



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

Dear Secretary Becerra and Administrator Brooks-LaSure:

We write to you on behalf of the Catholic Health Association of the United States (CHA) and Catholic Charities USA (CCUSA) in support of several provisions of the Notice of Proposed Rulemaking (NPRM) on *Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment and Renewal Processes*. As organizations that strongly support the Medicaid and Children's Health Insurance Program (CHIP), we know that several of these proposed policies will aid the many beneficiaries we serve.

CHA is the national leadership organization representing more than 2,200 Catholic health care systems, hospitals, long-term care facilities, clinics, service providers and organizations. Additionally, CCUSA represents 167 local Catholic Charities agencies that serve 15 million people in need across America. Both organizations interact and provide health and social services to millions of individuals, many of whom are part of the Medicaid and CHIP program. We support finalizing the 2022 NPRM as proposed, with the following comments, as these policy changes will ensure that beneficiaries are protected in the event COVID-19 Medicaid continuous coverage requirement comes to an end, with states acting on eligibility redeterminations for millions of people. We hope that the Centers for Medicare and Medicaid Services (CMS) will work closely with states to set implementation dates for these policies for the mutual benefit of streamlining the application, eligibility, enrollment, and renewal process for beneficiaries.

Types of acceptable documentary evidence of citizenship (§ 435.407) and Verification of other non-financial information (§§ 435.956 and 457.380)

CHA and CCUSA are committed to ensuring that immigrants have access to health care and are treated equitably and fairly. Catholic health care organizations serve immigrants, including refugees and victims

of human trafficking, in their clinics, emergency rooms, and in their facilities. The multi-step process to proving citizenship status is an obstacle that deters people from completing the application process due to language barriers, confusion and other challenges with navigating complex bureaucratic systems. 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 the burden on applicants and increase administrative efficiency without increasing the risk of erroneous eligibility determinations.

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. Proposed § 435.956 would remove this option in Medicaid and CHIP (by an existing cross reference in § 457.380). We support this change because allowing states to limit the number of ROPs would make it harder for eligible people to enroll. This would disproportionately affect certain vulnerable groups, including survivors of domestic violence and people experiencing homelessness, for whom electronic verification of immigration status is difficult.

We recommend CMS engage in oversight on states' implementation of this provision to ensure that states utilize ROPs correctly and individuals receive benefits during the ROP.

Transitions between Medicaid, CHIP and 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. While our member agencies, acting through caseworkers, aid individuals to ensure continuous coverage, 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, which would make it much more likely that households losing their Medicaid coverage 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.

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 due to different eligibility policies and verification rules and avoids having staff of CHIP agencies determine Medicaid eligibility.

Finally, we support CMS' 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 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 CHIP programs move to a system whereby payments and plan selection occur post-enrollment in order to minimize gaps in coverage.

Agency action on returned mail (§§ 435.919 and 457.344)

Current Medicaid and CHIP regulations do not specify steps states must take to follow up on mail that is returned as undeliverable, even though returned mail leads to a significant number of eligible people losing coverage. We support provisions in the proposed rule that would require states to take reasonable steps to determine beneficiaries' correct addresses by checking available data sources and making multiple attempts at contacting beneficiaries through multiple modalities before terminating coverage. The proposed requirements for acting on mail returned with in-state, out-of-state, and no forwarding addresses represent reasonable approaches to ensure that individuals who are likely still eligible remain so and that individuals who have moved out of state do not remain enrolled.

In addition to new procedures for acting on returned mail, we support CMS' proposal to permit states to accept information they receive from reliable sources, such as the post office or a managed care contractor, as long as the state does not receive a response from the enrollee that it is incorrect. We encourage CMS to go a step further and require states to accept this information, even if the enrollee does not respond to a request to confirm it. Requiring this is warranted given the reliability of the post office's National Change of Address database and enrollee reported/verified information shared by contracted managed care plans.

