National
Family Planning
& Reproductive Health Association

October 31, 2011

The Honorable Kathleen Sebelius
Secretary, US Department of Health and Human Services
Attention: CMS-2349-P
PO Box 8016
Baltimore, MD 21244-8016
Attention: CMS-9974-P
PO Box 8010
Baltimore, MD 21244-8010

The Honorable Timothy Geithner
Secretary, US Department of the Treasury
CC:PA:LPD:PR (REG-131491-10)
Room 5203
Internal Revenue Service
PO Box 7604
Ben Franklin Station
Washington, DC 20044

Re: "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010" (CMS-2349-P); "Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers; Proposed Rule" (CMS-9974-P); "Health Insurance Premium Tax Credit" (REG-131491-10)

Dear Secretary Sebelius and Secretary Geithner:

The National Family Planning & Reproductive Health Association (NFPRHA) is pleased to respond to the three proposed rules ("tri-regs") issued by the Department of Health and Human Services (HHS) and the Department of the Treasury ("Treasury") in the August 17, 2011, Federal Register, implementing certain provisions of the Affordable Care Act (ACA).[1]

NFPRHA is a national membership organization representing the nation's family planning providers – nurse practitioners, nurses, administrators and other key health care professionals. NFPRHA's members operate or fund a network of more than 3,700 health centers and service sites that provide high-quality family planning and other preventive health services to millions of low-income, uninsured, or underinsured individuals in 48 states and the District of Columbia.

[1] Portions of the discussion and recommendations in these comments were adapted with the permission of the National Women's Law Center and the National Health Law Program (NHeLP).

NFPRHA supports HHS' efforts to extend and simplify Medicaid eligibility and to provide financial incentives to states to facilitate the expansion of full-benefit Medicaid eligibility in the proposed rule "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010" (CMS-2349-P). NFPRHA is concerned, however, that certain sections of the tri-regs are written too broadly and could inadvertently penalize individuals enrolled in and eligible for certain limited-benefit programs under Medicaid, and potentially punish states for having expanded such coverage prior to the ACA's passage. NFPRHA offers the following comments and recommendations to address these concerns and strengthen the tri-regs.

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Ensuring that Individuals Enrolled in and Eligible for Medicaid Family Planning Expansions are Not Accidentally Excluded from Eligibility for the Premium Tax Credit (REG-131491-10)

NFPRHA is concerned that the "Health Insurance Premium Tax Credit" proposed rule does not fully contemplate the current inclusion of certain limited-benefit programs in Medicaid and that, as written, could actually punish states for expanding coverage to certain populations and for certain services prior to the ACA's passage.

Prior to the ACA, full-benefit Medicaid eligibility was limited to certain "categories" or "categorical groups" of individuals. Being low-income was not enough to qualify an individual for full-benefit Medicaid; that person had to be low-income AND fall into an additional category (such as children, pregnant women, parents, seniors, or people with disabilities), which left millions of low-income Americans in need of health coverage ineligible for Medicaid. The ACA changes this both by expanding full-benefit Medicaid income eligibility to 133% of the federal poverty level (FPL) and by simplifying Medicaid eligibility requirements. Beginning in 2014, low-income individuals under age 65 with incomes at or below 133% of the FPL will be eligible for full-benefit Medicaid, regardless of any qualifying category.

Since the 1990s, the Centers for Medicare & Medicaid Services (CMS) has been approving expansion programs, authorized as demonstration waivers by §1115 of the Social Security Act, to provide family planning services and supplies to individuals who are not eligible for full-benefit Medicaid. These family planning waiver programs are limited-benefit programs: enrolled individuals can only access a specific set of services, limited to family planning, and the programs do not provide Medicaid coverage for the broader, comprehensive health care provided to full-benefit Medicaid beneficiaries. Recognizing the importance of these programs to reducing unintended pregnancy, Congress included

a provision in the ACA to allow states to expand their Medicaid coverage of family planning through optional state plan amendments,[2] rather than by a waiver.

