

# American Federation of Labor and Congress of Industrial Organizations



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*Submitted by email to [www.regulations.gov](http://www.regulations.gov)*

October 31, 2011

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Room 445-G  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

Attention: CMS-2349-P

Re: Proposed Regulations on Medicaid Program  
Eligibility Changes Under the Affordable Care Act  
File Code: CMS-2349-P  
Docket ID: CMS-2011-0139-0002

Ladies and Gentlemen:

These comments on the proposed regulations on the eligibility changes to Medicaid under the Affordable Care Act<sup>1</sup> are submitted on behalf of the American Federation of Labor and Congress of Industrial Organizations ("AFL-CIO") and its 57 affiliated unions. The AFL-CIO, together with its community affiliate Working America, represents more than 12.2 million workers across the country. Our affiliated unions negotiate health care benefits for almost 40 million workers, retirees, and their family members while unions that are not affiliated with the AFL-CIO negotiate coverage for an additional 10 million. These benefits are provided through single employer and multiemployer plans, both insured and self-funded.

<sup>1</sup> The proposed regulations, issued by the Centers for Medicare & Medicaid Services ("CMS"), are published at 76 Fed. Reg. 51148 (August 17, 2011).

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the “Affordable Care Act” or “Act”) expand access to Medicaid as part of the overarching goal of making affordable health care coverage available to all individuals and families across the country. The Affordable Care Act also calls for the establishment of state Exchanges whose responsibilities include offering qualified health plans and making eligibility determinations for premium assistance credits and cost-sharing reductions for individuals whose income falls between 100 and 400 percent of the federal poverty line. Other provisions of the Act call for a coordinated and streamlined eligibility determination and enrollment process for Medicaid, the Children’s Health Insurance Program (“CHIP”) and premium assistance credits.

The proposed rule implements the eligibility changes made to Medicaid and CHIP and provides guidance on the responsibilities of the state Medicaid agency in connection with the coordinated and streamlined eligibility and enrollment system envisioned by the Act.

In our comments on the proposed regulations on the establishment of Exchanges<sup>2</sup> and the eligibility determinations to be made by the Exchanges,<sup>3</sup> we maintained that the process for determining eligibility for Medicaid, CHIP and federally funded premium assistance credits and cost-sharing reductions, as well as the appeals process for these determinations, are inherently governmental functions. As a result, these functions must be performed by employees in a merit-based personnel system, and they are not eligible for contracting to a non-governmental entity. The final rule on the Medicaid eligibility changes should clearly include this requirement.

We also urge CMS to take the opportunity in promulgating these final regulations, as well as those on the establishment of Exchanges and the eligibility determination process, to make clear that determining eligibility and enrolling eligible individuals are distinct functions and require that the eligibility functions for Medicaid continue to be conducted by merit-based staff, regardless of the state’s choice regarding the operation of its Exchange. If an Exchange is a non-profit entity, the final rule should assure that eligibility determinations will be made by governmental agencies. Further, if non-profit or governmental Exchanges contract out most Exchange functions, they must operate in a way to ensure compliance with the merit system requirements for eligibility determinations.

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<sup>2</sup> Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41866 (proposed July 15, 2011).

<sup>3</sup> Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market; Eligibility Determinations; Exchange Standards for Employers, 76 Fed. Reg. 51202 (proposed August 17, 2011).

Additional comments on the proposed rule on Medicaid are set forth below.

### **§431.10 Single State Agency**

The proposed rule modifies the current regulatory provision requiring the designation of a single state agency with overall responsibility for operation of the Medicaid program. The changes allow state Medicaid agencies to enter into agreements with government-operated Exchanges to determine eligibility for Medicaid.

A key addition included in the proposed rule is the specific provision in proposed Section 431.10(d) regarding agreements between the single state agency and other federal and state agencies that conduct Medicaid eligibility determinations. The proposed rule requires that merit protection principles be employed by the agency responsible for determining Medicaid eligibility.

We support limiting Medicaid eligibility determinations to government-operated Exchanges and oppose allowing these determinations to be conducted by non-governmental entities.

