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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

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; CMS-2421-P

Submitted via federalregister.gov

Dear Secretary Becerra and Administrator Brooks-LaSure,

First Focus on Children appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services’ proposed rule, Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment and Renewal Processes (hereinafter ‘2022 Proposed Rule’).

First Focus on Children is a bipartisan advocacy organization dedicated to making children and families the priority in federal policy and budget decisions. We advocate for the nearly [41 million children](#) covered by Medicaid and the Children’s Health Insurance Program (CHIP) to ensure they have access to timely, affordable, and high-quality health care. From well-baby and well-child visits, to vaccines, cancer treatment, dental services, and speech therapy, Medicaid and CHIP play a significant role in keeping kids healthy, in school, and on track to becoming healthy and productive adults.

We support CMS finalizing the 2022 Proposed Rule as proposed, subject to the comments below, with compliance dates as soon as is practicable. While Medicaid and CHIP are important programs that cover nearly half of America’s children, changes are needed to ensure children have consistent and stable coverage. Delays in preventative care, well-child visits, and developmentally appropriate screenings may cause unnecessary, long-term harm. As the COVID-19 Medicaid continuous coverage requirement comes to an end, these are particularly important changes that could help reduce coverage losses as states begin acting on eligibility redeterminations for millions of people. Children, especially minority children, are likely to be disproportionately impacted by the redetermination processes, and [millions of eligible children](#) will unnecessarily lose access to Medicaid and CHIP.

Therefore, CMS should consider the complexity of system updates when setting implementation dates and balance state workload with the overall benefit of implementing changes that can help reduce coverage losses as the COVID-19 continuous coverage requirement ends. For example, setting a near-term compliance date for proposed requirements regarding returned mail would help avert coverage losses. Phasing compliance dates is a reasonable approach should states need additional time to come into compliance, so long as states begin system updates upon finalization of the rule.

Our comments on the provisions of the 2022 Proposed Rule are as follows. Since some of our comments apply to multiple sections, we have listed the comments in the numerical order starting with the Medicaid provisions of the 2022 Proposed Rule.

I. Medicaid Eligibility Determination and Redetermination Processes

Transitions between Medicaid, CHIP and Basic Health Program (BHP) Agencies (§§ 431.10, 435.1200, 457.340, 457.348, 457.350, 600.330)

The Affordable Care Act (ACA) envisions a coordinated system of health coverage with seamless transitions between insurance affordability programs, including Medicaid, CHIP, BHP, and exchange coverage. Unfortunately, that seamless system has yet to be achieved. Many people still experience periods of uninsurance when their eligibility changes. We support the provisions in the rule aimed at improving coordination between insurance affordability programs.

The proposed rule would significantly increase the number of cases transferred from Medicaid to other insurance affordability programs, so when households lose their Medicaid coverage they can transition to other insurance affordability programs. Currently, Medicaid agencies are not required to transfer accounts of individuals who fail to respond to requests for information at renewal or when the agency becomes aware of information that may indicate ineligibility for Medicaid. In these situations, Medicaid agencies can terminate coverage without determining eligibility or potential eligibility for other coverage. The proposed rule would change this by requiring account transfers whenever the agency determines ineligibility, and its information shows potential eligibility for another insurance affordability program. This is especially important because many people fail to respond when they know they are no longer eligible for Medicaid, and under current rules they don't receive information about their potential eligibility for other programs.

Reducing disruptions in coverage when families become ineligible for Medicaid or CHIP is especially important for children, as a child who loses coverage, [even for a short time](#), may experience gaps in both coverage and access to care that can be detrimental to their development. If a coverage gap is prolonged, families may face expensive medical bills or may push off their child's care due to high out-of-pocket costs. Therefore, it is imperative that families be connected to and receive information on potential eligibility for other programs to reduce the likelihood of coverage gaps.

The rule would also greatly improve coordination between Medicaid and CHIP and reduce disruptions in coverage and care for children as their family income and other circumstances change. We support requiring Medicaid and CHIP agencies to accept eligibility determinations from the other program. The simplest and most effective way to do this is by using a shared eligibility system for both programs, which the preamble says all states have. Using a shared eligibility system reduces the possibility of error, because of different eligibility policies and verification rules and avoids having staff of CHIP agencies determine Medicaid eligibility.

