to contract with a provider described in such paragraph if such provider refuses to accept the generally applicable payment rates of such plan." Section 1311(c)(2) provides evidence that QHPs are required to contract with all essential community providers where available, because it provides the QHP safe harbor from contracting with ECPs if the ECP refuses to accept the generally applicable payment rates of the plan. This provision would be unnecessary if QHPs were not required to contract with all ECPs where available.

CMS argues that requiring all essential community providers would "inhibit attempts to use network design to incentivize higher quality, cost effective care by tiering networks and driving volume to providers that meet certain quality and value goals." There is nothing in the ACA, or our interpretation of the statute, that would prohibit a QHP from tiering an essential community provider, or driving volume away from essential community providers if they fail to meet cost and quality standards.

We also believe that it would be helpful to clarify the regulations related to the inclusion of I/T/U health care providers that serve Native Americans. Representatives from the Minnesota Departments of Commerce, Human Services and Health have started regular consultation meetings with representatives from Tribal governments in Minnesota regarding the development of an Exchange. As a result of these consultations, we recommend that QHPs include I/T/U providers as Essential Community Providers and utilize the Indian Health Care Addendum proposed by the National Indian Health Board.

Termination of Coverage for Qualified Individuals – § 156.270
Under § 156.270 standards are proposed for insurers regarding the termination of coverage of individuals enrolled in QHPs through the Exchange. The ACA and proposed rules require insurers to

provide enrollees receiving advance payments of the premium tax credit with a three-month grace period for non-payment of premium prior to coverage termination. Health insurers in Minnesota have raised concerns about the three-month grace period. While the insurer will receive the tax credit payment during these months, there may be a significant portion of the premium – the enrollee portion – that will remain unpaid. If the tax credit payments do not cover the cost of the incurred claims over this three-month grace period, it is unclear what options insurers will have for repayment. Further, there is concern that this situation creates an opportunity for gaming of the system by allowing individuals to essentially obtain four months of coverage for only one month of premium. In addition, because this policy applies only to tax-credit eligible enrollees it sets up separate processes for individuals at different income levels which may be administratively burdensome for insurers and the Exchange.

We ask that HHS engage in further discussions on this topic with the States. We suggest that the final rule permit States the flexibility to allow insurers to pend claims and retroactively terminate to the last paid date. We further suggest that the final rule specify that the Exchange or QHP issuers may delay a person's reenrollment or require payment of unpaid premiums prior to enrolling in another health plan.

General Comments on the Eligibility and Program Integrity Aspects of:

- **The Establishment of Exchanges and Qualified Health Plans;**
- **Exchange Functions in the Individual Market: Eligibility Determinations and Exchange Standards for Employers;**
- **Medicaid Program: Eligibility Changes under the Affordable Care Act of 2010; and**
- **Health Insurance Premium Tax Credits**

The proposed eligibility regulations are very thorough, and attempt to strike a balance between program simplicity, access to affordable coverage, and program integrity. However, we have concerns that these proposed regulations do not fully achieve the simplification and consistency necessary to coordinate eligibility determinations for Medicaid, eligibility determinations for the tax subsidies, and enrollment in a qualified health plan (QHP). We recommend that HHS and the IRS strive for additional simplification and consistency in order to make eligibility determinations timely, avoid gaps in coverage, minimize the burden on applicants, and reduce the complexity of the system itself. The proposed regulations contain significant variation between Medicaid and premium tax credit eligibility in: 1) the determination of household size; and 2) how income is counted for members of the household. These variations will result in the need for additional data from applicants and other sources for purposes of the Medicaid determination than what is anticipated as needed for the determination of eligibility for premium tax credits. The greater the paperwork burden, the higher the likelihood that people will not complete the steps necessary to obtain health care coverage. We strongly urge HHS and IRS to work with States on the eligibility determination process, with a greater eye toward consistency and simplicity.

We find it unlikely that the majority of eligibility determination can be made on the basis of electronic information alone, and it should be acknowledged that there will be a significant number of applications in which eligibility determinations cannot be made in real time. We have serious concerns about the complexity of determining current income when verification cannot be made by a trusted third party source. The proposed regulations require States to develop methodologies and technologies to essentially create point-in-time tax returns in order to apply the MAGI methodology

for Medicaid determinations. The challenge of accurately estimating MAGI income at a point in time will be significant and will likely be an administrative burden on applicants and States.

We request that HHS and IRS jointly consider additional opportunities for alignment and consistency in the following general areas:

- Household Size - Medicaid eligibility is determined for each unique individual, using information about themselves and individuals in their household, and this will continue using the modified adjusted gross income (MAGI) methodologies. Unlike Medicaid, eligibility for premium tax subsidies is determined for a household.

- Counting Income – Medicaid eligibility is determined using point-in-time income methods. Premium tax credits use retrospective, annual income from the tax return. Even if it is not possible to fully align the difference in methodologies, we request greater simplifications concerning how to easily reconcile the point-in-time income method required in Medicaid with the retrospective, annual income used for purposes of the premium tax credits (e.g., eliminating the exceptions under Medicaid for lump sum income and cash support).

- Program Integrity – The relationship between the proposed Medicaid regulations and existing program integrity requirements have not been adequately defined. We strongly recommend that CMS review and revise the various regulations governing program integrity in Medicaid to ensure that States are not liable for the return of Federal funding or cited for error due to the strong preference in the proposed regulations for self-attestation and electronic verification.

Without greater clarity on these important issues, States will be hard pressed to meet the expectations of both the Federal government and the public for prompt and simplified eligibility determinations.

Eligibility Standards – § 155.305
The meaning of incarceration established by § 155.305(a)(2) does not align with the meaning in Medicaid, which is more restrictive. Medicaid policy defines inmate as a person involuntarily confined, whether under arrest, awaiting disposition of charges, awaiting determination of sentence or serving a sentence, and precludes coverage for these individuals.

The Exchange will exclude incarcerated people from eligibility for a Qualified Health Plan with or without a subsidy, but the definition of "incarceration" is narrower than Medicaid. The Exchange exclusion applies only to people serving a sentence. When the Exchange is determining eligibility for either Medicaid or premium tax credits, the verification of incarceration will need to account for two different definitions. People under arrest or awaiting trial can qualify for premium tax credits under the Exchange, but cannot qualify for Medicaid. We recommend assessing if this difference is necessary.

To avoid a gap in coverage under the Exchange, it appears necessary to create an exception in the Exchange for individuals with income below 100% FPL who are considered “inmates” for purposes of Medicaid eligibility.

In describing the Medicaid eligibility determination, a person must have “a household income, as defined in 42 CFR § 435.911(b), that is at or below the applicable Medicaid MAGI-based income

standard." We believe this reference is incorrect. Household income is defined in 42 CFR 435.603(e). Section 435.911(b) identifies the Medicaid applicable modified adjusted gross income standard.

