Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

VIA ELECTRONIC TRANSMISSION

November 7, 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

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,

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 Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve high quality, affordable health coverage for America's children and families. As part of the McCourt School of Public Policy, Georgetown CCF conducts research, develops strategies, and offers solutions to improve the health of America's children and families, particularly those with low and moderate incomes.

There is clear evidence that many uninsured children are eligible for Medicaid or CHIP but not currently enrolled.[1] *Current Medicaid and CHIP eligibility and enrollment policies prioritize preventing ineligible people from enrolling, often at the expense of eligible people who must overcome significant administrative burdens to enroll and stay covered. The proposed rule would bring Medicaid and CHIP eligibility and enrollment policies into better balance by simplifying application and renewal processes, ensuring that applicants and enrollees have adequate time to respond to requests for information, and improving transitions between insurance affordability programs.* The proposed rule would also significantly improve participation in Medicare Savings Programs. We support the proposed rule and encourage CMS to finalize it, with some recommendations for improvement detailed below.

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I. Medicaid Eligibility Determination and Redetermination Processes

Overall, we support the proposed rules relating to Medicaid eligibility determination and redetermination processes. The Notice of Proposed Rule Making (NPRM) would establish minimum response times that states must allow applicants and enrollees to provide requested information to determine or redetermine eligibility, as well as more detailed timeliness standards for different types of eligibility determinations beyond the current and more general 45- and 90-day timeliness standards that apply respectively to MAGI and MAGI-exempt applications. The NPRM would align many aspects of application and renewal process rules for MAGI-exempt populations (disabled and dual eligibles) with rules put in place for MAGI groups (children, pregnancy coverage, Section 1931 parents, and Section VIII expansion adults) with implementation of the Affordable Care Act (ACA).

The rule would also require states to take specific actions to resolve returned mail, including a first-ever requirement that states must make two attempts to reach the enrollee via non-mail modes of communication, after sending an initial request for verification by mail. However, it would be helpful to expand the proposed process steps to other types of requests for information. The NPRM also establishes a new section (§435.919) that provides specific rules for how states process changes in circumstances based on the source of the change, i.e., beneficiary reported versus obtained from a third party. And it streamlines certain aspects of verifying citizenship. These proposed changes and additions to the Medicaid eligibility regulations will continue to build on the vision of the ACA to foster a streamlined, data-driven system that reduces administrative barriers, increases efficiency and timeliness, and promotes enrollment and retention. Detailed comments follow.

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

We are particularly appreciative of proposed changes at §§ 435.907 and 435.919 that would allow adequate time for applicants to provide requested information (15 days for MAGI and 30 days for MAGI-exempt) and when information is needed to verify a change in circumstances (response times of 30 days for all types of changes). The latter aligns with current policy allowing enrollees 30 days to provide requested information when the state is unable to make a renewal determination using data available to the state (also known as *ex parte*).

The proposed rule (§ 435.912) would maintain the current timeliness standards of 45 days for MAGI applications and 90 days for MAGI-exempt application but it also broadens timeliness standards to include redeterminations at renewal and changes in circumstances. State Medicaid plans will need to detail the state's timeliness standards within the maximum timeliness framework for different types of determinations or redeterminations. The proposed rule incorporates additional time for states to process renewals and redeterminations depending on when information is received from the enrollee. It also

provides additional time after the state determines the enrollee is no longer eligible on the current basis, and the agency is considering eligibility on another basis.

We support these additional standards to ensure that all applicants and enrollees have adequate time to provide information and receive a timely determination or redetermination, to which they are entitled. However, the expanded timeliness standards and exceptions, along with proposed changes establishing minimum response times for applicants and enrollees to provide information needed to verify eligibility, set up a variety of complicated scenarios that will require additional guidance for states to properly adopt and implement the standards.

B. Changes in circumstances (§ 435.919)

Proposed § 435.919 specifies new standards for processing changes in circumstances if such changes result in ineligibility. Importantly, the NPRM differentiates between changes reported by the beneficiary, received from a third party (i.e., data exchanges), and those that can be anticipated (i.e., when a child ages out). The rule would also address changes that may result in additional benefits or lower premiums or cost sharing adding a key provision that if a request for information (RFI) is not returned, the state may not disenroll the individual. The proposed rule also specifies that the 90-day reconsideration period applies to terminations resulting from changes in circumstances.

We support the addition of procedures and standards for processing changes in circumstances, particularly allowing enrollees 30 days to respond to an RFI. However, we are not in agreement with § 435.919(b)(2)(iii) relating to changes received from a third party. The proposed rule first requires the state to determine the reliability of the information § 435.919(b)(2)(i). If the state determines the information is reliable, it "may" verify the third-party information with the enrollee. If the enrollee doesn't verify the information, the state may not terminate coverage, but providing additional benefits or lower cost-sharing is at state option. For example, even if the state has reliable information that the enrollee's income has dipped below 100 percent of the federal poverty level (FPL), the state could continue imposing cost-sharing amounts as if the enrollee's income were higher. We support the prohibition on termination, but if the state has "reliable" information, it should be required to act on that information in the same manner as required for ex parte renewals.

Recommendation – Revise §435.919(b)(2)(iii) to require states to accept third-party information that is reliable and results in eligibility for additional medical assistance or lower premium or cost sharing charges without requiring information from the individual, consistent with the provisions at §435.916(a)(2)(i) and (ii).

