AMERICAN ACADEMY OF FAMILY PHYSICIANS

November 3, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244

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,

On behalf of the American Academy of Family Physicians (AAFP), representing more than 127,600 family physicians and medical students across the country, I write in response to the proposed rule "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes" as published in the September 7 version of the Federal Register.

Medicaid and the Children's Health Insurance Program (CHIP) combined cover almost 90 million individuals, providing access to needed and lifesaving health care services. Continuous, undisrupted coverage translates to improved access to preventive care, fewer disruptions in care, strengthened physician-patient relationships built on trust and continuity, and less costly emergency department visits.[i] Streamlining access to coverage and reducing churn helps improve access to high-quality, longitudinal primary care, and the AAFP recently provided many recommendations on these topics in addition to other facets of the Medicaid and CHIP programs in our recent comments to CMS.

Family physicians are many patients' first point of contact with the health care system and continue to provide care for many Medicaid and CHIP patients and their families from birth throughout their lifespans. **We agree that steps to streamline Medicaid, CHIP, and Basic Health Program (BHP) application, eligibility determination, enrollment, and renewal processes are needed to improve equitable access to whole-person care, including primary care and behavioral health care, for beneficiaries of all ages.** Streamlining these processes will help reduce enrollment churn, which in turn reduces administrative burdens on physicians and their practices and helps physicians maintain continuity and trust in their relationships with their patients.

The AAFP has supported the maintenance of effort and continuous enrollment provisions included in the Families First Coronavirus Response Act (FFCRA) to avoid coverage disruptions and ensure Medicaid beneficiaries could access health care during the COVID-19 pandemic. In light of the looming end of the COVID-19 public health emergency (PHE), we look forward to working with CMS to minimize coverage gaps as states initiate their eligibility redetermination processes. Like CMS, we remain deeply concerned that many currently enrolled Medicaid beneficiaries will lose coverage and be unable to get the care they need.

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In pursuit of improved program integrity and improved access to care for applicants and beneficiaries enrolled in Medicaid, CHIP, and BHP, the AAFP offers the following comments on the proposed changes to application, eligibility determination, enrollment, and renewal processes for these programs.

Facilitating Medicaid Enrollment

Facilitate Enrollment Through Medicare Part D Low-Income Subsidy "Leads" Data. Through Medicare Savings Programs (MSPs), Medicaid provides coverage of Medicare premiums and/or cost sharing for lower-income Medicare beneficiaries. MSPs are essential to the health and economic well-being of low-income Medicare enrollees, helping to free up limited income for food, housing, and other life necessities. However, many eligible Medicare enrollees living in poverty are paying over 10 percent of their income to cover Medicare premiums alone. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) included new requirements for states to leverage the Medicare Part D Low-Income Subsidy (LIS) program to help enroll likely-eligible individuals in MSPs.

MIPPA requires the Social Security Administration (SSA) to transmit data from LIS applications ("leads data") to state Medicaid agencies and requires states to accept leads data and act upon such data as if it constituted an MSP application. Despite these statutory requirements, not all states initiate an MSP application upon receipt of leads data from SSA.

CMS proposes to codify in regulation the statutory requirements for states to maximize the use of leads data to establish eligibility for Medicaid and MSPs. CMS proposes to clearly delineate the steps states must take upon receipt of leads data from SSA, including requiring states to accept the data and treat it as an application for Medicaid promptly and without delay, consistent with the timeliness standards, and determine MSP eligibility without requiring submission of a separate application.

AAFP Comments

The AAFP supports this proposal. We believe requiring states to use leads data to facilitate eligibility and enrollment in Medicaid and MSPs will improve enrollment in both programs and reduce cost barriers to care for eligible individuals. The AAFP has encouraged CMS to assist states with incorporating data from non-health programs into their eligibility determination processes. CMS should assist states with creating multi-benefit applications for these aligned programs and CMS can facilitate sharing best practices across states. Data flow between state agencies and with federal benefits programs should be maximized so that individuals are at least automatically referred to or have their applications initiated to benefit from other available programs for which they may be eligible without excessive administrative burden on both agency staff and beneficiaries. We appreciate that this proposal is in line with our previous recommendations and appreciate CMS' steps to support states in this regard.