The special residency rule for family members living outside the service area of the Exchange of the primary taxpayer in proposed 45 CFR § 155.305(a)(3)(iv) ensures that dependents or spouses temporarily living outside of the primary taxpayer's Exchange will receive coverage. However, additional guidance is necessary to operationalize this requirement. Specifically, we request that HHS clarify the final regulations to address:

- How the primary taxpayer purchases coverage for the dependent or spouse living in another State? Would the primary taxpayer have to initiate a new application process through the other State's Exchange? If so, this will add to the complexity of properly determining than an individual properly meets the residency requirements.

- If the primary taxpayer and dependent use two different Exchanges, how will the two Exchanges coordinate the tax subsidies?

- This would be a simpler process if the primary taxpayer could purchase coverage for the dependent or spouse in the other State's Exchange through the primary taxpayer's Exchange via a link or web portal. However, this would require a level of communication between Exchanges that does not seem to be envisioned by the proposed regulations. Does HHS expect inter-communication between the Exchanges or can the Federal hub facilitate communication between Exchanges?

Eligibility Determination Process – § 155.310
In §155.310(b), the proposed rule permits an individual to decline an eligibility determination for Medicaid and tax credits. We support this provision as it would allow consumers to directly select and enroll in a QHP if they do not want to submit additional information to apply for insurance affordability programs.

Under §155.310(g), an Exchange must notify an employer when an employee qualifies for a premium tax credit or cost-sharing reduction The rule proposes to notify the employer of the employee's identity. We ask that HHS reconsider whether it is necessary to specifically identify the employee and consider protections for employees who seek out premium tax credits or cost sharing reductions.

For purposes of premium tax credits, the term "household" consists of the taxpayer and all tax dependents of that taxpayer. Income for purposes of premium tax credits is the income of the primary taxpayer, and the income of all tax dependents of that taxpayer who are required to file a return. These are not the rules that will apply in Medicaid. Using two different requirements for Medicaid and the premium tax credits will add to the complexity of determining an individual's eligibility and make operating an Exchange more difficult. We request that the definition of "household" and the calculation of income be more aligned.

Additionally, we request that HHS and/or IRS clarify if the taxpayer who claims qualifying relatives as tax dependents is responsible for obtaining access to health care for those individuals claimed as dependents? If so, does this requirement change if these people do not live together?

Verification for QHP Enrollment – § 155.315
In the Preamble for this section, HHS requests comment on what electronic data sources are available and should be authorized for Exchange use and whether these information sources should be available on the Federal data services hub. We recommend that HHS and IRS work with States to make information reported by employers in quarterly wage filings available in the Federal hub for use by States to assist with verification and attestation of income for eligibility for Medicaid and tax credits.

Representatives from the Minnesota Departments of Commerce, Human Services and Health have started regular consultation meetings with representatives from Tribal governments in Minnesota regarding the development of an Exchange. As a result of these consultations, we also recommend that data maintained by the Indian Health Service (IHS) be made available in the Federal hub and utilized for verification of whether an applicant is a Native American. In addition to this data source, we acknowledge that there may also be additional tribal data sources that could be utilized.

Section 155.315(b)(1) requires the transmission to HHS of the SSN of the applicant who attests to citizenship. The proposed regulation allows the primary taxpayer to attest to information for other individuals. The applicant is the person who signs and submits the application. The process is unclear on the requirements for obtaining information on other individuals on the application. We request that HHS clarify whether, or not, there is any verification process for other individuals on the application, such as the spouse and tax dependents.

The timeframes for response when requesting documentation from individuals are different in length: for simplicity they should be the same. Section 155.315(b)(3) specifies a 90-day period from the request for information on citizenship and immigration status, but adds five days to the date of the request for a total of 95 days. Section 155.315(e) establishes a 90-day response time for requests related to inconsistent information. This section does not add five days to the date of the request. Moreover, the Medicaid processing periods are unspecified in length, but must be within reasonable time frames. These timeframes should be aligned in Medicaid and the Exchange. This alignment can be accomplished by specifying the same 90-day period be used in both programs, or by requiring States to use the same reasonable opportunity period in both programs.

Individuals Above 133 Percent FPL – § 435.218
The optional category for coverage of individuals is based on age and income above 133% of the Federal poverty level. This eligibility group appears to be a broad category for expanding coverage to any population except the elderly. The category would appear to include individuals under age 65 receiving title II benefits who are also receiving Medicare. We recommend giving the States the maximum flexibility regarding the criteria for this group, and the option to determine the subgroups for expansion.

In the alternative, States will need greater specificity in the regulations for both the definition of this eligibility group and the meaning attributed to 'phasing in' of this group. Under Title XIX, § 1902(hh) allows States to phase in by "category" or by "income." While the ACA and the preamble both mention that a State may phase in populations "based on the categorical group," the regulation does not address this aspect of the phase-in process. States will need specific guidance on whether they will have the option to limit coverage by categorical population in adopting this group, or whether a State electing this category must eventually cover all possible populations under age 65

within the selected income limit. We note that under the latter interpretation, States would be required to include dual eligible individuals under age 65 in this group.

The eligibility description for this group does not indicate what income methods apply, or whether an asset test applies or may apply. We recommend that HHS clarify this issue.

Premium Tax Credit Definitions – § 1.36B–1
Definitions and General Standards for Eligibility Determinations – § 155.300
Definitions and Use of Terms – § 435.4
Parents and Other Caretaker Relatives – § 435.110
Pregnant Women – § 435.116
Infants and Children under Age 19 – § 435.118
There is no longer a purpose in having general definitions for "dependent child" and "caretaker relative." These terms appear to relate only to eligibility under § 435.110. Dependent child is no longer a separate basis of child eligibility since it has been collapsed into child eligibility in § 435.118. Furthermore, the application of "deprivation" is an option only for parents and relatives within the § 1931 group in § 435.110. We therefore recommend that these terms be moved into § 435.110.

Because § 435.110 will refer to "parents and other caretaker relatives" in describing the § 1931 group, a definition for the term "caretaker relative" is no longer needed. We believe there are two better options: use two definitions, one for parents, and the other for caretaker relative; or adopt a single definition for the term "parents and caretaker relatives." If, as indicated in the preamble, CMS intends to recognize the State option to eliminate "deprivation" and "dependent child" factors in the meaning of "parents and other caretaker relatives", then "dependent" should be removed from the definition.

