COMMENTS REGARDING EXCHANGE FUNCTIONS IN THE INDIVIDUAL MARKET, ELIGIBILITY DETERMINATIONS, & EXCHANGE STANDARDS FOR EMPLOYERS; MEDICAID PROGRAM ELIGIBILITY CHANGES UNDER ACA, & HEALTH INSURANCE PREMIUM TAX CREDIT – RELEASED 8/17/11

(42 CFR PARTS 431, 433, 435, & 457 (CMS-2349-P); 45 CFR Parts 155 & 157(CMS-9974-P); 26 CFR Part 1(REG-131491-10)

TABLE OF CHARTS

Chart 1 – 42 CFR Part 431 1
Chart 2– 42 CFR Part 433 2
Chart 3– 42 CFR Part 435 3
Chart 4– 45 CFR Part 155 [cross reference with 42 CFR Part 435] 23
Chart 5– 42 CFR Part 457 28
Chart 6—26 CFR Part 1 33

Chart 1 – 42 CFR Part 431

Section/ FR Page	Description of Rule Provision	Comments
431.10/ 51184	Single State Agency	We support a final rule that enables the Medicaid Agency to retain its responsibility, through state merit employees, for setting Medicaid eligibility policies and ensuring that Insurance Affordability eligibility determinations by a governmental or quasi-governmental Exchange (e.g. public authority) are made consistent with those rules. The final rule should also clarify that such an Exchange can utilize a validated automated eligibility determination system for Insurance Affordability determinations, provided the Medicaid Agency controls the Medicaid rules engine. Finally, the rule should provide that if a Medicaid Agency controls the Medicaid rules engine and sets Medicaid policy as outlined above, and an Exchange utilizes an automated system to apply Medicaid-validated logic to information supplied and verified by the consumer and electronic verification sources, an Exchange can supplement state merit employees by use of contract staff and entities that employ individuals on a merit personnel basis, whether public or private, in order to make Medicaid eligibility determinations.

Chart 2– 42 CFR Part 433

Section/ FR Page	Description of Rule Provision	Comments
433.10/ 51185	Rates of FFP for program services++	
433.202/ 51185	Scope	We welcome the options available to states for FMAP claiming that will not require us to operate a “shadow” eligibility system for purposes of claiming. We specifically endorse allowing for state-specific approaches that may combine one or more aspects of some or all of the proposed methodologies. We also welcome and appreciate the retention by CMS of a team of evaluators to help further develop and refine the enhanced FMAP claiming methodologies, as well as the MAGI equivalent methodologies and support CMS’s formation of a “user group” with states to work on further developing and refining various approaches. We remain interested in a simple threshold income test, potentially in combination with an established FMAP proportion, but want to be sure that any option the state might ultimately be required to use would also include appropriate revisions to the existing claiming and reporting processes as necessary to easily enable the state to claim accurately and at the appropriate level. We want to be sure that the methodology available to the state reflects both appropriately enhanced FFP for all newly eligible enrollees and for our current Expansion State childless adult enrollees.
433.204/ 51185-86	Definitions	
433.206/ 51186	Choice of methodology.	
433.208/ 51186	Threshold methodology.	
433.210/ 51186	Statistically valid sampling methodology.	
433.212/ 51187	CMS established FMAP proportion.	

Chart 3– 42 CFR Part 435

Section/ FR Page	Description of Rule Provision	Comments
435.110/ 51188	**Parents and other caretaker relatives.** SCOPE: We propose to delete in its entirety § 435.110 for individuals receiving AFDC and to replace it with a new § 435.110 for existing eligibility that is continuing under sections 1902(a)(10)(A)(i)(I) and 1931(b) and (d) of the Act for parents and other caretaker relatives of dependent children (including pregnant women who are parents or caretaker relatives). These statutory provisions remain and are not superseded by the provisions of the ACA establishing a new adult group for individuals not otherwise eligible under section 1902(a)(10)(A)(i) of the Act. While the parent/caretaker relative category continues to apply, our proposed rules simplify this category considerably and provides States flexibility to set their income eligibility standard under this category within allowable Federal parameters. (b) *Scope*. The agency must provide Medicaid to parents and other caretaker relatives, as defined in § 435.4, and if applicable the spouse of the parent or other caretaker relative, whose household income is at or below the income standard established by the agency in the State plan, in accordance with paragraph (c) of this section.	We appreciate the simplification opportunities afforded the state by the collapsing of 15 existing mandatory and optional categories into three new mandatory categories of eligibility, for parent, pregnant women and children, in addition to the new mandatory category for childless adults and parents under 64 (435.119) The new parent category (435.110) raises several concerns about aligning eligibility levels and claiming. In New York, as nationally, Transitional Medicaid Assistance (TMA) has been available to certain low income parents, based on old AFDC income standards. If TMA continues after 2014, then Low Income Family (LIF) parents in the new 435.110 category will remain eligible for TMA. This will require two eligibility calculations for parents. Ideally, the state would like to collapse all parent categories into one below 138% of FPL in order to ease the administrative burden of determining parents eligible at different income levels. However, if TMA continues and the state collapses the new parent categories by raising the 435.110 level to 138%, it will be at financial risk for continued Medicaid coverage for parents who would otherwise have been eligible for premium tax credits. Another impediment to collapsing categories for parents is the inability to mandate benchmark coverage for the 435.110 parents. If the benchmark benefits are different from full Medicaid benefits, we will need to retain separate categories. We look forward to additional guidance, and to the opportunity to work with CMS, to address the benchmark issues.
435.119/ 51189	**Coverage for individuals age 19 or older & under age 65 at or below 133 % FPL.** Section 2001(a) of the ACA adds a new section 1902(a)(10)(A)(i)(VIII) of the Act (referred to as ''the adult group''), under which States will provide Medicaid coverage starting in CY 2014 to individuals under age 65 who are not otherwise mandatorily eligible for Medicaid under sections 1902(a)(10)(A)(i)(I) through (VII) or (IX) of the Act and have household income, based on the new MAGI methods described in section II.B of this proposed rule, at or below 133 % FPL. Although the Act specifies that this new group is for individuals under age 65, individuals under age 19 are not included because such individuals with household income at or below 133% FPL are covered in the eligibility groups under sections 1902(a)(10)(A)(i)(IV), (VI), and (VII) of the Act. We propose to replace the current § 435.119 (which addresses obsolete provisions for eligibility of qualified family members under section	We seek clarification as to whether we can claim regular (not enhanced) federal matching funds for individuals who would be in 435.119 but are disabled or have a special health care need or other basis for exemption from mandatory benchmark coverage under 1937. Medicaid Buy-In for Working People with Disabilities is an optional program. CMS has indicated that eligibility must first be determined for an individual in a mandatory category (e.g. 435.119) before someone can be determined in an optional category (WBI-WPD). Many people who might otherwise have been eligible under MBI-WPD will be eligible under 435.119, up to 138% FPL. If an enrollee experiences an increase in income and moves from 435.119 to MBI-WPD that should not pose a problem. However, if the enrollee medically improves and has an increase in income, she will not be able to move to the MBI-WPD medical improvement group. She would have to be in the MBI-WPD basic group in order to move to the medical improvement group. This "mandatory group first" rule does not work for states like New York that have a MBI-WPD

Section/ FR Page	Description of Rule Provision	Comments
	1902(a)(10)(A)(i)(V) of the Act for which the statutory authority ended on September 30, 1998), to establish this new eligibility group. Proposed § 435.119(a) and (b) set forth the policy, explained above. Reflected in proposed paragraph (b), financial eligibility for the adult group will be based on MAGI, as defined in section 1902(e)(14) of the Act and implemented at proposed § 435.603; there is no resource test. Section 1902(a)(10)(A)(i)(VIII) of the Act specifies that individuals may be eligible for the adult group if they ''are not described in a previous sub-clause of'' section 1902(a)(10)(A)(i) of the Act. Under these proposed rules, an individual is not eligible under the new adult group if the individual is otherwise eligible under section 1902(a)(10)(A)(i) of the Act and 42 CFR 435 subpart B, but may be eligible for the adult group if the individual is described in but not eligible for Medicaid under another mandatory group. This will mean that an individual who is a recipient SSI benefits, and so potentially eligible under section 1902(a)(10)(A)(i)(II) of the Act, may be eligible for coverage under the adult group in a State that has elected in accordance with section 1902(f) of the Act and § 435.121 to use more restrictive eligibility criteria for Medicaid than SSI. The new adult group will include parents as well as adults not living with children. It will also include individuals currently eligible under an optional coverage group (such as, for individuals with disabilities) who have household income, based on the new MAGI methods, at or below 133 % of the FPL and otherwise meet the criteria for coverage under the new group. At proposed § 435.119(c), we codify section 1902(k)(3) of the Act, which permits coverage of parents and other caretaker relatives under the new adult group only if their children under age 19 (or higher if the State has elected to cover children under age 20 or 21 under § 435.222) are enrolled in Medicaid or ''other health insurance coverage.'' In paragraph (c)(1), we propose to define ''other health insurance coverage'' to mean minimum essential coverage, as defined in § 435.4 of this proposed rule. Preamble on page 51153: States currently have the option to cover parents and other caretaker relatives at income levels above the standard for families under section 1931 of that Act. They can do so under the authority at section 1902(a)(10)(A)(ii)(I) of the Act and § 435.210 of the existing regulations. This option will continue under the ACA for coverage of parents and other caretaker relatives who are not eligible for mandatory Medicaid coverage under § 435.110 or the new adult group at proposed §	program, and we would like to confirm whether any exception or waiver might be available. We also seek to clarify the interaction between 435.119 and the optional Breast and Cervical Cancer Treatment program. CMS needs to resolve the conflict created by the new VIII eligibility category (childless adults) with mandated benchmark benefits and eligibility for individuals with disabilities under state medically needy programs. It is critical and we appreciate that the guidance enables states like New York, with a medically needy program for parents and persons with disabilities to determine disabled, non-Medicare individuals eligible for the new mandatory VIII category (435.119) if their income is below a MAGI level of 138% of FPL. However, it is also critical that states receive guidance on benchmark coverage under 1937 and available claiming under the ACA. Section 1937 precludes a state from mandating a person with a disability into a benchmark benefit package, though it can be offered as an option. The new VIII eligibility category requires mandating benchmark benefits. The state should be able to claim, at a minimum, its regular FMAP rate for enrolling such a person in full Medicaid, if required, and if the person declines benchmark coverage. In New York, as nationally, Transitional Medicaid Assistance (TMA) has been available to certain low income parents, based on old AFDC income standards. If TMA continues after 2014, then Low Income Family (LIF) parents in the new 435.110 category will remain eligible for TMA. This will require two eligibility calculations for parents. Ideally, the state would like to collapse all parent categories into one below 138% of FPL in order to ease the administrative burden of determining parents eligible at different income levels. However, if TMA continues and the state collapses the new parent categories by raising the 435.110 level to 138% of FPL, it will be at financial risk for continued Medicaid coverage for parents who would otherwise have been eligible for premium tax credits. Another impediment to collapsing categories for parents is the mandate for benchmark coverage for the 435.110 parents. If the benchmark benefits are different from full Medicaid benefits, we will need to retain separate categories. We seek further clarification on how to best align parent eligibility.

