June 11, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2392-P
PO Box 8016
Baltimore, MD 21244-8016

To whom it may concern:

On behalf of Altegra Health, I am pleased to submit the following comments in response to CMS-2392-P, a proposed rule that will extend access to enhanced federal financial participation for Medicaid eligibility and enrollment systems past the current regulatory deadline of December 31, 2015.

About Altegra Health

Altegra Health operates in all 50 states from 7 regional offices, as well as its headquarters in Miami Lakes, Florida, to provide a complete range of services to health plans, health plan members, and providers, including:

- **Risk adjustment**: Risk analytics, encounter reporting, and chart audit/coding solutions
- **Quality performance**: HEDIS®/quality solutions; member healthcare communications
- **Program assistance**: Identification and assisted enrollment into government-funded healthcare programs, community assistance programs, and privately-funded programs through our My Advocate™ service
- **Advisory services**: Consulting services that improve performance for health plans and providers

Altegra Health works with some of the largest health plans and providers in the nation, including:

- **Payers**: More than 150 Medicare Advantage (MA), Managed Medicaid, and Commercial Market plans
- **Providers**: Hospital systems, provider groups & integrated delivery networks
- **Other markets**: Accountable Care Organizations (ACOs), health insurance marketplace, ICD-10 transition

The mission of Altegra Health is to help healthcare organizations and their members receive the financial resources and other benefits to which they are entitled, enabling quality care at the right time, leading to improved health at a lower cost, and overall, a better quality of life. Altegra Health utilizes health plan data and Altegra Health's proprietary predictive analytics algorithms to assist health plans in delivering integrated health-related interventions that are specifically tailored to their members. In carrying out this mission, Altegra Health is committed to maintaining the strictest regulatory compliance and data security for health plans and the members that they serve.

Altegra Health's Eligibility and Enrollment Services

Altegra Health assists low-income MA beneficiaries to secure needed assistance through the following programs:

- **Medicare Savings Programs (MSPs)**: Altegra Health identifies MA beneficiaries who may benefit from dual enrollment in a MSP, including payment of their Part B premiums, and assists them as an authorized representative in applying to the appropriate state Medicaid agency.
- **Part D Low-Income Subsidies (LIS**): Altegra Health identifies MA beneficiaries who may qualify for the Medicare Prescription Drug Coverage LIS and assists them in applying for these benefits.
- **Community Link™**: Altegra Health's Community Link product guides health plan members through an extensive database of more than 9,000 public and privately-sponsored community programs to which they may qualify.

In 2014, Altegra Health helped more than 50,000 MA low-income beneficiaries enroll in MSP. Altegra Health has helped MA low-income beneficiaries secure approximately $1.8 billion in Part B premium savings. Altegra Health helps health plan members in all markets secure approximately $150 million in financial benefits through Community Link annually.

Recommendations for State Medicaid Eligibility Systems to Improve Enrollment for MSP Beneficiaries

Eligibility Systems Enhancements

1. **Automatic MSP Determination for All Medicare Beneficiaries Requesting Medicaid:** In states that do not have an application specifically for MSP, MSP applicants use an application form for all Medicaid categories. Eligibility for this population is often determined only for Aged, Blind and Disabled (ABD) Medicaid or Modified Adjusted Gross Income (MAGI) categories and is not also screened for MSP eligibility. Because the income and asset limits are lower for full-coverage ABD Medicaid than for MSP, applications are sometimes denied due to excess assets, or applicants are enrolled only in a Medicaid spend-down because their income exceeds the Medicaid program limit. States should consider modifying their eligibility systems to automatically determine MSP eligibility for all individuals who are entitled to Medicare and are applying for Medicaid.
2. **Minimize Room for Human Error**: Medicaid eligibility policy is complex, and in some states, caseloads are high and there is frequent staff turnover. To mitigate these challenges, eligibility systems could be programmed to minimize the potential for human error. For example, eligibility systems could be programmed so that eligibility workers cannot request proof of US citizenship for MSP applicants who declare to be US citizens and are entitled to Medicare, or to not allow an eligibility worker to deny MSP eligibility solely for failure to provide information about tax filing status or verification of an exempt asset such as homestead property, etc.
3. **Data Exchange Improvements**: For maximum efficiency, states should continue to enhance their data exchanges so verification of income and resources can be obtained electronically whenever possible.

