

February 21, 2013

Sarah deLone, Stephanie Kaminsky, Melissa Harris, and Leigha Basini
Centers for Medicare and Medicaid Services
Department of Health and Human Services
ATTN: CMS-2334-P
PO Box 8016
Baltimore, MD 21244-8016

RE: Proposed Rule for the Patient Protection and Affordable Care Act: Medicaid, CHIP and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing [CMS-2334-P]

Dear Ms. deLone, Kaminsky, Harris, and Basini:

The Children's Defense Fund (CDF) appreciates the opportunity to submit comments in response to the Proposed Rule for the Patient Protection and Affordable Care Act: Medicaid, CHIP and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing (as published in the *Federal Register* on Tuesday, January 22, 2013, 42 CFR Parts, 430, 431, 433, 435, 440, 447, and 457 and 45 CFR Part 155). 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 children get sick, drop out of school, get into trouble or suffer family breakdown.

CDF has worked for many years, in collaboration with others, to expand health coverage that is comprehensive, accessible and affordable for children and youth. We believe the landmark Affordable Care Act (ACA) moves us closer to that goal, particularly with the original promise of a strong single essential health benefits (EHB) package and through a "no wrong door system" of enrollment through the exchanges. While the proposed rule takes a number of important steps to modernize and streamline Medicaid eligibility and enrollment processes, we have a number of concerns we hope you will address in order to move us closer to ensuring *all* children access to affordable and appropriate health and mental benefits children need to survive, thrive and drive the economy of tomorrow. To ensure this standard can be met, we offer the following comments and recommendations, which are expanded upon below:

1. The ACA has mandated health coverage for nearly every American, yet the proposed rule will permit waiting periods to continue in CHIP. Coverage gaps are contradictory to the goal of coverage in the ACA: waiting periods in CHIP must be eliminated.

2. States should not be allowed to impose a lock-out period for a child whose family fails to pay a CHIP premium or enrollment fee.

3. States should not be permitted to use Medicaid and CHIP funds to enroll eligible children in private exchange coverage.

4. Young people benefiting from The Deferred Action for Childhood Arrivals (DACA) program are excluded from health coverage under an exemption outlined in the proposed rule. This decision works against the goals of the ACA and sets a damaging precedent for treating DACA children and young adults differently than other lawfully present immigrants. The decision to exclude DACA youth from health coverage must be reversed in the final rule.

5. HHS must require states to cover under Medicaid to age 26 any eligible former foster care youth who were in care on their 18th birthday and enrolled in Medicaid *regardless* of their state of residence.

6. In addition, we offer a number of comments on HHS' attempt to update many of the old Medicaid eligibility rules and streamline eligibility and enrollment systems across other federal statutes.

<u>The ACA has mandated health coverage for nearly every American, yet the proposed rule will permit waiting periods to continue in CHIP. Coverage gaps are contradictory to the goal of coverage in the ACA: waiting periods in CHIP must be eliminated.</u>

Despite the ACA's intent to promote continuous coverage, the proposed rule allows states to continue to impose a waiting period in CHIP on children who have recently been covered by group health insurance. While the proposed rule does establish a maximum waiting period of 90 days (which will require 18 states to reduce their waiting periods) and includes very specific circumstances under which a waiting period must be waived, *any* gap in coverage for a child – including a 90-day waiting period – can create serious impediments to a child's health and development, with far-reaching and costly impacts on the child, his or her family, and the health system in general. This is also contradictory to other parts of the ACA which recognize that children should connect with their pediatrician eight times in the first year of life alone.[1] Unfortunately, waiting periods have become prevalent among states attempting to reduce crowd out. While currently 38 states use waiting periods, CHIP does not require them. CDF strongly believes waiting periods do not make sense in a post-ACA world at a time when everyone is expected to enroll in coverage and can face penalties for failing to do so.

Because no child should have to go without health coverage for any period of time, states should be prohibited from applying *any* waiting period for CHIP coverage. Given the ACA's objective to promote continuous health coverage, along with the coordination issues and administrative burden of temporarily enrolling these children in the exchanges and then having them reapply for CHIP in 90 days, it does not make sense to continue CHIP waiting periods in any fashion.

Eliminating waiting periods is all the more important because, due to recent Treasury regulations,[2] many CHIP families may not qualify for subsidies in the exchanges if their employer offers coverage for one

[1] See ACA sec. 2713 and the Bright Futures periodicity schedule.
[2] Department of the Treasury, Internal Revenue Service Final Rule on the Health Insurance Premium Tax Credits, as published in the Federal Register on Friday, February 1, 2013. [26 CFR Part 1]

parent that costs less than 9.5% of household income. The CHIP waiting period and so-called "family glitch" are two important cracks in the ACA that create unnecessary obstacles to health coverage for children that must be addressed.

States should not be allowed to impose any lock-out periods for a child whose family fails to pay a CHIP premium or enrollment fee.

The majority of states (approximately 29) operating separate CHIP programs require families to pay premiums, or enrollment fees. Over the years, states have established different disenrollment policies for non-payment of premiums and enrollment fees in CHIP. Approximately 14 states impose a "lock-out period"; that is, a period of between one and six months that a child wait until being allowed to reenroll in the CHIP program after termination as a result of non-payment of premiums. In some states, this period can be until the unpaid premiums or enrollment fees are paid. Other states take a more punitive approach, barring a child from enrollment for a period of time even if the family pays the unpaid premiums or enrollment fees. Other states require individuals to go without CHIP coverage during the premium lock-out period, but do not require families to pay their premium back at the end of the specified time. An additional 14 states require individuals to reapply for coverage and/or repay outstanding premiums in order to re-enroll in CHIP (the majority of these states require both, but a few require only one or the other), but do not characterize their programs as having lock-out periods.