Benefits for Medicaid family planning expansion programs (both demonstration waivers and state plan amendments) are generally limited to family planning and related services and supplies; §1902(a)(10)(G)(XVI) of the Social Security Act limits family planning state plan amendments to "family planning services and supplies... including medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting."

Many of the individuals currently enrolled in or eligible for family planning expansion programs are at or below 133% of the FPL, and will therefore be newly eligible for and enrolled in full-benefit Medicaid under the ACA in 2014. Others are above 133% of the FPL, and may enter the insurance exchange, or they may still become eligible for full-benefit Medicaid if their state chooses to expand Medicaid eligibility above 133% of the FPL.

Section 1.36B-2 of the "Health Insurance Premium Tax Credit" proposed rule details eligibility for the premium tax credit under the ACA, which is available to help individuals and families below 400% of the FPL "afford health insurance coverage,"[3] and is designed to "make a qualified health plan affordable by reducing a taxpayer's out-of-pocket premium cost."[4]

Under §1.36B-2(a)(2) of the proposed rule, and along with other requirements, a taxpayer eligible for the premium tax credit is allowed the credit only if the taxpayer (or spouse or dependent) "[i]s not eligible for minimum essential coverage" as defined by the proposed rule. Under §1.36B-2(c)(2), the Treasury Department identifies government-sponsored programs which qualify as "minimum essential coverage" by reference to §5000A(f) of the Internal Revenue Code. Section 5000A(f)(ii) of the Internal Revenue Code includes coverage under "the Medicaid program under title XIX of the Social Security Act" in its definition of minimum essential coverage.

NFPRHA is concerned that, as written, the proposed rule might be interpreted to include individuals receiving family planning supplies and services through a demonstration waiver authorized by §1115 of the Social Security Act or through an optional state plan amendment under §1902(a)(10)(A)(ii) of the Social Security Act.[5] As of October 25, 2011, 29 states have received approval from CMS to expand Medicaid eligibility for family planning services through a §1115 demonstration waiver or

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[2] Authorized by §2303 of the ACA; codified at §1902(a)(10)(A)(ii) of the Social Security Act.

[3] Department of the Treasury, Internal Revenue Service, "Health Insurance Premium Tax Credit," REG-131491-10, p. 50932.

[4] *Ibid*.

[5] Authorized by §2303 of the ACA.

through an optional state plan amendment authorized by the ACA. These programs do not provide the full set of benefits contemplated by Congress as minimum essential coverage under the ACA, and should not preclude otherwise eligible low-income individuals from obtaining the premium tax credit to help "make a qualified health plan affordable."

The Department carved out a special rule for individuals receiving coverage under the veteran's health care program under chapter 17 or 18 of Title 38 of the U.S. Code, stating that coverage under these chapters is considered minimum essential coverage only if the individual is enrolled in certain veteran's health care programs identified in the forthcoming regulation issued under §5000A.[6] The Treasury Department should create a similar exception for individuals receiving family planning services and supplies through §1115 demonstration waivers or under §1902(a)(10)(A)(ii) of the Social Security Act.

In order to keep with the intent and spirit of the ACA, the Treasury Department should amend §1.36B-2(c)(2) of the proposed rule to include an exception stating that an individual is eligible for minimum essential coverage under title XIX of the Social Security Act only if the individual is enrolled in a Medicaid program identified as minimum essential coverage in the forthcoming regulations issued under §5000A. Family planning programs authorized through §1115 demonstration waivers and programs under §1902(a)(10)(A)(ii) of the Social Security Act should be excluded from the list of programs identified as minimum essential coverage in the forthcoming regulation under §5000A.