1. Returned mail

We are very enthusiastic about the proposed rule requiring states to follow-up on returned mail. We support the process which would require: (a) states to check various sources for

updated mailing addresses and other contact information; (b) mail a notice to both the old and new addresses, and then (c) make at least two attempts to follow-up with the individual via non-mail communication modes. Importantly, the rule prohibits states from terminating coverage for an individual who does not respond to the notice when mail is returned from the U.S. Postal Service with an in-state forwarding address. There is clear evidence that following up with an enrollee when information is needed is a key policy for promoting enrollment and retention of eligible individuals. We also believe the requirement to follow-up via non-mail communication modes should apply to all types of requests for information at renewal and for changes in circumstances.

We support the requirements for states to follow-up on returned mail. We believe these processes will promote retention of eligible individuals, reduce procedural disenrollments, avoid churn, and accelerate the pace at which states are adopting efficient, cost-effective, and timely enrollee communications using non-mail modes. Therefore, we recommend that follow-up requirements be added when information is needed to determine eligibility at renewal or when there is a change in circumstances.

Recommendation: Revise § 435.916 (renewal) and § 435.919 (changes in circumstances) to require the same follow-up process proposed for returned mail at §435.919(f)(3), requiring states to make at least two attempts to follow-up for information via non-mail communication modes.

2. Alignment of certain renewal processes for MAGI-exempt groups as required for MAGI eligibility

The proposed rule at § 435.916 would align 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. We also support proposed changes to § 435.952 requiring states to accept information obtained through an electronic data match as reasonably compatible with information provided by or on behalf of the individual if both sources are above, at, or below the applicable standard and clarifying that this includes resource information in addition to income and other information.

We support this alignment of processes and believe it will promote retention in non-MAGI Medicaid and make it easier for eligibility and call center workers, enrollees, assisters, and other stakeholders to understand the rules.

3. 90-day reconsideration period

As noted above, we support allowing enrollees a 90-day reconsideration period if disenrolled for procedural reasons when a change in circumstances is processed (§ 435.919(d)). However, it is not clear why 90-day reconsideration is limited to

disenrollment for procedural reasons. There is abundant evidence that temporary fluctuations in income, which occur more frequently for low-income wage earners, drive churn. Current regulations treat information submitted during the reconsideration period as a new application. Expanding the 90-day reconsideration period to all types of disenrollments would promote smooth re-enrollment for individuals regardless of why they lost coverage and potentially lower the volume of fair hearings requested when the beneficiary disagrees with the state's decision.

We recommend striking the language that limits the 90-day reconsideration period to termination "for failure to submit the renewal form or necessary information" at renewal (§ 435.916(a)(3)(iii)) and "for not returning the requested information" at (§ 435.919(d)), along with corresponding changes to § 457.344(d).

C. Requirement to Apply for Other Benefits (§ 435.608)

We support the proposed elimination of the current rule requiring Medicaid applicants to apply for other benefits to which they may be entitled. CMS's preferred approach, which we specifically endorse, would be to completely eliminate this current obligation on beneficiaries. This approach is the best policy for several reasons.

First, the current requirement is a barrier to application and enrollment and therefore coverage. Individuals can be denied if they fail to apply for benefits, and many others do not begin or complete the application process because of the burden or concern about other benefits. A large proportion of Medicaid applicants that fail to complete the application process (and of those who succeed) are individuals who would not even have been eligible for the other benefits, and for some applicants, their eligibility for the other benefits (if they were eligible) is irrelevant to their Medicaid eligibility determination. As such, the current policy is extremely overbroad and harms many applicants, often needlessly, for no purpose that is *necessary* to the goal of encouraging application for other benefits.

Second, the policy interferes with the development of a coordinated application and enrollment system, as was the objective of the Affordable Care Act (ACA). The ACA implemented a MAGI-based income counting methodology for most Medicaid enrollees to simplify income counting and facilitate real-time eligibility reviews. MAGI-based income counting only counts actual income (not the potential for future benefits) and the requirement to apply for other benefits undermines prompt application and real-time eligibility review and enrollment. In addition, the requirement—which does not apply to CHIP, BHP, and Marketplace subsidies—creates misalignment across programs, which disrupts efficient eligibility review across health programs. CMS's proposal to eliminate the requirement to apply for benefits directly advances the objectives of the ACA and is consistent with regulatory efforts—including this NPRM—to align health care programs.

Third, CMS sensibly proposes to eliminate a 1978 policy that no longer makes sense in 2022. The 1978 policy was developed for a Medicaid statute that generally based eligibility on eligibility for other programs, which in turn required applying for other benefits. The

modern Medicaid program is largely driven by income-based eligibility categories that have been de-linked from other programs. Moreover, as CMS notes in the preamble to the regulation, there is no statutory obligation for CMS to have this policy in place, particularly outside of any "link" to other programs, and the Secretary has statutory discretion to set standards for income counting without requiring application for benefits. CMS is correct to instead prioritize faithful implementation of the Affordable Care Act and the statutory mandate that eligibility be determined "in a manner consistent with simplicity of administration and the best interests of the recipients," as required by section 1902(a)(19).