The proposed rule would permit states to continue to impose premium lock-out periods in CHIP of up to 90-days for families that have not paid outstanding premiums or enrollment fees (§457.10). As noted earlier, a 90 day gap in coverage can have a profound impact on a child's health and development, and a child should not be subject to penalties for a failure to pay by another member of his or her family. We urge that §457.570 be revised to ban lock-out periods entirely, as contrary to the goals of a reformed health system as well as the health of children.

States should not be permitted to use Medicaid and CHIP funds to enroll eligible children in private exchange coverage.

In the CHIPRA law of 2009, Congress moved away from the use of Medicaid and CHIP funding to subsidize coverage in the individual market because it is rarely cost-effective, and such coverage is often subsubstandard. Medicaid offers the best health and mental health benefit package available – public or private – with virtually no cost-sharing for children, at a very low per enrollee cost. Similarly, CHIP offers a child-appropriate benefit package with limited cost-sharing, also at a low cost per enrollee. In contrast, the state defined EHBs may be relatively weak and are not designed with children's unique health and mental health needs in mind. In addition, the value of exchange plans, as defined in statute, are likely to require significantly more out of pocket spending than Medicaid or CHIP. Using Medicaid and CHIP dollars to buy insurance that is less comprehensive and likely more expensive is not a wise use of tax payer dollars. Even with the proposed wrap-around benefits that would be required under the proposed rule, we are deeply concerned that private insurers—especially those in the individual group market—will not understand and will not support the goals of EPSDT or allow for adequate access to services under that program. As result, CDF strongly opposes the proposed rules' allowance of the use of Medicaid and CHIP funds to support enrollment of eligible individuals in private insurance plans in the exchanges (§435.1015).

We urge HHS to re-examine the premium assistance proposal in the proposed rule in the context of the rules for waiver authority, as we harbor deep concern that this proposal is a waiver by another name, yet it lacks many of the safeguards for federal tax dollars and beneficiaries that federal waiver rules create.

However, if HHS is going to move forward and allow states to utilize premium assistance in this fashion—a proposal we do not support—we ask that you only do so in cases where it is truly cost-effective and not a waste of taxpayer dollars, as well as only in states where the benefits and cost-sharing protections have been certified as equal to, if not better than, what the child would have received in Medicaid or CHIP. In order to ensure such safeguards are in place, we offer the following recommendations:

- *Cost-effectiveness:* CMS should issue long-awaited guidance on the cost-effectiveness test for Medicaid and CHIP premium assistance options that were updated in CHIPRA and standardized in the ACA, subject to the comments below. Section 435.1015 includes a description of the test, and we urge you to modify that test and then issue guidance to apply a similar test to all of the premium assistance options that states have. A clear explanation—and ongoing enforcement by CMS—of the cost-effectiveness test is essential to ensuring that taxpayer dollars are used wisely and that premium assistance is a sound policy option for states to pursue for children and families.

- *Wraparound benefits and cost-sharing protections*: We are pleased the proposed rule emphasizes the importance of ensuring beneficiaries are able to fully access the wraparound benefits to which they are entitled and do not incur any additional cost-sharing charges in excess of amounts that would be imposed in Medicaid or CHIP. However, we are concerned that these "wraparound" protections are not always well implemented. There is little evidence that children, for example, are able to access the full EPSDT benefit when they are enrolled in premium assistance arrangements. The final rule should be amended to require states to inform families of their rights in this regard and to ensure that children are getting the services to which they are entitled. States must be required to track the cost of providing wraparound coverage to ensure cost-effectiveness and this information should be used to evaluate whether children who are allowed to buy coverage in the exchanges with CHIP or Medicaid dollars are getting all needed benefits covered by CHIP or Medicaid. Similarly beneficiaries must be aware of the limits on the cost-sharing they may be charged and should not incur any additional costs upfront for which they have to seek reimbursement. The state must bear the responsibility for tracking the out-of-pocket costs related to the wrap-around services incurred by the beneficiary.

- *Cost-effectiveness test:* The proposed rule should be clarified to ensure that the cost of the cost-sharing wraparound is included in the cost effectiveness test. The current language that reads "The cost of purchasing such coverage, including administrative expenditures and the costs of providing wraparound benefits for items and services covered…" could be interpreted to mean the cost of premiums to purchase coverage only, excluding the costs associated with covering copayments, deductibles and other cost-sharing requirements. However, this interpretation would mean that families could end up having substantially higher out-of-pocket costs if the wrap was fully implemented.

  The statutory definition of cost-effectiveness in CHIPRA is "the amount of expenditures under the State child health plan, including administrative expenditures, that the State would have made to provide comparable coverage of the targeted low-income child involved or the family involved." It is our view that "comparable coverage" clearly incorporates the provision of cost-sharing limits

into the cost-effectiveness test, and we are concerned that the regulatory language does not plainly do so. Cost-sharing standards are protective for children and their families in Medicaid and CHIP, and as such, states should be considering the value of the cost-sharing when calculating whether it is cost-effective to purchase private insurance for a beneficiary.[3]

Young people benefiting from The Deferred Action for Childhood Arrivals (DACA) program are excluded from health coverage under an exemption outlined in the proposed rule. This decision works against the goals of the ACA and sets a damaging precedent for treating DACA children and young adults differently than other lawfully present immigrants. The decision to exclude DACA youth from health coverage must be reversed in the final rule.

In July 2010, HHS defined "lawfully present" for the purposes of determining who would be considered eligible non-citizens under the ACA for coverage under Medicaid, CHIP, or the exchange.[4] Under that definition, individuals granted deferred action by the U.S. Department of Homeland Security (DHS) are considered "lawfully present" for determining eligibility for coverage under the ACA.