Finally, we support CMS's proposal to require that people be provided with a combined Medicaid/CHIP eligibility notice when either the Medicaid agency determines an individual ineligible for Medicaid and eligible for CHIP, or the separate CHIP agency determines an individual ineligible for CHIP and eligible for Medicaid. This requirement will alleviate confusion and should be finalized.

As noted above, we support proposed changes to improve transitions between programs, including requiring CHIP to accept eligibility determinations made by Medicaid. In the preamble, HHS emphasizes quick and seamless enrollment, but also acknowledges the difficulty in achieving that goal, especially when the separate CHIP program requires payment of an enrollment fee or selection of a plan. We encourage HHS to help separate CHIP programs move to a system whereby payments and plan selection occur post-enrollment in order to minimize gaps in coverage.

Types of acceptable documentary evidence of citizenship (§ 435.407)

We support CMS' proposal regarding citizenship documentation requirements. 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. Proposed § 435.407 would 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. We support this change because it would reduce burden on applicants and increase administrative efficiency without increasing the risk of erroneous eligibility determinations.

A [variety of challenges](#) deter eligible children of immigrants from program participation, such as limited English proficiency or cultural barriers, lack of information, fears about immigration consequences, and logistical and administrative issues. This multitude of barriers has lasting and harmful effects on immigrant families and the [18 million children of immigrants](#) living in the United States. All too frequently, eligible immigrant households [forgo utilizing federal programs](#), with consequences ranging from lower school attendance to higher uninsurance rates that affect the livelihood and opportunities of their children. Therefore, we strongly support any policy that would reduce burden on applicants.

Applications for other benefits (§ 435.608)

We support CMS's proposal to remove § 435.608 that requires applicants and enrollees to apply for other benefit programs as a condition of Medicaid eligibility. We agree that changes in Medicaid eligibility have made such a requirement outdated. Congress and the Clinton administration eliminated the Aid to Families with Dependent Children (AFDC) program and thereby delinked Medicaid eligibility for a significant number of enrollees. The ACA requires states to use Modified Adjusted Gross Income (MAGI) methodologies for many Medicaid eligibility categories, which must follow IRS rules and consider taxable income actually received. As CMS correctly observes, "there is no statutory mandate for the rule in § 435.608(a) that currently requires application for other benefits by Medicaid applicants and beneficiaries." (87 Fed. Reg. 54803.)

Requiring individuals and families to apply for pensions, annuities, and other benefits as a condition of Medicaid eligibility impedes access to medical care, unduly burdens applicants and enrollees, and ultimately harms people by delaying needed care. Accordingly, we disagree with the alternative approaches CMS suggests, including making the requirement a post-enrollment activity. Such a requirement may seriously limit the amount and scope of benefits for which an individual may be eligible.

CMS has highlighted how this current requirement is potentially limiting access to care for former foster youth, an eligibility group without an income test. Specifically, States have reported that individuals who otherwise meet all requirements to be enrolled or remain enrolled in this group are losing Medicaid coverage due to failure to provide information on application for other benefits, such as unemployment compensation. Other States have received beneficiary complaints related to the burden of this requirement and the impact on individuals who are required to apply for Social Security benefits before reaching their full retirement age.

Given that the current regulations create a barrier to coverage and an undue burden for certain children and families, we recommend revisiting this section.

We wholeheartedly agree with the fact that applications to other benefit programs as a condition of Medicaid eligibility should not be required for receipt of Medicaid benefits. However, we believe that all necessary information on other programs for which families are eligible should be made abundantly clear. In addition, state agencies should take all action at their disposal to reduce the burden of applying for other benefit programs, such as the Supplemental Nutrition Assistance Program (SNAP). For example, while some states already have [integrated](#) Medicaid and their non-health program eligibility systems, more states should be encouraged to streamline enrollment, such as automatically referring beneficiaries to non-health programs and presuming them categorically eligible.

Allowing Medically Needy enrollees to deduct prospective expenses (§ 435.831)

We support the proposed provision to give states the option to make it easier for some low-income people with catastrophic medical costs to enroll and stay enrolled by expanding the deduction of prospective expenses for medically needy eligibility. Under current regulations, states can opt for institutionalized individuals to have their predictable expenses deducted at the start of their budget period, meaning they have continuous coverage between budget periods and no lapse in eligibility due to a spenddown period. CMS proposes to give states the option to extend this policy to other individuals with “constant and predictable” services, including prescription drugs and home and community based long-term services and support (LTSS). 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 by permitting states to apply the same methodology for individuals who receive home- and community- based services (HCBS) to deduct their predictable medical expenses as well. Thus, this proposed change will help children and families who rely on HCBS retain their eligibility with less paperwork and administrative burden.

