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Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–2334–P
P.O. Box 8016
Baltimore, MD 21244–8016

Re: Medicaid, Children's Health Insurance Programs, 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.

Dear Ms. Tavenner:

On behalf of the Massachusetts Executive Office of Health and Human Services (EOHHS) and the Massachusetts Health Connector Authority (Health Connector), we appreciate the opportunity to provide comments on the 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 the Children's Health Insurance Program (CHIP), and Medicaid Premiums and Cost Sharing Notice of Proposed Rule Making (NPRM) published in the Federal Register on January 22, 2013. While the Department of Health and Human Services (HHS) offered guidance on a number of important areas for state Exchanges and Medicaid agencies to consider, our comments are focused on areas in which we have relevant experience that we think is important for your consideration and/or the NPRM would have a direct impact on the policy or operations of the Health Connector and MassHealth (the Massachusetts Medicaid and CHIP program within EOHHS).

More than six years ago, Massachusetts enacted landmark health reform legislation, chapter 58 of the Acts of 2006, which created the Health Connector, an independent governmental authority, to promote access to affordable health insurance for the Commonwealth's residents and small businesses. The Health Connector serves as the state's Exchange, assisting individuals and small employers in acquiring health insurance through our Commonwealth Care and Commonwealth Choice programs. Commonwealth Care is a subsidized insurance program available to adults in Massachusetts earning up to 300 percent of the Federal Poverty Level (FPL) who generally do not have access to Employer Sponsored Insurance (ESI) or other subsidized insurance and who meet certain eligibility guidelines. Commonwealth Choice is a non-subsidized insurance program available to individuals and small employers with 50 or fewer employees. Current enrollment in these programs is approximately 196,000 and 41,000 members, respectively. The availability of these programs and the MassHealth program, which has nearly 1.4 million members, as well as the individual and employer responsibility provisions of our state's health reforms, have led to Massachusetts having the highest rate of insurance coverage in the nation.

EOHHS, which handles the eligibility determinations for Commonwealth Care and has a long history of Medicaid and CHIP coverage expansions, has worked in partnership with the Connector on eligibility and enrollment issues that impact the individuals that move between MassHealth and Commonwealth Care. We are continuing this partnership as we work together to develop the computer systems and procedures necessary to support a seamless eligibility and enrollment system for all health coverage programs available to individuals seeking insurance.

The Commonwealth is proud that many components of the ACA are based on elements of the Massachusetts model, including, for example, Medicaid expansion, the individual mandate, standards defining minimum essential coverage and affordability, and the development of an Exchange to facilitate the purchase of health insurance.

Nonetheless, while many aspects of the ACA are broadly grounded in the elements of Massachusetts' health care reform initiatives, there are differences in the law which require modification of our current policies and operations to align with new federal requirements. EOHHS and the Health Connector are strongly committed to successfully adapting to federal health reform requirements to ensure Massachusetts residents have access to the full range of opportunities and benefits presented by the ACA.

Specific Comments
We appreciate the opportunity to provide comments to the proposed rule and offer ours in the following areas:

Part 431 – State Organization and General Administration

§431.10 Single State agency
The proposed rule at 42 CFR 431.10 authorizes Medicaid agencies to delegate to an Exchange the authority to conduct fair hearings on eligibility based on Modified Adjusted

Gross Income (MAGI). While the Commonwealth enthusiastically supports simplifications in processes that benefit consumers, the proposed procedures include provisions that may not accomplish this goal.

Specifically, §431.10(c)(2) allows the Medicaid agency to delegate authority to conduct fair hearings on Medicaid eligibility to a "public authority which maintains personnel standards on a merit basis." The Commonwealth is seeking clarification regarding the required standards to meet this merit-based personnel process. Additionally, the Commonwealth seeks clarification on the circumstances under which federal financial participation (FFP) for appeals conducted by an Exchange would be available.