A definition for "families and children" no longer serves any purpose in the MAGI-based eligibility structure beginning in 2014. In addition, this term includes children up to age 21, but it is no longer clear what the impact will be in a State that defines a child as a person under age 21. We recommend removing the definition of the term "families and children"

The term "tax dependent" is not defined consistently between the Medicaid eligibility rules, and the proposed regulation governing enrollment in qualified health plans. The definition at § 155.300 for purposes of enrollment in a QHP is limited to the meaning in § 152 of the Internal Revenue Code (IRC), which applies only to a qualifying child or qualifying relative. The term is used in Medicaid at § 435.4 to include those for whom an individual claims a deduction for a personal exemption according to 26 U.S.C. § 151, which includes oneself, one's spouse and each individual who is a dependent as defined in § 152 of the IRC. In the IRS proposed rules, § 1.36B-1(d) uses a description that is similar to the Medicaid definition, and adds a definition of "dependent" in § 1.36B-1(f).

The definition of "tax dependent" in § 155.300 and "dependent" in the IRS regulations (§ 1.36) while using a different term, have the same meaning, that is, the meaning assigned by a section of the IRC. It becomes confusing when the term "tax dependent" has a different meaning in the Medicaid regulations (i.e., § § 435.4 and 435.603(b)), is not used by the IRC, and is defined as "an individual for whom another individual properly claims a deduction for a personal exemption under § 151 of the Internal Revenue Code of 1986 for a taxable year." It will be confusing to use the same term in two different ways for eligibility. We suggest that a different term be applied in the Medicaid regulations.

Eligibility Standards – § 155.305
Parents and Other Caretaker Relatives – § 435.110
Section 435.110 provides for eligibility of parents and relative caretakers under § 1931 of the SSA. The preamble indicates that the requirement of the parent or caretaker to live with a "dependent child" and the deprivation factors inherent in the meaning of "dependent" are retained in the eligibility criteria under this section. States will have the option to eliminate the "deprivation" requirement under policy issued in 1997. However, CMS indicates that it retains optional eligibility for parents or caretakers in a medical institution who would otherwise qualify for Medicaid based on receipt of cash benefits if not in the institution; § 1902(a)(10)(A)(ii)(V); 42 CFR § 435.211.

Section 435.110(c) establishes a range within which States may set the income standard for this population. The minimum is a standard established by § 1931, which is a net income test using former AFDC methodologies. The maximum income standard is the higher of two tests: an effective income level for § 1931 eligibility, converted to MAGI-equivalent standards, or the State's AFDC standards as of July 16, 1996 increased annually by the CPI-U.

It is unclear why CMS chose to retain an optional basis of eligibility for a mandatory Medicaid category no longer connected to a cash assistance program. CMS is retaining the optional group for individuals in a medical institution under § 1902(a)(10)(A)(ii)(IV), for the mandatory group of parents and caretaker relatives in connection with § 1931 eligibility. CMS is not retaining this basis for children.

We recommend that CMS give consideration to a number of other factors that make more sense in the eligibility structure. First, parents/caretakers under § 1931 do not lose a basis of eligibility because of the loss of cash assistance. To treat them as if they lose the basis of eligibility because of the loss of cash assistance has the effect of extending the § 1931 rules beyond AFDC financial methodologies. Second, the benefit set for a categorical group includes mandatory coverage for inpatient hospital and nursing home care. Third, it is reasonable to allow parents and caretakers to follow the family's MAGI household rules. A parent with a stay in a hospital or nursing home who remains either a taxpayer or a tax dependent of his or her spouse continues to be in that household. When the parent/caretaker has an extended stay in a medical facility that causes the loss of tax dependent status or is permanently institutionalized, the person would be considered a separate household. Finally, even if a State does not elect the optional institutional basis for parents/caretakers, the person will have a basis under the new Medicaid adult group, and using MAGI rules, have the same household, family size and income as the person would under the parent group.

Revisiting a person's eligibility because of a temporary stay in a medical facility adds complexity and processing delays in a system where streamlining and simplicity is the goal. We recommend eliminating this optional category given that it appears to be unnecessary.

CMS states that it is codifying policy issued in 1997 allowing States to eliminate the "deprivation" requirement; 76 FR page 51154. Please confirm that eliminating the deprivation requirement means elimination of the "dependent" child factor for a parent or caretaker. In other words, does this result in eligibility of parents and caretakers for children under age 19, without regard to whether the child is deprived of parental support due to the death, absence, or unemployment of a parent?

If States have the option to eliminate these factors, then references to "dependent child" in the definitions and in § 435.110 should be changed to "child."

Section 155.305(c) of the proposed Exchange regulations requires that the Exchange must determine eligibility for Medicaid for pregnant women, children and caretaker relatives. Paragraph (c)(3) uses the term "dependent child." For the reasons stated above, this should be changed to "child."

We suggest that CMS consider an additional simplification in § 435.110 that would treat the eligible group as parents or caretaker relatives of children under age 19, unless a State elects the option to retain the deprivation factors for dependent children (in which case eligibility of parents or caretaker relatives would be based on living with dependent children).

CMS invites comments on possible approaches that might be used to avoid the requirement to retain AFDC financial methodologies for the small number of cases in which an elderly individual would be evaluated on the basis of a parent or caretaker relative, for which age is not a factor. CMS identified these two possible approaches: a) use MAGI eligibility rules under § 435.110 even if the individual is age 65 or older; or b) apply SSI methods to the parent/caretaker's eligibility.

Currently, individuals with Medicare who are age 65 or older may qualify as a parent or caretaker under the § 1931 basis of eligibility. In our view, States should have the option to continue to permit these individuals to qualify in this category using the MAGI-based rules that apply to all other parents or caretakers.

In January 2014, the maintenance of effort for adults expires. Do States have the ability to lower income standards to the minimum standard in § 435.110(c)(1)(1), or do the above provisions lock States into the effective income levels established at the time of the conversion? If a State has the option to adopt the minimum standards under § 1931 in January of 2014, the proposed regulation will permit States to utilize those net standards as MAGI-related gross income standards, rather than establish effective income levels or MAGI-equivalence. States may wish to do so to shift a larger portion of the § 1931 adult population into a category with a benchmark benefit set.

Pregnant Women – § 435.116
Individuals Above 133 Percent FPL – § 435.218

Section 435.116 collapses eligibility from a number of groups into one: § 1931, qualified pregnant women under § 1902(a)(10)(A)(i)(III); poverty level pregnant women under § 1902(a)(10)(A)(i)(IV), and optional poverty level pregnant women under § 1902(a)(10)(A)(ii)(IX).

Section 435.116, paragraphs (c) and (d)(4) establish minimum and maximum income standards for pregnant women. The minimum must be 133% of poverty or the standard in effect on December 19, 1989, or the standard authorized as of July 1, 1989, whichever is higher. The maximum is the higher of the effective income level for pregnant women as of March 23, 2010 or December 31, 2013, converted to a MAGI income standard.

