NEW YORK
state department of
HEALTH

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SUBJECT: New York State Department of Health comments filed on: Eligibility Changes Under the Affordable Care Act of 2010 (CMS-2349-P); Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers (CMS-9974-P); and Internal Revenue Service: Health Insurance Premium Tax Credit (REG-131491-10)

The New York State Department of Health, the agency responsible for Medicaid and the Children's Health Insurance Program (CHIP) is submitting comments on the three proposed regulations issued on September 9, 2011 concerning Medicaid eligibility, Health Insurance Exchange enrollment functions, and health insurance premium tax credits. New York acknowledges and appreciates the tremendous work of our federal partners at HHS and the Internal Revenue Service to align, streamline and simplify enrollment across all Insurance Affordability programs, as reflected in these proposed regulations. We appreciate the opportunity to provide comments to help maximize the degree to which the eligibility rules are aligned across programs. New York is committed to the vision created by the Affordable Care Act of a continuum of coverage based on income, with Medicaid as the foundation, as well as a more streamlined enrollment process for all those eligible for coverage. Thank you for the opportunity to submit these comments.

In this transmittal memo, we highlight a few high priority areas reflected in our detailed comments. New York's complete comments are provided in an attached chart, organized by section of the regulations for ease of review. Since the mechanics of how the new eligibility rules will work in practice can only be shown through actual case examples, we have attached a few scenarios that raise issues. The scenarios are a mix of those we want confirmation that we understand the rules correctly, those in which the rules appear contradictory, and those that introduce a level of complexity that creates administrative challenges in determining eligibility. We look forward to a dialogue with our federal partners on these scenarios and others as we implement the eligibility changes.

The high priority areas of greatest concern to New York are: 1) Maximizing Near Real Time Enrollment; 2) Aligning New Eligibility Rules with Program Integrity Requirements; 3) Aligning Claiming Rules with New Eligibility Levels; and 4) the Need for a Nimble Implementation Environment. Examples of concerns in each of these areas are provided below.

1. Maximize Near Real Time Enrollment

New York strongly supports CMS's vision of real time eligibility determinations using automated rules engines and trusted third party verification sources with minimal reliance on paper. In order to achieve this vision, the federal government needs to provide a robust federal data hub and eliminate some requirements that will impede streamlined enrollment.

Robust Federal Hub. New York's ability to successfully implement faster, more seamless MAGI eligibility determinations depends in large part on the data and services available through the federal hub. Ideally, the federal hub would include all the data needed to determine eligibility. The extent to which States need to supplement the data in the federal hub with a state hub creates complex data reconciliation issues, though we recognize some state data may be necessary such as unemployment income and new hires. New York seeks to automate the eligibility process without the need for a significant level of "behind the scenes" human intervention or additional requests for documents from applicants/enrollees. Otherwise, in light of significant state staffing and budget constraints, projected enrollment increases, and ongoing economic challenges, eligibility determinations could actually end up taking longer than they do today.

We offer the following considerations for the federal hub:

- *Minimize the reconciliation of competing data sources.* To the extent states rely on multiple data sources for an eligibility factor (e.g., income), it creates challenges in reconciling different results. Often the reconciliation process leads to requesting paper documents to verify eligibility which delays enrollment and causes applicants to abandon the process. At a minimum, HHS should work with states to develop a hierarchy of data sources, including self-attestation, to minimize the frequency in which paper documents are required to complete the enrollment process.
- *Provide the level of detail in the data necessary to determine eligibility.* The federal hub should return data in the level of detail needed to determine eligibility. Combined income or consolidated household size will not be useful to determine eligibility and will make it impossible for the Exchange to identify those households that should follow Medicaid rules (e.g., non-custodial parents claiming children and grandparents). The Exchange will need to know the relationship of all members of the household. In terms of income, states need the amount of income by source. If Medicaid needs to verify against more recent income (e.g., wage reporting), it will be critical to have the income from tax returns represented by wages as compared to other sources of income. Moreover, some sources of data will only be available electronically from the tax return. To build a complete and more recent picture of income, states may choose to rely on the wage reporting system for wages, and tax return data for interest income or other non-earned income.
- *Create services once rather than 50 times.* The availability of SSA data to verify citizenship is an example of a successful federal service that has enhanced eligibility verification and reduced reliance on paper documents. The goal of the federal hub appears to be to provide more data in this manner. In addition to federal data, the hub should also consider including proprietary data sources to provide more current income information and to verify the identity of the applicant prior to returning sensitive information for review. It will be more costly for each state to contract with vendors for the same information to verify eligibility than to have the federal government include some of these sources in the hub.

