November 5, 2013

Kristin Thorn, Medicaid Director
Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place, Room 1109
Boston, MA 02108

Submitted electronically to masshealthpublicnotice@state.ma.us

RE: Health Safety Net and MassHealth Regulations

Dear Director Thorn:

On behalf of the Affordable Care Today (ACT!!) Coalition, thank you for the opportunity to comment on the amended Health Safety Net and MassHealth regulations. Many of these regulations go a long way to ensuring we move forward with providing affordable coverage to low-income residents as we implement the Affordable Care Act (ACA). We have included below more specific comments on the proposed regulations.

Health Safety Net Eligible Services (101 CMR 613.000)
We appreciate the Executive Office of Health and Human Services' (EOHHS) strong commitment to maintaining the Health Safety Net (HSN) for residents who remain uninsured, underinsured, or experience gaps in coverage.

In general, the proposed regulations will maintain key aspects of the HSN while aligning some processes and policies with other ACA coverage programs. For instance, use of Modified Adjusted Gross Income (MAGI) to determine eligibility and utilizing Premium Billing Family Groups (PBFG) align with MassHealth policies and will improve affordability of HSN Partial coverage for families. We do request clarification as to whether MAGI will be used to determine eligibility for elderly applicants, as this income methodology will not be used for elderly MassHealth applicants.

Clarify the term Premium Assistance Payment Program operation by the Health Connector.
The term Premium Assistance Payment Program operated by the Health Connector is used throughout the regulations. We request clarification as to whether this refers to the ConnectorCare program only or to all those who receive advanced premium tax credits (up to 400% FPL).

Allow HSN coverage for the last two months of the grace period for non-payment of premiums.
At 613.04(1)(b), the proposed regulations state that people terminated from Premium Assistance Payment Program operated by the Health Connector due to failure to pay premiums are not considered low-income patients. We urge EOHHS to amend this policy in light of the federal Exchange regulations governing non-payment of premiums. While qualified health plans (QHPs) are required to pay all appropriate claims during the first month of the grace period, they may pend claims in the second and third months of the grace period. If premiums are not paid by the end of the grace period, the enrollee's coverage is retroactively terminated to the end of the first month of the grace period[1]. The preferable option would be for enrollees to maintain full coverage during the second and third months of a grace period. This will require state funding but we believe this would be a modest and important investment that will complete the goal of maintaining the same benefits provided today by the Commonwealth to low-income individuals. Alternatively, we request that EOHHS look into the feasibility of allowing claims in the second and third months of a grace period to be billed to the HSN for HSN-eligible services, as to protect patient from being billed for services during this period. That said, as the HSN has faced a shortfall for several years, it is important that the state make an additional investment to ensure services are covered for people who may face retroactive terminations in coverage due to federal rules.

We support the list of documents to be utilized for identity verification.
613.04(2)(c) provides a comprehensive list of documents to prove identity when determining eligibility for the HSN. We also appreciate the inclusion of a signed affidavit from someone who can attest to the person's identity. These policies will ensure that people who are indeed eligible for the HSN do not face undue barriers to proving their identity in order to receive HSN services.

Delete the reference to access to affordable insurance test.
The Health Safety Net statute (Chapter 118E, Sections 64-49) does not require a test for access to affordable insurance. We urge MassHealth to consider deleting this provision in the regulations, at 613.04(4)(b)(1), until the agency is ready to operationalize a rule imposing an eligibility restriction based on access to affordable insurance.

MassHealth (130 CMR 501.000-506.000 and 403.000)

501 General Policies

Delete authorization for enrollment caps in Family Assistance.
501.003(C) authorizes enrollment caps in Family Assistance which covers children with family income at 150-300% of poverty, HIV positive individuals at 133-200% of poverty and certain immigrants. This authority should be limited to the Small Business Premium Assistance program not Family Assistance. Only the proposed coverage rules for Small Business Premium Assistance program refer to an enrollment cap, 505.009(C), the Family Assistance rules do not, 505.005. Setting and implementing enrollment caps would require an amendment to the 1115 Demonstration (STC IV, 24).