Additional Proposals. CMS makes additional technical proposals to streamline enrollment and reduce administrative barriers for beneficiaries in this section:

- In making determinations of eligibility for MSPs, define "family of the size involved" to include at least the individuals included in the definition of "family size" in the LIS program – which includes the applicant, the applicant's spouse if they are living in the same household, and all other individuals living in the same household who are related to the applicant and dependent

on the applicant or applicant's spouse for one-half of their financial support – and give states the option to include additional individuals.
- Automatically enroll certain SSI recipients into the Qualified Medicare Beneficiaries (QMB) program, which also provides certain low-income beneficiaries help with paying for premiums, deductibles, and other cost sharing.
- Clarify the effective date of coverage under the QMB group for individuals who must pay a premium to enroll in Part A and reside in a group payer state in order to provide individuals with protection from Medicare premiums and cost sharing on the earliest possible date
- Allow noninstitutionalized individuals, under certain circumstances, to deduct their anticipated medical and remedial care expenses from their income for purposes of medically needy eligibility determinations
- Clarify that states are not permitted to request additional resource information from the beneficiary to determine eligibility if the resource information provided by an individual is reasonably compatible with the information received by an electronic data source, such as the state asset verification system (AVS)
- Allow verification of birth with a state vital statistics agency or verification of citizenship with the U.S. Department of Homeland Security (DHS) Systematic Alien Verification for Entitlements (SAVE) Program to be considered stand-alone evidence of citizenship without requiring separate verification of identity

AAFP Comments

The AAFP supports these policies to streamline enrollment processes and refine requirements and definitions to increase enrollment and access to benefits for eligible individuals. We specifically appreciate the proposal to define "family of the size involved" at the federal level and give states the option to include additional individuals. The AAFP supports a minimum federal standard for this for the sake of consistency and equality in access to benefits across states.

For many older adults, Medicare is the first line of health coverage and Medicaid often pays for beneficiary cost sharing. Too often, out of pocket costs for beneficiaries are a barrier to accessing needed care. Unfortunately, many Medicare beneficiaries are also eligible for several Medicaid benefits but aren't accessing them. These individuals, known as dual eligibles, are low income and have a high prevalence of chronic conditions and disabilities, substantial care needs, and disproportionately high Medicaid and Medicare expenditures.[ii] Dual eligibles often do not have another source of health insurance beyond Medicare and without Medicaid support they may be unable to access services that are not covered by Medicare, such as long-term services and supports.[iii] The AAFP supports federal policies that streamline and standardize access to Medicaid benefits for dual eligibles across states, assist beneficiaries with enrolling in benefits they are eligible for, and remove cost barriers.

Promoting Enrollment and Retention of Eligible Individuals

Aligning Non-MAGI Enrollment and Renewal Requirements with MAGI Policies. The 2012 and 2013 eligibility final rules established several eligibility and enrollment simplifications for Medicaid and CHIP beneficiaries who are eligible based on Modified Adjusted Gross Income (MAGI). The MAGI-based methodology considers an individual's taxable income and tax filing relationships to determine

financial eligibility for Medicaid. Among the 2012 and 2013 eligibility and enrollment simplifications were streamlined processes that made it easier for eligible individuals to apply for and remain enrolled in Medicaid and CHIP. However, beneficiary advocates raised concerns that these simplifications have not been afforded to non-MAGI based enrollees (those whose eligibility is determined by age, blindness, or having a disability).

CMS proposes to align non-MAGI and MAGI renewal requirements by applying the simplified processes that were adopted for MAGI populations in the 2012 and 2013 eligibility final rules to non-MAGI groups. CMS proposes to prohibit states from requiring in-person interviews, require states to redetermine eligibility only once every 12 months, and require states to use pre-populated renewal forms to minimize burdens on beneficiaries.

AAFP Comments

The AAFP supports CMS' proposals to apply these simplified processes to non-MAGI groups, eliminate in-person interviews, limit eligibility redeterminations to once every 12 months, and require the use of pre-populated renewal forms. These changes will help prevent unnecessary coverage loss and improve beneficiaries' continuous access to needed health care services.

We share CMS' concern that non-MAGI beneficiaries may face a greater risk of losing coverage due to procedural reasons, compounded by the fact that they may experience additional barriers related to document retention, communication (e.g., limited English proficiency and low health literacy), technology (e.g., printing costs, access to a computer or internet), and limited access to transportation.

