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November 7, 2022

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

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

Dear Administrator Brooks-LaSure:

The Medicaid and CHIP Payment and Access Commission (MACPAC) appreciates the opportunity to comment on the notice of proposed rulemaking (NPRM) on streamlining the Medicaid eligibility, enrollment, and renewal processes published on September 7, 2022 (CMS 2022). MACPAC is a nonpartisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP).

This proposed rule includes a number of provisions designed to meet the Administration's goals of simplifying the enrollment processes and maintaining coverage for eligible individuals, particularly children and individuals who are dually enrolled in Medicare and Medicaid. This letter draws on the Commission's work over the years and also highlights pertinent recommendations in areas addressed by the rule.

We provide specific comments below, but also would like to provide the Commission's overall support for the objectives of the rule. The Commission has long supported efforts to streamline enrollment and renewal processes for individuals and states, while balancing program integrity obligations. Specifically, in commenting on the earlier rules implementing the provisions of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), the Commission supported Centers for Medicare & Medicaid Services (CMS) efforts to establish seamless eligibility and enrollment processes across programs to promote simplicity for individuals and ease administrative burden for states. The Commission noted that in supporting these provisions, it was guided by the principles of ensuring administrative simplification, maintaining program integrity, and maximizing continuity of coverage and care (MACPAC 2013, 2011).

The Commission would also like to note that implementation of the proposed changes could create administrative burdens on states. The preamble of the rule notes that CMS is considering an earlier effective date with a separate, longer-term compliance period following finalization of the rule. The Commission encourages CMS to take such an approach to balance the availability of certain options while

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affording states additional time to implement processes that may require larger system changes. We make this comment in light of our concerns regarding state capacity to complete the growing backlog of pending verifications, redeterminations, and renewals at the end of the public health emergency (PHE). If states are also required to implement new rules for eligibility and enrollment processes at the same time, we have concerns that this would negatively affect states' ability to successfully unwind and may risk inappropriate coverage loss among beneficiaries. While the Commission supports the requirements established by the proposed rule, the implementation timeline should consider the administrative task of unwinding the PHE so as not to overburden states.

Facilitating enrollment through Medicare Part D Low-Income Subsidy (LIS) "leads" data

MACPAC supports these provisions to use Part D LIS data to increase enrollment in the Medicare Savings Programs (MSPs) and streamline MSP eligibility determinations. They align with the Commission's June 2020 recommendation aimed at improving participation in the MSPs, which required that states use the same definition of income, household size, and assets for purposes of determining eligibility for the MSPs that the Social Security Administration (SSA) uses to determine eligibility for LIS. We agree with CMS that increasing enrollment in the MSPs would have an overall positive impact on equity by increasing access to care for additional low-income Medicare beneficiaries. However, we acknowledge that increasing enrollment would also likely increase costs to states, with varying budgetary impacts depending on the financial subsidy or assistance provided, and add to their administrative burden.

The Commission has examined issues related to low MSP enrollment. In a 2017 report for MACPAC, the Urban Institute reported low participation rates across all MSPs and all age groups.[1] The Qualified Medicare Beneficiaries (QMB) program had the highest participation rate at 53 percent of estimated eligible beneficiaries. Of Specified Low Income Medicare Beneficiary Program-eligible beneficiaries, 32 percent participated. Of Qualifying Individual Program-eligible beneficiaries, 15 percent participated (MACPAC 2017a).[2] Building on that work, the Commission explored policy options aimed at increasing participation of eligible beneficiaries and thus improving their access to care. The Commission found that varying state approaches to program administration, conflicting enrollment and eligibility requirements between the MSPs and related federal programs serving similar low-income individuals, and lack of awareness among eligible beneficiaries contribute to low enrollment in the MSPs. The Commission recommended that states align their MSP eligibility determination methodologies related to income, assets, and household size with that of the LIS program (MACPAC 2020a).

Defining family size for the Medicare Savings Programs

The Commission supports this change. It aligns with our June 2020 recommendation to require that states use the same definition of income, assets, and household size as is used for LIS. It also maintains state flexibility to add more people beyond what the LIS program includes in family size and to adopt a different definition for other Medicaid eligibility groups (MACPAC 2020a).

Automatically enrolling certain Supplemental Security Income recipients into the Qualified Medicare Beneficiaries group

MACPAC supports the change to generally deem eligible for the QMB group certain Supplemental Security Income (SSI) recipients as it aligns with our goal of improving participation in the MSPs. From an equity perspective, this change increases the lowest income Medicare beneficiaries' access to assistance with coverage of out-of-pocket Medicare costs, which may facilitate their access to care.