As a state with an existing subsidized insurance program separate from, but coordinated with, the state's Medicaid program, the Commonwealth has six years of experience with parallel appeal programs. In our experience, individuals find it very confusing to have two separate appeal rights when they filed only one application for benefits. Furthermore, many hesitate to forfeit their right to appeal to the other agency, despite having resolved all discrepancies. We recommend that only one fair hearing opportunity be available to appellants, reducing their administrative burden while maintaining their due process rights. While a sizeable number of applicants are ineligible both for Medicaid and Massachusetts' Commonwealth Care program today, the state has mitigated confusion by creating a hierarchy of benefits in which individuals eligible for Medicaid are not considered for Commonwealth Care and therefore receive no Commonwealth Care appeal right in addition to their fair hearing right. We seek clarification as to whether an individual approved for Medicaid on a MAGI basis must also be given a denial for Advance Premium Tax Credits (APTCs).

Finally, the proposed regulations allow for delegation of MAGI-based eligibility decisions. This presents operational challenges for mixed households in which, for instance, a child qualifies for Medicaid while a parent qualifies for an APTC due to differing income thresholds based on age. We recommend that HHS issue additional guidance to clarify potential circumstances in which a non-MAGI based determination is implicated. We recommend that HHS explicitly authorize the option for an Exchange to also delegate appeals to the Medicaid office, allowing for mixed households to enjoy the same administrative simplicity afforded to entirely MAGI-based households.

§431.11 Organization for administration

The Commonwealth is supportive of CMS' proposal to delete the requirement for state plans to provide certain organizational information.

§431.221 Request for hearing

The proposed rule indicates that an individual must be able to request a hearing in the same ways an application may be filed: telephone, mail, in person, other commonly available electronic means and, at state option, via the internet website.

The Commonwealth is concerned about individuals making a request for a hearing by telephone and how such requests could be tracked. All other communication modes are in

writing and would offer greater ease in filing a request and would also provide a guarantee that a filing occurred. Please provide guidance regarding a State's obligations for telephone requests.

§431.224 Expedited appeals

The Commonwealth would like guidance on how the appeals entity would review a request for an expedited appeal.

We also request clarification of the situations in which expedited appeals apply.

The Commonwealth suggests that the burden should be on the appellant to demonstrate the circumstances for an expedited appeal and to provide medical documentation.

The Commonwealth suggests that the wording for qualifying circumstances for an expedited appeal be changed to "could *seriously* jeopardize the individual's life or health or ability to attain, maintain or regain maximum function" to match the standard at 42 CFR 438.410

The level of coordination required by the proposed rule also presents challenges with regard to expedited requests, as provided for in 45 CFR 431.224 and in 45 CFR 155.540. The Exchange will not have the necessary medical knowledge to determine when an appellant's "ability to attain, maintain, or regain maximum function" is jeopardized. Additionally, the requirement that a decision be issued within three days of receipt may be incompatible with the other consumer protections provided for in the proposed rule, namely, the 15 days' advance notice of hearing and the option to pursue a separate appeal with Medicaid. Furthermore, fact-finding may not be completed within three days, and it is in consumers' interest to allow for submission of verifications in support of a case. Currently, the three-day rule stated in 42 CFR 431.244 applies to denied services, not to determination of eligibility for participation in the program overall. The complexities in eligibility, especially where the appellant bears the burden of proof to dispute electronic data, makes issuing a decision in three days burdensome for agencies as well as for appellants, even those who are being assisted through the informal dispute resolution process.

Part 435 – Eligibility in the States, District of Columbia, the Northern Mariana Islands and American Samoa

§435.4 Definitions and use of terms

CMS proposes at §435.4 to include in the definition of lawfully present individuals who have been granted an administrative stay of removal by the U.S. Department of Homeland Security (DHS) and seeks comments on whether individuals granted a stay by the U.S. Department of Justice (DOJ) or a court should be included too. The Commonwealth agrees that all individuals granted a stay by DOJ or a court be included and strongly recommends that all individuals known to DHS that do not have a

deportation order, including Deferred Action for Childhood Arrivals individuals, be considered lawfully present.

§435.117, §457.360 Deemed newborn children

At §435.117 and §457.360, CMS proposes regulations relating to newborns deemed eligible for Medicaid or CHIP for one year from birth. Please clarify whether a newborn who was receiving benefits through CHIP as an unborn child during the mother's pregnancy, but whose mother was not independently eligible for Medicaid, may or shall receive deemed eligibility for a year from birth. The Commonwealth believes that these newborns should be deemed eligible for one year from birth and requests confirmation and clarification in the final rule. The Commonwealth also requests confirmation that FFP is available under Title XXI for post-partum care for the mother under these circumstances.

