STATE OF CALIFORNIA COMMENTS AND RESPONSES TO REQUEST FOR COMMENTS CMS PROPOSED ELIGIBILITY RULES (CMS-2349-P)		
Provision & Location	**Regulatory Reference**	**Summary**
Presumptive Eligibility (PE)		While not specifically addressed in the NPRM, clarification is needed on how PE for pregnant women, children and breast and cervical cancer patients will fit in with the new ACA processes to establish real-time eligibility using MAGI whenever possible. Participation in the Breast and Cervical Cancer Treatment Program is without regard to income or resources and is based simply upon the cancer screen eligibility. Will the application template developed by CMS address these differentiations? Additionally pursuant to Section 2202 of ACA, it appears that PE can be granted by hospitals. Please clarify whether hospitals may grant PE for all Medicaid populations or whether they may grant only to the extent the Single State Agency has implemented PE for given populations as indicated in their State Plan. If hospitals are allowed to do this for all Medicaid populations, please provide clarification in the regulations as to how this would actually be operationalized.
Medically Needy (MN)		Under the MN program, beneficiaries often have a spend down/share of cost (SOC) requirement. Under Medicaid rules, a person is not eligible until they have met their share of cost. There is no discussion as to how the MN program applies to individuals who are income ineligible for the new coverage groups, if at all. The Medicaid NPRM implies that individuals go directly to the Exchange if they become income ineligible for the new mandatory groups. States need flexibility in the treatment of MN individuals, specifically with the ability to tailor wraparound services such as Long-Term Care or Home and Community-Based Services for disabled populations in the Exchange or Medicare given the benefit limitations with essential health benefit packages. Will a beneficiary who is eligible under a MN category be able to opt out of the MN program and enroll in the Exchange if they are subject to a share of cost (whether or not they meet the share of cost) and have income that would otherwise make them eligible for the Exchange, or alternatively, can the beneficiary simply enroll in the Exchange before he/she meets his/her income spend down? Please clarify how States are to treat MN individuals who are subject to a spend down and what, if any, duty exists to send the data of the individual to the Exchange for an eligibility determination. When a family member, for example a father, is income ineligible for the parent/caretaker relative group and must have his eligibility determined under the MN group, is he in a family size of one person and are only his income and resources used for the MN eligibility determination, or are all of the income and resources of the family used for the MN eligibility determination for the father with all of the family members getting a person count for establishing the income and resource limits?

STATE OF CALIFORNIA COMMENTS AND RESPONSES TO REQUEST FOR COMMENTS CMS PROPOSED ELIGIBILITY RULES (CMS-2349-P)		
Provision & Location	**Regulatory Reference**	**Summary**
Transitional Medical Assistance (TMA)		Please clarify how States are to, if at all, address transitional medical assistance in a post-ACA environment. Will this transitional coverage still be required of Medicaid agencies and if so, how will it comport with the new coverage groups in terms of its applicability and the income eligibility provisions for Exchange coverage?