Section/ FR Page	Description of Rule Provision	Comments
	435.119. We note that parents and other caretaker relatives who are Medicare-eligible or elderly may be covered under § 435.110[parents/caretakers] and § 435.210, even though they are excluded from coverage under the adult group at § 435.119. Preamble on page 51159: Individuals *who qualify for medical assistance on the basis of being blind or disabled.* This exception applies only to those individuals for whom the determination of eligibility is made on the basis of being blind or disabled. Individuals who are blind or who have disabilities can also be covered under the new mandatory eligibility group for adults (codified at proposed §435.119) with MAGI-based household income at or below 133 percent of FPL. To the extent that their income exceeds that level, current financial methodologies will be used to determine their eligibility for coverage on the basis of being blind or disabled under an optional eligibility group for blind or disabled individuals. **ELIGIBILITY:** (b) *Eligibility.* The agency must provide Medicaid to individuals who: (1) Are age 19 or older and under age 65; (2) Are not pregnant; (3) Are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act; (4) Are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part; and (5) Have household income that is at or below 133% FPL for a household of the applicable family size. **COVERAGE FOR DEPENDENT CHILDREN:** (c) *Coverage for dependent children.* (1) A State may not provide Medicaid to a parent or other caretaker relative living with a dependent child if the child is under the age specified in paragraph (c)(2) of this section, unless such child is receiving benefits under Medicaid, the CHIP under subchapter D of this chapter, or otherwise is enrolled in other minimum essential coverage as defined in § 435.4 of this part. (2) For the purpose of paragraph (c)(1) of this section, the age specified is under age 19, unless the State had elected as of 3/23/2010 to provide Medicaid to individuals under age 20 or 21 under § 435.222 of this part, in which case the age specified is such higher age.	The new ACA requirement that parents and caretakers must have insurance for their children as a condition of parent/caretaker enrollment in Medicaid, together with the ACA coverage mandates and penalties, as establishing a broad new ACA framework and mechanism to help ensure coverage for children of individuals seeking Medicaid coverage. We believe this new framework should appropriately be construed as requiring elimination of medical support barriers to "real time" enrollment-- including the mandatory requirement for medical support cooperation as a condition of Medicaid eligibility. An applicant for Medicaid is additionally required to provide supplemental information to the child support agency, complete additional forms, and in some cases attend an appointment with the child support agency. Under any of these scenarios, the eligibility determination does not currently happen in "real time" and will not in the future. In order to maximize near real time Medicaid

Section/ FR Page	Description of Rule Provision	Comments
		enrollment, mandatory referrals to the child support agency for medical support should be eliminated. Voluntary referrals of a parent should continue.
435.218/ 51189	**Individuals above 133 percent FPL. [NEW]**	
435.403/ 51189-90	**STATE RESIDENCE.** Preamble on page 51160: We propose to simplify Medicaid's residency rules to promote achievement of the coordinated eligibility and enrollment system established under sections 1413 and 2201 of the ACA and discussed in section II.I of this proposed rule. We propose to redesignate and revise paragraphs § 435.403(h) and § 435.403(i) to § 435.403(i) (rules for individuals under age 21) and (h) (rules for individuals age 21 and older), which set parameters for States to determine who is a State resident. These revisions are not significantly different than the current rules. We do not propose changes to our current regulations regarding individuals living in institutions, receiving Federal foster care or adoption assistance under title IV–E of the Act, or adults who do not have the capacity to state intent. Note that policies regarding verification of residency are proposed at § 435.956(c) and discussed in section II.H.5 of this proposed rule. 1. Residency Definition for Adults (Age 21 and Over) (§ 435.403(h)) We propose to strike the term ''permanently and for an indefinite period'' from the definition for adults in redesignated § 435.403(h)(1) and (h)(4), and replace the term ''remain'' with ''reside.'' An adult's residency will be determined based upon where the individual is living and has intent to reside, including without a fixed address, or the State which the individual entered with a job commitment or seeking employment (whether or not currently employed). While proposing to remove the phrase ''permanently or for an indefinite period'' and use the term ''reside,'' we are maintaining existing policy that an individual must intend to remain living in the State in which he or she is seeking coverage. Persons visiting a State for personal pleasure or purposes of obtaining medical care are not residents of the State visited. By removing the term ''living'' in the State or replacing the term ''remain'' with ''reside,'' we do not intend to have any policy impact on State policy. Indeed, we note that section 1902(b)(2) of the Act refers to individuals who ''reside in the State''. We are removing the word	We support the goal of seamless coverage for individuals moving between states, but would oppose any requirement that a state pay for Medicaid or CHP for any individual who is not a state resident. The preamble stated that "these revisions are not significantly different than the current rules," but the new residency rules appear to include a substantial change, in terms of the new alternate basis to establish residency. The change is "entered seeking employment or with a job commitment." The latter basis appears to be an alternative to the "intent to reside" test. We seek clarification as to whether a state would be required under the new rule to determine an individual working in a state but residing elsewhere (i.e., lives in NJ but had entered New York seeking office employment) as a NY state resident under this test. If the intent is to limit this alternative to seasonal or migrant workers, we seek clarification on how that could be accomplished.

Section/ FR Page	Description of Rule Provision	Comments
	‘‘living’’ from the definition in order to simplify the language. An individual must still maintain present intent to reside in the State being claimed as the State of residence; a State would not be required to recognize an intent to reside at some future point in time. We have retained the term ‘‘living’’ for individuals who do not have the capacity to state intent, as we are not modifying the regulations for that population. Our proposal to remove language regarding permanency and ‘‘an indefinite period’’ will help to facilitate coordination of eligibility determinations across and between programs and is also consistent with long-standing statutory requirements. Under section 1902(b)(2) of the Act, States may not exclude from coverage an individual who resides in the State ‘‘regardless of whether or not the residence is maintained permanently or at a fixed address[.]’’ ***Individuals age 21 and over.*** (1) For an individual not residing in an institution as defined in paragraph (b) of this section, the State of residence is the State where the individual— (i) Intends to reside, including without a fixed address or, if incapable of stating intent, where the individual is living; or (ii) Has entered the State with a job commitment or seeking employment (whether or not currently employed). Our proposal will simplify State administration and make the rules clearer to the public. Our proposal to allow children to establish residency to the same extent as adults when a parent or caretaker is seeking or has confirmed employment is intended to ensure a consistent approach for migrant, seasonal workers and other families living in a State while employed or in search of employment. The proposed definition also allows flexibility for families in which children attend school in a State other than where the parents live; such children may be considered residents of the parents’ ‘‘home State,’’ if the parent expresses the requisite intent. However, we do not change States’ current flexibility to determine whether students ‘‘reside’’ in a State, as long as each individual has the opportunity to provide evidence of actual residence. The proposed rule excludes children who are visitors for pleasure or for purposes of obtaining medical care. Parents, caretakers, and persons acting responsibly on behalf of a child may attest to where the child resides, under new § 435.956(c).	

Section/ FR Page	Description of Rule Provision	Comments
	While we do not believe our proposed changes significantly affect Federal guidance on residency, we seek comments on the proposed modifications to § 435.403(h) and (i), particularly on the impact of this proposed rule on children eligible for Medicaid based on disability. We also seek comments on whether to change the current State residency policy with regard to individuals living in institutions and adults who do not have the capacity to express intent. ***Individuals under age 21.*** (1) For an individual under age 21 who is capable of indicating intent and who is emancipated from his or her parent or who is married, the State of residence is determined in accordance with paragraph (h)(1) of this section. (2) For an individual under age 21 not described in paragraph (i)(1) of this section, not living in an institution as defined in paragraph (b) of this section and not eligible for Medicaid based on receipt of assistance under title IV–E of the Act, as addressed in paragraph (g) of this section, the State of residence is the State: (i) Where the individual resides, including with a custodial parent or caretaker or without a fixed address; or (ii) Where the individual's parent or caretaker has entered the State with a job commitment or seeking employment (whether or not currently employed).	
435.603/ 51190-91	**APPLICATION OF MODIFIED ADJUSTED GROSS INCOME (MAGI).** **BASIS, SCOPE, AND IMPLEMENTATION:** (a) *Basis, scope, and implementation.* (1) This section implements section 1902(e)(14) of the Act. (2) Effective 1/1/ 2014, the agency must apply the financial methodologies set forth in this section in determining the financial eligibility of all individuals for Medicaid, except for individuals identified in paragraph (i) of this section and as provided in paragraph (a)(3) of this section. (3) In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid on or before 12/31/2013 and receiving Medicaid as of 1/1/2014, application of the financial methodologies set forth in this section must not be applied until 3/31/2014, or the next regularly-scheduled redetermination of eligibility for such individual under § 435.916, whichever is later, if the	The shift to a simpler, more automated approach to eligibility is complex and multi-layered undertaking. It is important to get implementation right in order to maximize the goals of ACA to ensure easy, fast enrollment in affordable, appropriate coverage. We request that CMS provide follow up guidance in the form of scenarios/examples of how the various aspects of eligibility determinations would work for different types of MAGI households (Exchange, CHP, Medicaid, any Basic Health Program], including mixed MAGI/non-MAGI households, and where "exception" rules under Medicaid would apply. These scenarios need to encompass a wide range of income levels and circumstances, with examples that include eligibility determinations, verification processes, and how claiming, reporting and audit would work. We need scenarios for each of the Insurance Affordability programs, and for the many types of "crossover" and mixed family cases that are expected. We have attached some specific questions/scenarios to aid in this process, and welcome the opportunity to work with our federal partners and other states in this effort. Detailed scenarios that "crosswalk" the Insurance Affordability programs will be especially critical to ensuring that the application of different rules for eligibility determinations and

Section/ FR Page	Description of Rule Provision	Comments
	individual otherwise would lose eligibility as a result of the application of these methodologies. **DEFINITIONS:** (b) *Definitions.* For purposes of this section— *Code* means the Internal Revenue Code of 1986. *Family size* means the number of persons counted as members of an individual's household. In the case of determining the family size of a pregnant woman, the pregnant woman is counted as 2 persons. In the case of determining the family size of other individuals who have a pregnant woman in their household, the pregnant woman is counted, at State option, as either 1 or 2 person(s). *Tax dependent* has the meaning provided in § 435.4 of this part. **BASIC RULE:** (c) *Basic rule.* Except as specified in paragraph (i) of this section, the agency must determine financial eligibility for Medicaid based on ''household income'' as defined in paragraph (d) of this section. **HOUSEHOLD INCOME:** (d) *Household income.* (1) Except as provided in paragraphs (d)(2) and (d)(3) of this section, household income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household, minus an amount equivalent to 5 percentage points of the FPL for the applicable family size. (2) The MAGI-based income of an individual who is included in the household of his or her natural, adopted or step parent and is not required to file a tax return under section 6012 of the Code for the taxable year in which eligibility for Medicaid is being determined, is not included in household income whether or not the individual files a tax return. (3) In the case of individuals described in paragraph (f)(2)(i) of this section, household income also includes actually available cash support provided by the person claiming such individual as a tax dependent. **MAGI-based income**: (e) *MAGI-based income* .For the purposes of this section, MAGI-based income means income calculated using the same financial methodologies used to determine modified adjusted gross income as	verifications for Exchange tax credits or cost sharing vs Medicaid, CHP or a Basic Health program do not set up a potential "black hole", where someone who should be eligible for one Insurance Affordability program or another ends up being ineligible for anything. It is also important to note that we adjust our current eligibility levels and rules to accommodate the ACA, it will be critically important to remain nimble and flexible as implementation will be phased and mid-course corrections will undoubtedly be required. As such, it is important for the state's relationship with its federal partners to remain flexible and support an environment of rapid change. Can the proposed rule be amended to allow a state to extend Medicaid coverage and delay renewals (otherwise due January 1, 2014 through March 31, 2014) until April 1, 2014? This would help simplify administration since the cases cannot be discontinued during this period based on the rule. Reference to "natural" parent is made throughout this section. Please change these references to "biological" parent throughout the proposed rules.