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Ensuring that Medicaid Meets the Needs of All Individuals Eligible for Coverage, and that State Efforts to Expand Certain Limited-Benefit Medicaid Programs Do Not Penalize States or Individuals (CMS-2349-P)

Defining "Newly Eligible" for the Purposes of the Enhanced FMAP Rate

The ACA provides significant financial incentives to states to fully implement the Medicaid eligibility expansion by providing for a significant increase in the Federal Medical Assistance Percentage (FMAP) for individuals who are considered to be "newly eligible" as defined in §1905(y)(2)(A) of the Social Security Act. Section 1905(y)(2)(A) defines "newly eligible" as:

> "…an individual who is not under 19 years of age (or such higher age as the State may have elected) and who, on the date of enactment of the Patient Protection and

[6] §1.36B-2(c)(2)(ii)

> Affordable Care Act, is not eligible under the State plan or under a waiver of the plan ***for full benefits or for benchmark coverage*** described in subparagraph (A), (B), or (C) of section 1937(b)(1) ***or benchmark equivalent coverage***..."[7] [emphasis added]

However, §433.204 of the "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010" proposed rule defines "newly eligible individual" as "an individual eligible for Medicaid in accordance with the requirements of the new adult group and who would not have been eligible ***for Medicaid*** under the State's eligibility standards and methodologies for the Medicaid State plan, waiver or demonstration programs in effect in the State as of December 1, 2009." [emphasis added]

The difference between the definition contained in statute and the definition contained in the proposed Medicaid rule is potentially significant, in that it could be interpreted to allow individuals currently enrolled in or eligible for certain limited-benefit Medicaid programs to be excluded from the "newly eligible" category for the purposes of the enhanced FMAP rate, which would harm states' ability to fully implement the ACA's Medicaid expansion.

Millions of individuals enrolled in or eligible for family planning expansion programs[8] have incomes under 133% of the FPL and will therefore be eligible for full-benefit Medicaid in 2014; however, if they are not considered "newly eligible," states would not receive the ACA's enhanced FMAP rate for their services, which could serve as a significant disincentive for states to promptly enroll them in full-benefit Medicaid coverage. Individuals currently enrolled in or eligible for programs through the Breast and Cervical Cancer Treatment Program (BCCTP) could face a similar problem under the proposed rule as currently written.[9]

Excluding individuals currently enrolled in or eligible for limited-benefit Medicaid programs contradicts the statute and would undermine the intent of the ACA's expansion of full-benefit Medicaid. It would also contravene CMS' previously expressed intent with regard to the family planning state option authorized by the ACA.[10] CMS' July 2, 2010, letter to state health officials ("RE: Family Planning Services Option and New Benefit Rules for Benchmark Plans") stated:

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[7] Social Security Act §1905(y)(2)(A).

[8] Authorized through a §1115 (Social Security Act) demonstration waiver or through an optional state plan amendment authorized by §2303 of the ACA.

[9] Social Security Act §1902(a)(10)(A)(ii)(XVIII). Benefits for this optional expansion are "limited to medical assistance provided during the period in which such an individual requires treatment for breast or cervical cancer." Social Security Act §1902(a)(10)(G)(XIV).

[10] Although the proposed rule would preclude only individuals in Medicaid state plans "in effect in the State as of December 1, 2009," and the first family planning state plan amendment was not authorized until 2010, NFPRHA is concerned that the proposed rule could also inadvertently impact family planning state plan amendments, as the majority of state plan

"Some of the individuals that a State might cover under this new option (depending on their income) may be eligible for a more comprehensive set of benefits as States implement Medicaid and other coverage expansions under the ACA. ***Taking up the new family planning eligibility group does not preclude or in any way affect receipt of the increased matching rate*** (based on the requirements in effect when this group becomes mandatory in 2014). CMS will issue separate guidance on the matching rate provisions in the new health insurance reform legislation."[11] [emphasis added]

NFPRHA therefore suggests modifying §433.204 to reflect the statutory language contained in §1905(y)(2)(A) of the Social Security Act, as follows:

"*Newly Eligible Individual* means an individual eligible for Medicaid in accordance with the requirements of the new adult group and who would not have been eligible for **full** Medicaid **benefits or benchmark Medicaid benefits under §1937** under the State's eligibility standards and methodologies for the Medicaid State plan, waiver or demonstration programs in effect in the State as of December 1, 2009." [suggested language underlined]