Last June, DHS announced that it would grant deferred action under its administrative authority to individuals residing in the United States who meet specific requirements. The DACA program was officially launched in August, 2012 to grant "lawfully present" status to certain undocumented young people who came to the United States as children and have pursued education or military service here. DACA ensures these young people will be issued Social Security numbers and are authorized to work in the United States. Once an individual has been approved for deferred action under DACA, these ACA regulations classified them as "lawfully present" under the ACA provisions discussed above and made them eligible for coverage.

However, in subsequent proposed rules—including the one open for comment—HHS specifically excluded youth granted deferred action under DACA from the definition of "lawfully present"—thereby barring DACA youth from obtaining health coverage through Medicaid, CHIP, or the exchange. In the proposed rule in question, HHS actually expanded the definition of those who are eligible under the ACA to include victims of trafficking, yet specifically excluded youth granted deferred action under DACA from the group of "lawfully present" individuals with access to health coverage under the ACA and through Medicaid and CHIP.

CDF has expressed concern about this policy in prior comments and once again we respectfully ask that HHS reverse the policy restricting eligibility for health coverage of youth granted deferred action through the DACA program. Most of the individuals who are likely to be granted deferred action under DACA are between the ages of 15 and 30 and live predominantly in states such as California, Texas, New York, Illinois and Florida, which have among the highest number of uninsured residents.[5] Many uninsured children and young adults live in low-income, working families, with parents working in industries where the high cost of health coverage has forced their employers to drop coverage for employees and their families.[6] These families are more likely to be among those who do not have a regular source of care due

[3] Specific comments on §435.1015

[4] HHS codified the list of immigration categories as considered "lawfully present" at Title 45 Code of Federal Regulations Section 152.2 for purposes of eligibility for the high-risk pool under the ACA, known as the Pre-Existing Condition Insurance Plan (75 Fed. Reg. 45013-45033, July 30, 2010).

[5] Migration Policy Institute, "Relief from Deportation: Demographic Profile of the DREAMers Potentially Eligible under the Deferred Action Policy" (August 2012); and Kaiser Commission on Medicaid and the Uninsured, "Health Insurance Coverage of Nonelderly 0-64, states (2009-2010).

[6] Kaiser Commission on Medicaid and the Uninsured, "Five Facts About the Uninsured Population" (September 2012).

to their income, insurance and immigration status.[7] Excluding DACA youth from coverage options under the proposed rule reduces their opportunities for preventive care, thereby maintaining reliance on community health centers, hospital emergency rooms and other safety net providers, which then contributes to poor health outcomes, increased heath disparities, as well as increased cost to the individual and the community.

Finally, the proposed rule is unjust and sets a damaging precedent. Deferred action is a form of relief already available to a range of individuals in the United States under DHS, and individuals who have been granted deferred action have long been considered by both Congress and federal agencies to be "lawfully present" in the United States. Individuals granted deferred action based on grounds other than DACA (e.g. need for a medical procedure or treatment in the United States), will remain eligible for all other relevant benefits under the ACA based on their "lawfully present" status; it is only children and young adults receiving "deferred action for childhood arrivals" status who will be ineligible for coverage. We remain very concerned that such a differential treatment sets a damaging precedent for policymakers looking to further discriminate against immigrants.

HHS must require states to cover under Medicaid to age 26 any eligible former foster care youth who were in care on their 18th birthday and enrolled in Medicaid *regardless* of their state of residence.

We are pleased that the proposed rule noted above take an important step toward implementing the Affordable Care Act's (ACA) provision (Sec. 2004) to ensure Medicaid to age 26, beginning in January 2014, to young adults leaving foster care at age 18 or older and who were enrolled in Medicaid. This provision is intended to complement the ACA provision that allows other young adults to receive health coverage to age 26 under their parents' health insurance plans, beginning in some cases as early as 2010 (Sec. 2004). This new mandate for Medicaid coverage for former foster care youth offers a promising opportunity to ensure that their health and mental health needs are better met in the future.

The comments below emphasize the importance of the ACA provision for former foster youth, highlight the positive aspects of the proposed rule that make clear which former foster care youth are eligible, and then strongly urge the Department of Health and Human Services (Department) to reverse the interpretation in its proposed rule that states will only be required to enroll eligible former foster care youth in Medicaid to age 26 if they remain living in the state where they were in foster care.

This provision of the ACA recognizes the challenges many young people, who leave foster care without returning to their families, being adopted or placed permanently with relative guardians, face in obtaining health coverage. They often carry with them significant health and mental health challenges that persist into adulthood. They face enormous challenges in getting the health services they need. Between 35 to 60 percent of children and youth entering foster care have at least one chronic or acute physical health condition that needs treatment, and between one-half and three-fourths have behavioral or social problems that require mental health services.[8] Not surprisingly then, youth who age out of foster care are more likely than their peers generally to report having a health condition that limits their daily activities and to

[7] Kaiser Commission on Medicaid and the Uninsured, "Key Facts on Health Coverage for Low-Income Immigrants Today and Under Health Reform" (February. 2012).

