



November 4, 2022

The Honorable Xavier Becerra
 Secretary of Health and Human Services
 U.S. Department of Health and Human Services
 200 Independence Avenue SW
 Washington, DC 20201

The Honorable Chiquita Brooks-LaSure
 Administrator Centers for Medicare and Medicaid Services
 U.S. Department of Health and Human Services
 200 Independence Avenue SW
 Washington, DC 20201

Re: Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes; Proposed Rule - CMS-2421-P

Dear Secretary Becerra and Administrator Brooks-LaSure:

Thank you for the opportunity to comment on, “Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes Proposed Rule - CMS-2421-P,” hereinafter referred to as the “proposed rule.”

The undersigned organizations represent millions of patients and consumers facing serious, acute and chronic health conditions across the country, including millions receiving healthcare coverage through

the Medicaid program. Our organizations have a unique perspective on what patients need to prevent disease, cure illness, and manage chronic health conditions. Our breadth enables us to draw upon a wealth of knowledge and expertise that can be an invaluable resource in this discussion. We urge CMS to make the best use of the knowledge and experience our patients and organizations offer in response to this proposed rule.

In March 2017, our organizations agreed upon three overarching principles¹ to guide any work to reform and improve the nation's healthcare system. These principles state that: (1) healthcare should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care; (2) healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare must be adequate, meaning healthcare coverage should cover treatments patients need, including all the services in the essential health benefit (EHB) package.

Our organizations greatly appreciate many of the provisions of the proposed rule, which will generally make it easier for patients to enroll in and maintain coverage through Medicaid and the Children's Health Insurance Program (CHIP). We recommend that the rule be effective 30 days after publication of the final rule, and that CMS require states to comply with the provisions eliminating access barriers in CHIP and the returned mail processes as soon as possible given their importance for protecting patients' access to care at the end of the COVID-19 public health emergency (PHE). We offer the following comments on the proposed rule:

Medicaid Eligibility Determination and Redetermination Processes

Our organizations generally support the provisions of the proposed rule relating to Medicaid eligibility determination and redetermination processes, with some changes suggested below. The improved eligibility determination and redetermination processes will help ensure that applicants and enrollees have adequate time to file and receive paperwork, respond to inquiries, and stay enrolled. Many applicants and enrollees may be struggling to manage a chronic illness or undergoing medical treatment while they file an application or respond to renewal requests, and reasonable policies are critical to their ability to enroll and stay enrolled.

Response times and timely determination and redetermination of eligibility (§§ 435.907 and 435.912)

Our organizations partially support proposed changes at § 435.907 that would allow adequate time for beneficiaries to provide requested information for new applications and at § 435.919 that would establish response times of 30 days when information is needed to verify a change in circumstances, for all types of changes. We recommend that all timeframes be at least 30 days, to allow applicants and enrollees sufficient time to respond. A 15 day response time – as the proposed rule provides for individuals to respond to requested information for *new* applications – is not sufficient, and there are numerous factors outside of an individual's control that would make it difficult to respond in that timeframe. These include delays in receiving mail, needing additional time to gather information from other organizations or agencies to respond, and navigating serious health issues for themselves or their family members.

We support the provisions at § 435.912 that would extend timeliness standards to include redeterminations at renewal and for changes in circumstances, better define timeliness standards, allow additional time for states to process renewals and redeterminations depending on when information is

¹ Consensus Health Reform Principles. Available at: <https://www.lung.org/getmedia/0912cd7f-c2f9-4112-aaa6-f54d690d6e65/ppc-coalition-principles-final.pdf>.

received from the enrollee, and provide additional time when the state determines an enrollee is no longer eligible on the current basis and the agency is considering another basis.