The above considerations weigh strongly in favor of CMS's proposed approach, which is to totally eliminate the requirement to apply for other benefits. If CMS considers an alternative approach, as discussed in the preamble to the regulation, we urge CMS to implement all of the suggestions described below in this paragraph. First, make the requirement a post-enrollment activity. This would reduce, but not eliminate, the harm caused by the policy. We also urge CMS to implement the proposal to only require application for benefits that are *actually* counted towards an individual's income determination. CMS should not allow individuals to remain uninsured for failure to apply for benefits that are not even relevant. In this context, we also support the NPRM proposals for an exemption for SSI recipients (or any other applicant who has already been subject to a requirement to apply for benefits), broad good cause exemptions, and requiring written notice of specific benefit application requirements for applicants. Nonetheless, we reiterate that the matrix of alternative options suggested in this paragraph are vastly inferior to the most simple and efficient solution—to eliminate the requirement.

We support the elimination of the § 435.608 requirement to apply for benefits in its entirety.

D. Verifying citizenship (§§ 435.407, 435.956 and 457.380)

Under current law, when an applicant's citizenship cannot be verified using data from the Social Security Administration (SSA), a two-step process is required: first verifying citizenship and then identity. The proposed rule would amend § 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 in addition to SSA data. This change would simplify the process because applicants would no longer have to provide separate proof of identity, reducing burden on applicants and increasing administrative efficiency.

When an applicant attests to citizenship or a satisfactory immigration status but the state is unable to verify such status, the state is required to provide a reasonable opportunity period (ROP) of 90 days (or longer) for verification. During the ROP, states must furnish Medicaid/CHIP benefits. Under current law, states have the option to limit the number of ROPs an individual may receive, though no state currently does so. The proposed rule would remove this option at §§ 435.956 and 457.380.

We support these changes. Requiring separate proof of identify when a state vital statistics system or DHS has already verified citizenship is redundant and inefficient. With respect to ROPs, some applicants such as survivors of domestic abuse and people experiencing homelessness are more likely to have difficulty with electronic data matches, making it harder for them to enroll. Allowing states to limit the number of ROPs could disproportionately impact these communities, widening health disparities and harming especially vulnerable populations. We recommend CMS engage in oversight on states' implementation of this provision to ensure that individuals are afforded a ROP and receive benefits during that time.

E. Allowing Medically Needy Enrollees to Deduct Prospective Expenses (§ 435.831)

We support the proposed provision to expand the deduction of prospective expenses for medically needy eligibility. Under current regulations, institutionalized individuals can have their predictable expenses deducted at the start of their budget period, meaning they have continuous coverage between budget periods and no technical lapse in eligibility due to a spenddown period. CMS proposes to extend this sensible policy to other individuals with "constant and predictable" services, including (but not limited to) prescription drugs and home and community based long-term services and support.

Many individuals receive these types of services for long-term health conditions that are very consistent, and such individuals should not need to document their expenses on monthly 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 (including costs associated with eligibility determinations and churning). The provision will also reduce one of the systemic biases towards institutionalization. We recommend that CMS consider adding (to LTSS 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 (at 54778 of the preamble), that individuals may not have their coverage terminated retroactively if they are found to not have met their spenddown after a reconciliation, and we encourage CMS to consider putting this requirement into the regulatory text.

We support the expansion of prospective deductions for medically needy enrollees to include non-institutional services. We recommend that CMS's regulatory text include the prohibition on termination coverage retroactively when individuals are found not to have met spenddown after reconciliation.

F. Optional Group for Reasonable Classification of Individuals Under 21 (§ 435.223)

We support the proposed rule to create an eligibility group implementing a statutory pathway for children that is missing from the current regulatory framework. Under the Medicaid statute, states have the flexibility to extend coverage to all children (or reasonable classifications thereof) using any of the many pathways under section 1902(a)(10)(A)(ii). However, the current implementing regulations (at 42 CFR § 435.222) only apply to two of the subprovisions on the list of statutory options and only apply to MAGI-based categories. The proposed regulatory provision (at 42 CFR § 435.223) would implement an eligibility pathway for the other subprovisions and non-MAGI enrollees, opening the door for states interested in structuring their coverage categories using these flexibilities.

We support the implementation of the optional group for reasonable classification of individuals under 21 who meet criteria for another optional group.

G. Coverage for Former Foster Youth Up to Age 26

The Support for Patients and Communities Act (PL 115-271) made a technical correction to the ACA's requirement for states to cover former foster youth until their 26th birthday who were enrolled in Medicaid, which takes effect January 1, 2023. A technical error in the ACA resulted in an interpretation that allowed states to cover only former foster youth who were in "the" state's care, not "a" state's care.

We encourage CMS to revise the provision at § 435.150 to reflect the statutory correction made by Congress in P.L. 115-271. Additionally, we encourage CMS to issue subregulatory guidance clarifying how states can use ex parte processes to automatically renew coverage for former foster youth.

II. Children's Health Insurance Program

The Children's Health Insurance Program (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 as compared to Medicaid and other insurance affordability programs. We support continuing to align CHIP with Medicaid and ending outdated practices as described in the proposed rule.

A. Aligning CHIP to Medicaid (§§ 457.340, 457.344, and 457.960)

CHIP enrollment and renewal policies generally mirror Medicaid, and the proposed rule would continue to align CHIP and Medicaid rules with some limited exceptions. We support alignment for timeliness standards, changes in circumstances, and returned mail policies, with the same recommendations noted above for Medicaid. See below for CHIP-specific recommendations.