Section/ FR Page	Description of Rule Provision	Comments
	defined in section 36B(d)(2)(B) of the Code, except that, notwithstanding the treatment of the following under the Code— (1) An amount received as a lump sum is counted as income only in the month received. (2) Scholarships or fellowship grants used for education purposes and not for living expenses are excluded from income. (3) *American Indian/Alaska Native exceptions.* The following are excluded from income: (i) Distributions from Alaska Native Corporations and Settlement Trusts; (ii) Distributions from any property held in trust, or that is subject to Federal restrictions, or otherwise under the supervision of the Secretary of the Interior. (iii) Distributions resulting from real property ownership interests related to natural resources and improvements— (A) Located on or near a reservation or within the most recent boundaries of a prior Federal reservation; or (B) Resulting from the exercise of Federally-protected rights relating to such real property ownership interests; (iv) Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal Law or custom; (v) Student financial assistance provided under the Bureau of Indian Affairs education programs.	
	Household. (f) *Household.* (1) *Basic rule for taxpayers not claimed as a tax dependent.* In the case of an individual filing a tax return for the taxable year in which an initial determination or redetermination of eligibility is being made, and who is not claimed as a tax dependent by another taxpayer, the household consists of the taxpayer and all tax dependents. (2) *Basic rule for individuals claimed as a tax dependent.* In the case of an individual who is claimed as a tax dependent by another taxpayer, the household is the household of the taxpayer claiming such individual as a tax dependent, except that the household must be determined in accordance with paragraph (f)(3) of this section in the case of— (i) Individuals other than a spouse or a biological, adopted or step child who are claimed as a tax dependent by another taxpayer;	We have concerns about eligibility determinations for non-custodial parents who claim a child as a dependent in cases where the custodial parent and child are not eligible for Medicaid and the child is not eligible for CHIP. How will the household be reconstituted to determine eligibility for premium tax credits or cost-sharing reductions? How will the applicant (if the custodial parent) be able to complete the application for the child or will the applicant have to stop and refer it to the non-custodial parent to apply on behalf of the child?

Section/ FR Page	Description of Rule Provision	Comments
	(ii) Individuals under age 21 living with both parents, if the parents are not married; and (iii) Individuals under age 21 claimed as a tax dependent by a non-custodial parent. (3) *Rules for individuals who neither file a tax return nor are claimed as a tax dependent.* In the case of individuals who do not file a Federal tax return and are not claimed as a tax dependent, the household consists of the individual and, if living with the individual— (i) The individual's spouse; (ii) The individual's natural, adopted and step children under age 19 or, if such child is a full-time student, under age 21; and (iii) In the case of individuals under age 19, or, in the case of full-time students, under age 21 the individual's natural, adopted and step parents and adoptive and step siblings under age 19 or, if such sibling is a full-time student, under age 21. (4) *Married couples.* In the case of a married couple living together, each spouse will be included in the household of the other spouse, regardless of whether they file a joint tax return under section 6013 of the Code or whether one spouse is claimed as a tax dependent by the other spouse. **No resource test or income disregards.** (g) *No resource test or income disregards.* In the case of individuals whose financial eligibility for Medicaid is determined in accordance with this section, the agency must not— (1) Apply any assets or resources test; or (2) Apply any income or expense disregards under sections 1902(r)(2) or 1931(b)(2)(C), or otherwise under title XIX, of the Act. **Budget period.** (h) *Budget period.* (1) *Applicants and new enrollees.* Financial eligibility for Medicaid for applicants and other individuals not receiving Medicaid benefits at the point at which eligibility for Medicaid is being determined must be based on current monthly household income and family size. (2) *Current beneficiaries.* For individuals who have been determined financially-eligible for Medicaid using the MAGI-based methods set forth in this section, a State may elect in its State plan to base financial eligibility either on current monthly household income and family size or projected annual household income for the current calendar year.	

Section/ FR Page	Description of Rule Provision	Comments
	(3) In determining current monthly or projected annual household income under paragraph (h)(1) or (h)(2) of this section, the agency may adopt a reasonable method to include a prorated portion of reasonably predictable future income, to account for a reasonably predictable decrease in future income, or both, as evidenced by a signed contract for employment, a clear history of predictable fluctuations in income, or other clear indicia of such future changes in income. Such future increase or decrease in income must be verified in the same manner as other income, in accordance with the income and eligibility verification requirements at § 435.940 *et seq.,* including by self-attestation if reasonably compatible with other electronic data obtained by the agency in accordance with such sections.	
	Eligibility Groups for which modified MAGI-based methods do not apply. (i) *Eligibility Groups for which modified MAGI-based methods do not apply.* The financial methodologies described in this section are not applied in determining the eligibility for individuals whose eligibility for Medicaid is being determined on the following bases or under the following eligibility groups. For individuals described in paragraphs (i)(3) through (i)(6) of this section, the agency must use the financial methods described in § 435.601 and § 435.602 of this subpart. (1) Individuals whose eligibility for Medicaid does not require a determination of income by the State Medicaid agency, including, but not limited to, individuals deemed to be receiving Supplemental Security Income (SSI) benefits and eligible for Medicaid under § 435.120, individuals receiving SSI benefits and eligible for Medicaid under § 435.135, § 435.137 or §435.138 of this subpart and individuals for whom the State relies on a finding of income made by an Express Lane agency, in accordance with section 1902(e)(13) of the Act. (2) Individuals who are age 65 or older. (3) Individuals whose eligibility is being determined on the basis of being blind or disabled, or on the basis of being treated as being blind or disabled, including, but not limited to, individuals eligible under § 435.121,§ 435.232 or § 435.234 of this part or under section 1902(e)(3) of the Act. (4) Individuals whose eligibility is being determined on the basis of the need for long-term care services, including nursing facility services or a level of care in any institution equivalent to such services; home and community-based services under section 1915 or under a	We are concerned, and seek clarification, regarding the preamble statement for 435.603(i) “Individuals otherwise eligible for Medicaid under an eligibility group to which MAGI-based methods apply… will not be excepted from MAGI based methods in determining ongoing eligibility under such group, simply because they may need long term care services”. The preamble says that the long term care MAGI exception is to be applied “in the case of individuals whose eligibility is based on the need for or receipt of such [long term care] services.” These two preamble statements conflict. If this preamble and rule are interpreted to mean that no asset test would be applied in the case of recipients who had previously been eligible under 435.110. 116, 118 or 119 but who now need long term care services; this would be a significant fiscal concern for the state. It would also appear inconsistent with the ACA 2002 provisions that the MAGI methodology shall not apply “to any determinations of eligibility of individuals for purposes of medical assistance for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, home or community-based services…” etc. We want to confirm that non-MAGI “medically needy” would be those in an optional category above the mandatory levels and not in one of the mandatory groups. 435.603(i)(1) - Individuals deemed to be receiving SSI, including, but not limited to, Pickles and Disabled Widows/Widowers, are not subject to MAGI-based methods. The proposed rule states that individuals who are deemed to be receiving SSI are excluded because an income determination for Medicaid is not required. However, except for 1619 (a) and (b) individuals, an

Section/ FR Page	Description of Rule Provision	Comments
	demonstration under section 1115 of the Act; or services described in sections 1905(a)(7) or (24) or in sections 1905(a)(22) and 1929 of the Act. (5) Individuals who are being evaluated for eligibility for Medicare cost sharing assistance under section 1902(a)(10)(E) of the Act, but only for purposes of determining eligibility for such assistance. (6) Individuals who are being evaluated for coverage as medically needy under subparts D and I of this part.	income/resource determination must be made by the State Medicaid agency to determine if they are individuals deemed to be receiving SSI. Therefore, the reason given for an exception in those cases is inaccurate because the state does an income determination. The regulatory citation for Disabled Adult Children should also be included in the list of regulatory citations for individuals who are deemed to be receiving SSI. 435.603(i)(5) - It is our understanding that individuals who are in receipt of Medicare, with the exception of the new proposed optional group (435.218), are not subject to MAGI-based methods for the purpose of determining Medicaid eligibility. Why does proposed rule 435.603(i)(5) exclude from MAGI-based methods only the determination of Medicaid eligibility for Medicare cost sharing assistance?
435.905/ 51191	**Availability of program information.** Section 1943(b)(4) directs States to establish a Web site (which must be linked to the Web site established by the Exchange operating in the State) that will allow individuals to obtain information regarding coverage under Medicaid and CHIP and compare such coverage to that available through the Exchange. Thus, we propose to amend § 435.905 to ensure that program information be made available electronically through a Web site in addition to providing information to applicants both orally and in writing. We propose to modify § 435.905(b) to eliminate specific requirements regarding quantity and electronic availability of bulletins and pamphlets, as we do not believe these are necessary in regulations.	Please confirm that states will be responsible for determining in what languages program information will be available. The Overview of the Proposed Medicaid Rule stated that HHS intends to issue additional proposed rules on related matters including appeals and notices. We request that CMS provide understandable and consumer friendly template language for any required notices by an Exchange, Medicaid or CHP Agency for Insurance Affordability eligibility determinations
435.907/ 51191-92	**Application.** …ACA direct the Secretary to develop and provide States with a single, streamlined application. The single application, to be used for all insurance affordability programs and available through a variety of formats including on-line and phone applications, will build on the successes many States have had in developing simplified applications. Accordingly, we propose to amend current regulations at § 435.907 to reflect use of the new single, streamlined application. The Secretary will develop the data elements for the application in collaboration with States and consumer groups. As permitted in section 1413(b)(1)(B) of the ACA, proposed § 435.907(b)(2) provides States the option to develop and use an alternative streamlined application, subject to	We request that HHS provide the data elements for the new single application as soon as possible. They are needed for states to design and program the eligibility system for MAGI eligibility. We request that the streamlined application not be "loaded up" with questions beyond what is required to establish MAGI eligibility for Exchange subsidies, Medicaid, CHP and any Basic Health program. We request that HHS provide the model application in English and in other common languages.