§435.150 Former foster care children

The Commonwealth supports CMS' proposal to give states the option to cover former foster care children of any state but seeks the following clarifications:

- Whether this provision requires the state to cover former foster care children who have already "aged out" of foster care, but are under age 26 at the time of application/determination.
- Whether the state of origin would be required to close a former foster child's case when the individual moves out of that state.
- Whether a former foster care child that moves out of state and then reestablishes state residency is entitled to Medicaid under 42 CFR 435.150.
- If a state chooses to cover the former foster care children of another state, please clarify whether individuals can self-attest as former foster care children of another state or if verification is required.

§435.407 Types of acceptable documentary evidence of citizenship

CMS seeks comment on whether one or two affidavits are warranted for citizenship verification. The Commonwealth recommends that only one affidavit be required for individuals who cannot use accepted documents to verify citizenship.

§435.602 Financial responsibility of relatives and other individuals

CMS proposes that, when a couple ceases to live together, the agency must count only the income of the individual spouse in determining his or her eligibility, beginning the first month following the month the couple ceases to live together.

The Commonwealth suggests that this language be changed to "beginning the first month following the month the couple ceases to live together, or on the date the agency receives notification that the couple ceases to live together, whichever is later."

§435.603 Application of modified adjusted gross income (MAGI)

We respectfully request that states have the option of whether to adopt the proposed provision to apply the 5 percent income disregard for MAGI only to the highest income threshold under which the individual may be eligible. States that already provide coverage for certain adults such as parents and caretakers up to or above the 133 percent FPL threshold would not benefit from the proposed selective application of the 5 percent income disregard. On the contrary, this proposed change would make eligibility rules unnecessarily complicated, burdensome to operationalize and difficult to communicate to applicants. Therefore, we request that this provision should be optional rather than required for states.

§435.956 Verification of other non-financial information

States are currently required to do a match through the Systematic Alien Verification for Entitlements (SAVE) process. The proposed rule seems to indicate that states should first attempt to verify lawfully present status through the federal data services hub and then, if that process is unsuccessful, to verify directly with DHS' SAVE system. It is our understanding that the federal data services hub uses the same information as the DHS SAVE system. Please clarify whether the federal data services hub process replaces the current SAVE process requirement. Please also clarify the immigration verification processes states should follow and the order in which the processes should be followed.

In response to the request for comment on appropriate verification procedures for veteran status, the Commonwealth suggests that the federal data services hub receive information from the Department of Defense and the Veterans' Administration.

Please clarify whether the federal data services hub will be able to provide verification of domestic violence for applicants that attest to this Qualified Alien status.

CMS proposes to implement the provision of a "reasonable opportunity" for individuals attesting to citizenship or satisfactory immigration status. The proposed rule requires that states first attempt to obtain verification through the federal data hub and other electronic data sources. If such verification is not available, CMS proposes that there should be a reasonable opportunity of 90 days to verify citizenship or satisfactory immigration status through documentation, during which time the individual receives Medicaid benefits.

According to CMS' prior final rule dated March 2012, states may accept self-attestation for all elements of eligibility except for citizenship or immigration status, or states may require documentation if no electronic verification is available/electronic verification is not reasonably compatible with the information provided by an applicant. In this case, Medicaid benefits would begin after verification has been provided.

We recommend that, for citizenship and immigration status, CMS allow states to follow a process similar to the reasonable opportunity period for verification of data elements other than citizenship or immigration status. This policy would achieve two key goals.

First, it would promote alignment and consistency between Medicaid and the Exchange. The Exchange final rule provides for a reasonable opportunity period for verification of citizenship or immigration status (similar to the Medicaid rule), and it also provides for a 90-day "inconsistency period" during which individuals may enroll in a QHP and receive APTCs pending verification of other elements of eligibility, such as income, if electronic verification is not possible. Allowing Medicaid programs to follow a similar process would facilitate a streamlined eligibility process for all applicants, especially for households with some members determined eligible for Medicaid and other members eligible for APTCs.