With respect to timeliness standards, CMS proposes to allow new CHIP applicants 15 days to provide requested information and 30 days to do so at renewal, aligning with the Medicaid standards for eligibility that are not on the basis of disability. CMS seeks comment on whether longer time frames should be allowed in the case of tailored CHIP programs for children with special health care needs (CSHCN), as they are proposing for Medicaid applications on the basis of disability. It is our understanding that CHIP programs for CSHCN offer additional benefits to qualifying children, but that the income and other eligibility standards are the same for all children.

> *We support applying the standard 15- and 30-day rules to CHIP rather than the longer timeframes applicable to Medicaid disability determinations and redeterminations, even in states that have CHIP programs offering enhanced benefits to CSHCN. Once enrolled, states can take additional time needed to determine whether the child also qualifies for any enhanced benefits.*

With respect to aligning CHIP rules on returned mail and address updates to Medicaid, proposed § 457.344 directs the state to treat an in-state mailing address as if it were out of state if the new address is outside the geographic region the CHIP program serves. However, these circumstances merit different treatment because the state can do more to enroll children within the state.

> *We recommend that if the 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, then transferring the account and sending a combined notice, as outlined in 42 CFR §§ 435.1200(h) and 457.350(g).*

B. Eliminating Access Barriers in CHIP

States are currently permitted to establish waiting periods and premium lockout periods of up to 90 days before children can enroll or reenroll in CHIP. The proposed rule eliminates these barriers which is long overdue. Additionally, the rule would bar states from imposing annual and lifetime dollar limits on CHIP benefits. We enthusiastically support the proposed rule's elimination of these barriers to coverage and care.

1. Waiting Periods (§§ 457.65, 457.340, 457.350, 457.805 and 457.810)

Waiting periods are unique to CHIP – they are not permitted in Medicaid, BHP, or Marketplace plans. When CHIP was created in 1997, there was concern that it would lead to public substitution of private coverage. Section 2102(b)(3)(C) of the Social Security Act (SSA) requires states to prevent such substitution and waiting periods have been one strategy. However, there is negligible evidence that CHIP waiting periods are effective at preventing dropping of employer-sponsored coverage. Substitution of private coverage can be effectively monitored by data matching. Such strategies satisfy the SSA requirement without the complexity of managing a waiting period, particularly post-ACA.

Following implementation of the ACA, states must comply with a list of exemptions in order to implement a waiting period, contributing to many states dropping them. If a waiting period does apply, states must transfer the child to the Marketplace temporarily and then transfer the child back to CHIP once the waiting period ends. Thus, waiting periods are an even less effective method to prevent substitution of coverage because children are simply covered by subsidized Marketplace coverage in the interim. Transferring coverage between the Marketplace and CHIP is administratively burdensome and likely leads to some children falling through the cracks.

> *We support eliminating waiting periods in CHIP as proposed at §§ 457.65, 457.340, 457.350, 457.805 and 457.810. This policy is unique to CHIP and is outdated in a post ACA world, burdening low- to moderate-income families who face high medical costs. CMS should* ***not*** *simply reduce the allowable length of waiting periods to 30 days or some other time period.*

2. Premium Lockout Periods (§ 457.570)

Premium 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. These policies are unnecessarily punitive and run counter to the goal to provide everyone with health coverage. As of January 2020, 14 states imposed a lockout period (most often for 90 days) for nonpayment of monthly or quarterly premiums, and some states require repayment of past due premiums as a condition of eligibility.[2] For low- and moderate-income families, premiums and lockouts pose a barrier to coverage and contribute to periods of uninsurance for children.[3]

Research has shown that children with a gap in coverage are less likely to have a usual source of care and more likely to have trouble affording health care compared to children who are insured year-round.[4] Low and moderate-income children and children of color are more likely to experience gaps in coverage. About 13 percent of children in families with income under 250 percent of the federal poverty level (FPL) experienced a gap in coverage in 2019 compared to seven percent of children in families with incomes above 250 percent FPL. Latino children (14 percent) and non-Hispanic Black children (12 percent) are also more likely to experience a gap in coverage compared to White children (seven percent).[5]

Any gap in coverage is a problem. Cost barriers lead to avoidance of needed care, and even healthy children need regular care to monitor their development, treat ear infections and other acute problems, such as stitches after an accident. For children with chronic conditions such as asthma, regular access to care is especially critical.

> *We support eliminating premium lockouts in CHIP as proposed at § 457.570. Even short gaps in coverage can cause a problem, therefore CMS should* ***not*** *simply reduce the allowable length of premium lockouts to 30 days or some other time period.*

Additionally, we recommend that CMS improve and clarify CHIP cost sharing rules. Medicaid.gov notes under Separate CHIP Program Cost Sharing, "for families with incomes at or below 150% of the Federal Poverty Level, premiums cannot exceed the amount permitted in Medicaid." And under § 447.55(a), states may not impose Medicaid premiums on individuals with income under 150 percent FPL. However, the CHIP rules are not consistent with these stated standards. Current CHIP rules at § 457.540 allow premiums below 150 percent FPL as long as the total premium and cost-sharing amounts fall under the aggregate five percent cap.

In 2017, the Medicaid and CHIP Payment and Access Commission (MACPAC) reiterated its support for aligning separate CHIP premium policies with those of Medicaid, specifically recommending eliminating CHIP premiums for families with incomes under 150 percent FPL.[6] HHS has also recognized that families with incomes below 150 percent FPL struggle to meet basic needs and do not have excess income for health insurance premiums, as evidenced by the Administration's expanded premium tax credits providing access to $0 premium plans in the Marketplace.