Eliminate other "conditions" for Medicaid eligibility that impede automated enrollment. There are other key barriers to real time determinations that need to be addressed in subsequent guidance. For example, as of 2014, parents and caretakers must have insurance for their children as a condition of their own enrollment in Medicaid. Taken together with the ACA coverage mandates and penalties, this establishes a broad new ACA framework and mechanism to help ensure coverage for children of individuals seeking Medicaid coverage. We believe this new framework should appropriately be construed as requiring elimination of medical support barriers to "real time" enrollment-- including the mandatory requirement for medical support cooperation as a condition of Medicaid eligibility.

2. Align New Eligibility Rules with Program Integrity Requirements

The proposed rules offer a great opportunity to simplify the eligibility determination and verification process and promote automated eligibility determinations. By providing tax data and other electronic verification sources, they also have the potential to improve program integrity over the largely paper-based process in current use. In order to be able to implement faster, streamlined eligibility determinations in an environment that does not include automated access to sufficient "real time" and current data sources by 2014, self- attestation becomes another important tool for the state to utilize. The proposed rules envision broad use of self-attestation for eligibility determinations, which would allow for much more automation. However, if Medicaid programs rely less on paper documents and more on attestation and electronic verification, the federal program integrity rules must be aligned with the proposed rules so that the state is not financially penalized for appropriately placing an increased reliance on this form of verification.

3. Align Claiming Rules with New Eligibility Levels

The state welcomes the options available for claiming enhanced FMAP that will not require New York to operate a "shadow" eligibility system based on old rules. We specifically endorse allowing for state-specific approaches that may combine one or more aspects of the proposed methodologies. We remain most interested in a simple threshold income methodology, potentially in combination with an established FMAP proportion, but want to be sure that the option available to the state would also include appropriate revisions to the existing claiming and reporting processes. This would be necessary for the state to correctly claim enhanced match for the newly eligible and for childless adults previously covered by New York as an Expansion state.

CMS needs to resolve the conflict created by the new VIII eligibility category with mandated benchmark benefits and disabled eligibility under state medically needy programs. It is critical and we appreciate that the guidance enables states like New York, with a medically needy program for parents and persons with disabilities, to determine disabled, non-Medicare individuals eligible for the new mandatory VIII category (435.119) if their income is below a MAGI level of 138% of FPL. However, it is also critical that states receive guidance on benchmark coverage under 1937 and available claiming under the ACA. Section 1937 precludes a state from mandating a person with a disability into a benchmark benefit package, though it can be offered as an option.

The new VIII eligibility category requires mandating benchmark benefits. The state should be able to claim, at a minimum, its regular FMAP rate for enrolling such a person in full Medicaid, if required, and if the person declines benchmark coverage.

The collapse of all prior mandatory and optional categories for parents into a mandatory category (435.110), while welcome as a needed simplification, raises several concerns about aligning eligibility levels and claiming. In New York, as nationally, Transitional Medicaid Assistance (TMA) has been available to certain low income parents, based on the 1996 AFDC levels. If TMA continues after 2014, the Low Income Family (LIF) level will need to be maintained to determine eligibility for TMA. This will require two eligibility calculations for parents. Ideally, the state would like to collapse all parent categories into one below 138% of FPL in order to ease the administrative burden of determining parents eligible at different income levels. However, if TMA continues and the state collapses parent categories, it will be at financial risk for continued Medicaid coverage for parents who would otherwise be eligible for premium tax credits. Another impediment to collapsing categories for parents is the mandate for benchmark coverage to the prior LIF level. If the benchmark benefits are different from full Medicaid benefits, we will need to retain a LIF category for parents. We seek further clarification on how to best align parent eligibility.

4. Need for Nimble Implementation Environment

The state also supports a phased in implementation that begins in, and extends well beyond, 2014. As we adjust our current eligibility levels and rules to accommodate the ACA, it will be critically important to remain nimble as implementation will be phased and mid-course corrections will undoubtedly be required. As such, it is important for the state's relationship with its federal partners to remain flexible and support an environment of rapid change.

Along these lines, we strongly endorse revamping the state plan amendment (SPA) process, which has historically been a very bureaucratic, lengthy, paper-intensive "stop the clock" process. We acknowledge and appreciate CMS' recent efforts to speed up the process and to make staff available for consultation regarding ACA implementation planning. We envision something along the lines of a submission of an operational work plan, which would be deemed approved by HHS within a relatively short time period if no action is taken to disapprove it. The very aggressive implementation timeline, and the ongoing need for flexibility in responding to newly emerging policies and guidance does not accommodate the current SPA process.
Finally, we credit our federal partners for their collaborative efforts, and for engaging with states in a number of different forums and methods (e.g., the technical advisory (TAG) groups, CMS/CCIIO calls with states, participation on various panels at Exchange planning meetings and conferences). We underscore the need for continued dialogue, particularly with State Medicaid Directors and State Insurance Commissioners, around coordinated implementation planning, including further policy review and revision based on questions and sample scenarios of how these rules affect households of different compositions.

New York appreciates your consideration of these comments and look forward to continuing to work with our federal partners to refine the proposed regulations.