Aligning Non-MAGI enrollment and renewal requirements with MAGI policies (§§ 435.907 and 435.916)

The ACA and implementing regulations streamlined eligibility determinations and renewals for people whose eligibility is determined using MAGI rules. MAGI is the basis for determining eligibility for most children and pregnant women, while the non-MAGI population includes children with disabilities or complex healthcare needs. However, eligibility determinations and renewals for the non-MAGI groups in many states continue to be done in a manner that is unnecessarily burdensome for applicants and enrollees, as well as for state eligibility workers.

To simplify the application process for children with disabilities and complex healthcare needs, we support CMS’ proposal to apply the requirement that individuals must be able to apply through all modalities currently specified in § 435.907(a). We also support prohibiting an in-person interview requirement for the non-MAGI groups but recommend that CMS go further and prohibit all interview requirements, for both the MAGI and non-MAGI groups. Finally, renewing eligibility no more frequently than every 12 months, sending a pre-populated renewal form, giving enrollees 30 days to respond, and allowing a 90-day reconsideration period have all proven possible to implement and effective at reducing churn on and off Medicaid for MAGI groups; therefore, we support extending these policies to the non-MAGI groups. In addition, requiring agencies to accept additional verification documents at renewal through all modalities will further streamline redeterminations for non-MAGI groups. We urge CMS to finalize these proposals to provide more stable coverage for people eligible for non-MAGI groups.

As stated above, keeping children consistently covered, especially those with chronic conditions or disabilities, leads to improved health status and well-being and promotes health equity. For states, any policy that helps retain eligibility and reduce churn, such as continuous coverage for 12 months, reduces administrative costs and labor while helping to promote more efficient health care spending. When children with chronic conditions and disabilities have consistent access to medications and their medical home, and when all children can access care when needed without interruptions, health care costs go down. Therefore, we support CMS's proposed changes to promote equity across all enrolled people by eliminating barriers to application, enrollment, and renewal for the non-MAGI groups, as we believe that will promote retention and streamline enrollment in Medicaid for children with complex healthcare needs and disabilities.

Timely Determination and redetermination of eligibility (§§ 435.907, 435.912, and 457.340)

We generally support proposed changes to §§ 435.907 and 435.912, and corresponding CHIP changes at § 457.340. The changes would ensure that applicants and enrollees have adequate time to furnish all requested information and that states complete initial determinations and redeterminations of eligibility within a reasonable timeframe at application, at regular renewals, and following changes in circumstances. We support the proposal to provide most applicants with at least 15 days, from the date the request is sent, to respond with additional information; this proposal will help ensure that new applications can be acted upon in a timely manner. We also agree that applicants applying on the basis of disability should be provided with at least 30 days to return additional information, since such information may be more challenging to gather.

In general, the timelines and changes that CMS discusses in the preamble appropriately account for the need to prevent denials of coverage without an accurate determination of ineligibility while at the same time minimizing the need to extend coverage beyond an enrollee's period of eligibility. CMS should clarify the regulatory text to ensure that the final rule accurately reflects this approach. Updated timeliness and performance standards for the state to complete redeterminations at renewal and upon changes in circumstances also are appropriate; we concur with the timelines that CMS includes in the proposed rule. Although we support giving applicants more time to return requested information, when needed, we urge CMS not to change the timeliness requirement for application processing if applicants are given more time. CMS should retain the current 45- and 90-day processing timelines to ensure that eligibility determinations are made in a timely manner, extending them could needlessly delay eligibility determinations and would not be in the best interests of beneficiaries.

In all cases, we recommend the use of calendar days to assure timely determinations and because we believe doing so is consistent with how most states currently calculate deadlines and thus would be less operationally challenging to implement. We also recommend that CMS require states to include a deadline based on when the item is expected to be sent (rather than the date the notice is generated – which can be days before it is mailed – or requiring individuals to calculate deadlines based on postmarks).