Second, this policy would balance Medicaid programs' interest in a seamless, streamlined eligibility process (facilitated by the rule to allow for self-attestation) and Medicaid programs' concerns about program integrity (facilitated by the rule to allow states to require verification).

The Commonwealth suggests adding "during any appeal process" to the list of triggers for a reasonable opportunity period.

In order to align with the proposed rule regarding Exchange processes and with current Medicaid rules related to verification of Citizenship and Immigration, the Commonwealth recommends that Medicaid be allowed to accept self-attestation of membership in a federally recognized tribe in order to provide appropriate cost sharing and other protections during a 90 day reasonable opportunity verification period.

§ 435.1110 Presumptive eligibility determined by hospitals

CMS' proposed rule at §435.1110(a) provides that a state Medicaid agency must provide, during a presumptive eligibility period, Medicaid to those determined presumptively eligible by a qualified hospital in accordance with the policies and procedures established by the State consistent with this section and §§ 435.1102 and 435.1103 "*but regardless of whether the agency provides Medicaid during a presumptive eligibility period under such sections*" (emphasis added). The preamble of this proposed rule, on the other hand, states that "a state Medicaid agency may limit presumptive eligibility determinations by qualified hospitals to the types of presumptive eligibility that the agency may elect to cover, as described at proposed § 435.1101 through § 435.1103." The preamble appears to permit a state Medicaid agency to prevent a qualified hospital from making presumptive eligibility determinations for a population if the agency has chosen not to cover presumptive eligibility for such a population. The proposed rule itself does not seem to allow for such an outcome. Massachusetts requests clarification on this proposed rule, and we respectfully recommend that states should be allowed to limit the populations qualified hospitals may determine presumptively eligible to only those that the state Medicaid agency elects.

CMS seeks comments regarding agency standards for qualified hospitals making presumptive eligibility determinations and whether such standards should be a federal requirement, a state requirement, or neither. States have a legitimate concern regarding program integrity, and Massachusetts supports a federal requirement that places standards

on the proportion of individuals determined presumptively eligible by a qualified hospital who submit a regular application before the end of the presumptive eligibility period. As hospitals play a larger role in the determination of presumptive eligibility, it is critical that they assist patients with completing a full application in order to ensure continuous access to coverage and care for individuals eligible for Medicaid. We believe it would be helpful for CMS to set national standards for hospitals' responsibility in this regard. Massachusetts also recommends that state Medicaid agencies have discretion to implement other program integrity requirements for qualified hospitals, such as limiting the number of presumptive eligibility periods for an individual in a given time period, such as one year.

The Commonwealth requests that the final rule state clearly whether hospital presumptive eligibility rules apply to individuals eligible under Title XXI or only those eligible under Title XIX.

The Commonwealth also requests clarification on the definition of a "qualified hospital" for purposes of presumptive eligibility determination. We recommend that CMS define "qualified hospitals" to mean acute care hospitals that operate under a state hospital license, but give states the option to expand that definition to include hospital licensed health centers or affiliated Community Health Centers. We also recommend that CMS exclude chronic disease and rehabilitation hospitals and institutions for mental disease from the definition.

§ 435.1205, §457.370 Alignment with exchange initial open enrollment period

CMS describes options for states during the Open Enrollment Period to facilitate a smooth transition to the use of the Single Streamlined Application and new coverage options available under the ACA. We appreciate the flexibility made available to states and believe that this flexibility will allow states to pursue a transition approach that is well suited to their individual circumstances. CMS also indicates that it is open to working with states to use 1115 waiver authority to allow states to apply MAGI-based methods to determinations of Medicaid eligibility effective with the 2013 open enrollment period. We respectfully request that states should have the option to apply MAGI-based methods to determine eligibility effective with the 2013 open enrollment period without an 1115 waiver. This option would allow states to coordinate with the Exchange, avoid consumer confusion, reduce the administrative burden of operating two systems and minimize any gaps in coverage for applicants. Furthermore, making this option available without 1115 authority would allow states to plan for the Open Enrollment Period immediately without undergoing the potentially time-consuming process of pursuing a new 1115 waiver or amending an existing waiver.