Section/ FR Page	Description of Rule Provision	Comments
	review and approval by the Secretary. Under the law, those who are limited English proficient (LEP) and persons with disabilities must have equal access to health care and the benefits. We intend to address the readability and accessibility of applications, forms and other communications with applicants and beneficiaries in future guidance. In § 435.907(c), we propose two alternative approaches related to applications for individuals who may qualify for coverage on a basis other than MAGI. First, we propose that States may use supplemental forms to gather additional information, such as information pertaining to resources, needed to make an eligibility determination. This approach would permit anyone seeking coverage to begin by completing the same single, streamlined application as all other applicants. Second, we propose to permit States to develop and use an alternative single, streamlined application form designed specifically to capture information needed to determine eligibility for individuals whose eligibility is not determined based on MAGI. Under the statute and proposed 435.907(c), such supplemental and alternative forms are subject to the Secretary's approval. We seek comment on both of the proposed approaches as well as other alternatives to ensure a simple application process. In § 435.907(d), we explain that the agency must establish procedures to allow persons seeking coverage to file an application through a variety of means including online, in person, over the phone and by mail. Applications may be submitted in person, but under this proposed rule, particularly in light of the seamless coordination process required for enrollment in Medicaid and the Exchange, in person interviews cannot be required for the individuals whose eligibility is based on MAGI. For individuals not seeking coverage for themselves (''non-applicants''), to ensure privacy we propose in § 435.907(e)(1) to codify the longstanding policy against requiring such individuals to provide Social Security numbers (SSNs) or information regarding their citizenship, nationality, or immigration status. To promote enrollment of eligible applicants, States may request an SSN of a non-applicant on a voluntary basis. Proposed § 435.907(e)(2) codifies existing policy grounded in Title VI of the Civil Rights Act of 1964, the Privacy Act, and Medicaid confidentiality provisions at section 1902(a)(7) of the Act to allow States	

Section/ FR Page	Description of Rule Provision	Comments
	to request an SSN of a non applicant only if: (1) Providing an SSN is voluntary; (2) use of a non-applicant's SSN is limited to processing the applicant's eligibility or for other functions necessary to the administration of the State's plan; and (3) the State provides notice that provision of an SSN is voluntary and indicates how the SSN will be used. In support of the proposed rule, we note that sections 1411(g) and 1414(a)(2) of the ACA specify that taxpayer information may only be used for eligibility determinations and other functions directly related to the administration of benefits. Section 1902(a)(7) of the Act directs States to have safeguards that restrict the ''use or disclosure of information concerning applicants and recipients only for purposes directly connected with the administration of the [State] plan * * *'' Non-applicant information used to determine an applicant's eligibility is considered to be information ''concerning'' the applicant or recipient; thus, this information must be appropriately safeguarded. We propose to continue the current policy that Medicaid applicants and beneficiaries must provide an SSN, if the individual has one. Under our current regulations at § 435.910, if an individual does not have an SSN, the agency must assist the individual in obtaining one. For background and a detailed discussion of the current policy on the collection of SSNs, see the *Tri- Agency Guidance* issued in conjunction with the Administration for Children and Families and the Food Nutrition Service, in September 2000, … Section 1943(b)(1)(A) of the Act directs Medicaid agencies to permit enrollment and reenrollment in the State plan or under a waiver through electronic signature. Accordingly, we propose in § 435.907(f) that States must accept applications signed through the use of electronic signature techniques, including telephonically recorded signatures, as well as handwritten signatures transmitted by **fax** or other electronic means. This is consistent with current practice in most States.	States should have discretion to handle the different modes of electronic signature techniques.
435.945/ 51193	**General requirements.** Preamble on page 51162: § 435.945(b) Consistent with current policy, State Medicaid agencies may accept self-attestation of all eligibility criteria, with the exception of citizenship and immigration status, *"the agency may accept attestation*	We urge CMS to provide a more "robust" federal hub for real time verifications, whether by 2014 or following, to include the following (in addition to SSA for identity/citizenship, HSA and IRS/Treasury) PARIS matches, death matches, SSA info on disability status, Title II income, and access to SOLQ data base in real time, rather than on query basis.

Section/ FR Page	Description of Rule Provision	Comments
	without requiring further paper documentation (either self-attestation by the applicant or beneficiary or by a parent, caretaker or other person acting responsibly on behalf of an applicant or beneficiary) of all information needed to determine the eligibility of an applicant or beneficiary for Medicaid. (pg 51193)". To ensure program integrity, States must comply with the requirements of section 1137 of the Act to request information from trusted data sources when useful to verifying financial eligibility. Adds language clarifying that States have express permission to accept attestation of income, age, birth date and State residency without requesting paper documentation. § 435.945 (d) The agency must furnish, in a timely manner, income and eligibility information needed for verifying eligibility for the following programs: (4 programs: from other agencies in the State and other States and Federal programs; Other insurance affordability programs; child support enforcement program IV-D; and SSA for OASDI & SSI benefits) § 435.945 (e) The agency must, as required under section 1137(a)(7) of the Act, and upon request, reimburse another agency listed in § 435.948(a) of this subpart or paragraph (d) of this section for reasonable costs incurred in furnishing information, including new developmental costs associated with furnishing the information to another agency. § 435.945(f) specifies that before a request for info from a third-party data source is initiated, an individual must receive notice of the information being requested and its use. Consistent with current State practice, we [HHS] anticipate that this notice would be provided as part of the application process. We [HHS] have deleted the current exception to this notice requirement when an individual's eligibility has been determined by another agency because, under our revised rule, proper notice is required only when the agency itself will be requesting data from another agency or program. The reporting requirements at redesignated § 435.945(g) remain unchanged; however the regulatory citations relating to MEQC and documentation have been updated. § 435.945(g), re: State Wage (under section 1137 of the Act), has been deleted, as we [HHS] believe these requirements are not within the	To the extent states rely on multiple data sources for an eligibility factor (e.g., income), it creates challenges in reconciling different results. Often the reconciliation process leads to requesting paper documents to verify eligibility which delays enrollment and causes applicants to abandon the process. At a minimum, HHS should work with states to develop a hierarchy of data sources, including self-attestation, to minimize the frequency in which paper documents are required to complete the enrollment process. We appreciate the state flexibility provided in the proposed rule regarding elimination of specific data agreement requirements re content, frequency and timing. But the regulations should require that all federal agencies with information pertaining to health coverage eligibility determinations by the Exchanges (DOL, SSA, HSA, IRS/Treasury, HHS) must either participate in the federal "data hub" or enter into appropriate agreements for data exchange with Exchanges and with Medicaid and CHP agencies, providing such data as may be needed to determine eligibility. The federal hub should return data in the level of detail needed to determine eligibility. Combined income or consolidated household size will not be useful to determine eligibility and will make it impossible for the Exchange to identify those households that should follow Medicaid rules (e.g., non-custodial parents and grandparents claiming children as dependents). The Exchange will need to know the relationship of all members of the household in order to make the appropriate determination. In terms of income, states need the amount of income by source. If Medicaid needs to verify against more recent income (e.g., wage reporting), it will be critical to have the income from tax returns represented by wages as compared to other sources of income. Moreover, some sources of data will only be available electronically from the tax return. To build a complete and more recent picture of income, states may choose to rely on the wage reporting system for wages, and tax return data for interest income or other non-earned income. The availability of SSA data to verify citizenship is an example of a successful federal service that has enhanced eligibility verification and reduced reliance on paper documents. The goal of the federal hub appears to be to provide more data in this manner. In addition to federal data, the hub should also consider including proprietary data sources to provide more current income information (e.g., The Work Number). It will be more costly for each state to contract with vendors for the same information to verify eligibility than to have the federal government include some of these sources in the hub. Also, identity management should be a federal service so that each state is not creating a separate system to authenticate identity. To ensure that Native Americans are afforded the same streamlining and simplification measures as other qualified individuals seeking coverage through Exchanges, data necessary to verify eligibility for special monthly enrollment periods, relief from the individual mandate and

Section/ FR Page	Description of Rule Provision	Comments
	purview of the State Medicaid agency. § 435.945(h) will require that data exchanged electronically under this section must be sent and received via secure electronic interfaces which, as defined in proposed § 435.4, must be consistent with 42 CFR part 433. § 435.945(i), pertains to written agreements between agencies engaged in data exchanges, has been modified to eliminate specific requirements regarding the precise content of such agreements and the timing and frequency of data exchanges to provide States greater flexibility. …allow States to take full advantage of the increased automation of electronic data matching enabled through the provision of enhanced Federal funding for the development and implementation of such systems available under 42 CFR part 433 subpart C.	cost-sharing provisions must be included in the federal data hub. Currently, documentation of Native American status is a paper process, which means that enrollment will not be in real time. We would like to clarify if/ when/how much the Exchange and/or the state will be required to pay for verification data from the federal hub or from federal agencies, where information is needed for eligibility verifications. We request further clarification on the specific verification sources and data elements that will be provided to states and the Exchanges through the federal hub. It is unclear from the rule whether charges to states are contemplated for the federal “hub” services (435.949), or only for state and other federal agency requests regarding financial eligibility (435.948) The Exchange will need its own data sharing agreement and ability to secure information directly from applicable federal agencies and/or the hub. The existing limitations on such information being provided to only one state agency need to be modified to permit the Exchange to directly secure and utilize such information in a timely and effective manner.
435.948/ 51193-94	**Verifying financial information.** (a) The agency must request information relating to financial eligibility from other agencies in the State and other States and Federal programs in accordance with this section. To the extent the agency determines such information is useful to verifying the financial eligibility of an individual, the agency must request: (1) Information related to wages, net earnings from self-employment, unearned income and resources from the State Wage Information Collection Agency (SWICA), the IRS, the SSA, the agencies administering the State unemployment compensation laws, the State administered supplementary payment programs under section 1616(a) of the Act, and any State program administered under a plan approved under Titles I, X, XIV, or XVI of Act; & (2) Information related to eligibility or enrollment from the Public Assistance Reporting Information System (PARIS), the SNAP, and other insurance affordability programs. (Note: all eligibility determination systems must conduct data matching through PARIS). (b) To the extent that the information identified in paragraph (a) is available through the electronic service established in accordance with § 435.949 of this subpart, the agency must obtain the information	As stated throughout, we request a robust federal data hub, and alignment of the eligibility verification rules with what is available through such federal hub in “real time”, to enable states like New York to largely automate the eligibility process. The proposed eligibility rules contemplate the ability to sort and re-aggregate individuals in a tax or Medicaid household, by their income amounts /FPL levels, sources of income, and relationships to other household members, in order to be able to properly determine tax credits, cost sharing and to automate Medicaid MAGI “exception” rules. We seek guidance regarding the specific data elements we will be able to obtain from IRS/Treasury or other federal hub data sources, to enable maximum automation/real time determinations of MAGI and MAGI exception eligibility. Assuming that some needed information may not be available through the federal hub on a real time basis by 2014, we urge that a state be allowed to determine eligibility based on attestation and available federal hub “real time” sources, and to provide appropriate notices to individuals/households outlining the basis for the determination, and the potential for further cost sharing reduction if the individual has a particular circumstance- e.g. grandparent responsible for child, income from educational grant/loan, or is Native American. It is also critical that the audit functions in Medicaid and CHP (MEQC/PERM) and the Exchange be aligned with the proposed eligibility rules, so that states will not be penalized for properly relying on self attestation. CMS has expressed support for a joint workgroup with states to focus on performance measures and alignment of audit standards with the ACA policies