[8] CRS report – source cited: This is based on single state studies and data from a nationally representative survey. John Landover, Director, Child and Adolescent Services Research Center, Rudy Child's Hospital, San Diego, "Health Care for Children in Foster Care," written testimony submitted for Subcommittee on Income Security and Family Support, House Committee on Ways and Means hearing, July 19, 2007. CRS report: http://greenbook.waysandmeans.house.gov/sites/greenbook.waysandmeans.house.gov/files/2012/R42378_gb.pdf

participate in psychological and substance abuse counseling.[9] In addition, these young adults are less likely to have health insurance. They can rarely afford private health insurance, infrequently have access to employment-based health care, and they lack birth parents through whom health benefits might be accessed.[10]

The ACA holds new hope for these already vulnerable young adults that until they turn 26 they will be able to receive the quality health and mental health care provided through Medicaid that is so critically important to their later success in life. The proposed rule intended to help former foster care youth retain Medicaid to age 26 include a number of important provisions. We are pleased that in the proposed rule the Department clarifies that:

- Any youth in foster care under the responsibility of the state or tribe who, on or after January 1, 2007, was in foster care at age 18 or older and enrolled in Medicaid, will be *eligible* for Medicaid to age 26, and may apply at any time before he or she reaches the age of 26. (p. 4604) In addition, children who remain in care in states where foster care is offered to age 2l can also be eligible at a later age provided they were in care and receiving Medicaid at age 18 or when they aged out of care. We are grateful that the Department did not limit eligibility to that higher age in states that extend foster care funding to age 21. It would have excluded from Medicaid eligibility a number of young people in those states that leave foster care at age 18 even though they could stay longer. To our knowledge, no state requires all youth to remain in care throughout the period for which extended foster care reimbursement is provided. (Sec. 435.150, p. 4687)

- Former foster care youth who are living in the state where they were in foster care at age 18 or older and enrolled in Medicaid will be able to receive Medicaid to age 26. States will be required to provide it. Unfortunately, this will not necessarily be the case for young people who leave the state where they were in foster care and determined eligible for Medicaid as a former foster care youth. States will have the option to decide whether or not to provide Medicaid to age 26 for eligible foster care youth who were not in foster care at age 18 and enrolled in Medicaid in their state. (p. 4687, Sec. 435.150(b)(3))

- These youth are eligible for Medicaid because of their status as former foster care youth and other eligibility rules that often apply for Medicaid, such as income or resource tests, and assessment of premiums and cost sharing, will not apply nor become barriers to their receipt of health coverage. (p. 4604)

    - These youth who were previously enrolled in Medicaid will be eligible as former foster care youth and, at least those living in the state where they were in foster care, must be covered even if the states decides not to take the new Medicaid expansion funds under the ACA.

    - As the ACA described, former foster care youth are also exempt from mandatory enrollment in an Alternative Benefit Plan (p. 4630, Sec. 440.315(h), p. 4700) and will instead receive more comprehensive "traditional" Medicaid benefits that include both

[9] Fred Wulczyn et al. (2005) Beyond Common Sense: Child Welfare, Child Well-being, and the Evidence for Policy Reform. New Brunswick: Aldine Transaction.
[10] Sonya Schwartz & Melanie Glascock (2008) Improving access to health coverage for transitional youth. National Academy of State Health Policy.

mandatory and state-selected benefits, including Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) services to age 21.

- If a state has elected to provide presumptive eligibility for children or pregnant women, the state may also elect to provide presumptive eligibility for former foster care youth. (p. 4611, Sec. 435.1103(b), p. 4697)

- When a former foster care youth approaches age 26, and loses eligibility as a former foster care youth, coverage shall not be terminated unless the individual is not eligible under any other adult Medicaid eligibility group. (p. 4604)

While recognizing the positive steps forward in the proposed rule, several critically important revisions are needed in the final regulations to ensure Medicaid to age 26 will truly be available to *all* eligible former foster care youth. Three changes, discussed in more detail below, are essential and all consistent with the intent and purpose of the ACA coverage for these young people:

1. Ensure all eligible former foster care youth will be able to enroll in Medicaid to age 26, regardless of whether they are residing in the state where they were in foster care.

2. Ensure that enrollment is as automatic as possible for former foster care youth by requiring states to implement presumptive eligibility, passive enrollment and passive renewal for them.

3. Include in the final regulations, or in a joint letter or guidance from the Centers for Medicare & Medicaid Services and the Administration for Children, Youth and Families suggested steps that state Medicaid and child welfare agencies should take to ensure enrollment is as easy as possible and that all eligible youth are notified about their opportunity to receive Medicaid to age 26.

Ensure all eligible former foster care youth receive Medicaid to age 26: We are pleased the Department specifically invited comments on its interpretation in the proposed rule that states are only *required* to provide Medicaid to age 26 if the youth who is eligible remains in the state in which he or she was in foster care at age 18 or older. For former foster care youth who move to different states during those next eight years, continued Medicaid is only *optional* – states can decide whether or not to extend Medicaid to age 26 for this group of former foster care youth, now young adults.

We strongly recommend that the final regulations replace this state option with a requirement that states provide Medicaid to age 26 for *all* eligible former foster care youth, without regard to the state in which they are living. Such a change would better address the needs of this particularly vulnerable and sometimes transient group of young people. We believe that the current interpretation in the proposed rule fails to take account of the facts and circumstances below:

The intent of this provision is to ensure that any young person who had been in foster care on their 18th birthday and was enrolled in Medicaid, regardless of where he or she had been in foster care and was now living, would be able to enroll in Medicaid to age 26.

Senator Mary Landrieu (D-LA), the chief sponsor of the provision, made clear her intent to make all eligible former foster care youth able to receive Medicaid to age 26 in her remarks delivered on the Senate floor on December 22, 2009:

"Some of the bill's most important provisions will benefit the most important population—children.

The underlying bill includes a provision allowing children to remain on their parents' plans up until the age of 26. I have children. I would like to think that by 22 or 23, they will be on their own, they will be gainfully employed and off my payroll. But any of us who have raised children know that sometimes it takes a little more time to launch our children. I see Senator Shaheen, who is nodding. She has done this herself. It takes a little time to launch them. According to the latest data from the Census Bureau, in 2007 there were an estimated 13.2 million uninsured young adults. So the bill includes this important provision to allow kids to stay on their parents' insurance for a bit longer as they transition into adulthood.

