May 7, 2012

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

RE: Interim Final Provisions of the Final Rule for the Medicaid Program: Eligibility Changes Under the Affordable Care Act of 2010 [CMS-2349-F] and Interim Final Provisions of the Final Rule for the Establishment of Exchanges and Qualified Health Plans: Exchange Standards for Employers [CMS-9989-F]

Dear Secretary Sebelius:

The Children's Defense Fund appreciates the opportunity to submit comments on the interim final provisions of the Final Rule for the Medicaid Program: Eligibility Changes Under the Affordable Care Act of 2010 and interim final provisions of the Final Rule for the Establishment of Exchanges and Qualified Health Plans: Exchange Standards for Employers. CDF's Leave No Child Behind® mission is to ensure every child a *Healthy Start*, a *Head Start*, a *Fair Start*, a *Safe Start* and a *Moral Start* in life and successful passage to adulthood with the help of caring families and communities. CDF provides a strong, effective and independent voice for *all* the children of America who cannot vote, lobby or speak for themselves. We pay particular attention to the needs of poor and minority children and those with disabilities. CDF educates the nation about the needs of children and encourages preventive investments before they get sick, drop out of school, get into trouble or suffer family breakdown.

For years CDF has worked to ensure health coverage for all children that is comprehensive, accessible and affordable and we believe the Affordable Care Act (ACA) moves us closer to that goal. The proposed rules reinforced a key piece of the ACA that would ensure children and their families can get enrolled and stay enrolled in quality health coverage through Medicaid, CHIP and the Exchanges. However, the final Medicaid and Exchange rules represent a significant departure from the original proposed rules and the intent of the ACA. We offer our comments on the interim provisions included in the final rules for Medicaid and the Exchanges together because as CDF made clear throughout the development of the ACA, we believe there must be a seamless system for eligibility determinations, enrollment, retention and renewal for children in Medicaid, CHIP and the Exchanges plans. To make sure the ACA works for children – particularly the most vulnerable children – Exchanges must be required to coordinate closely with Medicaid and CHIP. Together, these rules present an important opportunity to ensure all eligible children can get the health coverage they need through Medicaid, CHIP or the Exchange.

CDF offers the following comments:

CDF strongly opposes the bifurcation of the eligibility assessment and determination process between the Exchange and the Medicaid or CHIP agency. Children and their parents should be able to apply for health coverage at the Exchange, be assessed and be determined eligible for Medicaid, CHIP or premium tax subsidies through the Exchange in one stop. If the bifurcation is retained in the final rule, at a minimum, the Centers for Medicare and Medicaid Services

(CMS) must require specific safeguards to ensure that children and families are enrolled in the appropriate source of coverage in a timely and streamlined fashion.

The final rule allows states to elect to have their Exchange conduct merely a preliminary "assessment" of potential Medicaid and CHIP eligibility and then relinquish the final eligibility determination to the Medicaid/CHIP agency. Throughout the health reform debate and in our previous comments to CMS on coordination between Medicaid, CHIP and the Exchanges, CDF strongly advocated for an eligibility and enrollment system that is simple, seamless and coordinated across the three "affordability programs". We were pleased the ACA recognized the importance of such a system. The ACA was purposefully designed to create a seamless, streamlined eligibility process for consumers to submit a single application and receive an eligibility determination for enrollment in advance premium tax credits, cost-sharing reductions, Medicaid, CHIP, and, if applicable in a state, the Basic Health Program. Similarly, the proposed rules for the Establishment of the Exchanges and Qualified Health Plans (QHP), published in 2011, supported this "no wrong door" approach to coverage. They suggested the final regulations would offer multiple ways to apply for coverage but would also ensure that no matter how a family or individual chooses to apply for or renew coverage they would be screened for and enrolled in the appropriate program without having to take any additional or repetitive steps. In the proposed rules, Exchanges were expected to conduct eligibility determinations and also to enroll applicants in the appropriate affordability program, including Medicaid or CHIP.