Excepted Groups	**Preamble, Page 51159, third column, third bullet**	Eligibility NPRM Page 51159, third column, third bullet states that eligibility of individuals receiving long-term care (LTC) is excepted from MAGI when the eligibility determination must be based on the receipt of LTC. • What is meant by "when the eligibility determination must be based on the receipt of LTC"? Does that mean when spousal impoverishment provisions must be applied? When the institutionalized individual/child is applying for waiver services and requires institutional deeming? • What are States to do when household income (HI) of a family as reported by IRS includes the income of someone who is in long-term care (LTC)? What if the State is unaware that the MAGI/HI for the family coming through the web portal includes a person in LTC? Can States rely on the reported MAGI/HI for that family? • When the State discovers an individual is in LTC, how is the post-eligibility of that mixed household to be determined? What is the process States are to follow for the mixed families of individuals who require home and community-based waiver services? • If the State discovers an individual in the newly eligible group is institutionalized in a skilled nursing facility for a recuperative period, how is the State supposed to treat these individuals? Should they be moved out of the newly eligible group since the benchmark benefit packages for these individuals do not contemplate skilled nursing facility care? Clarification is appreciated on this matter. Please provide instructions as to how the States are to determine eligibility when households are mixed with individuals excepted under 1902(e)(14)(D). Will eligibility have to be determined with all family members in the household twice – once for individuals eligible under the new group and then a second time to establish the eligibility of family members eligible under other or excepted groups? Or will individuals who are excepted or eligible under other categories, be considered separately without regard to financial responsibility of spouse for spouse and parent for child? Pursuant to Section 2002 of ACA, it modifies Title XIX Section 1902(e)(14) (D)(i) (I) to except from the use of the MAGI methodology " individuals who are eligible as a result of being or being deemed to be a child in Foster Care under the responsibility of the State." • What does "under the responsibility" of the State mean? Is someone under the responsibility of the state if

Provision & Location	Regulatory Reference	Summary
		the State makes a state-only Foster Care payment, or must the state have an additional legal responsibility? • Who would be in the MAGI/household as returned from IRS for non-4E Foster Care and Adoption Assistance recipients? If States are to construct the household and determine MAGI how are the States to do this? How are non-4E Foster Care, Adoption Assistance and state subsidized guardianship payments to be treated?
Definitions **Page 51187, third column**	**435.4**	Section 435.4, the definition of "Effective Income Level" uses the term "disregard of a block of income". We believe that is a percentage of income, unrelated to the source of the income, for an entire group. Is this correct? Would it also include a specific amount for an entire group? Only dependent children can link a parent/caretaker relative for full coverage. We questioned why does the term "dependent child" not include "incapacity" as a basis for deprivation? We also noted that the dependent child only go up to 18 years of age, except for 18 year olds who are full-time students. Children up to 19 receive full coverage; however the parent/caretaker relative who cannot be in the parent/caretaker relative group would receive benchmark coverage under the new VIII group. It would be more seamless to change the definition to "child up to 19 years of age". We also noted that the term "dependent child" no longer includes "incapacity" as a basis for deprivation which would also result in rolling incapacitated parents/caretaker relatives into the VIII group. This may have been an unintentional omission. Please include the term in final regulations.
Medicaid Eligibility Categories **Page 51152, third column, third paragraph**	**435.110, 435.116, 435.118, 435.119**	***CMS solicits comments on proposing to collapse existing Medicaid eligibility categories, with the goal of making the program significantly easier for States to administer and for the public to understand.*** Generally speaking we see no problems with this consolidation and believe this will significantly help States in their efforts to streamline program administration. We appreciate State flexibility in managing coverage groups specific to our needs. Will women who are covered under the parent/caretaker relative group, or under the new VIII group, who become pregnant be permitted to stay in their coverage group for continuity of care or will the state be required to complete redeterminations and move them to the pregnant woman category? Please clarify in the regulations the hierarchy of eligibility determinations that States are to follow given the addition of the four new coverage groups.