[1] See 45 CFR 156.270

502 The Request for Benefits

Provide that the initial filing date is protected if identity proofing or other missing information is submitted on time, and accept additional documents to prove identity.
The proposed rules at 502.001 (A)(2) and (3) are not clear when an application is received. Section 501.001 defines an "application" as including all required verification even a disability supplement where applicable; this would mean there is no protected filing date even if an applicant who is asked for missing identity proofing or other information submits the missing information on time. The definition of an application in 501 should be changed and the 502 rules should be clarified to state that if there is identity proofing or other information not submitted at the time of application, it will be requested by a certain date and if submitted on time, the application will date back to the date it was initially received. This is how missing information is currently treated in a subsection that was deleted in the proposed rules, but should be retained in 502.001(E) (Rev. 9/1/2012).

If documents must be submitted for identity-proofing, the rule accepts documents at 504.005(A)(3). These are identity documents that may be submitted by US citizens who have submitted citizenship documents that do not double as proof of identity. The rule should be amended to include documents, like a US passport, that are proof of both citizenship and identity at 505.005(A)(1) and documents, like a green card, that are proof of an eligible immigration status and identity at 505.055(B) as well as the identity documents accepted by the Health Safety Net at 101 CMR 613.04(2)(c).

Allow all people applying in person to bypass identity proofing.
502.001(A)(2) states that identity proofing is not required if an applicant submits a paper application or applies in person at a MassHealth Enrollment Center (MEC). We request that MassHealth add that people applying in-person with a Navigator or Certified Application Counselor (CAC) also do not need to complete the identity proofing process.

Make determinations when missing information is not necessary to find an individual eligible for benefits.
The rules at 502.001(B), (C) and (D) and 503 provide that if missing information is requested and not supplied on time, the application will be denied for failing to supply information. There are three circumstances in which this rule should not be followed:

- Where the missing information is only relevant to enable an individual to qualify for a higher coverage type, a determination should be made. This will be true for example when an individual otherwise eligible for CarePlus attests to HIV positive status or breast and cervical cancer or alleges a disability, but fails to supply medical verification or when an immigrant otherwise eligible for Limited fails to verify an eligible immigration status. The rules at 502.007 provide for making a redetermination when such verification is missing (possibly referring to a redetermination after a Provisional Eligibility period), the same rule should apply at the time of application (if there is no Provisional Eligibility period). It should also extend to failure to verify US citizenship for purposes of Health Safety Net eligibility both here and in 502.007.
- The definition of "application" includes a disability supplement where applicable. However, an individual alleging a disability should be able to get a determination on non-

disability grounds whether or not he or she returns the disability supplement as well as while a disability determination is pending. This should be stated in the regulations.

- Finally, where reliable data is not reasonably compatible with a self-attestation of income, but would enable the applicant to qualify for MassHealth benefits, and no corroboration of a lower income amount is supplied on time, a determination should be made. This is the rule that applies to the Connector, 155.315(f)(5), and at continuing eligibility for MassHealth (Proposed 502.007). It would apply for example, if at application, a child's household income was attested to be under 150% FPL, but the data showed income over 150% but still under 300% FPL. Rather than deny the child any coverage, MassHealth should rely on the verified income amount.

Clarify that verification of residency is only required when MassHealth obtains information that is not consistent with self-attested state residence.
502.003 states that state residence must be verified; this requirement is also in 503.002(E). However, it is our understanding that MassHealth is not requiring a data match verifying that the individual lives where he or she claims to live. Rather, MassHealth will check data sources for information that is inconsistent with the individual's attestation of residence, such as an address in a commercial building, and only then seek documentation to resolve the inconsistency. The rule should state that verification of residence will be required only where MassHealth obtains information inconsistent with the self-attestation of residence.