But my question was, where do the young people who age out of the foster care system sign up, because they do not have parents? I was proud to work on a provision that Leader Reid included in this bill to ensure that every young person who ages out of the foster care system will be able to stay on Medicaid until the age of 26 starting in 2014 (italics added). Almost 30,000 young people age out of the foster care system every year, having never been adopted or reunified with their birth parents. The fact that they aged out is our failure as government. We have failed them once and we just can't fail them twice. We must support their transition to adulthood, and guaranteeing access to quality health care will help with that transition." (Congressional Record, Senate Legislative Action, pages S13731 – 13733)

As Senator Landrieu stated above and others noted in describing this coverage provision for former foster care youth, it is intended to provide health coverage to this group of youth who could not benefit from the other ACA provision that extended health coverage to youth to age 26 under their parents' insurance plans. Yet, no similar residency requirement is imposed on youth who can benefit from health coverage under their parents insurance to age 26. It seems unfair to treat young people who grew up with the state as a parent differently in this regard than those who grew up with their parents caring for them.

Under earlier interpretations by the Administration for Children, Youth and Families, other children age 18 or older who had been in foster care to age 21, adopted or placed with relative guardians as they leave foster care, continue, at least to age 21, to be able to receive Medicaid regardless of the state in which they are living. The state where they are living is required to provide coverage.

The Program Instruction (PI) implementing the Fostering Connections to Success and Increasing Adoptions Act (ACYF-CB-PI-10-11, pp. 4-5), for example, clarifies that Medicaid coverage is to continue for a youth if they move to a different state. Specifically the PI states that youth on whose behalf Title IV-E foster care maintenance payments or guardianship payments are being made, or who are subject to adoption assistance agreements, are categorically eligible for Medicaid provided the state provides Medicaid to youth these ages. This includes youth up to age 21 "whether or not the title IV-E agency in the State of residence has take the option to provided extended assistance." While at the time of this Program Instruction, Medicaid was not offered by every state beyond 19, the new Fostering Connections provisions being discussed would extend coverage to children who move from states that extend foster care coverage to 21 to states that do not extend coverage to 21.

With the assistance of the Interstate Compact on Adoption and Medical Assistance (ICAMA), children eligible for Title IV-E adoption assistance are automatically eligible to receive Medicaid in the state where the adoptive family lives (whether that is the state where the family lived when they adopted the child from foster care, or whether the adoptive family later moved to a new state) and in many states even state-funded non-Title IV-E children will receive Medicaid in the state where they live. It seems only fair therefore to make former foster youth who leave care without a permanency plan able to continue Medicaid regardless of the state in which they are residing after they leave foster care.

The requirement of having to remain in the state where you were in foster care will be especially challenging for many eligible former foster care youth.

The proposed rule, for example, does not seem to take into account situations like the Metropolitan Washington Area (and there are others) where children often are placed in foster homes in a state other than that which has responsibility for them. You may have a child with disabilities for whom the District of Columbia has legal responsibility, but who has been placed in a foster home in Maryland for several years. It is not clear where that youth, if eligible for Medicaid as a former foster care youth, must reside in order to be ensured of being able to enroll in Medicaid to age 26. Is he required to stay in Maryland or return to D.C. where he may still have siblings and other relatives? At a minimum, it seems that children in such situations should be ensured of getting coverage in either state.

It could be especially stressful and disruptive for a young person with special needs to have to weigh the potential loss of continued treatment and Medicaid when considering a move to a new state. The security that continuing Medicaid offers, especially to young people who have disabilities, chronic illnesses, or are receiving specialized treatment for mental health or physical health problems, is extremely important. Their health may be jeopardized when considering a move to a new state to be closer to family, to attend school or to take a better job when they have to worry about whether it will mean discontinuation of needed treatment.

It is also possible that a young adult could move to a state where no public support for Medicaid is available. This could happen if a state elected not to provide Medicaid to former foster youth to age 26 who were not previously in foster care in their state, and if the state also chose not to accept Medicaid Expansion funds under the ACA.

Given the vulnerability and size of this population, every effort should be made to enroll as many of the young adults in Medicaid as possible – rather than restricting enrollment from the beginning.

The estimated 195,000 former foster care youth who might be eligible under this provision, assuming every youth aging out of care from January 1, 2007 to December 31, 2013, applied right away would only be a very small percentage of the 4.8 million young adults ages 18 to 24 who were enrolled in Medicaid in 2011. Most at that time were probably more likely part of the 7.6 million young adults in that age range who were uninsured.

The only real data available on the mobility of former foster youth seems to suggest that the number of young people who leave a state where they were in foster care for a new state may be relatively small. This makes it even more sensible to let all former foster care youth regardless of where they are residing to be automatically eligible for foster care.

The language cited by HHS in the commentary to the proposed rule as support for its interpretation that states have the option whether or not to cover young adults who have left the state where they were in foster care is also subject to another interpretation.

The commentary to the proposed rule (p. 4604) states that it is the language that requires an individual be in foster care under the responsibility of "*the* state" and be enrolled in Medicaid under the "*the* state plan" or an 1115 demonstration that led HHS to the decision that the Medicaid mandate only applies to children who remain in *the same* state after they leave foster care rather than in "*a state*." However, another reading of that same language is possible. The reference to "under the responsibility of the state" could also be a reference to the fact that the children in foster care who are eligible for Medicaid must have been "under the responsibility of the state" as opposed to under the responsibility of a private child caring agency. In talking about children in care in the custody of a state, the use of the term "under the responsibility of the State" is a familiar term of art.

