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

**Patient Protection and Affordable Care Act:
Medicaid Program; Eligibility Changes**

The Florida Association of Community Health Centers, Inc. (FACHC) is pleased to respond to the above-cited request for comments from the Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS).

FACHC is the Florida primary care association (PCA), representing the state's 45 federally qualified health centers (hereinafter interchangeably referred to as FQHCs, CHCs or Centers) and over one million Florida residents (patients). Our organization is a private and non-profit, whose goal is to advance the quality and effectiveness of the most cost-effective form of providing primary care in the State.

FACHC is providing comments concerning the proposed rule provisions of the Affordable Care Act's Medicaid program eligibility standard changes and expansions of coverage. These adjustments would have a direct influence on our members. In large part, as has been laid forth by a CMS Preliminary Regulatory Impact Analysis of the proposal, FQHCs would benefit from this increase in Medicaid eligibility, as there would be a decrease in uncompensated care visits and an increase in patient responsibility. Especially in the landscape of Florida's Medicaid reform efforts and constantly increasing population, this rule's proposed improvements cannot come at a better time.

In general, FACHC has found the rule to be thoroughly considerate and well constructed; but we, nonetheless, appreciate the opportunity afforded to us by CMS to suggest improvements, discuss any concerns we have with specific pieces of the rule and work with the Agency in finding the best formula of success in providing access to cost-effective care to all Americans.

Regards,

A handwritten signature in black ink, appearing to read "Andrew Behrman", with a long horizontal flourish extending to the right.

Andrew Behrman
President and CEO
Florida Association of Community Health Centers

Background

CMS published 42 CFR Parts 431, 433, 435, and 457 on August 17, 2011, proposed rules that will implement Medicaid's new or expanded coverage eligibility created through the Affordable Care Act of 2010 (ACA). It is estimated that, by 2019, if the ACA is fully implemented, federally qualified health centers' (FQHC) total patient base will rise by approximately 50 million patients nationwide¹. Of this number, 44% are projected to be Medicaid beneficiaries, and 9% Exchange enrollees.²

In tough budget times at all levels of government, any increased costs to local and state jurisdictions will be met with a negative reception. The cost of annual recordkeeping and reporting requirements have been estimated at a total cost of \$65.4 million (of which the States will be responsible for \$32.7 million)³ by the CMS office of the Actuary (OACT)⁴, and the final total cost to States, including all provisions of the proposed rule, has been estimated by the OACT to be approximately \$80.3 billion. However, it has been determined that this cost should be minimized – to the extent of budget neutrality – if, in collaboration with planned and proposed Federal FMAP increase and expansion cost-sharing outlays, the States are able to enact and realize the savings embedded within the proposed changes. In fact, it is projected⁵ that States will only have to incur a challenge of 6% of the \$80.3 billion estimated cost (which would then be addressed by the built-in savings).

The cornerstone adjustment to current Medicaid policy is the expansion of coverage beyond the current federal minimums. For example, prior to the Affordable Care Act (ACA), States could not cover non-disabled, non-elderly adults who do not have dependent children, regardless of their income level, except through a Medicaid demonstration under Section 1115 of the Act. However, with exceptions detailed within the proposed rule, these individuals – and millions more who are economically disadvantaged – will be eligible to be brought under the umbrella of Medicaid coverage. By so doing, the intended impact and effect would be that those providing care, those paying for private insurance and those aiding in filling the funding gaps that result from uncompensated care (e.g. government) will all realize savings and an improvement in service.

Starting in calendar year (CY) 2014, the ACA extends and simplifies Medicaid eligibility by replacing the complex categorical groupings and limitations to provide Medicaid eligibility to all individuals under age 65 with income at or below 133 percent of the Federal Poverty Level (FPL) – provided an individual meets certain non-financial eligibility criteria. Children and, in some States, pregnant women will be eligible at income levels equal to or higher than the 133 percent level, depending on existing State-established income eligibility standards and the flexibility and availability of State policy makers to make such determinations.