CMS also requests comment on how to ensure that individuals who submit an application that was used for determining eligibility based on 2013 rules are assessed for eligibility for 2014 coverage. Similar to CMS' proposed approach for how individuals may be assessed for eligibility based on 2013 rules during the Open Enrollment period, we recommend that states should have flexibility in their handling of such applications. For example, states should be allowed to request that applicants submit a supplemental form

that includes the additional information needed to make a MAGI determination, or to redirect applicants to the new application. On the other hand, states also should have the flexibility to process these applications using 2013 rules and systems and determine eligibility based on a MAGI proxy when possible. All states are currently undergoing a process to convert their current income standards into MAGI equivalents. For example, Massachusetts uses gross income to determine eligibility and currently provides coverage for parents up to 133% FPL, so the MAGI-converted income standard may be 128% FPL (133% FPL minus a 5 percent income disregard). Given that this income standard is below 133% FPL MAGI, any parent who is determined eligible based on 2013 rules would also meet the MAGI standard and could be determined eligible for immediate Medicaid coverage. This approach may not work for all states or all applicants, but we recommend that states have maximum flexibility to process applications in a manner that is most efficient both for the state and for the consumer.

Part 440-Services: General Provisions

§440.315 Exempt individuals

CMS proposes to revise the definition of "medically frail" individuals, who are exempt from mandatory enrollment in an Alternative Benefit Plan. We have significant concerns about the vagueness of the definition of "medically frail" and the difficulty that states will have in operationalizing the exemption.

CMS also seeks comment on whether individuals with a substance use disorder should be added to the definition of "medically frail" and therefore exempted from mandatory enrollment in an Alternative Benefit Plan. We recommend that if this population is added to the definition of medically frail, CMS should narrow the definition to include only individuals that meet a defined disability test.

§440.347 Essential health benefits

CMS proposes to revise its regulations to state that "[a]lternative benefit plans must contain essential health benefits coverage, including benefits in each of the following ten categories, consistent with the requirements set forth in 45 CFR Part 156." The Commonwealth requests clarification on the meaning of the phrase "consistent with the requirements set forth in 45 CFR Part 156," particularly if the phrase adds any additional obligations to the requirement to select a benchmark plan that includes benefits in each of the ten essential health benefits categories. Since this requirement is already clearly enumerated within the proposed rule at § 440.347(a), it would be worthwhile to be more specific about exactly which additional provisions of 45 CFR Part 156 apply to the Medicaid benchmark plan. That said, the Commonwealth believes the rule should clearly confirm that state Medicaid programs have broad flexibility to choose a benchmark plan, including, but not limited to, the same options available within the commercial market. State Medicaid programs should not, however, be required to use the same plan that was selected as the benchmark for the state's commercial plans. We also recommend that a program's Medicaid State Plan benefits be considered Secretary-approved coverage for

their alternative benefit plans. We further request clarification of the time frame for CMS approval of Secretary-approved plans.

CMS seeks comments regarding whether the state defined habilitative benefit definition for the Exchanges should apply to Medicaid or whether states should be allowed to separately define habilitative services for Medicaid. MassHealth supports allowing states flexibility to separately define habilitative services for Medicaid.

Part 447-Payments for Services

§447.56 Limitations on premiums and cost sharing

CMS proposes that those Indians who are currently receiving or have ever received an item or service furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) or through referral under contract health services are exempt from all cost sharing.

In response to the request for comment on the feasibility of initiating a periodic renewal process for the Indian exemption, as well as an appropriate time frame for such renewals, the Commonwealth suggests that period renewal is not necessary as "currently receiving or have ever received an item or service have ever received an item or service furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) or through referral under contract health services" is not a condition that would expire.

We also request clarification of how states under a waiver program such as our Family Assistance Premium Assistance program would know that a member accrued and paid bills reaching the 5% of family income cap when the state is not processing claims for the member but only providing premium assistance.

The provision provides that states should apply the 5% cap to the Medicaid MAGI household (as defined in §435.603(f)). Please clarify the application of the cap in the situation when there are different MAGI households within the same family. For example, for a family of five, with three separate MAGI household compositions, will there be three 5% caps applied, so that the family effectively has a 15% out of pocket cap?