Application of Modified Adjusted	**435.603**	One of the goals of IRS reported MAGI/household income (HI) was to simplify and streamline the eligibility determination process into a real time determination. IRS is to report MAGI/HI to CMS pursuant to 36B of the

STATE OF CALIFORNIA COMMENTS AND RESPONSES TO REQUEST FOR COMMENTS CMS PROPOSED ELIGIBILITY RULES (CMS-2349-P)		
Provision & Location	**Regulatory Reference**	**Summary**
Gross Income (MAGI)		Internal Revenue Code. It appears, throughout this NPRM and preamble, that there are a majority of situations where IRS reported MAGI/HI cannot be used without at least requiring some manipulation on the part of the state, complicating and delaying real-time eligibility. It appears that the IRS reported MAGI/HI may not be useable in cases where: • Non-custodial parents claim a child as a tax dependent, • Tax dependents are not spouses, natural, adopted or step-children, • Spouses do not file jointly, • The child has income and files a return, • There is a mixed household with aged individuals or cases based upon LTC or HCBS services, • Income has changed or is expected to change, and • In all cases of an applicant. Will IRS be reporting MAGI with some of these changes already addressed in household income? Will IRS be reporting only individual MAGI's, leaving individual States to determine household income in all cases? Or will the State receive the MAGI/HI only for use in verifying client reported income? Will the IRS agree to calculate MAGI/HI based upon information obtained at the web portal from individuals/families and send electronically to CMS/IRS? We request guidance as to how MAGI/HI should be calculated. Such guidance should reduce the incidence of variance between the States as to the standards employed to calculate income, define tax dependency, and determine household composition. Specifically, please provide directions as to how to determine countable income, ascertain when an individual qualifies as a tax dependent for IRS purposes, and to determine when and the extent to which personal exemptions and deductions are used to calculate MAGI/HI. Further, for situations involving mixed households, such guidance should provide multi-scenario examples and complete sets of worksheets. Also, if a State is to rely upon prior year's tax forms to determine MAGI, please provide clarification as to how this standard should be derived from these forms. Absent such direct and comprehensive guidance, States must be both authorized and federally funded to purchase licenses and utilize commercial off-the-shelf tax preparation products with necessary modifications to meet States

Provision & Location	Regulatory Reference	Summary
		individual system requirements. Please clarify both the definition for and the process to be used to ascertain MAGI converted effective income standards in "the aggregate." Guidance is needed as to whether or not the IRS will make the adjustments to MAGI/HI for Medicaid treatment of lump sums, exemptions for educational scholarships, grants and American Indians/Alaskan Natives or if States have to include such questions relating to those items on their applications and make those adjustments as point-in-time determinations. For purposes of administrative savings, streamlining and simplicity, CMS should grant States flexibility in the treatment of income in terms of current monthly and/or annualized amounts for applicants and beneficiaries. As written, section 435.603 (h)(1) pertaining to applicants and new enrollees does not specify when applicants are transitioned to the status of current beneficiaries as described in 435.603 (h)(2). Additionally, as 435.603 (h)(1) requires that States premise Medicaid eligibility for applicants and new enrollees on monthly income, please clarify in section 435.603 (h)(2) that for current beneficiaries, States may elect the use of monthly household income and family size or projected annual income for the current calendar years. Please clarify whether SNAP or TANF client information may be used for converting and establishing MAGI eligibility. If a State can continue to show that, post-MAGI, their TANF population when made eligible under the TANF methodology/standard would also have been made Medicaid eligible had the MAGI standard/methodology been employed, can that State continue to use that system (the TANF application, methodology and workers) to make the Medicaid determination? Please clarify. The proposed definition of family size (Section 435.603(b)) permits a State to count a pregnant woman as one or two persons. Currently, a pregnant woman is counted as one for herself plus the number of fetuses she is carrying. This reduction in family size could disadvantage women with multiple fetuses. Please allow States the flexibility to continue their current determinations of family size taking into consideration multiple fetuses.
Gaps in Health Coverage Page 51156, first	**435.603(h)(2)**	***CMS solicits comments on how best to prevent a gap in coverage, including whether to ensure that State Medicaid agencies take into account a predictable future drop in income. There are challenges that will arise due to the reliance on monthly income for purposes of eligibility for Medicaid versus annual income for***

STATE OF CALIFORNIA COMMENTS AND RESPONSES TO REQUEST FOR COMMENTS CMS PROPOSED ELIGIBILITY RULES (CMS-2349-P)		
Provision & Location	**Regulatory Reference**	**Summary**
column, third paragraph		***purposes of eligibility for advance payments of premium tax credits.*** We strongly recommend that CMS grant States flexibility in the treatment of income in terms of current monthly and/or annualized amounts for applicants and beneficiaries to streamline eligibility, enable use of IRS reported MAGI, and coordinate eligibility time periods between Medicaid, CHIP and the Exchange when individuals move between programs to ensure no gaps in coverage.