In-person interviews may be challenging for enrollees over age 65 or those who have blindness or a disability to schedule, prepare for, participate in (especially without the appropriate and necessary accommodations), or reschedule. The lack of flexibility for this process for enrollees can result in inaccurate determinations of ineligibility or terminations of coverage. As mentioned, state agencies can gather any necessary information obtained through interviews over the phone or through other modalities. For these reasons, the AAFP supports applying the simplified processes to non-MAGI groups, requiring the use of pre-populated renewal forms, eliminating the use of in-person interviews, and limiting redeterminations to once every 12 months, which may reduce erroneous denials due to procedural reasons.[iv]

Further, as acknowledged in the rule, non-MAGI-eligible individuals who are 65 or older or have blindness or a disability are more likely to have a fixed income and therefore more likely to remain eligible for Medicaid coverage compared to MAGI-eligible individuals.[v] Despite the greater stability of income and eligibility of non-MAGI individuals, more frequent redeterminations pose an increased likelihood that these beneficiaries may lose coverage due to procedural reasons.[vi] Given the greater likelihood of non-MAGI groups maintaining eligibility, conducting redeterminations more frequently than once every 12 months for non-MAGI groups is not necessary.

Under federal Medicaid regulations, before a state can send out renewal documents and require enrollees to respond, it must first attempt to renew coverage ex parte, or by reviewing available data sources and trying to confirm ongoing eligibility. Ex parte renewals help individuals retain coverage and reduce administrative burdens for both states and enrollees. While 42 states process ex parte renewals, only 11 states report completing 50 percent or more of renewals using ex parte processes.

The AAFP has voiced support for the increased use of ex parte renewals and we urge CMS to monitor and enforce the requirement for ex parte renewals and support states in implementing them.

Acting on Changes in Circumstances, Timeframes, and Protections. CMS is concerned that a number of states are not taking appropriate steps to follow up on reported or detected changes in beneficiaries' circumstances within a reasonable period of time or in a manner that promotes continuity of coverage for eligible beneficiaries.

CMS proposes to require that states complete initial determinations, renewals, and redeterminations in a timely manner when people experience changes that could affect their eligibility. CMS proposes clear responsibilities states must act on amid a beneficiary's change in circumstances that may qualify them for a higher level of assistance, lower premiums, and/or lower cost sharing. CMS proposes to require that states must evaluate whether a reported change may result in ineligibility or a change in the amount of assistance. If additional information is needed, CMS proposes states must redetermine eligibility based on the available information or reach out to the beneficiary for additional information as necessary. If the beneficiary does not respond, CMS proposes the state cannot take adverse action and must continue providing the existing, less beneficial coverage.

CMS proposes states must give beneficiaries whose coverage was terminated, due to failure to provide information, a 90-day reconsideration period. If a beneficiary provides information within this time frame, CMS proposes the state be required to redetermine eligibility for that beneficiary without requiring a new application.

AAFP Comments

The AAFP supports these proposals to ensure that states complete initial determinations, renewals, and redeterminations in a timely manner. We appreciate the proactive nature of these proposed actions for states to take when beneficiaries experience a change in circumstances that may entitle them to a higher level of assistance, lower premiums, and/or lower cost sharing. We also support the proposal to redetermine eligibility after receiving necessary information from a beneficiary within the 90-day reconsideration period rather than requiring a new application. This will minimize procedural complication, ensure continuity of coverage for beneficiaries, and preserve access to needed health services.

Beneficiaries should be able to rely on their state Medicaid agency to ensure they are considered for and receive the level of assistance they are entitled to. As we know, many beneficiaries struggle with annual eligibility redeterminations alone and may not recognize or be able to request a redetermination of their assistance level amid a change in circumstances. Medicaid coverage is a lifeline to access to health care services for almost 90 million beneficiaries, many of them identifying as Black, Hispanic, Asian American, or another non-white race or ethnicity.[vii] Medicaid reduces the disparity in primary care utilization between minority and white beneficiaries, encouraging patients to receive care in less costly settings.[viii] A change in circumstances that may entitle beneficiaries to a higher level of assistance can increase access and primary care engagement to an even greater level, especially considering cost sharing can be a barrier to seeking care.[ix, x] When enrollees do seek care, greater utilization of preventive services has been shown to lead to improved health outcomes, reduced costly emergency department visits, and lower health care costs overall.[xi] The AAFP supports this proposal and recommends CMS require state agencies to take any action they can to

ensure maximum financial assistance for beneficiaries when warranted due to a change in circumstances, to ensure access to care for all enrollees.

In doing so, the AAFP recommends CMS require Medicaid agencies to use multiple forms of communication to reach enrollees to discuss their change in circumstances that may entitle them to a higher level of assistance or lower out of pocket costs, including text messages, phone calls, and emails, in addition to traditional paper mail, which is still important for enrollees who may not have access to technology.