4. **E-faxing**: Some states are still using paper fax machines and it would improve efficiency and eliminate paper jams, busy signals and equipment failures if they could convert to an electronic fax system that would allow them to send and receive faxes over the Internet.

Online Application Option for ABD Medicaid Population

In numerous states, ABD Medicaid applicants do not currently have the option to submit an electronic application for ABD Medicaid categories, including MSP. In other states, an authorized representative (AR) is unable to submit a MSP application online unless the AR is physically present with the applicant so that the applicant can electronically sign it himself/herself. In these states, online application tools were designed for use by the applicant independently, or only with face-to-face assistance from an AR. States should modify their online application systems so individuals can apply for ABD Medicaid categories online, and should accommodate ARs who do not provide in-person assistance.

In addition, online applications should be programmed to only request information that is relevant for the particular program(s) requested. For example, a MSP-only applicant should not be required to answer questions about tax filing status, whether they have access to health insurance through a job or have lost insurance in the last 90 days, if they have divested assets in the past five years, etc, in order to submit an online application.

All states' online application systems should have the ability to upload documents and allow applicants and their ARs to check application status and review correspondence electronically.

Enhancements to Medicaid Eligibility Letters and Notices

1. **Capacity to Issue Duplicate Letters and Notices to Authorized Representatives (ARs):** Federal regulations enable applicants to name an organization as his/her AR with the Medicaid application process and to request that their AR receive copies of all correspondence related to their application, including verification requests and eligibility decision notices. When Altegra Health receives copies of verification requests as an AR, it helps the applicant to submit the requested documents and can make a significant difference in preventing denials solely for lack of verification. When Altegra Health receives copies of annual renewal notices, it can help members retain their MSP benefits. States should modify their eligibility systems to have the capacity to issue duplicate copies of correspondence to ARs, so that organizations such as Altegra Health can utilize a team of application assistance professionals to work with the state to secure and maintain benefits for MSP applicants in the most efficient manner.
2. **Provide Ability for Caseworkers to Add Detailed Comments to Verification Requests:** The most common reason that applications are denied is for failure to provide verification, despite Altegra Health's best efforts to submit all required verification of income and assets with the application. Based upon the information provided to Altegra Health, these applicants have income and assets below program limits, but are often unable to provide all of the additional documents requested by the Medicaid agency in a timely manner. If the verification request is vague and does not contain specific information about the needed verifications, applicants are not clear about what documents the agency needs and can find it difficult to comply.
3. **Include Detailed Information in Decision Notices so Individuals can make an Informed Decision about whether to Appeal an Adverse Determination:** In some states, decision notices do not

include detailed information about the income and assets budgeted in the state's eligibility determination, and denial notices simply indicate that income and/or assets exceed program limits. Without specific information about the income and assets budgeted, additional follow-up is needed in order to confirm the state-determined eligibility for MSP and identify any agency budgeting error that may have occurred. Similarly, when an application is denied in some states for failure to provide verification, the decision notice provides that the application was denied for "failure to cooperate in verifying income" or "failure to cooperate in verifying the value of resources," but does not indicate which specific documents were not provided. In the absence of a detailed explanation of the reason(s) underlying an adverse determination, mistakes can stand uncorrected because applicants tend to presume actions taken by government employees are correct.

Telephone Communication Enhancements

In some states, phone calls are quickly answered, individuals can sign their application telephonically, and applicants can obtain information about their case through an automated system. In other states, it is difficult to conduct business by phone because of long hold times, dropped calls, no capacity to provide information in an automated manner, etc. States should consider using the enhanced funding for eligibility systems and eligibility workers to improve their telephone communication systems and improve member experience.

Conclusion

Altegra Health appreciates the opportunity to comment on CMS-2392-P. Please feel free to reach out to me or our team if we can be of further assistance.

Sincerely,

Kevin C. Barrett
President & CEO