The evaluation of eligibility for insurance affordability programs<sup>4</sup> is an inherently governmental function—it requires access to and the use of extremely personal information, such as income and immigration status, and it has significant and direct fiscal implications for both states and the federal government. Moreover, eligibility workers must make decisions on a number of complex issues as they determine eligibility even under the new streamlined process. For example, the proposed rule introduces a new standard of “reasonable compatibility” to be used in determining whether an applicant’s attestation on income or other eligibility criteria is consistent with other data available to the agency. *See* Proposed Section 435.952.

Private contractors and other non-governmental entities, including a non-profit Exchange, should not be permitted to conduct Medicaid eligibility determinations. The final rule should explicitly address this issue and clarify that private companies, including those under contract with a state or federally operated Exchange, cannot take over responsibility for eligibility determinations for affordability programs.

While not explicitly addressed in the text of the proposed rule, the preamble indicates that CMS may provide states choosing to establish a non-governmental Exchange the option of using the “co-location” of Medicaid workers to comply with the merit protection principles requirement in proposed section 431.10(d)(5). 76 Fed. Reg. at 51169. We are concerned about

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<sup>4</sup> Insurance affordability programs include advance payments of the premium tax credit, cost-sharing reductions, Medicaid, CHIP and the Basic Health Program.

the possibility that states would assign just one or two eligibility workers at sites where a private contractor or other non-governmental entity is processing large numbers of applications. In these situations, any co-located workers would simply be token representatives and could do no more than rubber-stamp the determinations made by the private contractor or other non-governmental entity.

As an alternative to co-location, we suggest that the final rule require states establishing non-governmental Exchanges to contract with the state Medicaid agency to conduct eligibility determinations. If the co-location option is retained, the final rule should provide more expansive and meaningful standards for determining what constitutes acceptable “co-location.” These standards should ensure that any co-located Medicaid eligibility workers have a meaningful role in eligibility determinations and provide guidelines for adequate staffing levels.

To the extent that the final rule permits private contractors to play a role in the eligibility determination process, we strongly encourage the inclusion of provisions prohibiting any contractor from offering financial incentives that discourage enrollment to its workers or subcontractors. For example, private contractors should not provide incentives for employees to meet numerical enrollment targets or for time spent on a case or telephone call.

Proposed section 431.10(c)(3)(ii) requires the state Medicaid agency to assure “[t]here is no conflict of interest by any agency delegated the responsibility to make eligibility determinations.” Similarly, proposed section 431.10(c)(iii) makes the state agency responsible for “guard[ing] against improper incentives and/or outcomes.” But, neither of these sections clearly applies to any contractors that may be involved in the eligibility determination process.

We urge CMS to adopt stronger language in the final rule requiring state Medicaid agencies to ensure that improper incentives and outcomes are not permitted and promptly addressed if they are found. Strong contract oversight will be needed to avoid inappropriate financial incentives. As part of that oversight process, CMS should adopt a policy requiring states to submit any contracts involving the eligibility or enrollment process for than \$5 million to CMS for prior review and approval, similar to the Department of Agriculture’s requirement for approval of Supplemental Nutrition Assistance Program Automated Data Processing contracts.

### **§435.907 Application**

The proposed rule in section 435.907(b)(1) calls for using the single, streamlined application developed by the Secretary. But, unlike the proposed rule on the establishment of Exchanges, it is silent with respect to combining the application with the enrollment form. Because the single application is to be used for all insurance affordability programs, we are

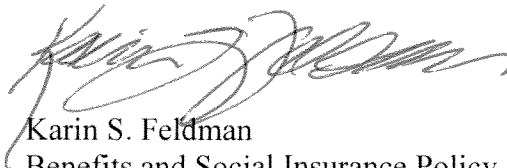
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concerned that the application which the state Medicaid agency is required to use will also include the enrollment form.

The final regulation should clarify that eligibility applications are separate from enrollment forms. Some of the confidential consumer information on the application should not and need not be transmitted to qualified health plans or Medicaid managed care providers. In addition, it is appropriate to separate the eligibility application from the enrollment form as only publicly administered entities can make eligibility determinations while both governmental and non-governmental entities can enroll individuals in health plans.

We appreciate the opportunity to submit these comments on the proposed regulations on the eligibility changes to the Medicaid program. If you have any questions about these comments or need any additional information, please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read 'Karin S. Feldman', written in a cursive style.

Karin S. Feldman  
Benefits and Social Insurance Policy Specialist