Section/ FR Page	Description of Rule Provision	Comments
	through such service. (c)(1) If the information identified in paragraph (a) of this section is not available through the electronic service established in accordance with § 435.949 of this subpart, the agency may obtain the information directly from the appropriate agency or program consistent with the requirements in § 435.945 of this subpart. (2) The agency must request the information by SSN, or if a SSN is not available, using other personally identifying information in the individual's account, if possible. [Preamble: Note that when an SSN is not available, the agency must assist the individual in obtaining a SSN in accordance with § 435.910. (d) *Flexibility in information collection and verification.* Subject to approval by the Secretary, the agency may request and use income information from a source or sources alternative to those listed in paragraph (a) of this section provided that such alternative source will reduce the administrative costs and burdens on individuals and States while maximizing accuracy, minimizing delay, meeting applicable requirements relating to the confidentiality, disclosure, maintenance, or use of information, and promoting coordination with other insurance affordability programs. Preamble: We [HHS] make explicit existing policy that use of any such alternative data source must meet applicable requirements relating to the confidentiality, disclosure, maintenance, or use of information…we add that the use of an alternative data source facilitate coordination between all other insurance affordability programs.	intended to simply, streamline and speed determinations, and we appreciate and look forward to the opportunity to participate. The federal hub should include and provide PARIS match data for states, along with guidance for reconciling. With the new Exchange framework under the ACA, It is not efficient or appropriate to continue to require that states reconcile PARIS matches without the benefit of electronic information needed to automate the process. A match in PARIS does not currently provide any information on whether Medicaid eligibility is correctly established in one state versus another. Reconciling the eligibility with the person and the other state is manual and time consuming. HHS should indicate whether IRS data can be used to verify residency or provide the verification of the correct state. Otherwise, this will continue to be a labor-intensive manual process. In addition, there are some key services that the federal hub will need to have in place (e.g. identity management) that states will also need, and which we would like to explore. We want to confirm that the state will have the flexibility to set parameters, e.g., avoid non-cost effective chasing when for example there is a $6 difference in premium for the household (CHP). We believe that a state should be allowed to consider cost-effectiveness in determining what data sources and verifications are "useful". There are references throughout to the state plan. We strongly endorse revamping the state plan amendment (SPA) process, to something more along the lines of a submission of a operational work plan which would be deemed approved by HHS within a relatively short time period if no action is taken to disapprove it.
435.949/ 51194	**<u>Verification of information through an electronic service.</u>** Preamble on page 51164: By enabling access to multiple Federal sources though **<u>a single inquiry,</u>** insurance affordability programs can receive prompt, reliable data through the same service, thereby alleviating multiple data inquiries that the State might otherwise have to make. Since all of the insurance affordability programs will rely on certain common sources (that is, SSA, DHS and IRS), once such information is gathered and evaluated by	We need the IRS/federal hub to supply states with the sources of income by dollar amounts, as well as the total MAGI income level and dollar amount, for the tax household and each individual. States will also need "relationship" information to verify the appropriate household composition (tax or Medicaid). The rules contemplate that applicants for health coverage will attest to their respective tax and Medicaid household composition/relationships, and to their household income. We are hopeful that such an approach proves workable, but subsequent policy guidance and

Section/ FR Page	Description of Rule Provision	Comments
	one program, reevaluation or reverification of data will not be necessary, and thus, not permitted by another program (unless an individual reports a change in circumstances). We propose at § 435.949(a) to specify the Federal agencies from which information will be available through the Secretary, including SSA, DHS & the IRS. (a) The Secretary will establish an electronic service through which States may verify certain information with, or obtain such information from, federal agencies, including the SSA, the Dept of Treasury, the Dept of Homeland Security and any other Federal offices that maintain records containing information related to eligibility for Medicaid or other minimum essential coverage. We propose in § 435.949(b) that, if data included in § 435.949 is available through the Secretary, States would be required to obtain such data through the service established by the Secretary. Other applicable regulations, including those set forth at § 435.948 [Verifying financial information], § 435.956 [Verification of other nonfinancial information], and § 435.960, remain in effect for information, which cannot be requested through the Secretary. (b) To the extent that information is available through the electronic service established by the Secretary, States must obtain the information through such service, subject to the requirements in subpart C of part 433 of this chapter. We propose § 435.949(c) to codify section 1413(c)(3) of the ACA, which provides that the Secretary may modify the methods used in the verification system established if she determines that modifications would reduce the administrative costs and burdens on individuals or agencies; ensure accurate and timely verification; comply with applicable requirements for the confidentiality, disclosure, program integrity, and maintenance or use of the information, including the requirements of section 6103 of the IRC; and promote coordination among insurance affordability programs. Section 435.949(c) is proposed to be consistent and coordinated with § 155.315 of the proposed Exchange rule. (c) The Secretary may provide for, or approve a request from a State to utilize, an alternative mechanism through which States may	implementation planning must avoid creating an overly complex application and/or "apparent" discrepancies that are not actually discrepancies but which would require additional, manual intervention and follow up. And as stated in the section above, the federal hub should include and provide PARIS match data as a shared service for states, along with guidance for reconciling. With the new Exchange framework under the ACA, It is not efficient or appropriate to continue to require that states reconcile PARIS matches without the benefit of electronic information needed to automate the process. A match in PARIS does not currently provide any information on whether Medicaid eligibility is correctly established in one state versus another. Reconciling the eligibility with the person and the other state is manual and time consuming. HHS should indicate whether IRS data can be used to verify residency or provide the verification of the correct state. Otherwise, this will continue to be a labor-intensive manual process. SOLQ is a rich data base that can currently only be accessed via individual inquiry or batch. We request that SOLQ to be included in the federal data hub. It is critical for the federal government to work closely with individual states to ensure that verification information provided is useful and in a useable format permitting maximum automation (data elements and programmed or programmable rules to apply to the data, not via batch, query or in report form. This is particularly relevant because of the requirement to use the federal hub ("service") where data is available.

Section/ FR Page	Description of Rule Provision	Comments
	collect and verify such information, if the Secretary determines that such alternative mechanism meets the criteria set forth in § 435.948(d) of this subpart.	
435.952/ 51194	**Use of Information and requests of additional information from individuals.** We are proposing to eliminate vague language at the end of § 435.952(a) regarding the requirement to independently verify information ''* * * if determined appropriate by agency experience.'' We expect processes to occur in real time wherever possible and we will be defining more detailed standards and other performance metrics, with State and stakeholder input, in subsequent Federal guidance. Accordingly, we also are proposing to delete the specific timeliness requirements contained in the current regulation at § 435.952(c), which now requires agency action within 45 days from the date new information is received. (a) The agency must promptly evaluate information received or obtained by it in accordance with regulations under § 435.940 - § 435.960 of this subpart to determine whether such information may affect the eligibility of an individual or the benefits to which he or she is entitled. Under § 435.952(b), as revised, if information provided by an individual is **reasonably compatible** with information that the agency has obtained from other trusted sources, the agency must act on such information and may not request additional information from the individual. To establish an appropriate balance between reliance on electronic verification and paper documentation, we propose to establish a ''reasonable compatibility'' standard governing when additional information, including paper documentation, can be requested from applicants and beneficiaries. (b) If information provided by or on behalf of an individual (on the application or renewal form or otherwise) is **reasonably compatible** with information obtained by the agency in accordance with § 435.948, § 435.949 or § 435.956 of this subpart, the agency must determine or redetermine eligibility based on such information. Under proposed § 435.952(c), no further information may be required	We appreciate the flexibility and discretion afforded the state to define what is "reasonably compatible". We request sub-regulatory guidance providing specific examples/scenarios where HHS would agree that verification is "reasonably compatible." For example, if the relevant household income represented by the most recent IRS tax data available through the electronic service under 435.949 is within a 5% range (up or down) of the attested current income for Medicaid (or prospective annual income for the Exchange), would that constitute "reasonable compatibility", such that a state could rely on the attestation to complete the eligibility determination? If the attestation was that the income had decreased by 10% and there was a reasonable explanation that supported the decrease (lower self-employment income in the last year due to fewer customers), would reliance on the attestation as a form of verification be sufficient? If the 10% decrease was based on an attested loss of employment earnings, due to hours being cut back, would a state be required to additionally check wage reporting? Or could a state determine it was not "useful", under 1937, to check wage reporting in such a case, since the attestation of lost wages due to hours cut back was "reasonably compatible" with a higher prior year tax return? It appears based on the proposed rules that an attested change (up or down) that did not change eligibility for Medicaid would be considered de facto "reasonably compatible"- is that correct? Assuming that a relatively small (1-5%) attested decrease changed the MAGI income from a level that would establish eligibility for an advance tax credit to one that would establish eligibility under CHIP or Medicaid level- could a state determine the attestation to be "reasonably compatible" with a slightly higher prior year tax return? In the case of an attested increase in income, it appears that under the Exchange rule 155.320, the attestation is sufficient verification to support calculations of premium tax credits and costs sharing, unless the Exchange finds the attestation not to be "reasonably compatible" with other information the Exchange may have. We believe the same rule should apply to an attestation of an increase in income that would appear to change a MAGI eligibility level from Medicaid to an Exchange subsidy level.