To create efficiency, the Commonwealth requests that CMS allows flexibility to allow the state to define what household to track out-of-pocket costs for, specifically in the situation where there are multiple MAGI household in a single family group. For example, we recommend allowing states to align the 5% cap with families or premium billing grouping, or other grouping defined by the state.

Part 457-Allotments and Grants to States

§457.805 State plan requirement: Procedures to address substitution under group health plans

At §457.805, CMS specifies that CHIP state plans must include a description of "reasonable procedures" to prevent substitution. CMS also requests comments on the viability of alternative strategies to reduce substitution of coverage to best balance the goal of preventing coverage gaps for children while ensuring that CHIP coverage does not substitute for coverage available under group health plans.

Massachusetts has found that offering premium assistance when employer-sponsored insurance is available and cost effective ensures that CHIP coverage is not used as a substitute for coverage available under group health plans. We recommend that if a state offers premium assistance it should be deemed to have in place the "reasonable procedures" to prevent substitution required by §457.805.

In §457.805(3), CMS proposes several exemptions to CHIP waiting periods that all states will be required to use. We support the items currently included on the list and recommend that CMS add an additional exemption: "(vii) The prior coverage was lost due to domestic violence." Massachusetts currently utilizes this exemption and has found that it is an important protection.

CMS also states that it is considering adding an additional affordability exemption, which is to be applied when the child's parent is determined eligible for advance payment of the premium tax credit for enrollment in a QHP through the Exchange because the ESI in which the family was enrolled is determined unaffordable in accordance with 26 CFR 1.36B-2(c)(3)(v). We support adding this affordability exemption to the waiting period regulations, and believe this will create additional alignment for families with household members receiving insurance coverage through multiple agencies.

Part 155 – Exchange Establishment Standards and Other Related Standards under the Affordable Care Act

§155.315 Verification process related to eligibility for enrollment in a QHP through the Exchange

A clear vision of national health reform is the development of a seamless, real-time eligibility determination process for individuals applying for health insurance coverage, including insurance affordability programs, through the Exchange. Since the passage of the ACA, the Commonwealth has worked to update and improve our existing eligibility system and create a Health Insurance Exchange (HIX)/Integrated Eligibility System (IES) to provide for real-time data exchange processes for both Medicaid and Exchange eligibility determinations.

Section 155.315(f) of the NPRM proposes allowing the Exchange to wait up to two days for electronic data sources to become available before proceeding with the inconsistency

process. As explained in the preamble of the proposed rule, this flexibility is intended to account for times when required electronic data sources are unavailable. The Commonwealth is developing the HIX/IES so that it will serve all consumers, regardless of when they are able to apply for coverage. Therefore, while we understand that there may be rare instances during which electronic data sources are unavailable, the success of the HIX/IES project is dependent on the continuous availability of such data sources. The Commonwealth has concerns that codifying §155.315(f) as proposed by the NPRM is inconsistent with the intent of the ACA as it may allow for more regular and longer interruptions in the availability of electronic data sources than otherwise anticipated.

§155.320 Verification process related to eligibility for insurance affordability programs

The proposed rule, §155.320(c)(3)(iii)(B), requires the Exchange to trigger the inconsistency process described in 45 CFR 155.315(f) if current data sources or other information provided by an applicant indicates that projected annual household income is in excess of the attestation by a "significant amount." As explained in the preamble of the Exchange final rule regarding the alternate verification process described in 45 CFR 155.320(c)(3)(iv), "given the sensitivity of the advance payment formula and the potential for large variations in cost-sharing reductions with small shifts in income," any change in household income is potentially significant. While the Exchange has a responsibility to ensure the accuracy of eligibility determinations and the equity of the process on applicants, a narrow interpretation of the term "significant amount" could place additional administrative burdens on applicants and the Exchange. We respectfully request flexibility to set standards according to the needs of our population.