However, the final Exchange and Medicaid rules represent a significant departure from the original proposed rules and, we believe, from the clear intent of the ACA that states establish a simple, unified pathway to health coverage for consumers. The final rules offer interim regulations that permit states to elect to have their Exchange conduct merely a preliminary "assessment" of potential Medicaid and CHIP eligibility and then relinquish the final eligibility determination to the Medicaid agency (§435.1200 and §155.302). We are deeply concerned that such a procedure will lead to a fragmented eligibility system in many states. This issue is of particular importance for children because they often reside in families that will be required to navigate both Exchange subsidies and Medicaid or CHIP. A large number of families interacting with the Exchange will have family members in different programs. In fact, the Urban Institute estimates that 75 percent of parents who qualify for subsidized Exchange coverage will have children who qualify for Medicaid or CHIP. Children in these families are most at risk of experiencing gaps in coverage if states fail to establish simple, user-friendly eligibility and enrollment systems.

CDF strongly opposes the proposed bifurcation of the eligibility assessment and determination process between the Exchange and the Medicaid/CHIP agency. If HHS retains this option, at minimum, specific safeguards must be included in the final regulation to ensure that children and families are enrolled in the appropriate source of coverage in a timely and streamlined fashion. Below, we offer some specific recommendations on how the coordination provisions of the final rule could be improved.

1. Establish Presumptive Eligibility

If a state elects to have its Exchange merely conduct a preliminary "assessment" of potential Medicaid/CHIP eligibility and then relinquish the final eligibility determination to the Medicaid/CHIP agency, HHS should require that – at a minimum - children assessed as potentially eligible should be presumed eligible for Medicaid until a final determination can be made by the Medicaid/CHIP agency. This will enable children to get the care they need until a full eligibility determination is processed.

2. Streamline the Approval Process

If a state chooses to adopt the process for eligibility determination as outlined by the interim final provision in the final rule, it must first be required to demonstrate that it can do so without harming children. To do so, HHS should require that states seeking to bifurcate their eligibility systems affirmatively demonstrate that: 1) their Medicaid agency has the capacity to conduct eligibility determinations in full compliance with the final Medicaid eligibility rule, including provisions requiring electronic verification of income; 2) their Medicaid and CHIP IT systems can accept and use data transferred from the Exchange; and 3) they can and will agree to all of the coordination protections included in the final rule. These protections, including the requirement that they not ask families for information that has already been provided and that they refrain from re-verifying any data already verified by the Exchange, will streamline the approval process for families.

3. Eliminate Duplicative Eligibility Determinations.

While CDF strongly opposes the bifurcated approach to eligibility determination, if states are allowed to choose to operate their Exchanges this way, HHS should ensure that the final rule prohibits states from conducting duplicative eligibility determinations. The final rule should require Exchanges in these states to conduct their Medicaid and CHIP assessments using the state's Medicaid and CHIP eligibility rules (rather than a generic version of the rules that fail to take a state's policy choices into account) and the same data sources as the state Medicaid/CHIP agency requires. This will help prevent the Medicaid/CHIP agency from repeating an Exchange's "assessment" of potential Medicaid and CHIP eligibility using slightly different rules. States should be expected to use a single shared system between the Exchange and Medicaid/CHIP agency so that eligibility determinations need to be made only once.

3. Strengthen Timeliness and Performance Standards

CDF is concerned the time periods outlined in the final rule are excessively long -- for children in particular. The timeliness standards outlined provide states with up to 45 days to conduct Medicaid and CHIP eligibility determinations for people without disabilities and 90 days for people seeking coverage under a Medicaid category for people with disabilities. For infants and children, these time-periods could result in coverage gaps at critical developmental stages. For example, the American Academy of Pediatrics' Bright Future guidelines, which are incorporated in the ACA, recommend that newborns see their health care providers three times by the time they are one month old, making it imperative that they not have to wait 45 days for coverage. Particularly given that the federal government is making a massive investment in new eligibility system technologies, we recommend that the final rule require eligibility determinations to occur within a few days if electronic data are available to verify eligibility. Under no circumstances should eligibility determinations take more than 30 days.