36B Treatment of Social Security Benefits **Page 51157, first column, second paragraph**	**435.603(e)**	Certain amounts of Social Security benefits are not counted as income under the 36B definition of MAGI. The section 36B treatment of Social Security benefits may increase State Medicaid costs, as some individuals who receive Social Security benefits would gain Medicaid eligibility using the 36B definitions. We would prefer to use an IRS reported MAGI for streamlining and simplicity. Further manipulation of data for Medicaid purposes adds complications and requirements for state intervention in the eligibility process. If IRS does not do the computation that adds the Social Security income back into MAGI, it would result in reduced simplicity for purposes of streamlining and may adversely impact an individual if States are to use currently monthly income for applicants and either a current monthly or annualized income for beneficiaries as proposed by the regulations. Based upon the number of people affected by this nationally, we believe that simplicity and streamlining should remain a priority.
Three types of income to codify current Medicaid rules **Page 51157, first column, fourth paragraph**	**435.603(e), 435.603(e)(2)**	***CMS solicits comments on proposed changes to IRS policies that will retain Medicaid treatment of the following income types: (1) Lump sum payments, which consist of non-recurring income received on a one-time-only basis, (2) Educational scholarships and grants, (3) American Indian and Alaska Native (AI/AN) income is the subject of special treatment and protections.*** Once again, this adds complexity to the eligibility process that could otherwise rely on IRS reported MAGI. In this case, if IRS reported MAGI were relied upon, individuals would be pushed into the Exchange. Due to the uncertainty of the number of individuals who may be impacted by this provision, we believe that simplicity and streamlining should remain a priority.
Household Composition	**435.603(f)**	The regulations need to address with more specificity how household income and household composition is to be constructed. In addition, the regulations should allow flexibility for states to define household income and composition to align Exchange/CHIP household income and family composition with Medicaid. Section 435.603(f) and Page 51158 first column, 3rd paragraph imply that non-elderly grandparents, uncles, aunts, non-caretaker relatives living with and being claimed as tax dependent by the taxpayer would not be in the

Provision & Location	Regulatory Reference	Summary
		taxpayers household; however, when looking at 435.603(f)(2)(i) as instructed and in referring to (f)(3) as instructed by (f)(2), a non-filer, tax dependent is not addressed. • This may be clarified by including the phrase, "except that the household must be determined in accordance with the rules for non-filers in paragraph (f)(3)…" Does a person sent from (f)(2) to (f)(3) need to be living with the taxpayer who is claiming them as a tax dependent? If there are situations where individuals can make choices about which household they are in, that needs to be captured in the regulations (for example, 50/50 custodial situations, or if a child chooses Exchange coverage in the non-custodial parents locale). CMS indicated verbally on the 10/5/11 teleconference that they had noticed some incorrect anomalies had appeared when working the NPRM text through three of their scenarios. CMS requested that States request that the regulatory language be repaired in light of these anomalies. Please clarify or correct the regulatory text as necessary.
Tax Dependent of Non-Custodial Parent **Page 51158, first column, third paragraph**	**435.603(f)(2)(iii)**	***CMS solicits comments on the proposed handling of Medicaid household composition for children who are claimed as a tax dependent by a non-custodial parent.*** When a child is claimed as a tax dependent by a non-custodial parent, the proposed regulations include an exception to the household composition allowing the child to be in the household of the custodial parent. We would like CMS to clarify households where custody is split exactly 50/50 and where time is spent one week with one parent and one week with the other parent. Section 435.603(f): • What happens in cases where custody is shared equally and the child spends exactly ½ of his/her time living alternately with each parent, but only one parent gets to claim the tax exemption? Please address both situations where the child switches more frequently than monthly (i.e., week-by-week), and month-by-month or less frequently. • Does the household composition of these children change with their movement from house to house? Do these parents have to essentially find plans that provide services statewide? How is MAGI/HI affected when parents live in border towns of two different States and the child crosses borders frequently? Section 435.603(f)(2) says that the tax dependent's household is the household of the taxpayer. What is meant by the household of the taxpayer? Once the household of the taxpayer is established, are the people included of the

Provision & Location	Regulatory Reference	Summary
		household of the taxpayer and the people included in the household of the tax dependent always the same in cases where none of the (f)(2) exceptions apply? • For example, when none of the exceptions in (f)(2) apply, if the taxpayer files a joint return with his spouse and they claim 3 common children as tax dependents, including a 30 year old son, their person count would be 5 people. Would the 30 year old son also have a person count of 5 in his/her household, or does the 30 year old's household include only the taxpayers for a person count of 3 (including the taxpayer and spouse who is also a taxpayer)?