In § 435.116(d)(1), States may apply an exception to full Medicaid benefits for pregnant women when the State covers pregnant women whose income is greater than the standard for the mandatory group.

It is not clear how a State covers pregnant women with income in excess of the income standard for the mandatory group. The preamble provides that the optional category for pregnant women under §

1902(a)(10)(A)(ii)(IX) has been collapsed within the new mandatory category. We request that CMS clarify if this means that States wishing to expand the income level for pregnant women can only do so through the expansion group for people up to age 65 under § 435.218. We recommend that the regulation retain the option under § 1902(a)(10)(A)(ii)(IX) so that States may opt to cover pregnancy-related benefits for pregnant women at higher income levels without expanding the standard for all other adults.

Infants and Children Under Age 19 – § 435.118
Eligibility for children under § 435.118 collapses several existing categories of eligibility for children: AFDC-related dependent child eligibility under § 1931; qualified children; mandatory poverty level infants and children; AFDC financially eligible children; and the optional basis for children who would be AFDC eligible if not institutionalized.

We appreciate the simplification that results from collapsing categories of eligibility for children. Adding a general definition of "dependent child" based on old AFDC criteria does not make sense in light of the collapse of all groups of children. As previously stated, we recommend that a definition for "dependent child" be incorporated into eligibility under § 435.110, as part of a State option in establishing eligibility for parents and caretaker relatives.

The optional category to define children up to age 21 is maintained, yet the new mandatory adult group begins coverage of individuals at age 19. If a State has adopted the option to cover children up to age 21, does this mean that children ages 19 and 20 must first be covered under the new adult group, unless the State applies a higher income standard for them? If the State specifies a separate income standard for these children, such as the poverty income level established by § 435.118, we recommend that CMS clarify that States can use the MAGI rules.

Definitions and General Standards for Eligibility Determinations – § 155.300
Application of Modified Adjusted Gross Income (MAGI) – § 435.603
Definitions – § 435.603(b)
Section 435.603(b) relates to the household size for pregnant women. It appears to have eliminated the option to account for multiple unborn children in the household size. We recommend CMS retain the current state flexibility to determine household size for a pregnant woman.

Section 435.603 seems to be the appropriate location for the primary definition of "tax dependent," given that the term is used only in § 435.603. We recommend it be moved out of general definitions to this section.

Also, there is no definition of "taxpayer" in this regulation. We note that for purposes of enrollment in a Qualified Health Plan, § 155.300 defines "primary taxpayer". CMS should define "primary taxpayer" for purposes of Medicaid.

Eligibility for Premium Tax Credit – § 1.36B–2
Eligibility Standards – § 155.305
Application of Modified Adjusted Gross Income (MAGI) – § 435.603
Household Income – § 435.603(d)
MAGI-based Income – § 435.603(e)
Income is defined in § 435.603(d) as the MAGI-based income of every individual in the household, subject to a 5% disregard.

The general definition of household income contains two exceptions as follows:

- The income of an individual living with parents is not counted if that individual is not required to file a tax return for the year in which Medicaid eligibility is being determined.

- If a tax dependent who is a qualifying relative receives "cash" support from the taxpayer claiming the person as a dependent, the relative must include that support in his or her own household income.

MAGI-based income under § 435.603(e) is income calculated according to § 36B(d)(2)(B) of the IRC, which is adjusted gross income, with two excluded items added back –income from foreign employers; and tax-exempt interest. There are three additional differences for Medicaid eligibility determinations: lump sums count in the month received; educational scholarships and grants do not count when used for educational expenses; and certain distributions and payments by tribes do not count.

The Preamble offers this description of the income rules:

> Consistent with the § 36B definition of household income, proposed § 435.603(d)(1) provides that, for purposes of determining Medicaid eligibility under § 435.603, ''household income'' is the sum of the income based on MAGI-based methods of every individual who is: (1) included in the individual's household; and (2) required to file a tax return under § 6012 of the IRC, except that, also consistent with § 36B definitions, the MAGI-based income of a child who files a tax return, but is not required to file, is not included in household income under proposed § 435.603(d)(2). The MAGI-based income of adults as well as children who are not included in the household of their parent(s) is always counted in determining the household income of the adult or such child as well as the household income of their spouse and children with whom they are living (if any).

Section 1401 of the ACA, which creates § 36B of the IRC, defines household income as:

> (A) HOUSEHOLD INCOME.—The term "household income" means, with respect to any taxpayer, an amount equal to the sum of—
> (i) the modified adjusted gross income of the taxpayer, plus
> (ii) the aggregate modified adjusted gross incomes of all other individuals who—
> (I) were taken into account in determining the taxpayer's family size under paragraph (1), and
> (II) were required to file a return of tax imposed by § 1 for the taxable year.

The Medicaid regulations are not clear regarding how the § 36B rules are being transferred to the Medicaid income determination. Greater specificity is required in the regulations about how income counts and whose income counts in order to guide States in how to make the Medicaid household income determination. We request that CMS provide more detailed guidance on how States can essentially create a point-in-time tax return to apply the MAGI methodology for Medicaid determinations.

For purposes of household income and premium tax credit eligibility through an Exchange, § 36B(d)(2)(A) counts the taxpayer's income, whether or not the person is required to file, while

income of tax dependents counts only if those individuals are required to file. To obtain premium tax credits, the primary taxpayer must file a tax return in order to receive those benefits, whether or not required to file. The Medicaid rules reference only § 36B(d)(2)(B), the calculation for modifying adjusted gross income.

In the Preamble, Medicaid household income is described as the MAGI-based income of every individual in the household who is required to file a tax return. However, the provisions of § 435.603(d) and (e) do not state that MAGI-based income is limited to income of individuals required to file a tax return. This is critical piece of the Medicaid eligibility determination that should be clearly expressed in the regulations.

CMS has explained in conference calls that their intention in the Medicaid regulations is to count, for purposes of Medicaid eligibility, largely the income of adults. This means that the income of adults will be counted, whether or not they are a tax filer, in other words, the formula for determining the income is the adjusted gross income formula that would appear on a tax return if an individual were to file, regardless of whether the individual files or is required to file a return. Therefore, the proposed Medicaid regulations will continue in some respects the current Medicaid requirement of deeming income from parents to children, but will also apply those deeming rules to stepparents. It is not clear whether or when income will be deemed from other caretaker relatives to children, or vice versa.

Based on communications with CMS, Medicaid will not follow the general rule for purposes of eligibility for enrollment in a QHP of not counting the income of individuals not required to file a return. CMS indicates they have developed a more limited exclusion for Medicaid, to exclude income of a child in the household of a parent or stepparent. Section 435.603(d)(2) excludes income for "an individual who is included in the household of a parent or stepparent, if that individual will not be required to file a return for the year in which Medicaid eligibility is being determined." As described, there is no age limit on the individual, and thus the effect would seem to be to exclude income of either an adult or a child when the household includes that individual's parent or stepparent. Clarification is necessary.