In addition, starting January 1, 2014, eligibility for Medicaid for most individuals, as well as for CHIP, will be determined using methodologies that are based on modified adjusted gross income (MAGI), as defined in the Internal Revenue Code of 1986 (IRC). Per the ACA, eligibility for advance payments of premium tax credits for the purchase of private coverage through the Exchange will use MAGI as it is defined in the IRC to determine eligibility as well.

FACHC is strongly encouraged by the developments within, and contents of, the proposed rule to which this response is being written – as well as a number of other proposed rules and provisions of the ACA that have been, and will soon be, implemented. We thank CMS for the opportunity to provide our input and suggestions, as follows.

¹ FACHC has previously submitted comments to CMS regarding the proposed Health Insurance Exchange (HIE) rule (can be retrieved or referenced from the FACHC website at www.fachc.org); this submission is in response to the Medicaid expansion proposal, with only an occasional reference to the HIE rule.

² Kaiser Commission for Medicaid and the Uninsured, *Community Health Centers: Opportunities and Challenges of Health Reform* (Aug. 2010), Fig. 9 <http://www.kff.org/uninsured/upload/8098.pdf>

³ Federal Register /Vol. 76, No. 159, Page 51181; CMS-2011-0139-0002; *Table 2 – ANNUAL RECORDKEEPING AND REPORTING REQUIREMENTS* <http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/pdf/2011-20756.pdf>

⁴ <https://www.cms.gov/medicaideligibility/downloads/CMS-2349-P-PreliminaryRegulatoryImpactAnalysis.pdf>

⁵ Both the CMS Office of the Actuary Analysis and an independent study conducted by The Urban Institute and Kaiser Family Foundation have found that around 94% of the costs of these proposed adjustments will be incurred at the Federal level. <https://www.cms.gov/medicaideligibility/downloads/CMS-2349-P-PreliminaryRegulatoryImpactAnalysis.pdf> & <http://www.urban.org/uploadedpdf/412361-consider-savings.pdf>

Comments and Proposed Rule Amendments

FACHC would like to commend the policy makers and those writing the proposed regulations that implement the key provision of Medicaid reform at the federal level. Section 2001(e) of the ACA adds a new section 1902(a)(10)(A)(ii)(XX) of the Act, giving individuals above 133% FPL (§ 435.218) an increased opportunity for health care through option starting in CY 2014 to provide Medicaid coverage to individuals under age 65 (including pregnant women and children). Children are included in this new optional group for individuals above 133 percent FPL if they are not already eligible for Medicaid⁶. In addition, assets will no longer be considered in determining financial eligibility for Medicaid or CHIP, which will also add tremendously to answering the need for affordable care and adequate coverage.

FACHC would also like to commend CMS in their writing of the Medicaid proposed rule, in that it revises the definition of an individual's state of residency in a way that benefits seasonal and migrant workers – a contingent of FQHC patient focus and FQHC scope of effort. As revised, the definition refers to the state where the individual: “(i) intends to reside, including without a fixed address or, if incapable of stating intent, where the individual is living; or (ii) has entered the state with a job commitment or seeking employment (whether or not currently employed).” The revision is beneficial to the patients of this residential status, in that it eliminates the requirement of intent to remain permanently in the state. CMS noted that the revision was intended to “ensure a consistent approach for migrant, seasonal workers and other families living in a state while employed or in search of employment.” FACHC is in agreement with this change and supports CMS in these efforts.

We would also like to extend our agreement with CMS regarding their decision to suggest that, to be consistent with sections 1413 and 2201 of the ACA, under the coordinated system proposed in these rules, if the Exchange finds that an individual is eligible for Medicaid or CHIP, the State Medicaid agency must enroll the individual without further determination of eligibility. Also, that the rule continues to later state that the Medicaid agency must assess potential eligibility for other insurance affordability programs⁷ when the agency determines that an individual is not eligible for Medicaid. Were CMS to require this as a mandatory feature of both HIEs and the Medicaid Agency(ies), this would greatly reduce duplication of effort and confusion of the patient, as eligibility would be more streamlined and the efforts already put forth will be shared, rather than “lost”, resulting in a possible delay of receiving coverage. Likewise, with the current technological advances in electronic health records (EHR) and health information technology (HIT), this coordination of effort should be less administratively taxing than if the entities were to not share information on Medicaid eligibility determination.