Clarify when provisional eligibility begins.
502.003(E) is not clear when the 90 day provisional period begins. Clearly it cannot be the date an "application" as defined in 501 complete with all required verification is received. Under the terms of the demonstration, if verifications are submitted within the 90 day period and the individual remains eligible, assistance is retroactive 10 days from the date of application. This should be more clearly stated in the rule. For children, the 10 day retroactive period must apply regardless of whether eligibility is later verified as now provided for in Presumptive Eligibility for Children (502.003 (C) rev. 9/1/2012). Otherwise, the repeal of Presumptive Eligibility for Children would violate the ACA's Maintenance of Effort requirement applicable to children's eligibility until 2019.

Clarify what the reasonable opportunity period means.
502.003(F)-(G) provide for a reasonable opportunity to submit verification of self-attested US citizenship or an eligible immigration status. However, the rules fail to state that applicants will be found eligible and enrolled based on their self-attested US citizenship or eligible immigration status during the reasonable opportunity period as required by federal law.[2]

Include Family Assistance children in hospital determined presumptive eligibility.
We believe it was an error to exclude MassHealth Family Assistance children in the list of people who can be determined eligible for MassHealth through hospital determined presumptive eligibility. This population should be included.

[2] 42 USC § 1320b-7(D)(4)(A)(ii) and 42 USC § 1396b(x)(4).

Redefine the hospital determined presumptive eligibility period.
The rule misstates the end date of the hospital presumptive eligibility period. Pursuant to the federal rule at 435.1110, hospital determined presumptive eligibility (PE) will follow the same rules as PE for children at 435.1102. The children's PE rule is clear when the PE period ends: for an individual who files an application by the last day of the following month, it ends when the state agency makes a decision, and for an individual who does not file an application by the last day of the following month, it ends on that last day.

Because MassHealth has obtained a waiver of the mandatory Medicaid 3 month retroactive coverage period, it must adjust the start date for the shortened 10 day retroactive period to at least begin with the hospital PE determination. Otherwise patients will be worse off with presumptive eligibility than with regular eligibility. This does not require a waiver of the hospital PE rules which we understand CMS was reluctant to do, but an adjustment to the current waiver of the 3 month retroactive eligibility period. Hospital PE begins on the date the hospital makes the PE determination, but, to be fair, if an application is filed on time and the individual is determined eligible by the agency, eligibility should date back 10 days from the date of the hospital PE determination not the later date of application.

Clarify improvements to Eligibility Reviews.
We strongly support the improvements to the Eligibility Review process at 502.007, such as allowing for automatic renewals maintaining or upgrading benefits based on data matching. However, the rules should clarify the process for downgrading benefits. We assume this will require an opportunity to correct outdated or erroneous data and an advance notice.

We also strongly support the use of prepopulated forms for Eligibility Review Verifications (ERVs). However, the rule is not clear that the beneficiary remains eligible during the second 90 day period referred to in the rule where the ERV is returned on time but verifications are not. It is also not clear that if the ERV is returned after termination but without verifications whether there is still an opportunity for reinstatement back to the date of termination.

503 Universal Eligibility Requirements
We support the improved residence and Social Security Number (SSN) requirements, which should enable more eligible people to obtain benefits.

504 Citizenship and Immigration

We support preserving coverage options for immigrants.
We strongly support the agency's commitment to fulfill its legal obligations with regards to equal access for immigrants as reflected in these regulations at 504.006. It is in keeping with our state Constitution's recognition of the rights of immigrants as recently affirmed by the Supreme Judicial Court, in a case brought by ACT Coalition member, Health Law Advocates: Finch v. Commonwealth Health Ins. Connector Auth., 461 Mass. 232 (2012).

Provide additional detail on terminology and acceptable documents.
We urge MassHealth to supply additional descriptions of the various types of eligible immigrants described in 504.003. This is a confusing area and it would be very helpful to have more

detailed information explaining the various types of eligible status in 504.003 as well as examples of acceptable proof in 504.005.

Additionally, one status listed as a Nonqualified PRUCOL status could be read to include some persons who are actually "lawfully present," specifically asylum applicants who have been granted employment authorization under 8 CFR 274a.12(c). We recommend changing the phrase "aliens who are asylum applicants" at 504.003(C)(8) to "aliens who are asylum applicants or have a pending application for TPS and who have not been granted work authorization."