As written, the exception makes it possible to exclude the income of a 30-year old adult child living with a parent when the parent takes the child as a tax dependent. It is unclear whether that was intended, or whether children who are not in a parent or step-parent's household were intended to be included. It makes sense for purposes of simplicity to apply the exclusion to any child without regard to where they live, and to any tax dependent (not a spouse) of a tax payer.

We recommend that § 435.603(d)(2) be revised as follows:

> The MAGI-based income of a household will not include the income of the following individuals not required to file a tax return under § 6012 of the Code for the taxable year in which eligibility for Medicaid is being determined, whether or not the individual files a tax return:
>
> > (i) A tax dependent other than a spouse in a taxpayer's or tax dependent's household; and
> > (ii) In a household determined using (f)(3) rules, a child under age 19, or under 21 and a full-time student.

This version is the most practical approach to income exclusion for individuals not required to file a return. It excludes income of children under 19, regardless of the rules for household; it will exclude the income of a tax dependent of a taxpayer, without regard to age or the relationship to taxpayer (with the exception of a spouse); it will exclude income of a full-time student under the age of 21 in the household of a non-tax filer parent or stepparent.

This version would also exclude the income of tax dependents who are not a spouse or a child when in the household of the tax payer. This means excluding the income of these individuals from the household income of the taxpayer without regard to whether filing is required.

Under the household rules of § 435.603(f)(2)(i), these tax dependents have a separate household determination from the taxpayer, may not live with the taxpayer, are not required to make their income available to the taxpayer, and will have their own sources of income counted for their household and eligibility determinations. The income of tax dependents who are not spouses or children of the taxpayer is being counted towards two households—that of the taxpayer and that of the tax dependent who is neither a spouse or a child of the taxpayer. We recommend not counting the income of those tax dependents as income in the taxpayer's household.

The description of income for Medicaid eligibility purposes requires clarification and we recommend a revision similar to the following:

> 435.603(e). An individual's MAGI-based income for purposes of paragraph (d) is income that would be included in determining modified adjusted gross income according to § 36B(d)(2)(B) of the Code, without regard to whether a tax return is filed, subject to the following exceptions to § 36B(d)(2)(B):

The need to predict the intent to file a tax return could complicate the eligibility determination. Someone will be required to make that prediction – either the taxpayer, or the tax dependent, or the Medicaid agency/Exchange based on estimated income reported. For QHP enrollment, the primary taxpayer is permitted to attest to his/her intention to file a tax return. We recommend the same use of attestation for Medicaid.

The use of "cash support" paid to tax dependents who are neither a spouse nor a child or stepchild is a new concept. "Cash support" should be defined. The requirement to identify it and count it will complicate the household income determination for a non-spouse, non-child tax dependent, because there is no trusted third party source for verification of this type of income. In the interests of simplicity, we recommend that the exception for cash support in the household of the qualifying relative be removed. We believe it is sufficient to account for qualifying relatives as tax dependents in the household of the taxpayer, in that the taxpayer benefits from the support provided by an increase in household size. This also reduces the complexity of the income determination process. The proposed Medicaid regulation does not identify the MAGI-based income determination for purposes of retroactive month Medicaid eligibility. This should be clarified.

These regulations should address the issue of deeming a sponsor's income. As written, the rules would exclude sponsor income in MAGI income determinations for a sponsored noncitizen, because that is not part of the IRS income calculation. If CMS believes that income determinations under the ACA override the provision in 8 U.S.C. § 1631 attributing a sponsor's income and resources to an alien for purposes of any Federal means-tested public benefits program, this should be clear in the regulation.

If, on the other hand, this provision remains a factor in Medicaid MAGI income eligibility determinations, sponsor income should be factored into the definition of MAGI-based income in § 435.603(e). The logical place is to include it in the § 435.603(e) list of exceptions to § 36B(d)(2)(B) income. States need to be able to develop consistent policy, whether they have developed more liberal policy related to sponsor deeming or continue to deem sponsor income.

The rules for QHP enrollment appear to accommodate noncitizens who are ineligible for Medicaid as a result of the deeming of sponsor income. 45 CFR § 155.305(f)(2) provides a special rule to deem noncitizens eligible for premium tax credits without regard to income when ineligible for Medicaid under 26 CFR § 1.36B-2(b)(5)(i) if their income is below 100% of the Federal poverty line. CMS should assure States that noncitizens ineligible for Medicaid due to sponsor deeming are included in that group.

Verification Process Related to Eligibility for Insurance Affordability Programs – § 155.320
Application of Modified Adjusted Gross Income (MAGI) – § 435.603
Household – § 435.603(f)

Section 435.603(f)(1) refers to an "individual filing a tax return for the tax year in which a determination is made. We request that CMS clarify whether an individual who is not required to file, but does file a return, should be treated as a taxpayer.

Tax Dependents: The general rule of § 435.603(f)(2) is that a tax dependent has the same household as the taxpayer, but there are numerous exceptions. The proposed Medicaid regulation and its exceptions described above differ greatly from the proposed rules used for determining household and household income for purposes of QHP enrollment at § 155.320(c)(3), under which the family size includes the primary taxpayer and all individuals for whom the taxpayer claims a deduction.

These variations will require multiple layers of determinations before eligibility will be determined. For Medicaid eligibility determinations household income will be calculated only on the basis of family members. If the taxpayer and spouse in that household are ineligible for Medicaid, a different household/family size must be used in the determination of eligibility for QHP. Income will be calculated based on that of the taxpayer, and any tax dependent who is required to file a tax return, and will include tax dependents who are not a spouse nor a child or stepchild. We recommend further alignment of the rules governing households and family size for eligibility determinations, across Medicaid and the QHP enrollment, in order to avoid the need to conduct multiple determinations.

It would appear that in § 435.603(f)(3), the terms "custodial" and "non-custodial" are being applied according to the IRS rules for qualifying child outlined in the IRS Publication 501, rather than the legal terms applicable to responsibility and control over a minor child of divorced parents. Current IRS rules require identification of the parent with whom the child lives for purposes of a tax deduction. Under the IRS rules the parents may agree on who takes the child as a dependent, regardless of where the child resides. We recommend that the proposed Medicaid regulation specify that the term "non-custodial" in § 435.603(f)(3) has the meaning under the IRS rules, or the terms "custodial" and "non-custodial" be defined. In the alternative, the proposed Medicaid regulation could be based simply on the parent who takes the child under age 21 as a tax dependent without living with the child.