Finalizing new standards regarding returned mail will help avert coverage losses that are anticipated as the COVID-19 public health emergency comes to an end.

We support alignment between Medicaid and CHIP provisions regarding agency action on returned mail, as proposed, with one exception. Proposed § 457.344(f)(5) instructs states to follow the out-of-state procedures when the new address is outside of the geographic area for separate CHIPs that are not

statewide. Instead, we recommend that if the new address is out of the separate CHIP program region but still within the state, CHIP should 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 sending a combined notice, as outlined in proposed §§ 435.1200(h) and 457.350(g).

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.

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. By comparison, eligibility determinations and renewals for people who are over age 65 or who are blind or have a disability (i.e., 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. The failure to streamline eligibility rules for non-MAGI groups has resulted in higher rates of procedural denials, even though older adults and people with disabilities are more likely to have stable incomes. Denials are more likely because these groups are more likely to lack transportation and have health-related barriers to responding to requests for documents. Therefore, we support CMS’ proposed changes to promote equity across all enrolled people by eliminating barriers to application, enrollment, and renewal for the non-MAGI groups.

To simplify the application process for older adults and people with disabilities, 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.

Implementing these proposals would ease the burden on caseworkers at our member organizations, as these policies would ensure that non-MAGI beneficiaries are covered.

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 when needed to return requested information, 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, as 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 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. 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.

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

Proposed § 435.909 would require states to automatically enroll nearly all Supplemental Security Income (SSI) beneficiaries into the Qualified Medicare Beneficiary program (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, all of whom would gain access to critical financial assistance with both Medicare premiums and cost-sharing and protections against balance billing. We support these proposed changes.

Determination of eligibility (§ 435.911)

CHA and CCUSA continue to advocate for the affordability in prescription drugs, especially for seniors and those with low incomes. As the preamble to the proposed rule points out, the Medicare Improvements and Patients and Providers Act of 2008 has long required the Social Security Administration (SSA) to transmit eligibility data collected from low-income subsidy (LIS) applications to State Medicaid agencies, such transmission to constitute an initiated Medicare Savings Plan (MSP) application, and state Medicaid agencies to accept such data and act upon such data as if they were an MSP application. This means that if an individual applies at SSA for the LIS and the individual is not already enrolled in an 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 an 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 an MSP.

Proposed § 435.911 would formally codify these requirements and implement them fully by specifying: (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 any additional required information including citizenship and immigration status. In addition, the state must notify individuals that they may be eligible for MSP benefits if more information is needed or if the SSA LIS 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 eligibility rules with LIS rules, 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, all of whom would gain access to MSP benefits, including assistance with Medicare cost-sharing and/or premiums. We support these proposed changes.

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.

Acting on changes in circumstances timeframes and protections (§§ 435.916, 435.919, and 457.344)

We strongly support changes that CMS is proposing to current regulations on changes in circumstances. The changes should be finalized to help reduce coverage losses for procedural reasons. CHA and CCUSA support the proposed requirement that agencies may not take adverse action if an enrollee does not respond to a request for information to verify a change reported by either the individual or a reliable third party that would qualify the enrollee for more favorable coverage. Enrollees we serve may not receive the request for additional information or be able to gather the appropriate documents in a timely manner, given other challenges they face. Defaulting to keep someone enrolled, especially when there is no evidence of ineligibility, is most beneficial for continuity of coverage and this must be preserved in the case of any adverse actions. Additionally, rather than give states flexibility to either act on reliable third-party information that may result in an increase in the amount of coverage or assistance a beneficiary is entitled to, or to contact the beneficiary to determine whether the information received is accurate, we recommend *requiring* action on such information from a reliable source as that would be in the best interest of beneficiaries.

We also support the proposed changes to require states to accept reports of changes in circumstances through all modalities listed in § 435.907(a), a 30-day period to verify changes in circumstances, a new 90-day reconsideration period for individuals who are terminated for failure to return requests for information about changes in circumstances, and clarifications about when the agency may and may not rely on third party sources of information reporting changes in circumstances. All of these proposed changes appropriately balance CMS' dual interests in assuring that individuals who are ineligible for Medicaid do not remain enrolled in coverage for which they are not eligible and in retaining coverage for individuals who continue to be eligible.