*Ensure that enrollment and re-enrollment is as automatic as possible***:** In order for these former foster care youth to get the Medicaid coverage they deserve and need, the Department must help to ensure that all eligible former foster care youth are notified about their eligibility and that enrollment and re-enrollment in Medicaid are automatic. We are very pleased that the ACA and proposed rule make clear that if a state has elected to provide presumptive eligibility for children or pregnant women, that the state *may* also elect to provide presumptive eligibility for former foster care youth. (Sec. 435.1103) We recommend that former foster care youth should be allowed, on their own, to be a presumptive eligibility group.

In addition, states should be encouraged to establish a passive enrollment and passive renewal procedure for these young adults when they move in and out of care, as a number have done as they implemented the Chafee Option to extend Medicaid to youth in foster care to age 21.

Take action now to put in place a streamlined eligibility determination process and an extensive outreach campaign to let young adults who were in foster care at age 18 since January 2007 and those who will be exiting care now and in the future know about the opportunity to retain Medicaid to age 26, beginning in January 2014: State Medicaid, Health Exchanges and Child Welfare Agencies should be encouraged to put in place procedures in advance of January 1, 2014, that will make verification of a former foster care youth's eligibility for Medicaid as automatic as possible. These should be outlined in the final regulations or in a joint letter from the Director for the Centers for Medicare & Medicaid Services and the Commissioner of the Administration for Children, Youth and Families to state child welfare and Medicaid agencies.

The regulations make clear that once former foster care youth who remain in the state where they were in foster care are determined eligible that enrollment in Medicaid coverage should be automatic. The path to determining eligibility is less clear. It is important that the burden be on the agencies, not the young adults, to prove eligibility. At a minimum, those steps should be identified in their Medicaid state plans and in the health care oversight plan that child welfare agencies must develop via collaborative efforts with state Medicaid agencies.

Beginning upon the effective date of the regulations, child welfare agencies should be required to forward to the Medicaid agency for enrollment all youth who are in foster care on their 18th birthday and enrolled in Medicaid. A number of states already use such a procedure for extending Medicaid to children to 21 through the Chafee Option. They should also be encouraged to forward to the Medicaid agency data on young people who since 2007 were in foster care and enrolled in Medicaid on their 18th birthday, to the extent they have it.

In addition, child welfare agencies should be required to notify all former foster youth who left care at age 18 or older on or after January 1, 2007, and were receiving Medicaid at age 18, that they are eligible for Medicaid to age 26 and provide instructions to them for applying for Medicaid beginning January 1, 2014, or subsequent to that date.

All youth aging out after the effective date of these regulations should be provided information in their transition plan and as they leave care about how they can enroll in Medicaid, effective January 1, 2014, and that enrollment should be automatic as proof of their eligibility has already been forwarded to the agency.

A toll-free telephone number should be established to help former foster care youth learn more about eligibility and enrollment procedures.

Steps should be taken immediately to begin extensive outreach efforts to notify foster care youth who have left care on their 18th birthday or later since January 1, 2007 and those who leave in the future about their potential eligibility for Medicaid to age 26**.** The success of the new coverage option will in large part be dependent on the success of these outreach efforts.

The final regulations, or a joint letter from the Centers for Medicare & Medicaid Services and the Administration for Children, Youth and Families to child welfare and Medicaid agencies, should recommend steps child welfare agencies must take to ensure that young adults leaving care know of their eligibility to access Medicaid to age 26. Steps like the following should be encouraged:

- Include information regarding this Medicaid benefit in the transition plan that is required for every youth within 90 days immediately before they age out of foster care required in section 475(5)(H) of the Social Security Act.
- Include information regarding this Medicaid benefit with applications for federally-supported education and training vouchers, state tuition assistance or other awards that go to youth who age out of foster care.
- Require child welfare agencies to notify former foster youth about their potential Medicaid eligibility when they collect data for the National Youth in Transition Database.
- Notify consumer assistance programs that are working to enroll eligible persons in health coverage under the ACA about former foster care youth's eligibility for Medicaid.

The Department should engage alumni of foster care, organizations of foster care alumni, child welfare advocates, and those operating transition programs for these young people in organized efforts to spread the word about the availability of Medicaid and encourage youth to re-contact the agencies they were in at age 18 to make sure they are eligible and to find out how, come January 1, 2014, they may apply. To facilitate an information exchange, the Department should establish a toll-free number referred to above.

Additional attention is given in the proposed rule to foster children, adopted children and children receiving kinship guardianship assistance payments, as well as independent foster care adolescents and individuals adopted under state adoption assistance agreements. In closing, we are pleased that the proposed rule, in addition to describing rules for the new Medicaid coverage for former foster care youth, also makes clear the current law provisions that assure Medicaid for Title IV-E foster care, adoption assistance, and kinship guardianship assistance payments. (Sec. 435.145). Just as Medicaid is critically important for youth leaving the system at age 18 or older, it is also critically important for those youth still in care, sometimes to age 21, and to those youth with adoptive families or relative guardians who are eligible to receive assistance to age 21. Optional eligibility also is provided for young people under age 21 under state adoption assistance agreements. (p.4609, Sec. 435.227).

We also appreciate the clarification that the option for states, which they have had since 1999, to extend Medicaid coverage to age 21 for youth who age out of foster care at age 18 (P.L. 106-169) is extended. To our knowledge just more than half of the states have currently taken that option.