While we understand the rationale for including the child under 21 in the household of the taxpayer who takes the child as a tax dependent, even when the child resides with the other parent. This

change in the proposed regulation is a significant departure from current Medicaid rules, in that the child will not be included in the household of the parent with whom the child lives. The parent with whom the child lives will always be providing support in some form or other, regardless of whether that parent gets the tax deduction. Although we understand that this adds complexity to the process, it makes more sense to allow the child to be included in two households, in the year that the non-custodial parent takes the tax deduction for the child. The child and the child's own income (if required to file a return) should be attributed to the household of the parent with whom the child lives. It would be preferable to include the child in the household of both the taxpayer parent, and the parent with whom the child lives. We note there is similar treatment for extended family tax dependents: While they are included in the taxpayer's household under § 435.603(f)(1), the household of extended family members consists of their own family members with whom they live under the rules of § 435.603, paragraphs (f)(2) and (f)(3). We recognize that this approach adds complexity to the process that is necessary to best ensure that the child has access to health care.

The rule that married individuals living together will always be included in one another's household is an overarching policy for the household principles in § 435.603(f)(1) through (3). We recommend that it be listed first in this subsection. We also recommend that CMS clarify whether, for Medicaid purposes, spouses who file a joint return are treated as separate taxpayers.

Section 435.603(f)(2)(iii) excludes from the household of the custodial parent those children under age 21 who are tax dependents of the non-custodial parent. Children who are full-time students can be taken as a tax dependent by either parent up to age 24. We request that CMS clarify the household rules for full-time students between ages 21 and 24.

Section 435.603(f)(3) proposes a general household rule for an individual in § 435.603(f)(3)(i) and (ii) and then creates an exception to the general rule in paragraph (iii). Paragraph (iii) should be written as a separate rule to avoid confusion.

Throughout § 435.603, the application of MAGI, inconsistent terms are used to describe parents and children. In some provisions "natural, adoptive or step" is used and in others it is "biological, adopted or step." We recommend the use of "biological, adoptive or step" consistently throughout.

Section 435.603(f)(2) reads: "In the case of an individual who is claimed as a tax dependent by another taxpayer, the household is . . ." This language implies that the individual is a taxpayer, however that need not be the circumstance. We recommend changing this language to "…an individual who is claimed as a tax dependent by a taxpayer…" rather than "another taxpayer."

Section 435.603(f)(2) and (3) creates confusion by requiring the use of rules in paragraph (f)(3) for the exceptions under (f)(2). Paragraph (f)(3) applies to people who neither file a tax return, nor are a tax dependent of a taxpayer. We recommend that CMS modify (f)(3) to refer to (f)(2) as follows:

> "(f)(3) In the case of individuals who do not file a Federal tax return and are not claimed as a tax dependent, <u>or in the case of individuals who meet an exception in 435.603(f)(2)(i) through (iii),</u> the household consists of the individual and, if living with the individual…"

Section 435.603(f)(2)(ii) refers to parents. We recommend the use of the phrase "biological or adoptive parents."

Section 435.603(f)(3)(iii) counts adopted and step-siblings in the household under certain circumstances. If the intent is to include biological siblings as well, we recommend that the intention be clarified.

Application of Modified Adjusted Gross Income (MAGI) – § 435.603
Budget Period – § 435.603(h)
This provision establishes policies for the treatment of income in establishing financial eligibility. Income eligibility for applicants must be based on "current" monthly household income and family size. For current beneficiaries, States may use either current monthly income or income projected for the calendar year. States will have flexibility to prorate reasonably predictable future income increases or decreases in either a monthly or projected annual income determination.

Section 435.603(h)(1) requires the use of current monthly income for applicants. Section 435.603(h)(2) allows the use of either current monthly income or projected annual income for current beneficiaries. Section 435.603(h)(3) allows income for new applicants to be prorated, but (h)(1) does not appear to allow States to project annual household income. In order to avoid gaps in which families could be ineligible for both Medicaid and the premium tax credits, we recommend that the ability to use current monthly income to project annual income be applied to both applicants and current beneficiaries.

When the preceding year's tax return is no longer relevant, it appears that applicants, Medicaid agencies, and/or Exchanges will be responsible for predicting a person's MAGI-based income. This will mean predicting gross income that may come from multiple sources, removing an amount of pre-tax dollars from gross income, and adding back some income. This will occur for each individual in the household, for whom electronic sources are not available. We request that CMS support State's streamlined, simplified systems by making uniform methodologies and technology available to States for the calculation of income that cannot be verified via electronic sources. We also recommend that the methodologies/technologies provide support States' needs to essentially create a point-in-time tax return to apply the MAGI methodology for Medicaid determinations.

Eligibility Standards – § 155.305
State Residence – § 435.403
This section makes minor changes to the Medicaid residency requirements to simplify the general residence standard. We support these revisions. However, we are concerned with the interaction of this regulation with the residency policies used for determining eligibility for enrollment in a QHP. Medicaid residency requirements will take into account policies of the State that maintain residence for individuals who are temporarily absent. We believe the Exchange policy in § 155.305(a)(3)(iv) permitting options for Exchange participation will result in complexities and many differences among States and Exchanges. These will be difficult to track in a system intended to be simplified and streamlined.

Single Streamlined Application – § 155.405
Application – § 435.907
Under § 155.405(a) per the ACA, HHS is required to develop and provide a single, streamlined form that may be used to apply for advance payments of the premium tax credit, cost sharing reductions, Medicaid, CHIP, and the BHP, if the BHP is operating in the Exchange service area. The regulation proposes the use of a single streamlined application to limit the amount of information and number of times an individual must make submissions to receive an eligibility determination and complete the enrollment process. It is stated that HHS plans to create both a paper-based and web-based dynamic

application. We support a single streamlined application for the MAGI population, but suggest that the language be clarified to allow consumers who use the web-based dynamic application to start the process at numerous points depending on their needs, as long as all applicable components are completed.

Section 435.907(c) addresses an application for Medicaid coverage on a basis other than MAGI. The ACA, at § 1413(b)(1)(C) conveys that States are not required to use the single, streamlined form for non-MAGI populations. Under this provision, the Secretary may allow a State to use supplemental forms or to use an alternative application. People who are eligible for Medicaid outside of the MAGI methodologies are vulnerable and require specialized services. The single, streamlined application will not meet the needs of these groups. States should be permitted to determine how best to facilitate the application process for non-MAGI groups without a complicated approval process. We recommend that States should not be required to obtain Federal approval for an alternative application form, given the needs of the populations, the frequency of changes in such forms, and the need to implement changes to coincide with printing deadlines and system changes.