Section/ FR Page	Description of Rule Provision	Comments
	from the individual unless the agency is unable to obtain information through electronic data matching or the information obtained is not reasonably compatible with that provided by the individual. In such cases, the agency may contact the individual and accept the individual's explanation without further documentation, if reasonable, or the agency may request additional information, including paper documentation. ''Reasonably compatible'' does not necessarily mean an identical match for the data, only that the information is generally consistent. Since what is ''reasonably compatible'' may vary depending on the particular circumstances, we are proposing to provide States flexibility to apply this standard. (c) An individual must not be required to provide additional information or documentation unless information needed by the agency in accordance with § 435.948[verifying financial info], § 435.949 [verification by electronic source] or § 435.956 [verification of other non-financial info] of this subpart cannot be obtained electronically or the information obtained electronically is not reasonably compatible with information provided by or on behalf of the individual. (1) In such cases, the agency may seek additional information, including a statement which reasonably explains the discrepancy or other additional information (including paper documentation), from the individual. (2) The agency must provide the individual a reasonable period to furnish such additional information. Under § 435.952(d), if the individual fails to respond to a request for additional information permitted under the proposed rule, the agency shall proceed to deny, terminate, or reduce Medicaid only after notice and appeal rights have been provided in accordance with part 431, subpart E. (d) The agency may not deny or terminate eligibility or reduce benefits for any individual on the basis of information received in accordance with regulations under § 435.940 through § 435.960 of this subpart unless the agency has sought additional information from the individual in accordance with paragraph (c) of this section, and	Specific federal requirements for timely processing can help support the Medicaid agency's efforts to ensure that other agencies (e.g., Exchange determining Medicaid MAGI eligibility, local districts) make timely determinations. We also seek clarification as to the requirement that an agency "must promptly evaluate" the information received in the context of the ACA contemplation and prior Exchange IT guidance re more "real time" evaluations. The proposed rule at 435.911 mandates the furnishing of Medicaid "promptly and without undue delay", both for the MAGI and non-MAGI populations. We would envision a shorter time frame for MAGI determinations, vs non-MAGI determinations, and the IT Guidance 2.0 previously issued talks in terms of "real time" MAGI determinations. However, our ability to truly more quickly make MAGI determinations will depend on whether or not we are able to obtain and utilize data and a consistent core set of MAGI rules from the federal hub or otherwise that will allow us to largely automate the determination of MAGI eligibility without the need for a significant level of "behind the scenes" human intervention. Absent "real time" access to trusted electronic verification sources, and in light of the severe staffing and budget constraints in states and economic stresses, "promptly" could end up being anywhere in the range from "real time" to the current 30-45 days and beyond. Without the ability to significantly automate the MAGI eligibility determinations, we are concerned about the level of labor intensive, time consuming work that will be required behind the scenes, and the impact on timely processing of enrollments. This behind the scenes work would include eliciting and checking follow up explanations/attestations that "reasonably explain the discrepancy" and/or requesting paper documents, and assisting consumers with complex coverage applications (e.g. those that involve individuals who reside in different states, or that have different rules applied depending on a family's composition or sources of income). We seek clarification as to whether deletion of the 45 day requirement would preclude states from setting their own timeliness requirements, and the extent to which states will have flexibility in this regard to set different time standards for different populations or circumstances. The Exchange regulations propose to treat the list of data sources described in 42 CFR 435.948(a) as primary sources of MAGI-based income data for purposes of verification. We want to confirm that the Exchange would utilize such data only and to the same extent as the Medicaid agency determines such sources are "useful" under SSA Section 1937 under these rules. Will it be acceptable for a state to assess eligibility based on what an individual attests is their current income (either current monthly income received, or current monthly income based on

Section/ FR Page	Description of Rule Provision	Comments
	provided proper notice and hearing rights to the individual in accordance with this subpart and subpart E of part 431.	annual income reasonably anticipated to be received), if that attestation is "reasonably compatible" with income data from IRS/Treasury? What "real time" employer coverage data base(s), if any, does CMS contemplate will be available to states through the federal hub to help automate the determination of access to minimum essential coverage (employer sponsored) for an employee? For Medicare, Tri-Care, Veterans, Medicaid (other states), MSP? If no employer coverage data base is available, how does CMS contemplate the MEC determination as impacting the "real time" eligibility determinations for those applicants seeking eligibility for tax credits? The proposed rule (435.952(d)) should specify that Medicaid is to be considered correctly paid and no recovery should be sought during the time period that the Medicaid agency enrolls an applicant for 90 days while awaiting information to resolve an incompatibility though to the effective date of proper notification in instances resulting in a discontinuance of coverage. How does CMS envision requirements involving Medicaid third party health coverage (TPHI) to be operationalized in the context of "real time" eligibility and enrollment determinations? We urge CMS to issue guidance on TPHI in the context of the ACA. One scenario would be an applicant with access to cost-effective employer sponsored coverage (ESI) which is not minimum essential coverage because it is not affordable to the employee. It is, however, less expensive in this example for the state to require the employee to enroll in the ESI with the state paying the premium and applicable cost sharing, than for the state to pay for Medicaid benefits for the applicant. Would the state be expected to determine eligibility and enroll the applicant in Medicaid, pending receipt of the necessary ESI information to determine cost effectiveness? What if the individual lost eligibility for Medicaid based on an increase in income- would she be allowed to disenroll from her employer plan in order to find more affordable insurance through the Exchange? (Special enrollment period?) Can a state require an individual to enroll in individual coverage through the Exchange as a condition of eligibility for Medicaid, if the state determines it is cost effective for the state to pay the QHP premium and cost sharing? Same or different outcome if individual is an employee of a participating employer through a SHOP Exchange? If allowed, is it correct that such QHP enrollment, in the form of TPHI for an MA individual, would be without advance tax credit or federal cost sharing subsidies?

Chart 4– 45 CFR Part 155 [cross reference with 42 CFR Part 435]

Section/ FR Page	Description of Rule Provision	Comments
155.200/ 51201	Preamble on page 51204: "Throughout this subpart, we refer to Medicaid and CHIP, but we note that for those States that choose to establish a Basic Health Program, all provisions applicable to Medicaid and CHIP will also be generally applicable to the Basic Health Program." Preamble on page 51204: "The proposed eligibility process is designed to minimize opportunities for fraud and abuse, including the use of clear eligibility standards and processes that rely on data sources in an electronic environment. We solicit comments regarding strategies to further limit the risk for fraud and abuse, and we look forward to working with States toward this goal." Preamble on page 51204: "Consistent with this streamlined, seamless eligibility and enrollment system, the ACA requires a simplification of Medicaid and CHIP eligibility policy and rules, which is in 42 CFR 435.603 and 42 CFR 457.315, proposed by the Secretary of HHS in the Medicaid Program; Eligibility Changes under the ACA of 2010 rule, published in this issue of the **Federal Register** (the Medicaid proposed rule)."	The shift to a simpler, more automated approach to eligibility is complex and multi-layered undertaking. It is important to get implementation right in order to maximize the goals of ACA to ensure easy, fast enrollment in affordable, appropriate coverage. We request that CMS provide follow up guidance in the form of scenarios/examples of how the various aspects of eligibility determinations would work for different types of MAGI households (Exchange, CHP, Medicaid, any Basic Health Program], including mixed MAGI/non-MAGI households, and where "exception" rules under Medicaid would apply. These scenarios need to encompass a wide range of income levels and circumstances, with examples that include eligibility determinations, verification processes, and how claiming, reporting and audit would work. We need scenarios for each of the Insurance Affordability programs, and for the many types of "crossover" and mixed family cases that are expected. We have attached some specific questions/scenarios to aid in this process, and welcome the opportunity to work with our federal partners and other states in this effort. Detailed scenarios that "crosswalk" the Insurance Affordability programs will be especially critical to ensuring that the application of different rules for eligibility determinations and verifications for Exchange tax credits or cost sharing vs Medicaid, CHP or a Basic Health program do not set up a potential "black hole", where someone who should be eligible for one Insurance Affordability program or another ends up being ineligible for anything, or result in an individual bouncing between programs frequently based on small fluctuations in income. It is also important to note that as we adjust our current eligibility levels and rules to accommodate the ACA, it will be critically important to remain nimble and flexible as implementation will be phased and mid-course corrections will undoubtedly be required. As such, it is important for the state's relationship with its federal partners to remain flexible and support an environment of rapid change.
155.300/ 51229	*Non-citizen* means an individual who is not a citizen or national of the United States, in accordance with section 101(a)(3) of the Immigration and Nationality Act. *State CHIP Agency* means the agency that administers a separate child health program established by the State under title XXI of the Act in accordance with implementing regulations at 42 CFR 457. *State Medicaid Agency* means the agency established by the State under title XIX of the Act that administers the Medicaid program in accordance with implementing regulations at 42 CFR parts 430 through	

Section/ FR Page	Description of Rule Provision	Comments
	456. *Tax dependent* has the same meaning as the term dependent under section 152 of the Code. (c) *Attestation.* (1) Except as specified in paragraph (c)(2) of this section, for the purposes of this subpart, an attestation may be made by the applicant (self-attestation), an application filer, or in cases in which an individual cannot attest, the attestation of a parent, caretaker, or someone acting responsibly on behalf of such an individual. (2) The attestations specified in § 155.310(d)(2)(ii) and § 155.315(e)(4)(ii) of this subpart must be provided by a primary taxpayer.	
155.300/ 51204-51206	**Relates to Definitions and Terms** Preamble on page 51205: "In support of our proposal that the Exchange determine an applicant's eligibility for CHIP, we propose to define ''applicable CHIP modified adjusted gross income (MAGI)-based income standard'' as the income standard applied under the State plan under Title XXI of the Act, or waiver of such plan, as defined at 42 CFR 457.305(a), and as certified by the State CHIP Agency pursuant to 42 CFR 457.348(d), for determining eligibility for child health assistance and enrollment in a separate child health program. The applicable CHIP MAGI based standard will also vary from State to State depending on the threshold established by the State CHIP agency. Both 42 CFR 457.305 and 457.348(d) are proposed in the Medicaid proposed rule. Preamble on page 51205: "We note that the Medicaid proposed rule does not specify that FPL is based on the data published as of the first day of the Exchange open enrollment period, which means that the FPL table used in eligibility determinations for Medicaid and CHIP may be different from that used for advance payments of the premium tax credit and cost-sharing reductions, depending on the date of the eligibility determination. However, we note that for the annual open enrollment period for coverage, the FPL tables for Medicaid, CHIP, and advance payments of the premium tax credit and cost-sharing reductions should be the same." Preamble on page 51205:	

Section/ FR Page	Description of Rule Provision	Comments
	"We propose to define ''primary taxpayer'' to mean an individual who (1) attests that he or she will file a tax return for the benefit year, in accordance with 26 CFR 1.6011–8; (2) if married (within the meaning of 26 CFR 1.7703–1), attests that he or she expects to file a joint tax return for the benefit year; (3) attests that he or she expects that no other taxpayer will be able to claim him or her as a tax dependent for the benefit year; and (4) attests that he or she expects to claim a personal exemption deduction on his or her tax return for the family members listed on his or her application, including the primary taxpayer and his or her spouse. We use this term in § 155.305 and § 155.320(c) of this subpart to describe the individual who would receive advance payments of the premium tax credit and would file a tax return to reconcile such advance payments." Preamble on page 51205: "In paragraph (b), we propose to clarify that, in general, references to Medicaid and CHIP regulations in this subpart refer to Medicaid and CHIP State plan provisions implementing those regulations. To the extent that the regulations outlined in this section refer to Medicaid and CHIP regulations, the Exchange would adhere to the rules of the Medicaid and CHIP agencies operating within the service area of the Exchange." "Lastly, in paragraph (c)(1), we propose that except as specified in paragraph (c)(2), for purposes of this subpart, an attestation may be made by the applicant (self-attestation), an application filer, or in cases in which an individual cannot attest, the attestation of a parent, caretaker, or someone acting responsibly on behalf of such an individual. In paragraph (c)(2), we propose that the attestations specified in § 155.310(d)(2)(ii) and § 155.315(e)(4)(ii), which result in the authorization of advance payments of the premium tax credit, must be made by the primary taxpayer. This is because these attestations are designed to ensure that the primary taxpayer appreciates and accepts the tax consequences that follow from receipt of advance payments.	
155.345/ 51236	**Coordination with Medicaid, CHIP, the Basic Health Program, and the Pre-existing Condition Insurance Program.** (b) *Responsibilities related to individuals potentially eligible for Medicaid based on other information or through other coverage groups.* (1) The Exchange must conduct basic screening for an applicant	We seek clarification on retroactive coverage in Medicaid- are we correct that it remains available in Medicaid, but could require a request for a full Medicaid determination once MAGI Medicaid eligibility was determined through the Exchange? We would like to prospectively enroll individuals into Medicaid who are moving from other coverage to avoid duplicate coverage. For example, a person might experience a drop in income

