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October 31, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244-8016

Re: CMS-2349-P—Medicaid Program Eligibility Changes Under the Affordable Care Act

To Whom It May Concern:

Community Health Councils (CHC) writes to share comments on the Department of Health and Human Services' notice of proposed rulemaking regarding the Medicaid program eligibility changes under the Affordable Care Act. CHC is a non-profit community-based health promotion, advocacy, and policy organization committed to improving health and increasing access to quality healthcare for uninsured, under-resourced, and underserved populations in South Los Angeles County. For over 20 years, CHC has worked to ensure that low-income communities and communities of color have access to the care they need and that they keep coverage independent of life changes that may occur.

The expansion of Medicaid in the ACA means more than 21 million Americans will finally be able to access affordable and comprehensive coverage. The California Healthcare Foundation estimates that more than 2.8 million Californians will obtain Medicaid coverage in 2014. Los Angeles will account for roughly half of California's new Medicaid enrollees. Given the high concentration of Medicaid beneficiaries and health care safety net users living in Los Angeles County, CHC writes in support of the recommendations provided by the National Health Law Program (NHeLP) related to the proposed regulations on Medicaid program eligibility. We believe the recommendations submitted by NHeLP provide a thorough overview of the necessary changes that HHS must incorporate into the proposed rules to ensure that communities can access affordable and robust Medicaid and CHIP coverage.

We commend HHS for taking major strides to simplify and streamline the enrollment process for Medicaid enrollees and to ensure seamless transition of coverage into the Exchange should an individual not be Medicaid eligible. Efforts like the simplified application, consolidation of eligibility groups, data matching requirements, and annual redetermination procedures will translate into cost savings for the state and will ensure that enrollees maintain coverage. That being said, we would like to express concerns regarding the screening process for Medicaid enrollees as outlined in the regulations.

Given the lack of clarity and consistency regarding a state's requirement to convert their minimum eligibility standards to a MAGI-equivalent standard, we feel it is premature to assume the proposed regulations will thoroughly ensure access to care for the most vulnerable populations eligible for Medicaid coverage. It should be a firm goal of HHS to ensure that no individuals or children eligible for Medicaid are worse off as a result of the expansion of Medicaid under the Affordable Care Act.

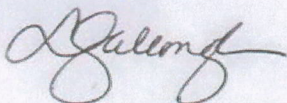
Without clarification regarding the use of non-MAGI based eligibility screening, some pregnant women, children, and individuals with disabilities may be negatively impacted by the proposed rules. Therefore, we write in support of the requirement that states convert their minimum eligibility standards into a MAGI-equivalent for ALL MAGI-based Medicaid categories. This is reflected in the issues and recommendations raised by the National Health Law Program in their comments regarding appropriate screening for Medicaid eligible populations.

Related to our concerns regarding MAGI and non-MAGI eligibility, lack of clarity regarding the benchmark benefits available to newly eligible populations raises significant concerns regarding the quality of coverage new enrollees will receive if screened for coverage using MAGI based eligibility. Because States are not required to determine if an individual would benefit from a non-MAGI screening, individuals run the risk of being enrolled into MAGI based Medicaid which may offer a more limited set of benefits compared to traditional Medicaid coverage which they may be eligible for under non-MAGI rules. Therefore, we strongly urge HHS to require that throughout the screening process, whether online, in person, on the phone, or through mail correspondence, States include screening questions to determine whether individuals are eligible for non-MAGI Medicaid to ensure adequate access to affordable care.

Finally, we believe that states should not be penalized for helping newly eligible individuals access the care they need under Medicaid. The proposed methodologies under Part 433 for calculating federal matching funds are problematic in that they may create a dual system for determining federal match which will be burdensome for both the state and enrollees. We believe the best approach would be for CMS to work with States to address state-specific needs and develop the appropriate FMAP proportion. Please note the concerns raised by NHeLP in their comments under state fiscal administration.

We would like to thank the Department for providing us the opportunity to provide input on policies that will directly impact the lives of children, seniors, families and communities. We look forward to working with you to build upon the strengths of our current healthcare coverage system and to make needed reforms to improve quality, access, and affordability of care for all individuals. We encourage you to continue to engage the public in the development, implementation and evaluation of these and other healthcare reform regulations. Should you require additional information or have any questions, please feel free to contact Sonya Vasquez, Policy Director, at 323.295.9372 extension 235.

Sincerely,



Lark Galloway-Gilliam, MPA
Executive Director