Streamlining Medicaid Eligibility and Enrollment Procedures

NFPRHA appreciates HHS's efforts to simplify Medicaid eligibility and enrollment procedures in the proposed Medicaid rule, and supports changes designed to:

- Enable individuals to apply for, renew, and enroll in Medicaid online (§435.905);
- Provide a simplified and streamlined Medicaid application (§435.907);
- Clarify and reinforce Medicaid residency rules in support of determinations based upon where the individual is living and has intent to reside, including without a fixed address, or based on where an individual has a job commitment or is seeking employment (§435.403); and
- Ensure that individuals eligible for coverage receive assistance, if needed, with the application and renewal process (§435.908).

NFPRHA supports the creation of an electronic service through which states can verify certain eligibility information with federal agencies such as the Social Security Administration, Department of Treasury, and the Department of Homeland Security. This service would improve states' ability to

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amendments approved to date were converted from §1115 demonstration waivers that were in existence on December 1, 2009.

[11] US Department of Health and Human Services, Centers for Medicare & Medicaid Services, Letter to State Health Officials, "RE: Family Planning Services Option and New Benefit Rules for Benchmark Plans," July 2, 2010.

verify eligibility data, especially when it originates from outside the verifying state, which to date has proved difficult at best.

NFPRHA applauds HHS' encouragement of self-attestation of eligibility criteria which, in conjunction with the creation of an electronic verification service, would help states ensure that those who are eligible for Medicaid are not blocked from enrollment due to missing, incomplete, or inaccurate application information. Low-income individuals are disproportionately impacted by documentation requirements, often lacking access to documents proving residency, income, or even identity. Expressly permitting states to accept attestation for eligibility criteria, including income, age, birth date, and state residency, would remove a significant barrier to coverage for many individuals.

However, NFPRHA notes that the proposed rule does not address the resources needed to conduct such verification for the millions of individuals who will become newly eligible for full-benefit Medicaid in 2014. Along with verification, the 2014 Medicaid expansion will require significant investments of staff and time – at both the state and local levels – to locate, enroll, and assist newly eligible individuals. Many of the individuals who will be newly eligible for full-benefit Medicaid in 2014 are already being seen in safety-net systems and health centers around the country, including publicly funded family planning centers. As HHS continues to prepare for and implement provisions of the ACA, NFPRHA hopes that HHS will consider how to utilize and assist safety-net providers and networks in the full-benefit Medicaid expansion, and provide the guidance and financial resources necessary to prepare for a successful expansion.

NFPRHA also encourages HHS to work to eliminate the barrier to care caused by the ongoing strict interpretation of rules related to citizenship and immigration status. The citizenship documentation requirements imposed by the Deficit Reduction Act of 2005 continue to be a major problem for low-income individuals seeking coverage for which they are eligible. According to a June 2007 Government Accountability Office (GAO) study, half of the 44 responding states reported declines in Medicaid enrollment due to the requirement, mostly due to delays in, or losses of, Medicaid coverage for individuals who appeared to be eligible citizens.[12] Other studies have also shown that citizenship documentation requirements create barriers to care primarily for qualified applicants. Given that the proposed rule requires states to verify eligibility information through an electronic service when possible, the requirement that applicants continue to provide paper proof of citizenship or immigration status should be reviewed and, where possible, eliminated.

[12] United States Government Accountability Office, *States Reported That Citizenship Documentation Requirement Resulted in Enrollment Declines for Eligible Citizens and Posed Administrative Burdens* (Washington, DC: June 2007).

Extending the Medicaid Coverage Month to Eliminate Gaps in Health Insurance Coverage (CMS-2349-P)

HHS specifically asked for comment on a provision it is considering adding to the proposed Medicaid rule that would "extend Medicaid coverage until the end of the month that the appropriate termination notice period ends." This provision would line the Medicaid proposed rule up with §155.410 of the "Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers" proposed rule, which prohibits individuals who have been terminated from Medicaid from enrolling through the Exchange until, at the earliest, the first day of the month following the date the individual loses Medicaid eligibility and is determined eligible for the Exchange; for individuals who lose Medicaid eligibility after the 22nd day of the month, enrollment cannot begin until at least the first day of the second month following such date.