Section 155.405(c)(2) of the proposed rule requires that an Exchange must accept applications from multiple sources, including the applicant, an authorized representative or someone acting responsibly for the applicant. HHS requests comment on the requirement that an individual must be able to file an application in person. While we fully support the consumer-focused intent of this provision, we suggest clarifying that these functions are permitted to be carried out by Navigators and existing State or county offices providing Medicaid services on behalf of the Exchange. We are concerned that as it is currently written, Exchanges may be required to have a physical administrative presence Statewide which could be prohibitively expensive and administratively burdensome to implement and sustain.

Section 435.907 addresses the form of Medicaid application. Section 435.907(d) lists five different methods that each State must make available for submission of an application, including via facsimile. We note that Exchange § 155.405(c)(2) does not include application by fax in its list of application methods. We believe these methods should be consistent in an optimal streamlined system.

Eligibility Standards – § 155.305
Determination of Eligibility – § 435.911
This is a new section addressing the Medicaid MAGI eligibility determination, or MAGI-screen. It specifies the Medicaid income floor of 133% FPL for groups with MAGI-based households and income, and specifies a MAGI eligibility determination first, followed by consideration of other Medicaid eligibility bases.

Section 435.911 describes a term “applicable modified adjusted gross income” for purposes of the Medicaid determination of eligibility. 45 CFR § 155.300 use the terms “applicable Medicaid modified adjusted gross income” but also “MAGI-based income standard” and reference 42 CFR § 435.911(b) for the meaning. We recommend consistent use of terminology and definitions throughout all of the proposed regulations.

Section 435.911(b) attempts to define applicable modified adjusted gross income standard as 133% of the Federal poverty level, unless a higher level is established for one of the eligibility groups listed. For precision, we recommend that the list eligibility groups be identified only by references to

the section number for each group, rather than adding shortened descriptions that can create discrepancies. The same issue occurs in paragraph (c)(1).

We note that § 155.305(c) governing the functions of the Exchange describes the Medicaid MAGI-based eligibility groups as well as the Medicaid groups excluded from MAGI. We recommend using cross-references to section numbers for each eligibility group in this section in order to avoid creating discrepancies.

In § 435.911(c)(2), we recommend that the introductory sentence read: "…for each such individual determined not eligible for Medicaid in accordance with paragraph (c)(1) of this section, the agency must collect additional information as needed…"

Verification Process – § 155.320
Use of Information and Requests of Additional Information from Individuals – § 435.952
The proposed regulations require verification under the following circumstances:

- Under § 155.320(c)(3)(ii)(A), the Exchange must first calculate household income based on the most recent tax return data available. The application filer must then attest whether it is an accurate projection of household income.

- Under § 155.320(c)(3)(ii)(B), to the extent that the tax data is not accurate or not available, the application filer must attest to the household income without requiring further verification except as provided in 155.320(c)(3)(ii)(C).

- Under § 155.320(c)(3)(ii)(C), the Exchange must require further verification if the attestation is not reasonably compatible with the tax return data used in paragraph (A).

However, it does not appear that the attestation under paragraph (B) will ever be reasonably compatible with the tax data used in paragraph (A), because the Exchange will only seek the attestation under paragraph (B) if the household income calculated under paragraph (A) is not accurate or unavailable. If the tax information is not accurate or available, how could it ever be reasonably compatible with the applicant's attestation under paragraph (B)? We request HHS to further clarify the relationship between these verification requirements.

A similar issue appears in § 155.320(c)(3)(iii). Under § 155.320(c)(3)(ii)(c), an applicant will only follow the process in subsection (iii) if their attestation is not reasonably compatible with their tax data. Yet § 155.320(c)(3)(iii)(A) requires the Exchange to use the attestation without requesting further verification if the attestation is reasonably compatible with the tax return data. How can the two be reasonably compatible if the only reason the applicant must supply the attestation is because the tax return data is not accurate or available? We request that HHS clarify this issue.

The verification process for advance payment of the premium tax credit and cost-sharing reductions under proposed 45 CFR § 155.320(c)(3)(ii) requires an applicant to attest whether the computation of household income represents an accurate projection of income from the benefit year. However, the regulation does not provide criteria (e.g., a range) for assessing accuracy, against which, an attestation can be made. In order to eliminate the subjectivity, we recommend that the Exchange require the applicant to attest to their current household income and that HHS provide criteria for the Exchange to assess and verify whether the tax return data is reasonably compatible.

We further request that HHS simplify the proposed regulations related to attestations that are not compatible with tax return data. If an Exchange determines that tax return data is not reasonably compatible with the attestation, the Exchange should follow the alternate verification process under § 155.320(c)(3)(v) for all applicants. The differing processes laid out in subsections § 155.320(c)(3)(iv) to (vi) create increased program complexity and should be avoided. Additionally, following the process in § 155.320(c)(3)(v) would be consistent with the process outlined in proposed 42 CFR § 435.952.

In §155.320(c) and (d), the rule proposes that an Exchange verify whether an applicant is enrolled in an eligible employer-sponsored plan by accepting his or her attestation without further verification, except in cases in which information is not reasonably comparable with other data. To assist with verification, we ask that health insurance reporting by employers on employee W-2 forms that starts in 2012 be available in the Federal hub as a verification source for employer-based coverage: W-2 reporting should also include information regarding whether the employee was offered coverage but did not take it. We also recommend that IRS quarterly reporting by employers include information on health insurance coverage. The Preamble also requests comment on whether the development of a central database to collect employer health insurance information should be considered. We support the development of this type of database and ask that States be consulted regarding the data elements and construction of the database for use in the Federal hub.

Use of Information and Requests of Additional Information from Individuals – § 435.952
Section 435.952 describes a process for using data obtained for eligibility purposes, and for seeking additional information. Real time processing does not seem a realistic expectation for the majority of Medicaid/CHIP eligibility determinations, given that current month income is required, and that low-income families experience frequent changes in income.

States can use self-attestation for income changes not reflected on the past year's tax return, but this is a person-by-person determination. The Exchange rules provide for the primary taxpayer to attest to another family member's tax filing status and income. We recommend that similar provisions be included in the Medicaid regulations.

Clarification is needed about the parameters for agency actions in this section. Section 435.952(b) indicates that a State may rely on electronic data when reasonably compatible with other information. However, § 435.952(d) provides that the agency may not deny or reduce benefits without contacting individuals for additional information. Does this requirement apply, even when trusted electronic sources provide data reasonably compatible with information provided by the individual? We request that CMS provide guidance on this issue.

Medicaid Agency Responsibilities – § 435.1200
Section 435.1200 addresses the Medicaid agency responsibilities to coordinate with an Exchange and insurance affordability programs. Section 435.1200(g)(1) requires the Medicaid agency to establish procedures for individuals determined ineligible for Medicaid that will assess potential eligibility for other insurance affordability programs and electronically transfer them to the other programs.