Requiring electronic verification and reasonable compatibility standards for resources

The Commission supports clarifying that states should, to the extent possible and when reasonably compatible, rely on electronic data for verifying eligibility criteria to streamline eligibility processes and alleviate state and individual burden. MACPAC's prior work has shown that states may realize efficiencies through connections to electronic data sources. In a study examining the effects of the ACA simplification changes, the six states interviewed reported that electronic data interfaces facilitated high rates of real-time eligibility determinations, auto-renewal, and reduced churn. Assisters in multiple states also praised the use of electronic data to verify information for speeding eligibility processing time. Most respondents remarked that the efficiencies gained through data interfaces reduced administrative costs and fluctuations on and off the Medicaid program, thereby promoting continuity of care (MACPAC 2018).

Multiple modes for submitting information

MACPAC supports codifying the requirement that all individuals, including individuals whose eligibility is not determined using modified adjusted gross income (MAGI), have multiple modalities through which to receive and send communications. In our recent work on beneficiary preferences for communications, we found that multiple modes are needed to reach beneficiaries with different communication preferences and comfort levels with technology. Having multiple methods to apply for Medicaid, as well as to receive and access information, is necessary to reach everyone. In most of the states we spoke with, the online application option was the most frequently used; in the other state, paper and phone options were the predominant methods. State officials and other stakeholders, however, noted that all methods for application are used and that the requirement that states offer multiple options is important for maximizing accessibility. Focus group participants spoke about the importance of having different options available, even if they might prefer a certain method themselves (MACPAC 2022a, PerryUndem 2022).

Aligning non-MAGI enrollment and renewal requirements with MAGI policies

MACPAC supports CMS objectives to streamline the renewal process for non-MAGI beneficiaries, as such a change would provide greater consistency across programs. Furthermore, aligning the approaches promotes the Commission's goal of equity, particularly for those who are over the age of 65 or eligible on the basis of disability.

In particular, MACPAC's earlier work on state systems following ACA implementation found that the states studied took varied approaches for streamlining their Medicaid eligibility processes, although all with the goal of simplifying the application, enrollment, and renewal processes for individuals and state administrators. Respondents noted that the use of electronic data sources facilitated real-time eligibility determination and automated renewals. They also indicated that auto-renewal processes were easier to implement than automated eligibility determinations, as renewals required fewer verifications than initial applications (MACPAC 2018).

Changes enacted with the ACA were generally intended to streamline and simplify processes for both the MAGI and non-MAGI populations. However, in some cases implementation may have been delayed for non-MAGI populations as states concentrated their efforts on the MAGI groups. For example, as of January 2016, only about half of states (24) processed MAGI and non-MAGI eligibility determinations through the same system (Brooks et al. 2017). However, as of January 2022, 36 states have an integrated system that determines eligibility for both MAGI and non-MAGI populations (Brooks et al. 2022). Using the same system may make it easier for states to process renewals for non-MAGI populations using ex parte and sending pre-populated forms, eliminating some of the technological barriers that impeded this approach in older systems.

Complicated enrollment and renewal procedures have been cited in the past as reasons why some non-MAGI populations do not access services for which they are eligible. For example, certain individuals who are enrolled in Medicare can receive Medicaid assistance with Medicare premiums and cost sharing, but participation rates have historically been and continue to be low. As described above, MACPAC found participation rates of around 50 percent (MACPAC 2017a). Elderly beneficiaries in focus groups when asked about enrolling in MSPs reported that the Medicaid enrollment process was difficult and they needed help to complete it (Perry et al. 2002). As such, simplified processes that were instituted for the MAGI population, such as requiring the use of prepopulated renewal forms, may be of particular relevance to the non-MAGI population.

While the Commission has not opined on a 12-month renewal period for non-MAGI populations, we would like to share findings from our recent work on churn that may provide insight to CMS as it finalizes the NPRM. Specifically, rates of churn were lowest for beneficiaries eligible for Medicaid on the basis of a disability and for those age 65 and older (3 percent). In addition, these individuals had the longest average length of coverage (11.9 months). These findings may suggest that non-MAGI populations are less likely to experience fluctuations in income or other changes that affect eligibility (MACPAC 2021).

Establishing timelines for responding to agency requests for information

MACPAC supports efforts to ensure that beneficiaries have the opportunity to respond and the clarification around when the timeline to respond begins. The Commission supports this for individuals in both Medicaid and CHIP.