CDF recommends that CMS develop stronger federal standards to appropriately define the navigator role and to ensure that consumers are adequately informed about their options for obtaining coverage information and enrolling in the plan that is right for them.

CDF is pleased the ACA recognizes some populations will need extra assistance navigating the enrollment process and that this process must be regulated. The final rule requires agents and brokers to comply with the terms of an agreement with the Exchange, including a requirement to register before assisting consumers, receiving training and abiding by information privacy and security standards. However, CDF believes that stronger federal standards are needed to appropriately define the navigator role to be played by brokers and to ensure that consumers are adequately informed about their options for obtaining coverage information and enrolling in the plan that is right for them. Because agents and brokers will be asked to serve an entirely different market place than they have traditionally served, we believe that it will be important for agents and brokers to demonstrate their capacity to serve the needs of low-income, underserved and vulnerable populations.

Federal and state standards should require that agents and brokers have the ability to help families with the full range of affordable coverage options. More specifically:

1. HHS should strengthen the interim regulation to ensure that if a state chooses to allow agents and brokers to assist with applications for financial assistance through the insurance affordability programs, that the agents and brokers are held to the same high expectations that are required of navigators. Agents and brokers should be held to a conflict of interest standard and code-of-conduct standard that, at a minimum, requires them to act in the best interest of consumers and prohibit them from steering enrollees toward specific plans or engaging in other activities that may undermine an Exchange's success. States should be required to develop rules regarding mandatory agent and broker disclosure of a) financial compensation, b) conflicts of interest, and c) the option for a consumer not to use an agent or broker to apply for insurance affordability programs, choose a plan, or enroll in an a QHP.

2. States opting to permit brokers to serve the "assistance" function should be required to include in their exchange blueprint details of the compensation arrangements with these brokers, along with a description of how they will monitor and minimize adverse selection and the prohibition against their directing enrollees into coverage for reasons unrelated to the consumers' best interests.

CDF recommends that CMS include two specific qualifying events for special populations that trigger the special enrollment periods during which they can enroll.

CDF is pleased the final rule recognizes the value of Exchanges holding special enrollment periods for special populations. Since the final rule suggests that CMS will provide additional guidance relating to the circumstances in which an Exchange should be required to notify individuals of the availability of coverage during special enrollment periods, we urge you to include two in particular as qualifying events that could trigger special enrollment periods: 1) youth transitioning out of the juvenile justice system and 2) youth exiting from foster care.

Youth involved in the juvenile justice system have extensive health needs. Mental health disorders, including serious mental illness, are prevalent, substance abuse is widespread and physical health problems are very common among this population. Tens of thousands of these youth leave secure confinement every year and many have difficulty accessing health and mental health coverage upon their release. For those who are fortunate enough to receive good care while incarcerated, few return to environments where they can maintain the same quality and routine of care. Studies show that

youth released from secure confinement are more likely to use emergency departments for routine health care and to postpone care, thereby aggravating routine health issues.

Ensuring that all youth leaving the juvenile justice system have the opportunity to be screened by the Exchange for Medicaid, CHIP or premium tax credits will improve access to critical physical and behavioral health services for these children once they leave the system and return home. This could ultimately improve the health and mental health and ultimately their ability to remain in their communities.

Similarly, children and youth exiting foster care to return to their families or exiting foster care at age 18 or older to live independently should be considered special populations that trigger a special enrollment period. Children and youth in foster care often have experienced trauma and serious health and mental health problems and will continue to need health and mental health coverage when they leave care. A lapse in treatment could jeopardize their futures as many of these health conditions have been demonstrated to persist through adulthood.

Thank you for the opportunity to respond to the request for comments on the interim final provisions in the Final Rule for the Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010 and the Final Rule for the Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers. The development of a seamless system for eligibility determinations, enrollment, retention and renewal where the Exchanges coordinate closely with the Medicaid and CHIP agencies is critical to ensuring all children access to comprehensive quality care that is accessible and affordable. We appreciate your consideration of our comments and would be pleased to discuss them with you further. Thank you for your leadership in promoting quality, affordable health care for children.

Sincerely yours,



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