We support alignment between Medicaid and CHIP provisions regarding timely determinations and redeterminations of eligibility, as proposed. HHS specifically seeks comment on whether CHIP programs for children with special health care needs should be aligned with the longer timeframes allowed for Medicaid disability determinations, but we believe the shorter 15- and 30-day timeframes are appropriate for all CHIP eligibility determinations and redeterminations because CHIP eligibility standards are the same for all children, even if some children are eligible for additional benefits.

Shorter deadlines are often a burden for families — who may be balancing multiple needs of their children — to determine what information is needed, locate it, and send it back to their state. Because of such deadlines, eligible children may lose their coverage if their parents don't respond in time. This is especially a concern in states with low-income eligibility levels for children because even a minor, temporary increase in family income can cause a child to be ineligible and lose their coverage. Therefore, we strongly support the proposed changes which will allow families adequate time to provide the necessary information to state agencies.

Changes in circumstances (§ 435.919)

The proposed rule specifies new standards (§ 435.919) for processing changes in circumstances if such changes result in ineligibility. Importantly, the proposed rule 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 with a key provision that the state may not disenroll the individual if a request for information (RFI) is not returned. The proposed rule would establish RFI response times of 30 days, for all types of changes, aligning with current policy allowing enrollees 30 days to respond when the state is unable to make a renewal determination using data available to the state (also known as *ex parte*). The proposed rule also specifies that the 90-day reconsideration period applies to procedural terminations following a change 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 requires the state to determine the reliability of the information § 435.919(b)(2)(i), but it does not require the state to act on reliable data. If the enrollee does not verify the information, the state may not terminate coverage, but it is not required to provide additional benefits or lower cost-sharing. 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.

States that use strict redetermination and renewal policies make it difficult for families to maintain their children’s coverage. As mentioned in the above section, quick turnarounds (i.e. 10 days or shorter time frames) create an undue burden for families to determine what information is needed, locate it, and send it back to their state. Because of such deadlines, eligible children may lose their coverage if their parents don’t respond in time. A child who churns in Medicaid/CHIP due to short deadlines will experience unnecessary gaps in both coverage and access to care that can be detrimental to their development; even a short gap in coverage can harm a child by reducing their access to necessary care. Therefore, we strongly support RFI deadlines of 30 days.

Agency Action on Returned Mail (§§ 435.919 and 457.344)

We are enthusiastic about the proposed rule requiring states to follow-up on returned mail. 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 nonmail communication modes. Importantly, the rule disallows 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.

These proposed changes are even more important considering the potential end to the Public Health Emergency (PHE) and subsequent “Unwinding” period. Children have faced significant housing insecurity during the pandemic. More than [one in five renters](#) living with children reported they were not caught up on last month’s rent. This number is even higher for Black households, with [nearly 30% of Black renters](#) with children behind on rent. For the beneficiaries who have not updated their mailing address after moving, states will be unable to supply enrollees with these much-needed documents via the mail. This puts millions of children and families at risk of losing coverage even though they remain eligible, which threatens their access to vital services like vaccinations, developmental screenings, and treatment for acute and chronic illnesses.

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 application, renewal or when there is a change in circumstances.

90-Day Reconsideration Period (§ 435.919(d))

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 clear evidence that temporary fluctuations in income, which are more frequent for low-income wage earners, drive churn. Many families experience some income fluctuation, but their income does not change substantially or for the long term. Expanding the 90-day reconsideration period to all types of disenrollments would promote smooth reenrollment 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. In addition, keeping children covered leads to improved health status and well-being, promotes health equity, and alleviates the impact of seasonal work, overtime, and variable work hours on low-income families.

We recommend striking the language that limits of 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)).

II. CHIP

Following passage of the ACA, CMS made notable gains in establishing a streamlined and coordinated eligibility and enrollment system across all health coverage programs. However, some CHIP administrative barriers, including waiting periods, remain in place that are not allowed in Medicaid and other insurance affordability programs. We 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)

CHIP enrollment and renewal policies generally mirror Medicaid, and the proposed rule would continue to align CHIP with 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).

Eliminating Access Barriers in CHIP (§§ 457.805, 457.570 and 457.480)

Having uninterrupted health care coverage throughout childhood allows children to have consistent access to well-child visits, vaccinations, and specialty care. Children need regular, routine checkups so that any social, emotional, or developmental delays are detected early and before beginning school. A child who churns in Medicaid and/or CHIP will experience gaps in both coverage and access to care that can be detrimental to their development; even a short gap in coverage can harm a child by reducing their access to necessary care. If a coverage gap is prolonged, families may face expensive medical bills or may put off their child's care due to high out-of-pocket costs. Therefore, we strongly support removing any policy that will cause a child to lose coverage, such as waiting periods, premium lockouts, and annual and lifetime dollar limits.