Changes in circumstances (§ 435.919)

Our organizations support the addition of procedures and standards for processing changes in circumstances proposed in § 435.919, particularly allowing enrollees 30 days to respond to a Request for Information (RFI) and specifying that the 90-day reconsideration period applies to terminations resulting from changes in circumstances. While we support the proposed rule's prohibition on termination when an individual hasn't responded to an RFI, we believe that states should be required to act on reliable information and implement a favorable change even if they don't hear back from the enrollee, as is already required for *ex parte* renewals.

Our organizations strongly support the provisions in the proposed rule requiring states to follow-up on returned mail. Even before the pandemic, Medicaid beneficiaries struggled to maintain coverage during redetermination periods because of lost or delayed mailings.² We support the process which would require states to check various sources for updated mailing addresses and other contact information, mail a notice to both the old and new addresses, and then make at least two attempts to follow-up with the individual via non-mail communication modes *prior* to terminating coverage in response to returned mail. We recommend that the requirement to follow-up via non-mail communication modes should be extended to all types of requests for information at renewal and for changes in circumstances. As CMS determines implementation dates for various provisions of the proposed rule, CMS should require states to comply with these returned mail processes as soon as possible, as these provisions could help to prevent erroneous coverage losses at the end of the PHE.

Finally, as noted above, we support allowing enrollees a 90-day reconsideration period if disenrolled for procedural reasons when a change in circumstances is processed. However, we recommend providing 90-day reconsideration periods for all types of disenrollments. This would promote re-enrollment of individuals with temporary changes in circumstances and reduce administrative burden for enrollees and states.

Alignment of MAGI-exempt processes with MAGI processes (§ 435.916)

The Affordable Care Act (ACA) established a new methodology to streamline determinations of income eligibility for Medicaid based on Modified Adjusted Gross Income (MAGI), which is used for many eligibility groups including most children, pregnant women, adults and parents. The proposed rule at § 435.916 would align processes for eligibility groups exempt from MAGI rules with many of the streamlining and simplification requirements adopted for MAGI groups under the ACA, including disallowing a requirement for an in-person interview, conducting renewals only once a year, sending pre-populated forms, providing 30 days to return renewal information, accepting renewals through the four modalities, and providing a 90-day reconsideration period if information is returned after a procedural disenrollment. Our organizations strongly support these provisions which will reduce barriers to enrollment and renewal for people with disabilities and chronic health conditions. These provisions will also make it easier for applicants, agency staff, and other stakeholders to understand the rules.

² Kaiser Family Foundation. Recent Medicaid/CHIP Enrollment Declines and Barriers to Maintaining Coverage. September 2019. Available at: <http://files.kff.org/attachment/Issue-Brief-Recent-Medicaid-CHIP-Enrollment-Declines-and-Barriers-to-Maintaining-Coverage>.

Verifying citizenship (§§ 435.407 and 435.956)

Our organizations support the proposed rule's amendments to § 435.907 to allow two additional data sets, state vital statistics systems and data from the Department of Homeland Security (DHS), to be used as "standalone" proof of citizenship. This would simplify the process because applicants would no longer have to additionally provide separate proof of identity, reducing burden on applicants and increasing administrative efficiency. We also support the proposal to remove the option for states to limit the number of reasonable opportunity periods for applicants to verify citizenship or immigration status. These changes will remove barriers to care that make it more difficult for immigrants to enroll in and maintain their healthcare coverage.

Requirement to apply for other benefits (§ 435.608)

Our organizations support the proposed elimination of the current rule requiring Medicaid applicants to apply for other benefits to which they may be entitled. More specifically, we recommend that CMS implement its preferred approach, to completely eliminate this current obligation on beneficiaries. This approach is the best policy for several reasons. First, the current requirement is a significant barrier to application and enrollment, including for many individuals that are not even eligible for the other benefits. Second, the policy interferes with the development of a coordinated and real-time application and enrollment system, since it creates delays and is misaligned with MAGI-based income counting and the eligibility process for other programs, such as CHIP. Third, the current policy is not required by the statute and conflicts with the statutory obligation to implement eligibility policies that are simple and in the best interest of enrollees.