We recommend that CMS eliminate CHIP premiums for families with income under 150 percent FPL to further align Medicaid and CHIP rules and remove this barrier to enrollment for children.

3. Annual and Lifetime Dollar Limits on Benefits (§ 457.480)

CHIP is also unique in continuing to allow annual and lifetime dollar limits on benefits. The proposed rule states that 12 states have an annual dollar limit on at least one CHIP benefit and six states have a lifetime dollar limit on at least one benefit, most commonly on dental or orthodontia coverage. The rule also notes that though no state imposes an aggregate annual or lifetime limit on all CHIP benefits today, states have imposed such limits in the past. (See 87 Fed. Reg. 54816, September 7, 2022). States have also imposed dollar limits on benefits other than dental and orthodontia historically, including dollar limits on vision and hearing.[7] Health care costs typically grow faster than other costs, and inflation is expected to hit the health care sector especially hard soon, which could bring the real value of covered benefits down over time unless properly indexed.

We support eliminating annual and lifetime dollar limits in CHIP as proposed at § 457.480. Such limits are not allowable in Medicaid or other insurance affordability programs, and continuing to allow them in CHIP is unjustified.

C. Program-specific review process: continuation of enrollment (§§ 457.1170 and 457.1180)

Proposed §§ 457.1170 and 457.1180 would clarify that beneficiaries have a right to *benefits* during review of a suspension or termination of CHIP eligibility and § 457.1170 would also add such a requirement if the state fails to meet timeliness standards at application or renewal. *We support these changes. Aligning CHIP review processes with Medicaid will*

promote administrative efficiency, and ensuring that beneficiaries have access to benefits during these review processes will protect children from harmful gaps in coverage.

III. Medicaid and CHIP Recordkeeping

A. Maintenance of records (§§ 431.17 and 457.965)

Currently, 42 CFR 431.17 requires state Medicaid agencies to maintain individual records on each applicant and beneficiary that contain, among other information, the agency's decisions on initial eligibility, renewal, and termination, and the basis for those decisions. The regulation also requires state agencies to retain these records for a period required by the Secretary and to store them on a microfilm system. Similar provisions apply to CHIP at § 457.965.

The proposed rule would update this regulation to take into account changes in Medicaid eligibility policies and technology since 1986. It would also align CHIP recordkeeping rules with corresponding updates to § 457.965. Three basic changes are proposed:

1. Case Records

The proposed rule would specify the information that states would be required to include in their case records for each applicant and beneficiary. This information falls into nine categories: (1) information contained on the initial application; (2) the electronic account , if any, received from the Marketplace or CHIP; (3) any documentation relating to any eligibility determination or denial; (4) information on the services paid for on behalf of the individual, including relevant diagnoses; (5) changes in circumstances reported; (6) information contained on all renewal forms; (7) all notices provided to the applicant or beneficiary; (8) all records relating to fair hearings; and (9) information relating to verification of income and eligibility.

We support updating the recordkeeping regulation to specify the information that state Medicaid and CHIP agencies must include in applicant and beneficiary case records. These specifications will reinforce the importance of the information and documentation that state agencies need to have in order to properly administer their eligibility and enrollment systems. These specifications will also help ensure that federal auditors, including contractors doing Payment Error Rate Measurement (PERM) eligibility reviews, will have the information and documentation they need to determine whether state Medicaid agencies are complying with the requirements for an accurate, fair, and streamlined eligibility and enrollment system.

In particular, we support requiring the inclusion of each type of information proposed in § 431.17(b)(1) with the exception of (b)(1)(iv) related to specific services received. While it is essential for program integrity purposes that state Medicaid agencies and the federal government know how Medicaid funds are being spent, information on services received, amounts paid, and individual diagnoses have nothing to do with eligibility and enrollment.

The state's Medicaid Management Information System (MMIS), 42 CFR 433.111(b)(2)(ii)(B), is the appropriate custodian for these potentially sensitive claims and diagnostic information, because the information in the MMIS system is safeguarded per 42 CFR 433.112(b)(9).

The preamble makes clear that CMS is not proposing that each of the types of information required to be included in a beneficiary's case record be "stored in a single system," 87 FR 54806. However, the proposed text would allow a state to store *all* of the required types of information—including the claims and diagnosis data—in the same system. This would create an unnecessary risk of disclosure of beneficiary diagnosis information that more than outweighs any benefit of including the claims and diagnosis information in the same system. 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 information.

The proposed rule is silent on whether, in the case of a dependent child, state agencies are required or allowed to include the information relating to the child in the case record of the parent. We urge that CMS clarify that, for purposes of proposed § 431. 17(b), the phrase "individual record for each applicant and beneficiary," the state agency must maintain a case record for a dependent child that is separate from the case record of the child's parent, if any. This will help maintain continuity of the case records of child applicants and beneficiaries regardless of differing eligibility standards and processes for their parents.

2. Record Retention

The proposed rule would require that state Medicaid and CHIP agencies retain applicant and beneficiary case records for a minimum of three years after the applicant or beneficiary's case is no longer active**.** We suggest 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. This would more closely align the retention policy for these records with that for Medicaid managed care organizations under 42 CFR 438.3(u) and 457.1201(q) and for drug manufacturers participating in the Medicaid Drug Rebate Program under 42 CFR 447.510(f).