505 MassHealth Coverage Types

We applaud MassHealth for using the ACA as an opportunity to streamline MassHealth coverage types and to ensure current and future MassHealth members maintain or gain access to comprehensive benefits.

We support allowing people with breast or cervical cancer to apply directly to MassHealth. Previously people with breast or cervical cancer had to apply through the Women's Health network. The proposal to allow this population to directly apply to MassHealth will simplify and streamline the process.

Clarify MassHealth Standard eligibility at 505.002.

- (I) The rule provides for eligibility for people receiving services from the Department of Mental Health (DMH). However, it should describe people eligible for services from DMH whether receiving services or not including those on any wait list.
- (J) The rule on the Medically Frail may provide that individuals have a choice of CarePlus or Standard, but should not require they first be enrolled in CarePlus and opt in. It should not require a rule change to move to a different approach. We also again urge the agency to consider individuals determined eligible for EAEDC on the basis of disability to be "medically frail," and to provide for identifying other medically frail individuals through a review of utilization records indicating certain chronic conditions, repeat use of detoxification services, or other relevant factors.
- (K) EAEDC recipients may be eligible for Standard, CarePlus 505.008(B) or Family Assistance 505.005(G). In each coverage type there is a requirement that EAEDC recipients be uninsured. These coverage types are not generally limited to the uninsured. Indeed, most allow for premium assistance. EAEDC recipients are by definition an extremely poor and vulnerable group, and there is no reason they alone should have to meet an added "uninsurance" criteria.
- (L) Transitional Medical Assistance requires that a child be living with the parent but does not require that the child be in the MAGI household of the parent or the parent in the MAGI household of the child. The reference to MAGI should be removed.
- (P) It is not clear how (C) Provisional Eligibility relates to the medical coverage dates described in (A) and (B) of this section. The regulations should explain how these provisions interrelate.

We support improvements in Family Assistance at 505.005.
We strongly support the decision to eliminate the 6 month waiting period for children with incomes from 200-300% of poverty and to make premium assistance available to insured children at higher income levels.

We also support limitation to the lock-out period for children terminated for nonpayment of premiums to 90 days. However, the rule should provide for reactivating coverage after the 90 days expires or at the least notifying families when the lock-out period expires in order for this to be the meaningful protection required by federal law. 457.570.

For EAEDC recipients, we urge you to drop the "uninsurance" requirement in Family Assistance 505.005(G) and CarePlus 505.008(B).

506 Financial Requirements

Clarify MAGI household composition and income rules.
We urge the agency to follow the federal MAGI definitions more closely in order to make the new concepts in the MAGI methodology easier for both MassHealth workers and the public to understand. For example, we suggest you explain Adjusted Gross Income, what modifications to income apply to both the Connector and MassHealth and what further modifications apply only to MassHealth. The final authority on MAGI is not the state regulation, but the Internal Revenue Code and federal Medicaid regulations.

Clarify application of 5% Federal Poverty Level (FPL) deduction at 506.007.
Final federal rules limit application of the 5% deduction to "the highest income standard" for which the individual is eligible. 435.603(d)(4). It is unclear how this will apply in Massachusetts. Apparently states that had already programmed their systems with an across the board 5% disregard have until 2015 to comply. (78 FR at 42187). If MassHealth is applying the 5% disregard only to the highest income standard in 2014 as 506.007 says, it should explain what this means.

As we understand the federal rules, the 5% disregard should at least apply to the 150% Medicaid income standard and the 300% Separate CHIP income standard for uninsured children. Also since both the parents' standard and the new adult group standard is 133% FPL, the 5% disregard should apply to both. The Disabled adult standard is not governed by the federal rules but by the 1115 which states that the 5% deduction will apply to the 133% FPL standard for disabled adults. Further clarification on when the 5% deduction applies should be in the rules.