In reference to a different section, FACHC suggests that the proposed Medicaid regulations allow migrant workers, who are determined to be eligible Medicaid beneficiaries in State “A” obtain Medicaid benefits in a state where they work seasonally, or State “B”. A provision to Section 42 C.F.R. § 431.52 should be added, in which seasonal farmworkers, as Medicaid beneficiaries of State A, would be permitted access to Medicaid benefits in State B, with the providers in State B would be paid by State B's Medicaid agency. In other words, Medicaid eligibility should be transferrable. The Medicaid proposed rule does not expressly permit or prohibit this. Through the use of technology and sharing of electronic medical records, this provision for, and assurance of, continuity of care will provide a fiscal reprieve to providers who may otherwise have to absorb an uncompensated care visit.

The Medicaid proposed rule states that CMS is considering a requirement that terminations of Medicaid eligibility take effect on the last day of a calendar month. This would minimize coverage gaps that occur when Medicaid coverage terminates before Exchange coverage commences. Specifically, under the Exchange proposed rule, Exchange enrollment may commence no earlier than the first day of the month after the month when a person loses Medicaid eligibility; therefore, it would be in the best interest of the patient to be granted this coverage continuity in order to avoid a potential coverage gap. It has also been suggested that this provision would aid in the continuity of care provided by states that are transitioning Medicaid into more of a “managed care” environment – as is the attempt currently being undertaken on a statewide basis in Florida. FACHC would support CMS in making this proposal a part of the final rule.

In an analysis provided to FACHC, conducted by Feldesman Tucker Leifer Fidell LLP, proposed 42 C.F.R. § 435.916 is referenced and commented on as:

⁶ Therefore, if a State covers children above 133 percent FPL under a separate CHIP and adopts coverage under this new optional group, the State ultimately must shift coverage of children with income at or below the income standard from CHIP to Medicaid under this group.

⁷ Section 1943(b)(1)(C) of the Act directs States to ensure that any individual who applies for, but is determined ineligible for, Medicaid or CHIP is screened for eligibility for advance payment of the premium tax credit, cost sharing reductions, and enrollment in a qualified health plan offered through the Exchange.

“The proposed rule contains positive provisions to promote continuity of Medicaid coverage, but it does not go far enough. In order to minimize churning, CMS proposes to require Medicaid redeterminations to occur once every 12 months for beneficiaries whose eligibility is based on MAGI. States currently have the discretion to require eligibility determinations more frequently (although few do). While the provision in the proposed rule helps to ensure longer periods of coverage, it does not guarantee a continuous year of eligibility, because redeterminations can be conducted more frequently if the Medicaid agency obtains information through the data match suggesting the need for a new eligibility review.”

Though this interpretation appears to be quite distressing, FACHC’s own internal analysis was presented with an alternate concern, regarding this situation, which needs clarification and may put the cited analysis’s concern to rest. In § 433, under eligibility methodology option 3, the proposed rule reads:

“We also propose that once an individual is determined to be either a newly eligible individual or an individual who would have been eligible under the December 2009 standards for FMAP determination purposes, the determination would be applicable throughout the 12-month eligibility period after a person is determined eligible.”

FACHC was unable to identify clarification of this point, which would respond to the concern about continuity of care (through those services and payment methods for which an individual is originally determined eligible) for a complete 12-month cycle, regardless of the discovery of evidence following eligibility approval that would deem the individual ineligible.