The concept of "churning" – wherein individuals cycle between Medicaid and the exchange based upon fluctuations in income, among other variables – is of great concern to NFPRHA members, who serve primarily low-income populations and have significant experience with the fluctuating incomes and circumstances of their patients. Ensuring continuity of coverage and quality of care, regardless of payer source, is a priority for NFPRHA and its members. Therefore, NFPRHA strongly supports including a provision to extend Medicaid coverage to the end of the month immediately prior to the month in which the terminating individual's exchange enrollment is allowed to begin, which would help bridge potential gaps in coverage for individuals cycling between Medicaid and the exchange.

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Ensuring that Individuals Eligible for Optional Medicaid Coverage are Provided with Full Eligibility Determinations (CMS-9974-P)

Section 1902(a)(10)(A)(ii) of the Social Security Act lists various populations that states have the option of including in their Medicaid program, and a number of states have §1115 demonstration waivers to expand Medicaid coverage to certain populations. States may cover some of these optional coverage groups with income standards that can exceed 133% of the FPL. The ACA does not eliminate these coverage groups, and states may want to continue to cover these populations despite the availability of the exchange and tax credits for some individuals above 133% of the FPL. For example, all states currently cover women who have breast or cervical cancer,[13] and 29 states have programs

[13] §1902(a)(10)(A)(ii)(XVIII).

expanding Medicaid eligibility for family planning services through a §1115 demonstration waiver or through an optional state plan amendment.[14]

There are some holes in the proposed regulations that must be filled to ensure that women and men who are eligible for such coverage are told about it, are given eligibility determinations, and properly enrolled. Section 435.911(c) of the "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010" proposed rule requires that state Medicaid agencies must determine eligibility for (1) mandatory coverage on the basis of modified adjusted gross income (MAGI), and (2) whether such individual is eligible for Medicaid on any other basis. The second part would include screening for eligibility for individuals eligible for programs such as the Breast and Cervical Cancer Treatment Program (BCCTP) and Medicaid family planning expansion programs.

Section 155.305 of the "Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers" proposed rule, however, sets out the eligibility standards that must be determined by the exchange. Section (c) requires the exchange to determine an applicant's eligibility for Medicaid if the applicant has a household income at or below the applicable Medicaid MAGI-based income standard and meets other eligibility criteria. Under the proposed exchange rule, an exchange is not required to determine eligibility for all optional Medicaid categories that are covered in that state.

Section 155.345(c) of the "Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers" proposed rule requires an exchange to provide an opportunity for an applicant to request a full determination of eligibility based on eligibility criteria that are not addressed in §155.305. However, this requirement is insufficient to ensure that individuals can access all programs available to them. If an individual does not know that categories beyond the MAGI-based criteria exist, the obligation should not be on the individual to request that an exchange provide an eligibility determination based on the full range of eligibility criteria.

Therefore, §155.305 of the proposed exchange rule should be amended to include a requirement that an exchange determine eligibility for Medicaid on any basis of eligibility offered in that state. Individuals should be informed of all their options, screened for eligibility and provided that choice.

At the very least, §155.345(c) should be amended to require an exchange to notify applicants of the Medicaid programs that may be available to them so that the applicant can request an appropriate

[14] §1902(a)(10)(A)(ii)(XXI).

determination of Medicaid eligibility from the state agency. If the exchange does not notify individuals that they may be eligible for Medicaid in a category that goes beyond the MAGI income-based determination, those individuals may never know that they are foregoing an opportunity that may be advantageous.

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We appreciate the opportunity to comment on the tri-regs. If you require additional information about the issues raised in these comments, please contact Robin Summers at 202-293-3114.

Sincerely,

Clare Coleman
President & CEO