<u>In addition to the aforementioned issues that will have a significant impact on children and low-income families, CDF appreciates HHS' attempt to update many of the old Medicaid eligibility rules and streamline eligibility and enrollment systems across other federal statutes.</u>

Despite the clear intent of the law to establish a "no wrong door" eligibility and enrollment system, we do not believe children and low-income families will experience a seamless, streamlined eligibility determination and enrollment process for Medicaid, CHIP and the exchanges under the current approach outlined by HHS in previously issued regulations. When families come to the exchange and are eligible for CHIP and Medicaid, the Department in prior regulations has allowed exchanges to refer them to Medicaid and CHIP agencies to enroll, rather than to require they be enrolled in CHIP and Medicaid by the exchange. This increases the chances of children (and adults) "falling through the cracks" and remaining uninsured. While we are still strongly opposed to this bifurcated approach, we are pleased the proposed rule takes the following steps to make the eligibility and enrollment system less onerous on the family:

1) Appeals

   CDF is pleased the proposed rule requires appeals of eligibility determinations to be structured to offer the greatest benefit to children and families, place as little burden on the family as possible, and recognize that children and families may have very few preferences related to Medicaid, CHIP or exchange coverage. This should be maintained in the final rule.

2) Notices

   CDF is pleased the proposed rule requires the use of a single combined notice that would be produced after all Modified Adjusted Gross Income (MAGI)-based eligibility determinations have been made. This notice should decrease the burden on families to navigate the complex health system and should be maintained in the final rule.

3) Alignment of Medicaid Eligibility Requirements and Coverage Options established by other Federal Statutes

   CDF supports the proposed §457.320(c), which would permit a separate CHIP program to cover "lawfully residing" children or pregnant women otherwise eligible for CHIP, and would align the "lawfully present" rules for Medicaid and CHIP. We support this section not because of the underlying limitation on eligibility it represents, but because it would streamline policies between CHIP and Medicaid and also because it would allow pregnant women to be covered if lawfully present as well.

   There are also a number of other provisions in § 435.117 that CDF supports:

   - The clarification at (b)(1)(i) of § 435.117 that a child born to a mother covered by Medicaid for labor and delivery as an emergency medical service pursuant to section 1903(v)(3) of the Act shall be deemed eligible for Medicaid during the child's first year of life.

   - The proposed revisions to § 435.117(b) that would allow eligibility for the newborn so long as the baby was a member of the mother's household and the mother either remained eligible for Medicaid or would remain eligible if still pregnant.

- CMS' interpretation at §435.117(b)(1)(ii), which would allow babies born to pregnant women on CHIP with household income at or below the applicable Medicaid income standard for infants under §435.118 of the Medicaid eligibility final rule to be automatically enrolled in Medicaid, and those born to pregnant women with income above the applicable Medicaid income standard to be automatically enrolled in CHIP.

- §435.117(b)(1)(iii), which requires that states be provided with the option to consider as deemed newborns in Medicaid those babies born to mothers covered as a child under a separate CHIP plan for benefits for the date of birth. CMS has solicited comments on whether states should have the option to extend automatic Medicaid enrollment to the extent that the state determines that, under normal circumstances, such babies would be likely to meet requirements for Medicaid eligibility. We believe that the best option is for all babies born to mothers covered as a targeted low-income child under a separate CHIP plan to be enrolled in Medicaid because of its pediatric-appropriate EPSDT benefit.

- Proposed §435.117(b)(1)(iv), which would grant states the option to treat as deemed newborns in Medicaid the babies born to mothers covered under a Medicaid or CHIP demonstration under section 1115 of the ACA, unless the demonstration's special terms and conditions specifically address this issue. We also support the new proposed paragraph (c) in this section, which would give states the option of recognizing the deemed newborn status from one state for purposes of enrolling babies born in another state without need for a new application. Beyond the rationale presented, pediatricians repeatedly report that cross-state insurance issues create significant access to care issues, and this should help address at least some of those issues.

With regard to CHIP deemed newborn eligibility, we support the attempt to cross-apply as many of the Medicaid rules to state CHIP programs as possible in the deemed newborn eligibility context. In particular, we support:

- §457.360(b) that would extend deemed newborn eligibility under CHIP to babies born to mothers covered as targeted low-income pregnant women under a separate CHIP for the date of birth;
- §457.360(c) that creates a state option to extend deemed newborn eligibility to babies of mothers covered as targeted low-income children under a separate CHIP (not as targeted low-income pregnant women) for the date of birth, to the extent that the state has not extended Medicaid eligibility to the babies; and
- §457.360(c)(2) that creates a state option to provide CHIP deemed newborn eligibility to babies of mothers who were receiving CHIP coverage in another state for the date of the child's birth or to babies of mothers covered by Medicaid or CHIP under an 1115 demonstration.

4) Verification Exceptions for Special Circumstances

CDF supports the proposal to bar states from requiring documentation from applicants who would be clearly unable to provide it due to their circumstances (including those who are homeless, or are victims of domestic violence or natural disasters).

5) Presumptive Eligibility

CDF strongly supports the opportunity for hospitals to be granted the authority to determine that an infant is presumptively eligible for Medicaid/CHIP as set forth in the proposed rule. This opportunity will go far – as states do not have to approve the request – to enroll eligible children in Medicaid at a critical time of risk in their lives – their mother's labor and delivery. Many hospitals already devote significant resources to enroll eligible children and other populations in health insurance affordability programs. This proposed section holds the promise of streamlining and easing the burden on consumers and families during a challenging time. We also support other presumptive eligibility changes in the proposed rule, but would recommend deleting its new provisions for attestation of citizenship, immigration status and residency as we believe that income is the only statutory basis for determining presumptive eligibility.

6) Essential Health Benefits

We strongly support the ACA's application of essential health benefits (EHB) requirements to Medicaid benchmark and benchmark-equivalent plans, now also known as Alternative Benefit Plans. It is vitally important that individuals covered by Medicaid have access to benefits and protections at least as generous as those receiving coverage through the exchanges.