In our work on beneficiary communication preferences, stakeholders raised concerns about the amount of time that people have to respond to requests for information. In four of the states we spoke with, the amount of time given is 10 calendar days, in one it is 10 business days, and in another it is 30 days. Beneficiary advocates, legal aid organizations, provider organizations, and others advocated for making the timeframe longer, ideally aligning with the 30 days that people have at renewal (MACPAC 2022a). Similar concerns regarding the time to respond to notices were raised during expert panel discussions on unwinding the PHE (MACPAC 2022b, 2020b).

Furthermore, those relying on paper notices realistically have a shorter window to respond. Many stakeholders told us that by the time a letter arrives in the mail, people may have just a few days to gather and return documents, such as paystubs or bank statements. Notices can also get lost in the mail or may be sent to outdated addresses. We also heard some confusion about whether the response period begins with the date on the notice or the date that a beneficiary received it. While the use of electronic notices addresses some of these concerns, not all beneficiaries have access to or are comfortable using technology (MACPAC 2022a).

Given this feedback, the Commission does not believe that 10 days is sufficient time for individuals to respond to notices, and would suggest that CMS rely on information provided by states and beneficiaries and their advocates in determining the appropriate timeframe as noted in the preamble. Additionally, given the varying requirements across programs, CMS may want to consider coordinating with the Supplemental Nutrition Assistance Program (SNAP) to align timelines.

Requiring agency action on returned mail

The Commission agrees with CMS that addressing missing contact information is needed given the implications for potential coverage loss if individuals enrolled in Medicaid or CHIP are unaware of actions they must take because they have not received information.

In prior work for MACPAC, both state officials and beneficiary stakeholders reported challenges in delivering renewal and change of circumstance notices to beneficiaries, as well as in obtaining timely responses to those

notices that are successfully delivered. While applicants and beneficiaries can choose to receive notices electronically, states primarily send notices by mail, which can frequently be hampered by inaccurate addresses. Medicaid beneficiaries frequently change addresses, making it challenging for states to keep contact information up to date. Additionally, the use of multiple complex Medicaid databases (e.g., for determining eligibility, sharing information with managed care plans, etc.) can complicate efforts to maintain accurate addresses when updates are received (Zylla et al. 2020).

Stakeholders identified several strategies to mitigate these challenges, including using more up-to-date contact information, such as from managed care plans, providers, other health and human service programs, or the United States Postal Service. Following up with telephonic or electronic communications and allowing individuals multiple modes to respond can also facilitate responses (Zylla et al. 2020). A multi-prong approach was also supported by additional MACPAC work showing that beneficiary preferences for communication and use of technology varies, so providing all available options maximizes the ability for beneficiaries to complete processes in a way that best meets their needs (MACPAC 2022a, PerryUndem 2022).

MACPAC has also recently convened two expert panels to discuss the challenges states face in reaching beneficiaries and the need for effective communication strategies as they prepare for the end of the PHE. (MACPAC 2022b, 2020b). Speakers on these panels shared concern that many of these challenges are not unique to the pandemic but are exacerbated by it, including, for example, having outdated addresses for beneficiaries with unstable housing. In addition, mailed notices may not reach beneficiaries in a timely fashion or even at all, as notices can get lost in the mail (MACPAC 2022a). Moreover, change-of-address requests may not be processed in a timely manner by the post office or by Medicaid (PerryUndem 2022).

In a recent letter on the use of text messages, the Commission expressed its concern about the potential for coverage loss by individuals who remain eligible but do not complete renewals because they do not receive mailed notices. MACPAC agrees with CMS that ensuring states have accurate contact information for all beneficiaries is critical (MACPAC 2022c).

Easing transitions between Medicaid, CHIP, and Basic Health Program

MACPAC’s recent work on transitions between insurance coverage programs showed gaps in coverage. The Commission agrees that the focus on coordination across Medicaid and CHIP may be helpful in addressing some issues with transitions.

Specifically, MACPAC’s analysis showed that many children who disenrolled from Medicaid and CHIP transitioned to either Medicaid, CHIP, or exchange coverage. For example, of children covered by Medicaid in states with separate CHIP, 21.0 percent transitioned to separate CHIP and 1.6 percent transitioned to the exchange. Similarly, of children covered by separate CHIP, 47.4 percent transitioned to Medicaid and 3.3 percent transitioned to the exchange (MACPAC 2022d).

Our analyses also found that many of those who transitioned between programs experienced gaps in coverage. For example, of children transitioning between Medicaid and CHIP, 18.4 percent of children who transitioned from Medicaid to separate CHIP and 16.7 percent of children who transitioned from separate CHIP to Medicaid experienced a 1 to 12-month gap in coverage. An even greater proportion of children transitioning between coverage types experienced a coverage gap when transitioning to the exchange: 65.8 percent of children transitioning from Medicaid to the exchange and 42.6 percent of children transitioning from CHIP to the exchange experienced a 1 to 12-month gap in coverage (MACPAC 2022d).