Spouses/parents, all children under 19 or 21 (full-time student) **Page 51159, first column, second paragraph**	**435.603(f)(3)**	***CMS solicits comments on the proposed rule for household composition of non-filers at Section 435.603 (f)(3): Treatment of spouses/parents (including stepparents) and all children (including stepchildren and stepsiblings) under age 19 or, if a full-time student, under age 21, who are living together, as members of the same household. This proposed policy will avoid the gap in coverage for 19 and 20 year olds.*** CA believes that to ensure no gaps in coverage, the household composition rules need to be the same as those for the Exchange to avoid individuals being ineligible for both programs. Please clarify the introductory sentence of regulations at (f)(3) to clarify how (f)(3) is to apply to other individuals living in the home who are being claimed as tax dependents (those cited in (f)(2)(i))? For example, the household is not clear for the grandparents, uncles, aunts, non-caretaker relatives who are living with and being claimed as tax dependents by the taxpayer. In addition, please indicate how to treat a custodial parent who files a tax return who does not claim the child as a tax dependent? Please note that there appears to be a drafting error in 435.603 (f)(3)(iii) in that natural siblings are omitted from the individuals who comprise the household size. Please clarify.
SSI Children who reach 18 years old. **Page 51159, second column, third paragraph**	**435.603(i)(3)**	***CMS solicits comments as to whether there might be children still eligible under this mandatory coverage group (1902(a)(10)(i)(II)) as of 2014, and therefore, whether they should be identified in these regulations.*** California no longer has any eligible children in this group.
65 or older are categorically excepted from MAGI **Page 51159, third**		***CMS solicits comments on the following: Exception of all elderly individuals from MAGI methodologies for all eligibility groups could result in States having to retain application of AFDC financial methodologies in a small number of cases in which an elderly individual is being evaluated for coverage on the basis of being a parent or caretaker relative, for which age is not a factor. Possible approaches we (CMS) might adopt to avoid this result - for example, interpreting the exception to apply only in the case of elderly individuals when age is a condition***

STATE OF CALIFORNIA COMMENTS AND RESPONSES TO REQUEST FOR COMMENTS CMS PROPOSED ELIGIBILITY RULES (CMS-2349-P)		
Provision & Location	**Regulatory Reference**	**Summary**
column, first paragraph		***of eligibility or of applying SSI methodologies (which will continue to be used for most MAGI-excepted groups) in determining the eligibility of elderly individuals for coverage as a caretaker relative.*** It would be much simpler to apply a MAGI methodology to those who are parents/caretaker relatives and who do not need their age to establish eligibility. Currently aged parents/caretaker relatives are included in the mandatory Section 1931(b) program. Please make the regulations a little clearer that seniors and persons with disabilities who can establish eligibility under one of the four new mandatory groups, must have their eligibility established on that basis before consideration under other optional categories where their eligibility would be based upon their being a senior or a person with a disability.
Residency **Page 51160, third column, second paragraph**	**435.403(h) and (i)**	***CMS solicits 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.*** Currently state residency is based upon physical presence with the intent to remain permanently or indefinitely. The proposed regulations determine residency on the basis of residing or intent to reside. Generally speaking we do not see major problems with this; however, please make a distinction in regulation, as has been stated in the preamble, between someone who is visiting and someone who resides in the state. Please also provide regulatory clarification for the residency of a non-filer child for whom parents share custody equally over state boundaries for short periods of time, e.g., one week here, one week there. Lastly, the proposed regulations do not address individuals who did not enter the state to work and who enter States for short periods of times and technically have residency in multiple States or countries.