Section/ FR Page	Description of Rule Provision	Comments
	requesting an eligibility determination for insurance affordability programs under § 155.310(b) of this subpart to determine if an applicant is potentially eligible for Medicaid based on factors not otherwise considered in this subpart, including disability, and must transmit to the State Medicaid agency promptly and without undue delay the name of such applicant, other identifying information, and all other information provided on the application submitted by or on behalf of such applicant to, and obtained and verified by, the Exchange. (c) *Individuals requesting additional screening.* The Exchange must— (1) Provide an opportunity for an applicant to request a full determination of eligibility for Medicaid based on eligibility criteria that are not described in § 155.305. (2) If an applicant requests such a determination, transmit promptly and without undue delay the applicant's name, other identifying information, and all other information provided on the application submitted by or on behalf of such applicant to, and obtained and verified by, the Exchange to the State Medicaid agency.	and move from tax credit coverage to Medicaid. If the Medicaid effective date is the first day of the month of the application, there could be overlap with Medicaid and Exchange coverage. States should be able to move people between programs with no gaps or overlaps in coverage.
155.350/ 51236	**Special eligibility standards and process for Indians.** Preamble on page 51205: "This definition means an individual who is a member of a Federally-recognized tribe. Applicants meeting this definition are eligible for cost-sharing reductions or special cost sharing rules on the basis of Indian status, which are described in § 155.350 of this subpart."	
155.355/ 51237	**Right to appeal.** Preamble on page 51223: Section 1411(f) of the Affordable Care Act directs the Secretary to establish a process for a Federal official to hear and make decisions on appeals of eligibility determinations. Section 1411(e)(4)(C) of the Affordable Care Act also provides that the Exchange notify applicants and employers of appeal processes when notifying the applicant or employer of an eligibility determination. As described in § 155.200(d) of the Exchange NPRM, published at 76 FR 41866, the Exchange will establish a process to hear individual appeals of eligibility determinations. We propose that an individual may appeal any eligibility determination or redetermination made by the Exchange under subpart D, including determinations of eligibility for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing	It appears that further guidance on Exchange appeals is pending, and that those pending procedures would apply to Exchange determinations of eligibility to enroll in a QHP and to appeals of advance premium tax credit determinations and cost sharing reductions. It also appears that the Exchange will be required to follow the processes for information verification and requests for additional information for CHP and Medicaid MAGI determinations set forth in 435.952 (See 155.320), which may or may not include the provisions in 435.952 regarding fair hearings. The Overview of the Proposed Medicaid Rule stated that HHS intends to issue additional proposed rules on related matters including appeals and notices. We request that CMS provide understandable and consumer friendly template language for any required notices by an Exchange, Medicaid or CHP Agency for Insurance Affordability eligibility determinations. We want to clarify whether an Exchange will be required to provide a Medicaid fair hearing in

Section/ FR Page	Description of Rule Provision	Comments
	reductions. We intend to propose the details of the individual eligibility appeals processes, including standards for the Federal appeals process, in future rulemaking. (a) *Individual appeals.* The Exchange must include the notice of the right to appeal and instructions regarding how to file an appeal in any determination notice issued to the applicant pursuant to § 155.310(f), § 155.330(d), or § 155.335(h) of this subpart.	accordance with 42 CFR 431 Part E (435.952(d)) for Medicaid MAGI denials, terminations, etc. Does anticipated appeals guidance under 155.355 contemplate the possibility of a simpler, faster, uniform appeals process that would apply to all Exchange MAGI determinations? This could potentially be accomplished while retaining the fair hearing process for “full” Medicaid determinations requested pursuant to 155.345, as well as for non-MAGI, and possibly for MAGI “exception” cases, at least until such time as there is reliable, available data sources to enable greater automation of the eligibility determination Such an approach would require further refinement of proposed rules 435.952(d), 155.345, 155.355, or could be the subject of future guidance. We want the Exchange to be able to quickly help consumers enroll in the correct coverage program based upon information available to the Exchange in “real time” to the extent possible. We envision an appropriate process with understandable notices that would let consumers know that, although they are receiving coverage based on the information they provided and included in the notice, under certain circumstances (a person with a disability or in need of long term care, or a grandparent responsible for their grandchild, or a custodial parent whose child is claimed as a tax dependent by a non-custodial parent, or a person with unpaid medical bills) they could potentially qualify for more affordable coverage, and the process for requesting a full Medicaid determination. Finally, we seek clarification on the availability and requirements for aid continuing with respect to a Medicaid appeal of a MAGI determination.

Chart 5– 42 CFR Part 457

Section/ FR Page	Description of Rule Provision	Comments
457.310/ 51196	**Targeted low-income child.** (b) *Standards.* A targeted low-income child must meet the following standards: (1) * * * (i) Has a household income, as determined in accordance with § 457.315, at or below 200% FPL for a family of the size involved; (ii) Resides in a State with no Medicaid applicable income level; (iii) Resides in a State that has a Medicaid applicable income level and has a household income that either— * * * * * (B) Does not exceed the income level specified for such child to be eligible for medical assistance under policies of the State plan under title XIX on June 1, 1997; or (iv) Is not eligible for Medicaid as a result of the elimination of income disregards as specified under §435.603(g) of this chapter.	The regulations indicate that states are no longer permitted to use block of income disregards after 2014. The preamble indicates that states are required to maintain eligibility standards for children until 2019 and this requirement will be addressed further through sub-regulatory guidance. New York State currently uses block income disregards to cover children between 200 and 400% of the FPL. Given the maintenance of effort requirements, will CMS confirm that states currently using block of income disregards to cover children with household incomes over 200% FPL must continue to do so until 2019 and may continue to do so after 2019?
457.315/ 51196	**Application of MAGI and household definition.** Currently, States use different methods for defining income and household composition under CHIP. Many States operate their programs through expansions of Medicaid coverage. Among States with separate CHIP programs, some follow Medicaid financial methodologies while others rely on different methods, including gross income tests. While we recognize that the statutory application of MAGI rules to CHIP represents a change for some States, doing so is consistent with broader goals of coordination across programs. The adoption of MAGI-based methodologies to determine income for CHIP represents a necessary alignment with other insurance affordability programs and is particularly important for families both because children will be moving among different programs as family circumstances changes and because CHIP-eligible children will often be in families where the parent is eligible for a premium tax credit through the Exchange. Because the statute provides that CHIP apply the new MAGI methodologies in the same manner as Medicaid, we propose at § 457.315 that, in determining financial eligibility for CHIP, States use the methodologies for determining household composition and income as those proposed for Medicaid at § 435.603(b)–(h), as well as the exception, codified at proposed	The shift to a simpler, more automated approach to eligibility is complex and multi-layered undertaking. It is important to get implementation right in order to maximize the goals of ACA to ensure easy, fast enrollment in affordable, appropriate coverage. We request that CMS provide follow up guidance in the form of scenarios/examples of how the various aspects of eligibility determinations would work for different types of MAGI households (Exchange, CHP, Medicaid, any Basic Health Program], including mixed MAGI/non-MAGI households, and where "exception" rules under Medicaid would apply. These scenarios need to encompass a wide range of income levels and circumstances, with examples that include eligibility determinations, verification processes, and how claiming, reporting and audit would work. We need scenarios for each of the Insurance Affordability programs, and for the many types of "crossover" and mixed family cases that are expected. We have attached some specific questions/scenarios to aid in this process, and welcome the opportunity to work with our federal partners and other states in this effort. Detailed scenarios that "crosswalk" the Insurance Affordability programs will be especially critical to ensuring that the application of different rules for eligibility determinations and verifications for Exchange tax credits or cost sharing vs. Medicaid, CHP or a Basic Health program do not set up a potential "black hole", where someone who should be eligible for one Insurance Affordability program or another ends up being ineligible for anything.

Section/ FR Page	Description of Rule Provision	Comments
	§435.603(i)(1), to permit States to rely on a finding of income made by an Express Lane Agency in accordance with section 2107(e)(1)(E) of the Act. As discussed in section II.B. of this proposed rule, our proposed MAGI- based methods for determining Medicaid eligibility mirror the section 36B definitions of MAGI and household income, except in a very limited number of situations. Effective January 1, 2014, the CHIP agency shall apply the financial methodologies set forth in paragraphs (b) through (h) of § 435.603 of this chapter in determining the financial eligibility of all individuals for CHIP. The exception to application of such methods for individuals for whom the State relies on a finding of income made by an Express Lane agency at § 435.603(i)(1) also applies.	It is also important to note that we adjust our current eligibility levels and rules to accommodate the ACA, it will be critically important to remain nimble and flexible as implementation will be phased and mid-course corrections will undoubtedly be required. As such, it is important for the state's relationship with its federal partners to remain flexible and support an environment of rapid change.
457.320/ 51196	**Other eligibility standards.** Section 457.320(a) lists the various eligibility standards States may adopt for one or more groups of children. We propose eliminating ''resources'' and ''disposition of resources'' in conformance with the law. The ACA also eliminates the use of income disregards other than a disregard of 5 percent of income specified under section 1902(e)(14)(I) of the Act. This means that, as of 2014, States no longer will be able to raise their effective income standards for their CHIPs through the use of a ''block of income'' disregard. The maximum income standard will be the higher of 200 percent FPL, 50 percentage points above the applicable Medicaid income level defined in section 2110(b)(4) of the Act and § 457.301, and the effective income standard in effect in the State (taking into account any income disregards adopted) as of December 31, 2013, converted to a MAGI-equivalent income standard in accordance with section 1902(e)(14)(A) and (E) of the Act. CHIP regulations currently allow States the option to adopt eligibility standards related to residency. The following changes to the regulations governing residency standards for separate CHIPs are proposed to ensure coordination between all insurance affordability programs. Further discussion on the rationale behind the proposed changes can be found in section II.C of this proposed rule. We propose at § 457.320(d) to modify the definition of residency for noninstitutionalized children who are not wards of the State under CHIP to reference the Medicaid	