Section 155.320(d) of the NPRM proposes that the Exchange verify whether an applicant is enrolled in an employer-sponsored plan or is eligible for qualifying ESI by checking available electronic data sources, including any data regarding the employment of the applicant and members of his/her household. If such data is unavailable or not reasonably compatible with the individual's attestation, the Exchange must conduct a post-eligibility verification by contacting the employer(s) of a statistically significant random sample of such applicants. Given that electronic data matches will likely not be available during the Exchange's first year of operation, we appreciate the flexibility to conduct post-eligibility verifications. However, the Commonwealth currently has established processes related to the verification of enrollment in and eligibility for employer-sponsored insurance which we would like to leverage for this purpose. We believe other states may also have these systems and processes in place for public programs that they are currently operating. We respectfully request that HHS provide flexibility under Section 155.320(d) for states to define the factors that would trigger a post-eligibility verification and how to conduct the necessary investigations.

To be eligible for the Health Connector's Commonwealth Care program, an individual must be uninsured. When an applicant indicates they work for an employer who offers insurance or that s/he works more than 100 hours per month, the case is investigated to determine whether the applicant has access to employer-sponsored health insurance. This investigation is also performed as part of the redetermination process for existing

members. The Health Connector is requesting flexibility under Section 155.320(d) to develop a post-eligibility verification process that builds upon this existing technical and procedural base to develop a post-eligibility verification process that can quickly and accurately determine the insurance access of applicants and members.

The Commonwealth is also concerned that identifying the employee by name as part of this post-eligibility verification process might expose the employee to potential retaliation by an employer. We urge HHS to consider modifying this requirement so that the Exchange has the flexibility to identify and implement a process by which the employee's identity would not be provided to the employer.

§155.330 Eligibility redetermination during a benefit year

45 CFR 155.330(d) requires the Exchange to conduct periodic data matches on death for all QHP enrollees. §155.330(e)(2)(i) of the NPRM proposes to clarify that, if a periodic data match identifies updated information regarding death, the Exchange must inform the enrollee of this update and allow 30 days for the individual to respond prior to terminating coverage. The NPRM does not clarify under proposed §155.330 whether the Exchange would be permitted to terminate coverage retroactively to the date of death, which is standard practice in the non-group market today. We respectfully recommend that Exchanges have the flexibility to align with non-group market standards and allow for retroactive terminations in the instance that the Exchange obtains updated information regarding death.

§155.520 Appeal requests

Please clarify timelines for requesting an appeal. Current Medicaid fair hearing rules at 42 CFR 431.221(d) require Medicaid agencies to allow "a reasonable time, not to exceed 90 days" to request a hearing and we recommend that Exchanges be given the same flexibility. Allowing this flexibility will facilitate alignment of appeal rights when an eligibility decision implicates both Medicaid and Exchange eligibility or affects a mixed household.

Please clarify the timeframe for appeal decisions. The Commonwealth recommends that the timeframes for appeal requests and decisions be the same for Medicaid and the Exchange to ensure operational efficiency and eliminate confusion for applicants and members.

The proposal that notice of receipt of an appeal request must be sent by the appeals entity is unduly burdensome. The electronic application should be able to track the date an appeal was requested. If the individual prefers to request the appeal in writing, s/he should send the request by certified/return receipt requested mail.

§155.520 of the proposed rule allows an appellant to appeal a decision from a state-based Exchange to HHS if the person disagrees with the appeal decision issued by the state-based Exchange. While acknowledging the language in ACA §1411(f) which requires appeals to be reviewed by a federal officer, the Commonwealth is concerned that this provision would be operationally burdensome. In particular, state law provides for a right

to seek judicial review of a final agency decision provided the action is filed within 30 days. As the regulations are written, a decision to seek HHS review would not toll the statutory limitations period for filing an action for judicial review. As a result, appellants would be presented with a confusing procedural choice, and may well have parallel simultaneous procedures that could result in conflicting adjudications. The Commonwealth is therefore requesting further clarification on the interaction between a state-based Exchange appeals process, the HHS review, and state judicial process including when an HHS review would commence relative to a state judicial review.

In addition, the proposed rule allows a state the option to establish a state-based Exchange appeals entity for individual appeals and employer appeals; however, states without an appeals process may rely on the HHS appeals process for individual and employer appeals. The Commonwealth proposes that the rule explicitly confirm that a state can elect to have a state-based Exchange appeals process for some categories of appeals (for instance, individual eligibility or APTC determination appeals) and not for others (for instance, employer appeals of APTC eligibility determinations.)