If CMS considers an alternative approach to limiting the current regulation, as discussed in the preamble to the regulation (and which we consider inferior to eliminating it), we urge CMS to implement its proposals to (1) make the requirement a post-enrollment activity; (2) require application only for benefits that are *actually* counted towards an individual's income determination; (3) create an exemption for Supplemental Security Income (SSI) recipients or any other applicant who has already been subject to a requirement to apply for benefits; (4) broaden good cause exemptions; and (5) require written notice of specific benefit application requirements for applicants.

Allowing medically needy enrollees to deduct prospective expenses (§ 435.831)

"Medically needy" enrollees qualify for Medicaid, despite being over the income limits, because they have large medical expenses that reduce their countable income below the income limits. However, because Medicaid has not had flexible policies for counting recurring expenses, individuals in home and community-based settings have had a significant administrative burden to repeatedly document their expenses to maintain eligibility—a burden which does not apply to expenses for institutional care. Our organizations support the proposed provision to expand the deduction of prospective expenses for medically needy eligibility to include any "constant and predictable" services, including (but not limited to) prescription drugs and home and community-based services (HCBS). Many individuals receive these types of services for long-term and chronic health conditions, and such individuals should not need to document their expenses on monthly basis (or other short periods). We support this new provision as it will improve continuity for enrollees, reduce their administrative burden, and likewise reduce the burden on states. The provision will also reduce one of the systemic biases towards institutionalization.

We recommend that CMS consider adding (in addition to HCBS and prescription drugs) an example addressing chronic illness management, such as "medical supplies or therapies to treat chronic illness" (e.g., dialysis, diabetes testing supplies, oxygen therapy, etc.). Finally, we appreciate CMS's confirmation

that individuals may not have their coverage terminated retroactively if they are found to not have met their spenddown after a reconciliation.

Improving Participation in the Medicare Savings Programs

Our organizations strongly support the provisions in the proposed rule that would significantly improve participation in the Medicare Savings Programs (MSPs), especially those that rely on information from other programs, including Supplemental Security Income (SSI) and Low-Income Subsidy (LIS), to streamline enrollment. These programs provide critical financial assistance via Medicaid to low-income seniors and people with disabilities also eligible for Medicare. The Medicaid and CHIP Payment and Access Commission (MACPAC) has previously reported that participation in these programs is very low, with only 15-53% of eligible individuals enrolled, depending on the program. MACPAC also found that lack of beneficiary awareness, barriers to enrollment, and lack of automated and streamlined enrollment were key factors in low participation.³

CHIP

CHIP covered over 9 million children and pregnant women in 2020, providing them with affordable, comprehensive health coverage. Following passage of the ACA, CMS tried to establish a streamlined and coordinated eligibility and enrollment system across all health coverage programs. However, CMS left in place some CHIP rules that resulted in more punitive red tape compared to Medicaid and other insurance affordability programs. Our organizations support continuing to align CHIP to Medicaid and ending outdated practices as described in the proposed rule.

Aligning CHIP to Medicaid (§§ 457.340 and 457.344)

Our organizations support alignment of CHIP enrollment and renewal policies for timeliness standards, changes in circumstances, and returned mail policies, with the same recommendations noted above for Medicaid, and have some additional recommendations for CHIP. With respect to timeliness standards, we partially support CMS's proposal to align CHIP with Medicaid standards for eligibility not on the basis of disability. We believe that 30 days should be a minimum timeframe for enrollees to both respond to requested information and to do so at renewal (for both programs). Additionally, with respect to returned mail and address updates, while we generally support aligning CHIP to Medicaid, we recommend that if a new address is out of the separate CHIP program region but still within the state, that CHIP proceed with determining eligibility for Medicaid, CHIP and other insurance affordability programs within the state and available in the region where the new address is located (instead of following the Medicaid "out of state" policy), and then send a combined notice. These changes will simplify the enrollment and renewal processes for both enrollees and states.

