American Hospital Association

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October 31, 2011

Donald Berwick, M.D., M.P.P.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

RE: CMS–2349– P,* Medicaid Program Rules Implementing Eligibility and Subsidy Provisions of the Affordable Care Act of 2010, Proposed Rule *(Vol. 76, No. 159), August 17, 2011

Dear Dr. Berwick:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations and our 42,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule implementing provisions of the *Patient Protection and Affordable Care Act* (ACA) that simplify eligibility, streamline enrollment, coordinate functions with the Affordable Health Insurance Exchanges (exchanges) and create options for states in claiming the increases in the Federal Medical Assistance Percentage (FMAP) for the newly eligible Medicaid populations.

The AHA strongly supports the basic premise of the ACA to expand health insurance coverage through both private and public programs. The approach CMS has taken to ensure there is "no wrong door" for individuals seeking health coverage by simplifying, streamlining and coordinating enrollment for the Medicaid program, and the exchanges will go a long way to realizing the ACA's coverage goals. **The AHA supports the general direction CMS has taken to implement these ACA eligibility provisions. Our comments focus on the application and redetermination process as well as the alternative methodologies proposed for states to claim the higher FMAP for the newly eligible populations.**

ELIGIBILITY, APPLICATION PROCESS AND APPLICATION ASSISTANCE

The AHA supports CMS's efforts to simplify the Medicaid eligibility categories and to streamline the application for all insurance affordability programs (i.e., Medicaid and the premium tax credit program offered through the exchange). We recommend that any state alternative application be no more burdensome than the model application developed by the Secretary of Health and Human Services. The proposed rule implements the ACA requirement that eligibility, beginning in 2014, be based on modified adjusted gross income or MAGI. The proposed rule recommends collapsing the existing myriad eligibility categories into just three categories: 1) parents and caretaker relatives; 2) pregnant women; and 3) children. The rule proposes to streamline the enrollment process through the use of a single application, a web-based application process and an electronic transmission of information.

The AHA also is supportive of requiring that states provide application assistance to individuals that seek it, in particular the disabled and those with limited-English proficiency. For many years hospitals have worked to assist patients in securing public health insurance through Medicaid or the Children's Health Insurance Program (CHIP). These efforts range from community-based outreach enrollment activities to trained on-site hospital staff that assist in the enrollment process when patients are seeking care. The AHA encourages CMS and the state Medicaid programs to utilize hospitals' experiences in facilitating enrollment and their expertise in working with patients with limited-English proficiency as the agencies implement the Medicaid application assistance requirements of the ACA.

INCOME VERIFICATION, REDETERMINATION AND COORDINATION WITH THE EXCHANGE AND OTHER INSURANCE AFFORDABILITY PROGRAMS

The AHA strongly supports CMS's proposed requirement that states use federal electronic verification services to perform verification tests for income, citizenship and immigration status. The AHA also strongly supports the use of an applicant's self-attestation of eligibility information. The proposed rule allows states to accept self-attestation of eligibility criteria, except for verification of citizenship and immigration status.

The AHA believes the use of federal electronic verification services through the redetermination stage of enrollment would go a long way to ensure the continuity of coverage. If a redetermination cannot be made with the electronic service, the proposed rule would require the states to pre-populate a renewal form with the available information and request additional information from the individual. **The AHA supports CMS's proposal to use a pre-populated form for redetermination for those individuals where the federal electronic verification service could not verify all eligibility criteria.**

The proposed rule notes that there may be instances where individuals, because of changes in their income, will no longer be eligible for Medicaid. The ACA envisioned that these individuals would be able to seek coverage through the exchange. But the proposed rule notes

that there may be gaps in coverage between when the exchange-based coverage begins and the Medicaid coverage ends. **The AHA recommends that Medicaid continue to cover an individual seeking private coverage through the exchange until the date when the exchange-based coverage begins to maintain continuity of coverage for the individual.**

The AHA supports giving states several options in designing their enrollment coordination process among Medicaid, the state exchange and other affordable insurance programs (i.e., CHIP and the optional State Basic Health Program). These options allow states continued flexibility in the design of their exchanges and the required coordination with the Medicaid program.

FMAP FOR NEWLY ELIGIBLE INDIVIDUALS AND EXPANSION STATES

Under the ACA, states will receive a higher FMAP for services provided to newly eligible adults covered through the mandated Medicaid expansion. Newly eligible adults are those who are not otherwise eligible for Medicaid as of December 1, 2009. The proposed rule would give states three alternatives, largely based on statistical sampling methods, for claiming the higher FMAP for these newly eligible populations. The proposed rule's preamble notes the burdens and costs to both the states and the federal government if states were required to operate a double eligibility system that determined on a case-by-case basis whether an individual is a newly eligible adult or would have been eligible under the state's pre-ACA eligibility rules. On October 26, CMS conducted an open forum with states and other stakeholders regarding the RAND contract to conduct a feasibility study on the three "claiming" methodologies proposed by the rule.

The AHA strongly supports CMS's efforts to allow stakeholder input at this early phase of the claiming methodology feasibility study. The AHA recommends that CMS require states to conduct an open and transparent process for determining the methodology the state will choose to claim the FMAP for the newly eligible adults.

The AHA also recommends that CMS require that state claiming methodologies include the total cost of providing care to patients. In describing the claiming methodology labeled *Alternative #2 Statistically Valid Sampling Methodology,* CMS proposes that states specifically exclude Medicaid supplemental payments from medical expenditures paid to providers when providers are paid under a managed care capitated payment arrangement. The AHA believes all payments should be in the claiming methodologies including costs associated with patients for whom supplemental payments such as Disproportionate Share Hospital or Upper Payment Limit are made to reflect providers total cost of care.

The AHA is a strong advocate of the ACA's promise of private and public coverage expansions through Medicaid and the state exchanges. We look forward to working with you and your staff to continue to realize this promise.

If you have any questions about our comments, please contact Molly Collins Offner, policy director, at mcollins@aha.org or (202) 626-2326.

Sincerely,

/s/

Rick Pollack
Executive Vice President