In particular, we support the following proposed by CMS in the rule that have special application to maternal and child health:

- Provisions of §440.386 requiring states to give public notice before implementing a state plan amendment that establishes an Alternative Benefit Plan with either more or less coverage than the approved state plan, or changes to cost-sharing or benefits. We also commend HHS for requiring in this section states to describe the method of assuring compliance related to full access to EPSDT services for children;
- Affirmation at §440.315(h) that former foster care children are statutorily exempt from mandatory enrollment in an Alternative Benefit Plan;
- Language at paragraph (b) of §440.345 codifying provisions of the ACA providing that Alternative Benefit Plan coverage provided to individuals of child bearing age must include family planning services and supplies; and
- Provisions at §440.345(d) stating that the Alternative Benefit Plans must include future updates or revisions made by the Secretary to EHBs.

Additionally, we are pleased HHS made some critically important clarifications to the manner in which EHBs will be provided under Alternative Benefit Plans. First, we applaud the statement that the Medicaid EPSDT benefit—the gold standard for children—continues to apply, and that any limitation relating to pediatric services that may apply in a base benchmark plan in the context of individual or small group markets do not apply to Medicaid. In addition, we appreciate the clarification that preventive services described by Section 2713 of the ACA must also be provided under all Alternative Benefits Plans for no copay. These include critical services for pregnant women and children: all services receiving an "A" or "B" recommendation from the U.S. Preventive Services Task Force, all immunizations recommended by the CDC's Advisory Committee on Immunization Practices, preventive care and screening for infants, children and adolescents recommended by the Bright Futures guidelines, and preventive services and screenings for women recommended by the Institute of Medicine and adopted by HRSA.

However, HHS notes that definition and coverage provisions for EHBs described in the proposed rule published on November 20, 2012, "Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation," apply to Medicaid except in specific circumstances. We expressed a number of concerns with those rules which, by extension, would apply here as well. Our recommendations follow.

The state defined habilitative benefit definition for the exchanges should not apply to Medicaid: We strongly urge you to adopt our recommendation that a state's definition of the habilitative benefit for the EHB in the exchange should not apply to Medicaid. We urge HHS once again to require states and plans to adopt the definition of habilitative services put forth by the National Association of Insurance Commissioners (NAIC), which was included in the Department's proposed rule defining medical and insurance terminology. According to the NAIC definition, habilitative services are: "Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings." (NAIC Glossary of Terms for the Affordable Care Act.)

An alternative definition to consider is provided in the Medicaid law, which defines habilitation services as "…services designed to assist individuals in acquiring, retaining and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings." (Social Security Act, Section 1915 (c)(5)(A).)

Any benefits package must limit the ability of insurers to circumvent the requirement to cover the full range of pediatric services: We understand that benefit substitution among EHB categories would be prohibited for Alternative Benefit Plans, as it is for exchange plans. We believe, however, that benefit substitution, even when restricted to substitution within benefit categories, could be extremely problematic for children's and pregnant women's access to critical health care services. Therefore, we urge HHS to prohibit all benefit substitutions or, at a minimum, to give states the flexibility to disallow substitutions. For instance, the EHB category of "rehabilitative and habilitative services and devices" could encompass a number of specific services, such as physical therapy, occupational therapy, speech therapy, home nursing care, private duty nursing, and other services. Under the proposed rule, an insurer could substitute home nursing care for a different type of service within this category that is actuarially equivalent, but not sufficient to meet the specific needs of a child with a complex or chronic health condition. This type of substitution would lead to an EHB category that excludes an important service and threatens a child's ability to secure necessary services to meet his or her full developmental potential. We are especially concerned that benefit substitution could be used to undermine EPSDT standards for children's care.

In the event that benefit substitution within categories is maintained as an option, we recommend that a more restrictive standard be established. The proposed standard that the plan must merely meet an overall actuarial equivalence test on the value of their benefits compared to the EHB benchmark plan is insufficient to serve as a true standard. It is impossible to predict exactly what health care needs a child will have as he or she grows and develops. No child should be denied necessary services because their parent or guardian did not anticipate the services he or she would need, or chose the "wrong" health insurance plan.

7) <u>Verification Procedures for Individuals Attesting to Citizenship or Satisfactory Immigration Status</u>

CDF commends HHS for streamlining the complicated requirements of citizenship verification put into place for Medicaid and CHIP in 2006. These regulations have proven burdensome and administratively costly while resulting in the denial or delay of coverage of eligible citizen children, pregnant women and parents. We appreciate the clarification that states must first use the federal data services hub or the existing electronic data match with the Social Security Administration to confirm citizenship before asking for documentation from individuals. However, there will be times when documentation is needed and we believe the proposed streamlining of the process and the simplification of acceptable documents, including accepting copies of documents or affidavits, will greatly ease the burden on families and states and ensure that eligible children and families are not inappropriately denied or delayed coverage. Finally, we are particularly pleased with the clarification that citizenship verification is never required for newborns whose delivery was covered by Medicaid or CHIP and that once citizenship has been verified for any applicant it need not be re-verified at renewal or after a break in coverage.

Thank you for the opportunity to comment on the Proposed Rule for the Patient Protection and Affordable Care Act: Medicaid, CHIP and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing. Ensuring comprehensive health and mental health coverage for all children that is easy to get and to keep is critical to their lives, health and future, and the prosperity of our nation. While CDF is strongly supportive of a number of the steps HHS has taken to modernize and streamline eligibility, there are many opportunities to amend the proposed rule to better ensure access to comprehensive and affordable coverage for *all* children. It is critically important that children be better – and certainly no worse – off than before passage of the ACA. We look forward to working with you to ensure that all children realize the promise of the ACA. We appreciate your consideration of our comments and would be pleased to discuss them with you further.

Sincerely yours,



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