Section/ FR Page	Description of Rule Provision	Comments
	definition for children at proposed § 435.403(i). As under § 435.403(i), for purposes of CHIP eligibility, a child under the proposed rule is considered a resident of the State in which he or she resides (for example, with a parent or caretaker and including without a fixed address), or in which a parent or caretaker is employed or seeking employment, including seasonal workers. The provisions of the proposed rule are not intended to effect a significant change in policy, and are discussed in more detail in section II.C.2 of this proposed rule. The provision at § 435.403(m) of the Medicaid rule, involving situations in which two or more States dispute a child's State of residence, is also applied under the proposed rule to CHIP; under that provision, physical location governs. (d) *Residency.* (1) Residency for a noninstitutionalized child who is not a ward of the State must be determined in accordance with § 435.403(i) of this chapter. (2) A State may not— (i) Impose a durational residency requirement; (ii) Preclude the following individuals from declaring residence in a State— (A) An institutionalized child who is not a ward of a State, if the State is the State of residence of the child's custodial parent or caretaker at the time of placement; or (B) A child who is a ward of a State, regardless of where the child lives (3) In cases of disputed residency, the State must follow the process described in § 435.403(m) of this chapter.	
457.330/ 51196-97	**Application.** 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. The State shall use the single, streamlined application used by the State in accordance with § 435.907(b) of this chapter, and otherwise comply with the provisions of such § 435.907 of this chapter, except that the terms of § 435.907(c) of this chapter (relating to applicants seeking coverage on a basis other than modified adjusted gross	CMS should modify the CHIPRA regulations on crowd out to better align with Medicaid and the Exchange. Current CMS regulations require CHIP programs to monitor crowd out for those with incomes below 250% of FPL and implement a mechanism to prevent crowd out if the monitoring shows evidence of crowd out above a certain level. New York monitors crowd out by asking 6 questions on the application. Three of the questions are indicators of crowd out. In 13 years of monitoring, the percentage of applicants exhibiting crowd out behavior has never reached the trigger (8%) to implement a waiting period. We recommend CMS eliminate the requirement to monitor for those below 250% of FPL. This will eliminate the need to add questions to the streamlined application that are not needed for any other Insurance Affordability program. It is reasonable to place a higher standard for preventing crowd out on applicants with incomes

Section/ FR Page	Description of Rule Provision	Comments
	income) do not apply.	above 250% of FPL. However, we still recommend not loading the streamlined application with crowd out questions and would prefer not to impose waiting periods. In terms of monitoring, perhaps a back-end sample to measure crowd out could be used to trigger whether a waiting period is needed. If a waiting period is retained, it should make exceptions for children moving among programs (Medicaid, Exchange) and children should be permitted to enroll in a Qualified Health Plan during the waiting period despite the administrative burden this would create.
457.335/ 51197	**Availability of program information and Internet Web site.** To implement section 1943(b)(4)of the Act, relating to the establishment of Web sites to facilitate application and enrollment in all insurance affordability programs, we propose adding § 457.335 similar to the rule proposed for Medicaid at § 435.1200(d), discussed in section II.I. of this proposed rule. The terms of § 435.905 and § 435.1200(d) of this chapter apply equally to the State in administering a separate CHIP.	
457.340/ 51197	**Application for and enrollment in CHIP.** We propose removing the mention of enrollment caps in § 457.340(a) to support the role of CHIP agencies in accepting the single streamlined application and screening for all insurance affordability programs regardless of whether CHIP enrollment is capped. (a) *Application assistance.* A State must afford families an opportunity to apply for CHIP without delay and must provide assistance to families in understanding and completing applications and in obtaining any required documentation. Such assistance must be made available to applicants and enrollees in person, over the telephone, and online, and must be provided in a manner that is accessible to individuals living with disabilities and those who are limited English proficient. We propose to revise § 457.340(b) to specify that all CHIP agencies require applicants who have an SSN to provide it. We recognize that the Privacy Act makes it unlawful for States to deny benefits to an individual based upon that individual's failure to disclose his or her Social Security number, unless such disclosure is required by Federal law or was part of a Federal, State or local system of records in operation before January 1, 1975. However, section 1414(a)(2) of the ACA authorizes the Secretary to collect and use SSNs where necessary to administer the provisions of,	

Section/ FR Page	Description of Rule Provision	Comments
	and amendments made by, the ACA. We believe such section provides the authority for the requirement of SSNs when applicants are using the coordinated system and streamlined application designed by the Secretary under section 1413 of the ACA. However, similar to Medicaid, non-applicants cannot be required (but may be requested) to provide an SSN. Consistent with Medicaid regulations at § 435.910, the CHIP agency must not deny or delay services to an otherwise eligible applicant pending issuance or verification of an applicant's SSN. (b) *Use of Social Security number.* A State must require each individual applying for CHIP to provide a Social Security number (SSN) in accordance with § 435.910 and cannot require nonapplicants to provide an SSN consistent with the requirements at §435.907(e) of this chapter. We propose revisions to the effective date of eligibility in § 457.340(f) to ensure that the method adopted by the State for determining the effective date of coverage will provide for a coordinated transition of children between programs as family circumstances change, without gaps or overlaps in coverage. (f) *Effective date of eligibility.* A State must specify a method for determining the effective date of eligibility for CHIP, which can be determined based on the date of application or through any other reasonable method that ensures coordinated transition of children between programs as family circumstances change and avoids gaps or overlaps in coverage.	We concur that effective dates should be aligned to avoid either a gap or overlap in coverage, but sometimes it is difficult to do that especially if the Medicaid effective date is the first day of the application. For example, you would want to keep a child in CHIP and move the child prospectively to Medicaid without a gap or overlap. Sometimes a small overlap in unavoidable and is preferable to a gap. And it is critical that the MEQC/PERM and any Exchange audit requirements be aligned to enable implementation of a policy that does not penalize small overlaps in coverage that are necessary to provide continuity of coverage.
457.353/ 51198	**Monitoring and evaluation of screening process.** States must establish a mechanism and monitor to evaluate the screen and enroll process described at § 457.350 of this subpart to ensure that children who are: (a) Screened as potentially eligible for other insurance affordability programs are enrolled in such programs, if eligible; or (b) Determined ineligible for other insurance affordability programs are enrolled in CHIP, if eligible.	

Chart 6—26 CFR Part 1

Section/ FR Page	Description of Rule Provision	Comments
1.36B-1/ 50939	**Premium tax credit definitions.** (d) Family and family size. A taxpayer's family means the individuals for whom a taxpayer properly claims a deduction for a personal exemption under section 151 for the taxable year. Family size means the number of individuals in the family. Family and family size include an individual who is exempt from the requirement to maintain minimum essential coverage under section 5000A.	
1.36B-2/ 50940	**Eligibility for premium tax credit.** (a) In general. An applicable taxpayer (within the meaning of paragraph (b) of this section) is allowed a premium assistance amount only for any month that the applicable taxpayer, or the applicable taxpayer's spouse or dependent-- (1) Is enrolled in one or more qualified health plans through an Exchange; and (2) Is not eligible for minimum essential coverage (within the meaning of paragraph (c) of this section) other than coverage described in section 5000A(f)(1)(C) (relating to coverage in the individual market). 3(iv) Special rule for continuation coverage. An individual who may enroll in continuation coverage required under federal law or a state law that provides comparable continuation coverage is eligible for minimum essential coverage only if the individual enrolls in the coverage.	Could CMS confirm whether an individual who has disenrolled from COBRA coverage is still considered eligible for the premium tax credit?
1.36B-2/ 50941	**Employer-Sponsored Minimum Essential Coverage.** [§1.36B-2(c)(3)] (3) *Employer-sponsored minimum essential coverage*—(i) *In general.* For purposes of section 36B, an employee who may enroll in an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and an individual who may enroll in the plan because of a relationship to the employee (a related individual) are eligible for minimum essential coverage under the plan for any month only if the plan is affordable and provides minimum value. Government-sponsored programs described in section 5000A(f)(1)(A) are not eligible employer-sponsored plans.	It would appear that if an individual is enrolled in Employer Sponsored Minimum Coverage then the standard of affordability and minimum value do not apply and they would not be eligible for a premium tax credit. While presumably the general purpose of exempting all individuals actually enrolled in Employer Sponsored Coverage from these standards is to ensure they do not drop coverage to enroll through the exchange, it seems burdensome for individuals to have to remain in coverage that is unaffordable.
1.36B-2/ 50941	**Affordable Coverage.** [§1.36B-2(c)(3)(v)] (v) *Affordable coverage*—(A) *In general*—(*1*) *Affordability.* Except as	While we understand the rationale for this rule, we encourage consideration of amending the regulation to take into account the affordability of family coverage that would give consumers

Section/ FR Page	Description of Rule Provision	Comments
	provided in paragraph (c)(3)(v)(A)(*2*) of this section, an eligible employer-sponsored plan is affordable for an employee or a related individual if the portion of the annual premium the employee must pay, whether by salary reduction or otherwise (required contribution), for self-only coverage for the taxable year does not exceed the required contribution percentage (as defined in paragraph (c)(3)(v)(B) of this section) of the applicable taxpayer's household income for the taxable year.	more access to affordable coverage. There will be instances where self-only coverage would be deemed affordable but family coverage is not. This could create challenges for families in affording coverage for the entire family and leave dependents without coverage.
1.36B-3/ 50943	**Computing the premium assistance credit amount.** (a) In general. A taxpayer's premium assistance credit amount for a taxable year is the sum of the premium assistance amounts determined under paragraph (d) of this section for all coverage months for individuals in the taxpayer's family. … (f) Applicable benchmark plan--(1) In general. Except as otherwise provided in this paragraph (f), the applicable benchmark plan for a coverage month is the second lowest cost silver plan (as described in section 1302(d)(1)(B) of the Affordable Care Act (42 U.S.C. 18022(d)(1)(B))) offered at the time a taxpayer or family member enrolls in a qualified health plan through the Exchange in the rating area where the taxpayer resides for-- (i) Self-only coverage for a taxpayer-- (A) Who computes tax under section 1(c) (unmarried individuals other than surviving spouses and heads of household) and is not allowed a deduction under section 151 for a dependent for the taxable year; (B) Who purchases only self-only coverage for one individual; or (C) Whose coverage family includes only one individual; and (ii) Family coverage for all other taxpayers. (2) Family coverage. If an Exchange offers categories of family coverage (for example, two adults, one adult with children, two or more adults with children, or children only), the applicable benchmark plan for family coverage is the coverage category that applies to the members of the taxpayer's coverage family who enroll in a qualified health plan (such as a plan covering two adults if the members of taxpayer's coverage family are two adults).	In the case of a student dependent living out of state, California for example, that individual could be covered by a QHP in California. Yet, they are a dependent of the parent's household in New York. For the estimated premium amount, the cost of covering that individual in the second lowest silver plan is added to the estimates for the other family members in New York. Is CMS contemplating providing this type of data on out of state costs in a format that is current and easily accessible to states and taxpayers? Exchanges will likely have different tiers of coverage including Two Adults, Parent and Children, and Two Parents and Children. The preamble of the NPRM states that if there are multiple tiers of family coverage the applicable tier for determining the benchmark plan will be the one that most closely resembles the family structure of the individual seeking coverage. If this is intended, the regulation should be revised to clearly state which tier will apply for coverage other than single-only.