Waiting Periods

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. Waiting periods are unique to CHIP. Section 2102(b)(3)(C) of the Social Security Act (SSA) requires states to prevent substitution of private coverage for public coverage and waiting periods have been one strategy. However, there is negligible evidence that waiting periods are effective. Substitution of private coverage can be monitored by data matching, and states can consider policy changes, such as premium assistance, to make private coverage more affordable if substitution is occurring. Such strategies satisfy the SSA requirement without the complexity of managing a waiting period.

States must comply with a list of exemptions in order to implement a waiting period but 11 states still have them. In these states, a waiting period may only apply to a child following the loss of group health coverage and only in limited circumstances. If a waiting period does apply, states must transfer the child to the Marketplace temporarily and then enroll the child in CHIP once the waiting period ends.

We support eliminating waiting periods in CHIP as proposed at §§ 457.65, 457.340, 457.805 and 457.810. This policy is unique to CHIP, burdening low- to moderate income families. CMS should not simply reduce the allowable length of waiting periods to 30 days or some other time period.

Currently, [11 states](#) enforce waiting periods for children who apply to a CHIP. These waiting periods require children to “go bare” without any insurance through CHIP even though they meet income and other eligibility requirements. These waiting periods are an archaic standard that means children are uncovered while they are growing, developing, and, over the last two years, living through a pandemic. CMS should eliminate the state option for waiting periods.

Premium Lockout Periods

Premium lockout periods create a forced period of uninsurance for children during which they may miss needed care and families may [incur large medical bills](#). As of January 2020, [14 states](#) imposed a lockout period

for nonpayment of premiums, and some states [require repayment](#) of past due premiums as a condition of eligibility. [For low- and moderate income families](#), premiums and lockouts pose a barrier to coverage and contribute to periods of uninsurance. [Research](#) has shown that children with a gap in coverage are less likely to have a usual source of care (i.e. a medical “home”) and more likely to have trouble affording health care compared to children who are insured year-round. Low and moderate-income children and children of color are more likely to experience gaps in coverage. Cost barriers lead to avoidance of needed care, and even healthy children need regular care to monitor their development.

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.

Annual and Lifetime Dollar Limits on Benefits

CHIP is 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 states that though no state imposes an aggregate annual or lifetime limit on all CHIP benefits today, states have imposed such limits in the past (87 FR 54816). Health care costs typically grow faster than the economy, 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.

III. Transitions Between Insurance Affordability Programs

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

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 § 1943(b)(3) of the SSA, requiring streamlined enrollment systems compliant with § 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.

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.

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 states should refrain from taking appropriate action when they have reliable information to move forward. 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 make enrollment immediately effective, and conduct other processes (such as premium payment and plan selection) post-enrollment.

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.

Conclusion

The changes outlined in this proposed rule could not come at a more important time as we get closer to the end of the Public Health Emergency and the subsequent Medicaid redeterminations for all current enrollees, i.e. the “Unwinding” period. Children are especially at risk of losing coverage, with nearly [6.7 million children expected to lose Medicaid](#), and children of color will bear the brunt of these losses, making up nearly two-thirds of the expected coverage losses.

While some losses result from normal changes in eligibility, if pre-pandemic termination patterns hold, millions of children who still qualify for Medicaid or CHIP are likely to lose their coverage unnecessarily. Therefore, it is imperative that policies be put in place now to prevent the unnecessary loss of coverage for millions of children.

We have included numerous citations to supporting research, including direct links to the research. We direct CMS to each of the materials we have cited and made available through active links, and we request that the full text of each of the studies and articles cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act. If CMS is not planning to consider these materials part of the record as we have requested here, we ask that you notify us and provide us an opportunity to submit copies of the studies and articles into the record

We thank you for the opportunity to comment on this issue. If you have further questions, please contact Olivia Gomez, Director of Health and Nutrition Policy, at OliviaG@firstfocus.org.

Sincerely:

A handwritten signature in blue ink that reads "Bruce Lesley". The signature is written in a cursive style with a large, stylized 'L'.

Bruce Lesley
President