



October 31, 2011

*Submitted Via the Federal eRulemaking Portal at: <http://www.regulations.gov>*

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-2349-P  
P.O. Box 8010  
Baltimore, MD 21244-8010

**RE: CMS-2349-P; Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010**

Dear Sir or Madam:

I am writing on behalf of Molina Healthcare, Inc. (“Molina Healthcare”) to offer comments in response to the “Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010” proposed rule. The proposed rule was published in the Federal Register on August 17, 2011 (Vol. 76, No. 159). Molina Healthcare requests that these comments be considered in conjunction with companion comments to another proposed rules published on August 17, 2011 – “Patient Protection and Affordable Care Act: Exchange Functions in the Individual Market: Eligibility Determinations: Exchange Standards for Employers.”

Molina Healthcare is a multi-state health care organization focused exclusively on government-sponsored healthcare programs for low-income families and individuals. Our 30-year history places us amongst the most experienced managed care companies serving the financially vulnerable. Our commitment to quality is reflected in the recognition we have received from the National Committee on Quality Assurance (NCQA). Molina remains a leader in the number of its health plan NCQA accreditations, with a total of nine accredited health plans.

Molina Healthcare contracts with state governments and serves as a health plan providing a wide range of quality health care services to families and individuals enrolled in Medicaid, Medicare and the Children’s Health Insurance Program (CHIP). Today, Molina Healthcare provides healthcare assistance to approximately 1.6 million members in ten states across the country.

Last year, Molina Healthcare acquired Health PAS, and formed Molina Medicaid Solutions (MMS), a subsidiary of MHI. Health PAS is a new, high-performance, real time Medicaid management information system (MMIS) that adapts quickly to regulatory and marketplace changes and meets all functional and performance requirements of the modern Medicaid system. MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. MMS is also customizable to support additional government systems including Decision Support Systems.

MMS currently holds contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program. Each year, MMS processes over three hundred million healthcare claims, making payments to over two hundred thousand providers for four million people, issuing more than \$24 billion in benefit payments. As part of the Molina Healthcare family, MMS is the only solution of its kind implemented by a health care company with more than 30 years of experience supporting state Medicaid and other government-sponsored programs.

The proposed rule implements provisions of the Affordable Care Act related to Medicaid and CHIP eligibility, enrollment simplification, and coordination. With the enactment of the Affordable Care Act, the Congressional Budget Office has projected 16 million new people will be covered nationally by Medicaid by 2019. With the influx of these new eligible members, simplifying the eligibility and enrollment processes is critical to ensure all individuals receive the necessary and proper healthcare services. Molina Healthcare strongly supports that appropriate steps are taken to enroll all persons in health care programs for which they are eligible by improving, streamlining, simplifying and enabling electronic and uniform applications and eligibility and renewal procedures and by providing continuous coverage to beneficiaries of government-sponsored programs. Please find our comments and recommendations regarding the proposed rule below.

#### **A. Changes to Medicaid Eligibility**

According to Amendments to Part 435, Subparts A Through D, consolidating several categories of eligibility into four groups -- children, pregnant women, parents and other caretaker relatives, and the new adult group -- will enhance the ease of enrolling the new participants in the Medicaid program as well as continue to ease the burden of verification and reenrollment for current members. While we endorse simplification of eligibility requirements, we are unclear as to how, under these new categories, certain populations such as the aged, blind, and disabled (ABD) will be documented. For example, ABDs require tremendous amounts of services, care management and coordination and their specific healthcare needs must be recognized in order to receive additional services and supports that this population requires. We recommend that a process be set to recognize these members in the eligibility determinations to ensure they receive the proper care and services unique to the ABD population. This designation and information will also aid health plans in delivering specialty care and services to them in a timely manner.

#### **B. Financial Methodologies for Determining Medicaid Eligibility Based on MAGI Under the ACA**

“Churn,” due to income fluctuation, will be a major issue for the low-and moderate-income populations as individual’s transition between Medicaid and the health insurance exchange (Exchange). In fact, it is estimated that within six months, more than 35 percent of all adults with family incomes below 200 percent of the federal poverty level will experience a shift in

eligibility from Medicaid to an Exchange, or the reverse; within a year, 50 percent, or 28 million, will<sup>1</sup>. State Medicaid agencies have a deep understanding of the needs of a low-income population and are poised to help manage the expected high level of churn among federally-funded subsidized insurance and state Medicaid and CHIP programs.