3. Format of and Access to Case Records

The proposed rule would require that state Medicaid and CHIP agencies maintain applicant and beneficiary case records in an electronic format. It would also require that state agencies make the records available on request to the Secretary, Federal and state auditors, and "other parties" who request and are authorized to review such records.

We support updating the current regulation to require keeping applicant and beneficiary case records in electronic format. We support making case records available on request to CMS and Federal and state auditors for legitimate program integrity purposes. We do not, however, support making these records available to "other parties" who request and are

authorized to review such records. The regulation should specifically enumerate what agency or individual has a legitimate program integrity purpose for accessing individual beneficiary records, particularly those relating to services received and diagnoses.

B. Case Documentation (§ 435.914)

Currently, state Medicaid agencies are required to make a finding of eligibility or ineligibility on each application it receives and to include in each applicant's case record the facts supporting the agency's decision. The proposed rule would amend this regulation to expand the requirements to include beneficiaries as well as applicants and extend it to renewals as well as new applications. We support these amendments, which would consolidate eligibility and enrollment information for each applicant or beneficiary in one case record, making it easier to hold state agencies and their vendors accountable for performance.

The proposed rule would also clarify that that case record must include the information and documentation described in § 431.17(b)(1). As explained above, we support the inclusion of the information and documentation described in that provision in a beneficiary's case record other than the claims data and related diagnoses. We believe that CHIP case documentation requirements should be aligned with Medicaid, but note that there is not a separate case documentation section for CHIP. We suggest CMS ensure that § 457.965 achieves alignment with §§ 431.17 and 435.914.

IV. Transitions Between Insurance Affordability Programs

A. Medicaid Single State Agency and Responsibilities for a Coordinated Eligibility and Enrollment Process (§ 431.10 and § 435.1200)

We support CMS's effort to improve coordination between Medicaid and other programs, particularly CHIP. While we support most of the provisions in the regulation, we have some recommendations for improvements.

1. Coordinated Eligibility Determinations

The proposed rule requires Medicaid agencies to accept determinations of MAGI-based eligibility made by separate CHIP programs. The proposed rule offers several options for states to implement this in compliance with their ultimate accountability for Medicaid eligibility processes. While we agree with the intent of CMS's framework, we do not believe that allowing (and paying for) multiple eligibility systems is consistent with seamless or efficient eligibility determinations. We believe CMS should transition all states toward unified eligibility systems that the Medicaid agency maintains. Separate CHIP agencies could either access the unified eligibility system or delegate CHIP eligibility determinations to Medicaid. Furthermore, Medicaid and CHIP unified systems should have the capacity to conduct full MAGI and non-MAGI determinations. Such an approach to enrollment systems

is consistent with section 1943(b)(3) of the SSA, requiring streamlined enrollment systems compliant with section 1413 of the ACA, which in turn requires a secure, electronic interface to determine eligibility for all insurance affordability programs based on a single application.

We recommend that CMS direct all states to use a shared eligibility system and provide other, time-limited options to only those states that show they are unable to do so. We support conforming language in § 431.10 allowing CHIP and BHP agencies to make Medicaid determinations consistent with the single state agency requirement.

2. Prioritizing Minimum Essential Coverage

The proposed rule also requires that Medicaid agencies must, in addition to determining eligibility for other programs when an individual is *ineligible* for Medicaid, also determine eligibility when the individual is only eligible for a Medicaid benefit that is not minimum essential coverage.

We support the requirement at § 435.1200(e)(4) to require determinations of eligibility for other programs if an individual has not been found eligible for minimum essential coverage.

3. Medicaid Determinations of CHIP Eligibility

Regardless of the eligibility system policy, we support the proposed regulation requiring Medicaid agencies in states with separate CHIP programs to make CHIP eligibility determinations and transfer files to CHIP. We agree with the preamble to the proposed rule that Medicaid agencies have or can obtain the necessary information for CHIP determinations. Furthermore, the proposed rule would require states to move forward with CHIP determinations and transfers regardless of whether individuals have confirmed reliable data. This policy is critical because under current regulations, even though a Medicaid agency may find that an individual is likely eligible for CHIP, the state can terminate the enrollee (without transferring their file) if the individual fails to respond to an RFI. There is no reason that states should refrain from taking appropriate action when they have reliable information to move forward with. Doing so would be inconsistent with maximizing enrollment and the intent of an *ex parte* process.

The preamble to the proposed regulation also requests comments on the challenges in effecting immediate CHIP enrollment (from Medicaid) in some instances, such as where a premium needs to be paid or there is a plan selection process. We believe that CMS should require states to effectuate CHIP enrollment immediately based on the Medicaid agency's eligibility determination—with any additional steps moved to post-enrollment processes. CMS could require that the existing 30-day payment grace period apply to the first month of premiums and individuals could be passively enrolled into a plan while they have an opportunity to proactively select a plan.

We support the requirement for Medicaid to make CHIP eligibility determinations and file transfers, and that this be effectuated when reliable information is available, regardless of whether individuals confirm the information. Second, we recommend that, in addition to unifying eligibility systems, CMS require states to make enrollment immediately effective, and conduct other processes (such as premium payment and plan selection) post-enrollment.