FACHC would like to request clarification of this point and would suggest that CMS determine in their final rule that an individual be eligible for services for a full 12-month period, following approval – regardless of being deemed ineligible at some point following the approval. This 12-month span should commence on day 1 of approval and conclude a full calendar year (leap year included) later. For example, should an individual be determined ineligible for Medicaid coverage on day 364 or day 1, following approval, then coverage under this method should be ceased upon the 365th day (or 366th in leap years). This will work to the benefit of the patient and the state, as the patient will be guaranteed a certain level of consistency and continuity in care, while the state will be strongly encouraged to properly and thoroughly examine all relevant information and data in making an accurate Medicaid determination.

In another section of the proposed rule, which has brought concern to FACHC, it is stated that Medicaid agencies would be required to re-determine eligibility automatically, using the data matching system – rather than requiring the beneficiary to submit a newly signed application, if the agency is “able to do so based on reliable information contained in the individual’s account or other more current information available to the agency...”⁸ Conversely, Medicaid agencies are also provided the option to require applicants to submit documents proving eligibility. In other words, the streamlined process is at the state’s discretion. Though the requirement to resubmit personal information on an annual basis is cumbersome and labor-intensive on the parts of both the individual and the agency, in many instances, the citizen’s perspective of “individual freedoms” and the state’s ability to access necessary personal information (e.g. tax returns) may prove to be a “non-starter” for many states’ Legislatures and policy-makers who favor personal liberties and responsibilities, while preferring a reduction of government oversight into individuals’ personal affairs. By allowing this option to be determined by the States, CMS is correctly balancing federalism with States’ rights and accurately measuring the differences between technological capabilities amongst the states. This clarification (i.e. State options) should be included in the final published rule.

There are a number of other instances in which FACHC, currently finding itself within the realities of Florida politics, would strongly agree with and applaud CMS’s suggested allowances that provide States with the power to make decisions regarding a large number of fiscal and policy interests. For example, FACHC supports CMS in considering permitting States to convert to MAGI-based methodologies prior to 2014 through section 1115 demonstrations. This would give States the additional flexibility, for individuals eligible for Medicaid, based on MAGI, to maintain eligibility as long as annual income based on MAGI methods for the calendar year remains at or below the Medicaid income standard.⁹ Should a State make the choice to follow up on this proposal – should it be included within the final rule – then that State would be provided with an opportunity to implement the policy in advance, aiding in the patients’ transitions in 2014, as well as an individual HIE’s policy creation(s) – adding to the seamlessness and fluidity of moving into the future Medicaid eligibility regulations.

⁸ § 435.916(a)(2)

⁹ Provisions of Proposed Rule Implementing MAGI Methods: in determining ongoing eligibility of individuals enrolled in the Medicaid program as of January 1, 2014, the financial methodologies based on MAGI shall not be applied until the next regularly-scheduled redetermination of eligibility after December 31, 2013 or March 31, 2014, whichever is later, if such individual otherwise would lose eligibility as a result of the shift to MAGI-based methodologies before such date.

Similarly, FACHC finds agreeable CMS's suggestion to allow States to develop a coordinated eligibility and enrollment system for all insurance affordability programs. Whereas Section 1943(b)(3) and Section 1413 of the ACA direct the Secretary to develop and provide States with a single, streamlined application, CMS proposes that States may use supplemental forms to gather additional information, such as information pertaining to resources, needed to make an eligibility determination and develop and use an alternative single, streamlined application form designed specifically to capture information needed to determine eligibility for individuals whose eligibility is not determined based on MAGI. By allowing States to determine their own guidelines and forms, this may result in a small amount of red tape in relation to inter-state Medicaid agreements/interactions/information sharing, but will also grant the States the flexibility to outline their own information needs and technological data systems.

The proposed rule states that, while CMS is undertaking a number of business processes, structural and system improvements designed to support modernized IT systems and streamline the manner in which it works with States and minimize burdens in review and approval processes, enhanced funding at a 75% Federal matching rate is being made available for States to maintain and operate their eligibility systems. FACHC is strongly encouraged by this fiscal support to States for the improvement of its technology.

If you wish to contact FACHC with any questions or comments:

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