Eliminating access barriers in CHIP (§§ 457.805, 457.570 and 457.480)

Our organizations recommend that CMS finalize several proposed regulations that will promote alignment (with Medicaid and other coverage programs), access to health care, and fairness in CHIP policies. As stated above, our organizations believe these are critically important policies to ensure access to care for children and urge CMS to require states to implement them as soon as possible when publishing the final rule.

Our organizations support CMS's proposal to completely eliminate waiting periods in CHIP. There is negligible evidence that families frequently drop employer coverage to enroll in CHIP or that waiting

³ Medicare and CHIP Payment and Access Commission, "Report to Congress on Medicare and CHIP," June 2020, <https://www.macpac.gov/publication/june-2020-report-to-congress-on-medicaid-and-chip/>.

periods are effective at preventing that from happening. In reality, the policy results in children going without health insurance and/or low- to moderate-income families fighting through red tape to get their children enrolled.

We also support CMS's proposal at § 457.570 to completely eliminate premium lockouts in CHIP. Lockout periods create a forced period of uninsurance for children during which they may miss needed preventive or acute care and families may incur large medical bills.⁴ For low- and moderate-income families, premiums and lockouts pose a barrier to coverage and contribute to periods of uninsurance for children.⁵ Low and moderate-income children are more likely to experience gaps in coverage, as are children of color; Latino children (14%) and non-Hispanic Black children (12%) are more likely to experience a gap in coverage compared to White children (7%).⁶ For children with chronic conditions, regular access to care is especially critical.

Finally, we support completely eliminating annual and lifetime dollar limits in CHIP as proposed at § 457.480. Such limits are particularly unfair to individuals with serious or long-term illnesses and are not allowed in Medicaid or even private Marketplace coverage. To the extent that CMS allows non-monetary limits, such as limiting the number of physical therapy visits per year, we recommend that CMS implement a policy requiring reasonable and accessible exceptions processes. Individuals with health care needs struggle to find out about, understand, and get through such non-monetary limits, which can delay (or totally block) care, worsen outcomes, and decrease quality of life.

Medicaid and CHIP Recordkeeping

Our organizations broadly support (with a few exceptions) the regulatory provisions to modernize Medicaid and CHIP recordkeeping requirements. This will promote transparency and build trust in Medicaid program integrity. It will help make available the information and documentation needed to determine whether state Medicaid agencies are complying with the requirements for an accurate, fair, and streamlined eligibility and enrollment system. We also believe it is important to clarify recordkeeping requirements so that Payment Error Rate Measurement (PERM) eligibility reviews based on incomplete records, which erroneously find "ineligible" enrollees, do not distract stakeholders and the public from the real and significant problem the Medicaid program needs to address: persistent *underenrollment* in the program.

While we generally support the proposed regulatory approach, we do not believe eligibility record data should include enrollee claims or diagnostic information. Either a beneficiary's claims and diagnostic information should not be included in the beneficiary's case record at all, or the regulation should prohibit states from including this category of information in the same system as the eligibility-related

⁴ Tricia Brooks, "Now is the Time to Remove CHIP Waiting Periods and Welcome Kids into Coverage," Georgetown University Center for Children and Families (April 17, 2020), <https://ccf.georgetown.edu/2020/04/17/now-is-the-time-to-remove-chip-waiting-periods-and-welcome-kids-into-coverage/>; Aubrianna Osorio and Joan Alker, "Kids with Gaps in Coverage Have Less Access to Care," Georgetown University Center for Children and Families (October 15, 2021), <https://ccf.georgetown.edu/2021/10/15/kids-with-gaps-in-coverage-have-less-access-to-care/>.

⁵ Samantha Artiga, et al., "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings", Kaiser Family Foundation (June 1, 2017), <https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/>.