We support alignment between Medicaid and CHIP provisions regarding changes in circumstances, as proposed.

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

We support the proposal to modify 42 C.F.R. § 435.952(b) and (c) to clarify that CMS' longstanding reasonable compatibility policy applies to the verification of financial resources for non-MAGI eligibility groups. Reasonable compatibility avoids unnecessary requests for verification by comparing the applicant's or enrollee's attestation to available electronic data sources and evaluating whether any difference identified in those data sources affects eligibility. If both the self-attestation and the data source show income or assets are at or below the eligibility threshold, the state determines the person eligible.

Because the current reasonable compatibility requirements were issued before states had implemented asset verification systems (AVS) to electronically verify financial resources for older adults and people with disabilities, some states do not apply reasonable compatibility rules to resources identified via AVS.

The proposed rule properly clarifies that reasonable compatibility applies to resource information and the proposal should be finalized to decrease burden and reduce the number of non-MAGI applicants and enrollees who are locked out of coverage for procedural reasons. We also support CMS' proposal to establish the primacy of electronic verification of resources by requiring states to first check electronic data sources for financial resources before asking the individual for additional information and documentation.

In addition, as the preamble to the proposed rule notes, states already have the flexibility to align MSP income and asset counting rules with LIS rules. But states that have not already fully aligned eligibility rules must continue to request additional information needed to determine MSP eligibility which is not provided through the LIS eligibility data provided by SSA.

To address this issue, proposed § 435.952 would require state Medicaid programs to adopt enrollment simplification policies related to income and resources that are counted in determining MSP eligibility but not counted in determining 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, proposed § 435.952 would require states to process MSP applications and determine MSP eligibility based on self-attestation (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 information provided through self-attestation. 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.

Prohibit waiting periods (§§ 457.65, 457.340, 457.805, 457.810)

States are currently permitted to establish waiting periods of up to 90 days before children can enroll or reenroll in CHIP. Waiting periods disrupt continuity of coverage and are administratively difficult to implement. A waiting period may only apply to a child following the loss of group health coverage (not Medicaid or another insurance affordability program) and only in limited circumstances. 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. We support eliminating waiting periods in CHIP as proposed at §§ 457.65, 457.340, 457.805, 457.810. This policy is unique to CHIP, burdening low-to moderate-income families. HHS should eliminate waiting periods altogether rather than reducing the allowable length of waiting periods to 30 days or some other time period.

Prohibited coverage limitations, preexisting condition exclusions, and relation to other laws (§ 457.480)

CHIP is also unique in continuing to allow annual and lifetime dollar limits on benefits, which are not permitted in Medicaid or on essential health benefits in the Marketplace. 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 Proposed § 457.480, which would eliminate annual and lifetime dollar limits in CHIP. Such limits are not allowable in Medicaid or other insurance affordability programs and continuing to allow them in CHIP is unjustified.

Conclusion

CHA and CCUSA are guided by the singular mission of serving the poor, marginalized, and underserved. Over decades of providing healthcare and social services, we have seen the transformative and healing power of the Medicaid and CHIP program on people's lives. We hope that CMS continues to promote policies that streamline the application, eligibility determination, enrollment, and renewal process for beneficiaries as this work allows our members to continue serving their communities. Thank you for the opportunity to comment on this important issue. If you have further questions, please contact Paulo Pontemayor (ppontemayor@chausa.org) at CHA or Lucreda Cobbs (lcobbs@catholiccharitiesusa.org) at CCUSA.

Sincerely,



Lisa A. Smith
Vice President, Advocacy and Public Policy
Catholic Health Association of the United States



Brian R. Corbin
Executive Vice President
Catholic Charities USA