§155.525 Eligibility pending appeal

The proposal in 45 CFR 155.525 regarding eligibility pending appeal presents operational challenges related to receipt and processing of appeals. The current wording of the proposed rule implies that any appeal of a benefit redetermination that is submitted within the 90 day timeframe qualifies for eligibility pending appeal. However, current rules at 45 CFR 155.430 allow the Exchange to terminate an enrollee's coverage with fewer than 90 days notice. As a result, eligibility pending appeal could result in the need for retroactive enrollment and the accompanying premium payments and advance premium tax credits for those prior months, which would be a burden for appellants, QHP issuers, and Exchanges. Furthermore, this is another discrepancy with existing Medicaid rules, which require that an appellant file the request for fair hearing before the appealable action occurs (42 CFR 431.230). We recommend that 155.525(b) be amended to require the same timeframe for requests for aid pending appeal as is found in the Medicaid rule.

We seek clarification on how non-payment of premiums affects eligibility pending appeal. We recommend that QHP issuers be allowed to proceed with a non-payment termination regardless of an individual's status as receiving aid pending appeal.

Additionally, retroactive eligibility as implemented by a hearing decision in accordance with 45 CFR 155.545 is an important provision for individuals who do not qualify for continued enrollment during the appeal process. We recommend limiting retroactive eligibility to only those appellants who do not qualify for eligibility pending appeal. Those who do qualify for and accept continued benefits during the appeal process will not have a need for retroactive coverage. Those who qualify and elect not to continue benefits should not be given an opportunity to retroactively enroll because this will lead to adverse selection for QHP issuers. Appellants who did not have any medical expenses during the months not covered will not have an incentive to pay premiums retroactively. While this is also the case for those not qualified for eligibility pending appeal, we

believe that retroactive eligibility is an important consumer protection and corrective mechanism.

§155.550 and 555 Appeal record and Employer appeals process

Sections 155.550 and 155.555 of the proposed rule require the appeal record, including a transcript or recording of hearing testimony and exhibits introduced at the hearing, to be made accessible to the appellant, employee, employer, and to the public depending on the context. The proposed rule allows for an exception for federal and state privacy, confidentiality and disclosure laws; however, the Health Connector is concerned that making the appeal record publicly available will have unintended adverse consequences.

For instance, fear that a person's personal information, even if redacted, could be accessed by anyone would discourage someone from appealing a determination. Appeal records will necessarily contain a significant amount of personal information, including income and household composition, and potentially other information about medical conditions. The record would need to be redacted, a process which is burdensome, labor intensive and as a result, costly.

Specific to employer appeals, Section 155.555(h) requires that the Exchange appeals entity not disclose an employee's tax return information to the employer. As income information will be relevant to both the employer and employee appeals, it will be difficult for the Exchange not to reveal this information in an employer appeal. Disclosure of an employee's eligibility information could contribute to discrimination by the employer on the employee who was awarded APTC based on their lack of affordable employer-subsidized insurance. The Health Connector seeks further clarification as to the exact information from an employee that must be revealed to an employer for an appeal.

The Health Connector is requesting that HHS allow for flexibility in making appeal records publicly available. For example, the hearing could use de-identified exhibits that would not contain an individual's private information. For employer appeals, we recommend allowing the employer to view only a notice containing the employee's name and an income threshold and not include an employee's other eligibility information as part of the appeal record.

Section 155.555 sets up a process for an employer to appeal an employee's determination of eligibility for an insurance affordability program based on the determination that the employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does not provide affordable coverage with respect to that employee. The proposed rule outlines a process whereby both employers and employees are able to participate and present evidence in the other's appeal and where the appeal outcomes have consequences for the other party. Presumably, if an employer who is appealing succeeds in establishing that it offered affordable insurance to the employee, this would have an effect on the employee's eligibility for APTCs. But if an APTC eligibility decision were changed as a result of the employer's appeal, the employee would presumably have an appeal right. This process could create a contradiction between different outcomes from employee and employer appeals depending on when

each appeal occurs. Consequently, the Health Connector is seeking further clarification as to the sequencing of the employer and employee appeals and when such appeal outcome is final.

We thank you for consideration of our comments and look forward to continuing to work with the federal government on successful implementation of the ACA.

Sincerely,

John Polanowicz
Secretary