⁶ Joan Alker and Aubrianna Osorio, "Why is Medicaid/CHIP Continuous Eligibility So Important for Kids?," Georgetown University Center for Children and Families (October 8, 2021), <https://ccf.georgetown.edu/2021/10/08/why-is-medicaid-chip-continuous-eligibility-so-important-for-kids/>.

information. In addition, while we support making case records available upon appropriate request to CMS and Federal and state auditors, we recommend that CMS not extend such access to other third parties, or that CMS at a minimum build additional safeguards to protect enrollee confidentiality if it does extend access. Finally, we also recommend that state Medicaid and CHIP agencies be required to maintain individual case records for a minimum of 10 years after the case is no longer active.

Transitions between Medicaid, CHIP, and Other Programs

Our organizations support CMS's effort to improve coordination between Medicaid and other programs, particularly CHIP, and provide some recommendations to improve the proposed regulations. These recommendations are aligned with CMS's overarching goal of advancing a seamless eligibility and enrollment system as required by the ACA.

Medicaid agency responsibilities for a coordinated eligibility and enrollment process with other insurance affordability programs (§ 435.1200)

Our organizations support the proposed regulation requiring Medicaid agencies in states with separate CHIP programs to make CHIP eligibility determinations and transfer files to CHIP. We also specifically support the proposed provision to require states to move forward with CHIP determinations and transfers regardless of whether individuals have confirmed reliable data. This is consistent with maximizing enrollment and the intent of an *ex parte* process, including how reliable information is used in other parts of the Medicaid eligibility regulations (where it does not need to be confirmed to be the basis for action). We also recommend that CMS require states to effectuate enrollment immediately based on a Medicaid eligibility determination—with any additional steps moved to post-enrollment processes. CMS could require a grace period for payment of the first month of premiums and allow individuals to be auto-assigned temporary plans while plan choice is subsequently effectuated.

We also support the provisions of the proposed rule requiring that individuals receive a combined eligibility notice when either (a) the Medicaid agency determines an individual ineligible for Medicaid and eligible for CHIP or (b) a separate CHIP agency determines an individual ineligible for CHIP and eligible for Medicaid. We recommend that CMS conform the definition of combined notices at §§ 435.4 and 457.340(f) to implement its stated policy requiring families transitioning from Medicaid to CHIP to be informed about premium requirements or plan selection processes they need to complete before enrollment. We also appreciate CMS's clarification that under current regulations Medicaid and CHIP would be expected to issue a single combined notice for all household members to the maximum extent possible. These policies will reduce confusion for enrollees and ultimately promote continuity of coverage. We recommend that CMS work to fully require this policy for determinations of eligibility for Basic Health Programs and other insurance affordability programs.

Finally, our organizations support the proposal at § 435.1200(e)(4) to require Medicaid agencies to determine eligibility for other programs if an individual has been found eligible for coverage that is *not* minimum essential coverage. CMS should also consider whether a similar requirement should be developed for individuals found eligible for spenddown coverage who may also be eligible for CHIP.

Conclusion

Thank you for the opportunity to provide comments on the proposed rule. As outlined above, our organizations recommend that the rule be effective 30 days after publication of the final rule, and we urge CMS to require states to comply with the provisions eliminating access barriers in CHIP and the returned mail processes as soon as possible given their importance for protecting patients' access to

care at the end of the COVID-19 PHE. If you have any questions about our comments, please reach out to Hannah Green with the American Lung Association at hannah.green@lung.org.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Kidney Fund
American Liver Foundation
American Lung Association
Arthritis Foundation
Asthma and Allergy Foundation of America
Cancer Support Community
CancerCare
Cystic Fibrosis Foundation
Epilepsy Foundation
Family Voices
Hemophilia Federation of America
JDRF
Lupus Foundation of America
March of Dimes
Muscular Dystrophy Association
National Alliance on Mental Illness (NAMI)
National Eczema Association
National Health Council
National Hemophilia Foundation
National Kidney Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
Susan G. Komen
The Leukemia & Lymphoma Society