Alternative application approaches **Page 51161, first column, third paragraph**	**435.907(c)**	***CMS solicits comments on two alternative application approaches: (1) States may use supplemental forms to gather additional information 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; (2) 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.*** CMS has stated that it will provide a template for States to use in developing their streamlined application; however, none has been provided as yet and this is important for States as we are moving forward with system design and development. This is another area where CMS is going to be securing a vendor to work with States on the

Provision & Location	Regulatory Reference	Summary
		development of such an application – given our work to date in the State, we hope to be partners in this effort. To the extent more information is needed for data-gathering purposes, for determining FMAP for newly eligibles, in the case of individuals for whom IRS reported MAGI/HI is not useful, or in the case of mixed MAGI/Non-MAGI households the application will necessarily increase in complexity. System designs will need to be employed to differentiate the treatment. Please provide guidance regarding the use of telephonic applications and electronic signatures under penalty of perjury.
Coverage Month Page 51162, second column, fourth paragraph	**Proposed 155.410 Exchange Regulations**	***CMS solicits comments on possibly adding a provision to the regulations to extend Medicaid coverage until the end of the month. Comments are invited on this potential approach to coverage, its likely impact on maintaining continuous coverage, whether the costs of this approach outweigh the benefits, or whether we should retain the current policy that provides State flexibility to end coverage at any time during a month.*** CA agrees that eligibility should be extended to the end of the month or flexibility to do so be allowed. This will also serve to reduce coverage gaps and capitation rates are usually based upon a monthly fee. However, to the extent Medicaid coverage is required to be extended to the end of the month, such individuals should be treated as a newly eligible and States should have the ability to claim the increased FMAP for rendered services.
Program Integrity Page 51163, first column, paragraph five	**435.945(a)**	***CMS provides that program integrity is a top priority and should be considered in commenting on the proposed rule.*** CMS should provide quality control and audit protection within the regulations for States that rely upon information received through data matches and parameters/definition for the term “reasonably compatible”. Any systems changes to gather data for federal repositories, quality control or audit purposes, need to be addressed before eligibility systems and applications are developed because they need to be used to gather the required information. Please specify what these requirements will be and whether 90 percent FMAP will be available for those systems changes as well. We request clarification that CMS will redesign quality control requirements with State participation to permit State-specific processes and standards given the new eligibility requirements, data matches and individual system

Provision & Location	Regulatory Reference	Summary
		capabilities. Additional information would need to come from the federal "hub" to ensure that individuals are not covered in more than one State followed by additional information to determine true residency.
Redeterminations	**435.916**	Section 435.916 states that redeterminations are now only every 12 months for MAGI eligible populations. Please clarify in the regulations the extent to which monthly budget periods would still be relevant, especially if a State annualizes income. In addition, the regulations should allow flexibility for states to define when monthly budget periods are relevant to allow states the ability to synchronize redeterminations across Medicaid, CHIP and the Exchange.
Renewal Form Page 51166, second column, first paragraph	**435.916(a)(3)**	***CMS solicits comments on the proposed renewal process. It includes the provision of a pre-populated renewal form containing information that is relevant to the renewal and available to the agency. Provide the individual with a reasonable period—-these rules propose at least 30 days--to furnish necessary information and to correct any inaccurate information either in person, online, by telephone, and via mail.*** CA is in agreement that 30 days is a sufficient period within which to return a pre-populated form however we request State flexibility to establish redetermination models that align with State program integrity policies. . Please include regulatory permission for States to determine whether the information in their files is reliable enough to renew eligibility without contacting the beneficiary.
Reconsideration Period Page 51166, second column, third paragraph	**435.916(a)(3)(iii)**	***CMS solicits comments on the following: Reconsideration period for individuals who lose coverage for failure to return the renewal form. Individuals who return the form within a reasonable period after coverage is terminated would be redetermined without the need for a new application. We considered specifying a 90-day reconsideration period to align with the 3-month retroactive assistance period provided under section 1902(a)(34) of the Act, but did not specify a particular length of time in this proposed rule. We seek comments on the use and length of a specified reconsideration period.*** CA currently has a 30-day period, however, we support State flexibility to opt for a 90-day period.