4. Combined Eligibility Notice

The proposed rule requires that individuals receive a combined eligibility notice when either the Medicaid agency determines the individual ineligible for Medicaid and eligible for CHIP, or a separate CHIP agency determines the individual eligible for Medicaid and ineligible for CHIP. We support this policy, as it will reduce confusion for enrollees and ultimately promote continuity of coverage. The preamble notes that a combined notice will help families transitioning from Medicaid to CHIP learn about premium requirements or any plan selection process they need to complete; however, it is not clear the regulation requires combined eligibility notices to include this information. We recommend that CMS conform the definition of combined notices at §§ 435.4 and 457.340(f) to implement the proposed policy.

The preamble also clarifies 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. We appreciate this clarification, though we urge CMS to specify the narrow set of circumstances when a combined eligibility notice for all family members would not be possible.

We support the requirement for Medicaid and CHIP programs to use combined eligibility notices. We recommend that CMS explicitly require such notices to specify any additional steps needed to effectuate coverage. We also recommend that CMS require combined notices for Medicaid, CHIP, Exchanges, and BHPs, and that CMS specify the limited scenarios where full family combined notices would not be required.

V. Improving Participation in the Medicare Savings Programs

We strongly support the provisions in the proposed rule that would significantly improve participation in the Medicare Savings Programs (MSPs). These programs — the Qualified Medicare Beneficiary (QMB) program, the Specified Low-Income Medicare Beneficiary (SLMB) program and the Qualifying Individual (QI) program — provide critical financial assistance to low-income seniors and people with disabilities also eligible for Medicare. For individuals with incomes below 100 percent of the federal poverty line, the QMB program covers Medicare Part B premiums (and Part A premiums, if applicable) and Medicare deductibles and other cost-sharing. The SLMB and QI programs pay for Part B premiums for individuals with incomes between 100 and 120 percent of the federal poverty line and 120 and 135 percent of the poverty line respectively. To give a sense of the value of these benefits, the standard monthly Part B premium in 2022 is $170.10 or $2,041.20 annually.

Despite legislative and administrative improvements over the past two decades that were intended to increase MSP participation among eligible low-income Medicare beneficiaries, participation remains relatively low. As the Medicaid and CHIP Payment and Access Commission (MACPAC) has previously reported, QMB participation is estimated to be only 53 percent. Among those eligible for SLMB, participation is only 32 percent and among those eligible for QI, participation is only 15 percent. Moreover, participation is actually lower among seniors on Medicare than people with disabilities on Medicare. For example, QMB participation is 48 percent among those aged 65 and older, compared to 63 percent among those aged 18-64. SLMB participation is 28 percent among those aged 65 and older, compared to 42 percent among those aged 18-64. MACPAC finds that along with a lack of beneficiary awareness, barriers to enrollment, such as differences between state Medicaid eligibility rules and those for the Medicare Part D Low Income Subsidy (LIS) — which covers Medicare premiums and cost-sharing related to prescription drugs — and lack of automated and streamlined enrollment, were key factors in low participation.[8]

A. Individual enrollment (§ 406.21)

The proposed rule would add a new subparagraph (c)(5) to § 406.21 making QMB coverage effective in the month Part A entitlement begins (for those who are not eligible for premium-free Part A coverage in so-called "group payer" states, discussed below,) or a month later if an individual is determined eligible for QMB the month entitlement begins or later. This would align with existing Medicare policy for individuals who enroll in Part A during the general enrollment period. But as noted in our comments to § 435.909, all SSI beneficiaries should be deemed eligible for QMB benefits and enrollment should be initiated into Part A, even those in group payer states.

B. Definitions and use of terms (§ 435.4)

The proposed rule adds a new defined term to § 435.4: "Low-Income Subsidy Application data (LIS leads data) means data from an individual's application for low-income subsidies under section 1860D-14 of the Act that the Social Security Administration electronically transits to the appropriate State Medicaid agency as described in section 1144(c)(1) of the Act." The definition is appropriate for the new requirement in § 435.911 (as discussed below) for states to accept LIS leads data, treat receipt of such data as a Medicaid application (for MSP benefits) and promptly and without undue delay determine MSP eligibility without requiring a separate application.

C. Application of financial eligibility methodologies (§ 435.601)

The proposed rule would add a new paragraph (e) to § 435.601 that would define "family size" for determining MSP eligibility. Currently states have flexibility in how they determine family size for the purposes of MSP eligibility and many states only include a spouse living in the household in such definition. In order to promote the proper and efficient administration of the Medicaid program, further facilitate alignment of eligibility methodologies between the LIS and MSPs and increase MSP enrollment, the proposed rule

would require a definition of family size to include at least the individuals included in determining family size under the LIS. That would include not just the spouse but all relatives, by blood or marriage, who reside in the household and are dependent on the applicant or spouse for at least half of their financial support. This change would better align the definition of family size between the LIS and MSPs while also ensuring MSP eligibility for more individuals who happen to live with dependent adult children, grandchildren or other relatives.