Additional requirements in separate CHIP coverage may contribute to these gaps in coverage. For example, states may require payment of a premium or other action, such as plan selection, before enrollment in separate CHIP. CMS may wish to further examine the issues that lead to these gaps and consider whether additional avenues for streamlining the transition, such as post-enrollment premium payment or a grace period for the initial premium payment, may be warranted.

The proposed rule does not address improving transitions to the exchange. However, as noted above, very few children who disenroll from Medicaid and CHIP transition to the exchange, and of those who do, a large proportion experience gaps in coverage. As such, CMS could consider whether changes to the provisions governing coordination between Medicaid, CHIP, and the exchange should also be addressed.

MACPAC's prior work on beneficiary preferences for communications during the eligibility process highlighted the importance of providing timely, adequate, and accessible written notice of any decision affecting eligibility. Issues with the current notice process, including their readability, inadequate time to respond to requests for information, and receiving multiple, and occasionally contradictory, notices, could also affect combined notices. However, having to issue combined notices may create state burden, given the limited state capacity to improve notices (MACPAC 2022a).

Prohibiting premium lock-out periods in separate CHIP

In our 2017 recommendations on the future of children's coverage, the Commission 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 (MACPAC 2017b).[3]

In making this recommendation, the Commission acknowledged that although CHIP premiums can help to offset state and federal costs of coverage and signal to enrollees the importance of their contribution to the cost of coverage, in practice these premiums are relatively modest. Even at relatively low levels, however, premiums can increase the number of children in families with income below 150 percent FPL who are uninsured. In addition, to reducing uninsurance, eliminating premiums for children with incomes below 150 percent FPL would align CHIP premium policies with Medicaid policies for lower-income children (MACPAC 2017b).

To further align premium policies across programs, the Commission supports the proposed changes to eliminate the lock-out period for individuals in separate CHIP with incomes below 150 percent FPL. We have not examined the implications of premiums or lock-out periods for individuals with incomes above 150 percent FPL.

Prohibiting waiting periods in separate CHIP

The Commission supports the elimination of waiting periods in separate CHIP to reduce complexity and promote continuity of coverage for children.

In its March 2014 report to Congress, the Commission recommended the elimination of waiting periods, citing four primary reasons. First, eliminating CHIP waiting periods will reduce uninsurance and improve the stability of coverage. Second, although CHIP waiting periods were instituted to deter crowd-out of private coverage, it is not clear that they have been effective. Third, eliminating CHIP waiting periods is consistent with the Commission's goal of more simplified and coordinated policies across various programs. And fourth, eliminating CHIP waiting periods will reduce administrative burden and complexity for families, states, health plans, and providers (MACPAC 2014). In 2017, the Commission reiterated this recommendation (MACPAC 2017b).

Thank you for the opportunity to comment on this proposed rule. We appreciate CMS's continued efforts to simplify and streamline the eligibility, enrollment, and renewal processes for states and beneficiaries.

Sincerely,

Melanie Bella, MBA
Chair

cc: The Honorable Ron Wyden, Chair, Senate Finance Committee
The Honorable Mike Crapo, Ranking Member, Senate Finance Committee
The Honorable Frank Pallone, Jr., Chair, House Energy and Commerce Committee
The Honorable Cathy McMorris Rodgers, Ranking Member, House Energy and Commerce Committee

Endnotes

[1] Using data from 2009 and 2010, this analysis filled a gap in the research on MSP participation by linking data from the Survey of Income and Program Participation (SIPP) with administrative data from the Medicaid Statistical Information System (MSIS) to estimate program-specific participation rates for the MSPs and to identify variations in participation rates by individual characteristics and geographic location. We estimated participation rates in each MSP measured by enrollees as a share of eligible beneficiaries (MACPAC 2017a).

[2] The analysis also found that individuals enrolled in the MSPs were less likely than eligible non-enrollees to have private health insurance coverage, and were more likely to be younger, under age 65, have lower assets, and be eligible for Medicaid on the basis of a disability. Enrolled beneficiaries were also more likely to be receiving benefits from other government programs, such as SSI and the Supplemental Nutrition Assistance Program. Enrollment in these other government programs may serve as a touchpoint for beneficiaries who are eligible for the MSPs (MACPAC 2017a).

[3] The recommendation to align premium policies in separate CHIP with premium policies in Medicaid was first made in the Commission's March 2014 report to Congress.

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