Beneficiaries no longer MAGI Eligible Page 51166, second column, fourth paragraph	**435.916(a)**	***CMS solicits comments on the application of the ex parte redetermination and pre-populated form to those beneficiaries who are eligible for Medicaid on a basis other than MAGI.*** CA is supportive of the use of ex parte redeterminations for non-MAGI populations but again request State flexibility in its use and that such activities would be at the option of the State. Additionally, to the extent asset verification systems are in place and there is federal audit and quality control protection in the regulations, we

STATE OF CALIFORNIA COMMENTS AND RESPONSES TO REQUEST FOR COMMENTS CMS PROPOSED ELIGIBILITY RULES (CMS-2349-P)		
Provision & Location	**Regulatory Reference**	**Summary**
		believe this should be at the option of the State and would serve to simplify and streamline the redetermination process for this population.
Report Changes **Page 51166, second column, fifth paragraph**	**435.916(c)**	***CMS solicits comments on whether more modernized procedures to report changes should be available to both the MAGI and MAGI-excepted populations.*** CA is in agreement with CMS extending reports of changes online, over the phone, or by email. We currently accept information provided by mail and over the phone. On-line updates can be accepted in some counties. Verification may still be required depending upon the update.
Self-Attestation **Page 51193, second column**	**435.940, 435.945**	Self-attestation is good in terms of simplification, but must balance with program integrity activities. It will be critical for States to receive sooner vs. later from CMS identified performance standards for system design and development including the appropriate look-back periods for self-attestations.
Verifying Financial Eligibility **Page 51193, third column**	**435.948**	Changes that affect eligibility must still be reported within 10 calendar days. States know of no electronic database that will provide current income. Not all employers or types of income can be verified through the "work line". Absent CMS audit and quality control protection in these regulations for reliance by States on data match information, much income verification will require paper documentation and adjustments to MAGI/HI that will impede the goal of real-time eligibility determinations. Please obtain or make changes necessary to require IRS to provide CMS current income information based upon current income tax withholding for provision through the hub to States for their use in determining/verifying current income.
Newly Eligible Approaches (3) **Page 51174, first column, second paragraph**	**433.10(c)(6)**	***CMS solicits comments on the following: Identifying newly eligible individuals for purposes of applying the correct FMAP rate (1) using upper income and other thresholds across categorical eligibility groups, (2) using a sampling methodology across individuals in the adult group and related Medicaid expenditures, (3) using an extrapolation from available data sources to determine the proportion of individuals covered under the new adult group.*** The NPRM proposed methodologies for claiming the increased FMAP are envisioned to prevent States from having to run dual eligibility systems when determining the newly eligibles vs. those who would otherwise be eligible. Of utmost importance is the ability for States to ensure they have reliable data to call upon in running any methodology that is presented. Also, despite the intentions of CMS not wanting States to have to run dual eligibility determinations, as presented, this may be required. We strongly encourage CMS to work with States

Provision & Location	Regulatory Reference	Summary
		the development of whatever methodology is finally decided upon and that this be a collaborative process from start to finish. The threshold methodology appears to be very labor intensive, involves tracking individual claims throughout the year, and while intent is to avoid dual eligibility determination scheme, the extensive obligations involved may ultimately lead to similar results in practice. Use of the statistically valid sample requires the retention of, and expertise in the interpretation and application of old eligibility rules. To the extent the CMS established FMAP Proportion methodology is in the final regulations, the approach should be modified to require CMS to establish State specific models or formulas developed through negotiation with respective State's rather than developing a single formula/model to determine the State's FMAP proportion. Additionally based on the CMS FMAP conference call held on 10/21/11, CMS indicated that the formula used for each State would be negotiated cooperatively with each State to mitigate any bias in favor of CMS thus we request this clarification in the final regulations.