D. Automatic entitlement to Medicaid following a determination of eligibility under other programs (§ 435.909)

The proposed rule would amend § 435.909 to require states to automatically enroll nearly all Supplemental Security Income (SSI) beneficiaries into QMB, in order to increase QMB participation and promote the proper and efficient administration of the Medicaid program. Currently, though all individuals eligible for SSI meet the income and resource eligibility limits for QMB, some eligible individuals are not enrolled into the QMB program because of procedural and technical barriers, such as a requirement to file a separate application with a state Medicaid agency for QMB benefits. According to the regulatory impact analysis for the proposed rule, automatic enrollment would increase QMB enrollment by an estimated 470,000 more people (full-year equivalents) in 2023 and by 980,000 more by 2027, who would all newly gain access to critical financial assistance with both Medicare premiums and cost-sharing and protections against balance billing.

In addition, the proposed rule would streamline QMB enrollment for SSI beneficiaries who must pay a premium to enroll in Medicare Part A by requiring most states (currently 36 states and the District of Columbia) to deem them eligible for QMB benefits and initiate their enrollment into Part A in the same month they are enrolled in Part B. The exception would be so-called "group payer" states, for which the proposed rule would provide a state option to deem individuals eligible for QMB benefits and initiate Medicare Part A enrollment without making them first apply for "conditional" Part A enrollment with the Social Security Administration. To ensure that SSI beneficiaries in these states who are not eligible for premium-free Part A to also gain QMB benefits on a timely basis, the final rule should similarly require deemed QMB eligibility and initiated Part A enrollment without first having to file for conditional Part A enrollment.

E. Determination of eligibility (§ 435.911)

As the preamble to the proposed rule points out, the Medicare Improvements and Patients and Providers Act of 2008 has long required SSA to transmit eligibility data from LIS applications to State Medicaid agencies, such transmission to constitute an initiated MSP application, and state Medicaid agencies to accept such data and act upon such data as if they were a MSP application. This means that if an individual applies at SSA for the LIS and the individual is not already enrolled in a MSP, SSA sends the application data (known as "leads data") to the state Medicaid agency and the state must accept as verified the information sent by SSA and initiate a MSP application. If the state needs more information

to process the application, it should send out a prepopulated application to the individual that only requests the information that has not already been provided by SSA. But according to the preamble, not all states are in full compliance, with over one million people enrolled in full LIS benefits who are not enrolled in a MSP.

The proposed rule would amend § 435.911 to formally codify these statutory requirements and implement them fully: (1) states must accept LIS leads data, (2) treat receipt of such data as a Medicaid application (for MSP benefits), (3) promptly and without undue delay determine MSP eligibility without requiring a separate application, (4) request additional information needed to determine MSP eligibility, (5) not request other information that is already included in the leads data, (6) accept any information verified by SSA without further verification, and (7) collect additional information including citizenship and immigration status. In addition, the state must notify individuals that they may be eligible for MSP benefits but more information is needed (in the event that the leads data is insufficient to support a determination of MSP eligibility) and give individuals 30 days to provide such information. Furthermore, if a state has fully aligned MSP methodologies with LIS methodologies (as discussed below), states could then determine eligibility without additional information (except for citizenship and immigration status information). According to the proposed rule's regulatory impact analysis, these amendments would result in 240,000 more people (full-year equivalents) enrolled in MSPs in 2023 and by 520,000 more by 2027, who would newly gain access to MSP benefits, including assistance with Medicare cost-sharing and/or premiums.

F. Use of information and requests for additional information from individuals (§ 435.952)

As the preamble to the proposed rule notes, state already have the flexibility to align MSP income and asset counting methodologies with LIS methodologies. But states that have not already fully aligned methodologies must continue to request additional information needed to determine MSP eligibility which is not provided through the leads data.

To address this issue, the proposed rule includes sound amendments to § 435.952 that would require state Medicaid programs to adopt enrollment simplification policies related to income and resources that are counted in determining MSP eligibility but not LIS eligibility. This would simplify administration and serve the best interests of beneficiaries by allowing state Medicaid programs to use the leads data more efficiently, reduce administrative burdens on states and beneficiaries, and increase MSP enrollment. Specifically, the proposed rule would require states to process MSP applications and determine MSP eligibility based on attestations by the beneficiaries (rather than requesting documentation) related to dividend and interest income, burial funds, cash value of life insurance and the value of non-liquid assets, unless states have information that is not reasonably compatible with the attestations. States may then, if appropriate, verify such information after enrollment, including having the option to request the individual to provide documentation if electronic verification is not available. Individuals, however, must be given at least 90 days to respond and provide any necessary information

requested. In addition, for the cash value of life insurance, states would be required to assist individuals in obtaining that information from their insurers.

Finally, the proposed rule makes clear in amendments to § 435.952(c) and conforming technical amendments to § 435.940 that if data collected from state electronic asset verification systems, as required by section 1940 of the Social Security Act, are reasonably compatible with attestations, states are not permitted to request additional resource information.

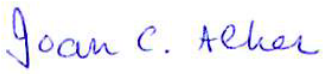
VI. Conclusion

The proposed rule would make it easier for eligible people to enroll and stay enrolled in Medicaid and CHIP. Streamlining application and renewal policies and improving transitions between insurance affordability programs will help reduce harmful gaps in coverage. The proposed rule also makes some important updates for children enrolled in the CHIP program that will promote coverage. We encourage CMS to move forward with finalizing these regulatory improvements.

Our comments include numerous citations to supporting research for the benefit of the CMS. We direct CMS to each of the studies cited and made available through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the formal administrative record on this IFC for purposes of the Administrative Procedures Act.

If you have questions regarding our comments, you may contact us at (202) 784-3138.

Sincerely,



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