Allow Premium Assistance for coverage in individual market at the request of the beneficiary at 506.012.
Federal regulations permit premium assistance for coverage purchased in the individual market in limited circumstances. 435.1015. We are aware that this option poses risks to beneficiaries. However, insurance in the individual market provides certain mandated benefits not generally available in MassHealth such as Applied Behavioral Analysis (ABA) for individuals with Autism Spectrum Disorder (ASD). For families who need such services, there should be an

opportunity for them to obtain premium assistance, but, as required by the federal regulations, premium assistance in the individual market must be the choice of the beneficiary. We believe premium assistance will be cost effective in terms of savings from other higher cost MassHealth covered services for children with ASD who now go without needed treatment. Ideally, the agency will add these services to all MassHealth coverage types soon.

Require that the Basic Benefit Level defined in 501 include at least Essential Health Benefits and take account of cost sharing as well as premiums in determining the cost effectiveness of Family Assistance Premium Assistance.
Before parents are required to enroll in employer sponsored insurance (ESI) instead of obtaining direct Family Assistance for their children, there should be more scrutiny of the scope of benefits and the extent of cost sharing. The state should develop a better method than the "shoebox" method for determining when premiums and cost sharing exceed 5% of family income. Putting the entire burden on families to document these costs means few families benefit from the 5% cap, even if their expenses do indeed comprise more than 5% of family income.

403.00 Home Health Agency Services

Ensure MassHealth CarePlus members receive adequate access to home health services.
403.420 restricts home nursing services in CarePlus to individuals discharged after an acute inpatient hospital admission. No other MassHealth coverage type contains this limitation on home nursing services. We urge you not to restrict home nursing for the 300,000 beneficiaries in CarePlus. Not only will the restriction deny medically necessary care for no apparent reason, it may also increase costs. If home nursing is not available to follow up on outpatient treatment or for discharge from a chronic or rehabilitation hospital or skilled nursing facility, it may lead to more inpatient admissions or longer institutional stays which will be more costly for MassHealth as well as imposing more risks and inconvenience on patients.

The ACT!! Coalition appreciates the opportunity to comment on proposed changes to the Health Safety Net and MassHealth regulations and looks forward to our continued collaboration on ACA implementation. Should you have any questions, please contact Suzanne Curry at (617) 275-2977 / scurry@hcfama.org or Vicky Pulos at (617) 357-0700 x318 / vpulos@mlri.org. Thank you.

Sincerely,

The ACT!! Coalition

ACT!! Coalition Member Organizations

AARP Massachusetts
AIDS Action Committee
American Cancer Society
American Heart Association / American Stroke Association
Association for Behavioral Healthcare
Boston Center for Independent Living
Boston Children's Hospital
Boston Medical Center
Boston Public Health Commission
Cambridge Health Alliance
Children's Health Access Coalition
Coalition for Social Justice
Committee of Interns and Residents/SEIU Healthcare
Community Catalyst
Community Partners
Disability Policy Consortium
Episcopal City Mission
Families USA
Greater Boston Interfaith Organization
Health Care For All
Healthcare for Artists
Health Law Advocates
Home Care Alliance of Massachusetts
Joint Committee for Children's Health Care in Everett
Massachusetts Academy of Family Physicians
Massachusetts Association of Community Health Workers
Massachusetts Breast Cancer Coalition
Massachusetts Building Trades Council
Massachusetts Business Leaders for Quality, Affordable Health Care
Massachusetts Chapter of the American Academy of Pediatrics
Massachusetts College of Emergency Physicians
Massachusetts Communities Action Network
Massachusetts Council of Community Hospitals
MIRA Coalition
Massachusetts Health Council
Massachusetts Hospital Association
Massachusetts Law Reform Institute
Massachusetts League of Community Health Centers
Massachusetts Medical Society
Massachusetts Organization for Addiction Recovery
Massachusetts NOW
Massachusetts Public Health Association
NARAL Pro-Choice Massachusetts
National Association of Social Workers – Massachusetts Chapter
Neighbor to Neighbor
Partners HealthCare
Public Policy Institute
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Tobacco Free Mass
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UMass Memorial Health Care
Western Mass Health Access Coalition