We support the regulation, §435.603(h)(2), to provide additional flexibility for states to maintain eligibility for individuals eligible for Medicaid based on MAGI “as long as annual income based on MAGI methods for the calendar year remains at or below the annual income standard.” Having the flexibility to take into account a predictable future drop or increase in income can help reduce concerns about medical coverage for individuals that may end up in the churn.

### **C. Periodic Redetermination of Medicaid Eligibility (§435.916)**

The proposed rule allows that states schedule regular redeterminations or renewals for beneficiaries whose eligibility is based on MAGI once every 12 months. To minimize “churn,” the eligibility process both for exchange subsidies and Medicaid should be annual and should result in continuous 12-month eligibility. State exchanges will be required to embrace the “no wrong door” approach to eligibility determinations and to ensure this work is integrated smoothly with the state Medicaid agency eligibility processes. To the extent feasible, state exchanges should contract with state Medicaid agencies to ensure an efficient and integrated approach to eligibility. Exchanges should have an annual eligibility determination and open enrollment process, and state Medicaid agencies should adopt similar rules to the extent allowed by federal regulations.

Streamlining the redetermination process by creating flexibility such as requiring beneficiaries to complete a renewal form only if there has been a change in circumstance; permitting individuals to report changes online, by telephone, by mail, or in person; and providing beneficiaries with forms that include pre-populated data when supplemental information from beneficiaries is required reduces the administrative burden on the state, member, and health plan. Molina supports proposals that would reduce an unintentional gap in coverage and disruption of the continuity of care for this population.

Molina also supports the expansion of the standards to include options for permitting all beneficiaries to report changes online, over the telephone, by mail or in person. With the reliance on methods for communication that go beyond the in-person interview, allowing members alternatives to the mandatory in-person interview will give members the flexibility in their communication methods with the state. This flexibility will help reduce individual non-participation in the renewal process, prevent them from dropping coverage and ensure they continue to receive quality healthcare.

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<sup>1</sup> “ Issues in Health Reform: How Changes In Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges,” Benjamin D. Sommers and Sara Rosenbaum, Health Affairs, February 2011

**D. Application and Enrollment Procedures for Medicaid (§435.907)**

In §435.907(b), CMS proposes to implement the ACA requirement that states use a new single, streamlined application form for individuals eligible for Medicaid based on MAGI methodologies. We support the use of a streamlined application process to more effectively use administrative resources for state and health plans, reduce the time delays associated with a fragmented procedure and to further reduce the pressure that states already feel with the application process. A more effective and efficient process would lead to reduced costs and decreased enrollment time and burden for members.

We propose revisions to §457.330 similar to those proposed for Medicaid at §435.907 to implement the use of a single, streamlined application for all insurance affordability programs, which builds on the successful experience many states have had with joint Medicaid-CHIP applications

Also, we propose revisions to §435.1200 similar to those proposed for Medicaid at §435.907 to promptly enroll members without further determination. Applicants should be able to make a plan choice at application in addition to eligibility. Making that determination at this juncture will eliminate another unnecessary step in the enrollment process.

**E. Provisions of Proposed Regulation Implementing Application of MAGI to CHIP**

CMS further proposes to apply the proposed regulation implementing MAGI as the basis for eligibility determinations to the CHIP program. Molina supports this proposal to streamline the eligibility process for CHIP, making it more consistent with Medicaid regulations and processes and more efficient for states, members, and health plans.

Based on Molina Healthcare's experience and expertise providing healthcare assistance to those who rely on government programs, we are pleased to provide a voice for the financially vulnerable during this transformative period in health care public policy. Thank you for the opportunity to provide comments on this important regulatory proposal and for your consideration of the special needs and circumstances of low-income families and individuals.

Sincerely,

MOLINA HEALTHCARE, INC.

By: \_\_\_\_\_

  
John M. Puente  
Vice President, Deputy General Counsel