Section 435.1200(g)(2) requires an assessment and transfer of individuals potentially eligible for other insurance affordability programs, while they have a Medicaid eligibility determination pending after not meeting a MAGI basis. We think this group consists only of those adults who do not qualify under § 435.119 due to income above the MAGI standard or because they qualify for

Medicare. All other individuals ineligible under a MAGI-related basis will fall under (g)(1). We recommend the group of individuals in 435.1200(g)(2) be described as "individuals ineligible for Medicaid under § 435.119."

Coordination with Medicaid, CHIP, the Basic Health Program, and the Pre-existing Condition Insurance Program – § 155.345
Periodic Redeterminations of Medicaid Eligibility – § 435.916
Medicaid Agency Responsibilities – § 435.1200
The proposed regulations governing responsibilities of the Exchange and Medicaid agencies use inconsistent terminology regarding the coordination of eligibility for QHPs and Medicaid. In proposed 42 CFR § § 435.916(a)(4), 435.1200(g)(1), and 435.1200(g)(2)(i), the term "assess" is used. In proposed 42 CFR § 435.1200(f)(1) and 45 CFR § § 155.345(b)(1), and 155.345(c) the term "screen" is used. Plus the regulations use the term "determine" throughout. While "screen" and "determine" are fairly unambiguous terms, the term "assess" is ambiguous and could mean either "screen" or "determine" as it pertains to eligibility. We request that the terminology be standardized.

Annual Eligibility Redetermination – § 155.335
Periodic Redeterminations of Medicaid Eligibility – § 435.916
42 CFR § 435.916(a) requires the agency to attempt to redetermine Medicaid eligibility by first using information available to the Medicaid agency. If the agency can determine continued eligibility based on information on hand, the agency will then send a notice to the beneficiary informing the beneficiary of the decision and the basis for the decision of continued eligibility. If the beneficiary believes all information in the notice is correct, he does not need to take further action. He does not need to sign, return, or otherwise confirm the correctness of the information.

45 CFR § 155.335 provides for a similar process to redetermine of eligibility for insurance affordability programs. The Exchange will attempt to redetermine eligibility based on available information. The Exchange will then send a notice to the enrollee informing of the eligibility decision and the basis for the decision. If the enrollee agrees that all information on the notice is correct, he must sign and return the notice.

This discrepancy between Medicaid and insurance affordability programs does not seem desirable in a streamlined system. We request that HHS clarify the rationale for enrollees in an insurance affordability program to sign and return the redetermination notice while having different requirements for Medicaid beneficiaries.

Additionally, we believe that the requirement on individuals in an insurance affordability programs is unnecessary. There do not appear to be consequences if the QHP enrollee fails to return the notice. If the QHP enrollee believes that all information on the notice is correct and fails to return the notice, the Exchange, under proposed 45 CFR § 155.335(g), will simply determine eligibility based on the information on the notice.

There appears to be a drafting error in 45 CFR § 155.335(e)(2). The paragraph references paragraph (h)(1). Should this reference be to paragraph (g)?

Other Comments on Bases of Eligibility Needing to be Addressed in Part 435 – Eligibility
Part 435 does not account for the new mandatory group enacted by § 2001(a) of the ACA for coverage of children up to age 26 who were in foster care when they reached adulthood. It is necessary to include this section because § 1902(a) of the SSA requires continued coverage of foster

children who were enrolled after they reach adulthood, regardless of income, and gives priority to this group over § 435.119.

The proposed regulations do not account for two optional groups in § § 2303(a) and 2402(c) of the SSA: the optional group for coverage of family planning services; and the optional group for home and community-based services under § 1915(i). We recommend that all eligibility groups added by the ACA be included in these regulations.

Although the proposed Medicaid regulations do not address the benefit packages available to the adults newly eligible under the new § 1902(a)(10)(A)(i)(VIII), we are aware that the CMS interpretation of this law would potentially inhibit the provision of home and community-based waiver services to disabled individuals under age 65 who are not receiving Supplemental Security Income (SSI) and not yet entitled to Medicare. Many of these individuals are already eligible for Medicaid in many States through other optional categories of eligibility, for whom these home and community based services are vital in preventing institutionalization and allowing these individuals to live and work in the community. These groups can include categorically needy poverty-level groups, as well as the two optional categories for people with disabilities with earned income ("working disabled"). We request CMS to explore other possible interpretations that will allow these individuals to remain in the optional categories with access to the full Medicaid benefit, without necessarily requiring the addition of home and community-based waiver services to the benchmark benefit set.

Single State Agency – § 431.10
Organization for Administration – § 431.11
We support CMS' modifications to § § 431.10 and 431.11 regarding the roles and responsibilities for the single State Medicaid agency. We believe that these changes will enhance protections for enrollees from conflicts of interest, improper incentives, and improper outcomes. Additionally, CMS notes that it has not found any authority to deviate from the requirement that Medicaid eligibility determinations must be made by a governmental entity and invites comments from States on any other analysis that might permit eligibility determinations by a non-governmental entity. We concur with the CMS analysis.

Rates of FFP for Program Services – § 433.10
We support CMS' clarification of the enhanced FMAP rates for newly eligible and non-newly eligible under § 1902(y) of the SSA, especially as those rates apply to expansion States. Both the proposed regulation at § 433.10, and the commentary make clear that the highest enhanced FMAP rate is available for newly eligible adults without children in expansion States. We also interpret the proposed regulation to allow the highest enhanced FMAP rate for other newly eligible adults (e.g., parents with income above 138% FPG) in expansion States. However, we suggest one clarification in the proposed regulation -- § 433.10(8)(iv) should also provide that the highest enhanced rate applies to all newly eligible individuals in expansion States, both for adults without children and all other newly eligible adults. That paragraph as written only applies to adults without children. Also, the commentary says that expansion States will receive the lower, enhanced FMAP, but does not specify that the lower enhanced FMAP applies only to individuals who are not newly eligible in expansion States. We recommend that CMS clarifying that statement to be consistent with the proposed regulation and eliminate all ambiguity.

Choice of Methodology – § 433.206

We applaud CMS' flexibility and willingness to explore various methods to identify those who are newly eligible and those who are not, for purposes of the different matching rates, in order to avoid duplicative eligibility determinations under the old and new eligibility rules. However, because of the use of validation requirements, in the statistical sampling method and potentially the CMS-developed algorithm method, it appears that States may still be required to maintain pre-ACA eligibility rules in their systems. In Minnesota, all adults without children will be newly eligible by definition, and relatively few other adults will be newly eligible. We would look for a method of identifying those other adults that is the least burdensome and expensive and does not require verification by checking cases against old eligibility rules. We urge CMS to create a fourth option that allows CMS and the State to agree on a negotiated methodology. This fourth methodology will allow both CMS and States to design methodologies that take into account unique characteristics of the State and to ensure accurate identification of the newly eligible, while minimizing the administrative burden on States.