CMS should continue to support states in preparing information technology (IT) systems for eligibility redeterminations and determinations, including the implementation of electronic health record (EHR) and patient portal reminder messages for clinicians and patients. CMS could partner with major EHR developers to facilitate the implementation of automated EHR alerts at the point of care that direct patients to contact their managed care plan or state Medicaid agency any time their contact information changes to ensure they receive timely notifications about application requirements. These alerts could also prompt clinicians to inform patients when their Medicaid coverage may be up for redetermination and remind them to ensure contact information is up-to-date and respond to eligibility notices. Alerts in patient portals could include guidance and information on how to report contact information changes and changes in circumstances that might affect Medicaid eligibility, as well as direct patients to resources that can connect them with alternative coverage and safety net care in the event they lose Medicaid coverage.

The AAFP applauds the March 2022 guidance published by CMS providing states with more time to complete eligibility redeterminations and outlining waivers and other strategies states can use to update beneficiary information once the COVID-19 PHE ends. We were pleased that CMS focused heavily on various strategies states can use to minimize churn and instead facilitate continuous health coverage. We are also supportive of the requirements for states to submit redetermination plans, as well as CMS' planned monitoring and oversight activities to ensure states' redetermination operations are not resulting in errors or unnecessary coverage losses. The AAFP is strongly supportive of these goals.

To take advantage of the work states put into their redetermination plans, the AAFP recommends CMS consider requiring state redetermination plans to be continually updated and made publicly available. The plans are ideally effective in minimizing unnecessary disenrollment at the end of the PHE, but they may also be helpful for states to use as a reference guide for eligibility redeterminations in general. Requirements in this rule may be built into state plans and can serve as a resource for states, particularly in preparation for any future event during which continuous enrollment for all beneficiaries may be reinstated.

In cases where states must seek available beneficiary contact information, in addition to the agency's Medicaid Enterprise System and the agency's contracted managed care plans, we appreciate CMS providing examples of third-party data sources for states to take advantage of, including the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Department of Motor Vehicles, and the USPS National Change of Address database. We recommend CMS encourage states to use SNAP and TANF data to automatically renew beneficiaries for coverage when they continue to be eligible without requiring paperwork, including situations in which the beneficiary may be entitled to a higher level of assistance. These strategies help reduce burden on state Medicaid agency personnel and enrollees, increase efficiency, and reduce the

likelihood of eligibility churn.[xii] CMS should continue encouraging states to employ these strategies and provide technical assistance to states when challenges arise with implementing them.

Timely Determination and Redetermination of Eligibility. States are currently required to determine the eligibility of new applicants within 90 calendar days if they apply on the basis of disability and within 45 calendar days for applicants applying on all other bases. However, the current regulations do not establish standards to ensure that applicants have enough time to gather and provide additional information and documentation requested by a state in adjudicating eligibility. Also, current regulations do not apply to redeterminations.

CMS proposes to require states to provide applicants with at least 15 calendar days from the date the request is postmarked or the electronic request is sent, to respond with the additional information. For applicants whose Medicaid eligibility is being considered on the basis of a disability, such as individuals under age 65 who may be eligible for the age and disability-related poverty level group, CMS proposes to require the state agency to provide the applicant with at least 30 calendar days, from the date the request is postmarked or the electronic request is sent, to respond.

CMS seeks comment on the appropriate minimum timeframe for applicants to submit requested information and whether this should be a longer timeframe for individuals applying based on disability. CMS also seeks comment on the appropriate timeframe for reconsideration periods at the time of application, renewal, and a change in circumstances.

AAFP Comments

The AAFP has shown support for CMS requiring states to provide beneficiaries who are eligible based on MAGI methodologies with a minimum of 30 days to return their pre-populated renewal form and any requested information. However, we remain concerned that 30 days is too short a time period for beneficiaries to be able to return the requested information. We recommended CMS extend this minimum period to 60 days to ensure beneficiaries have adequate time to respond to renewal requests.

The AAFP has similar concerns in the context of determination and redetermination of eligibility. We feel the CMS proposal to require states to provide MAGI applicants with at least 15 calendar days from the date the request is postmarked or the electronic request is sent, to respond with the additional information, and 30 calendar days for non-MAGI applicants is too short a time period for beneficiaries to gather the necessary information and respond. We again recommend CMS extend the period to 60 days for all beneficiaries to ensure they have adequate time to respond with additional information. In line with the original proposal, we recommend CMS consider extending this period for non-MAGI applicants or those applying on the basis of a disability to 75 days, for example, because some individuals with disabilities may need more time to gather documentation related to their disability determination.

Whatever the decision on the number of days, we recommend CMS standardize the number of days for beneficiaries to respond throughout all parts of the Medicaid application, renewal, and redetermination processes. A uniform set of days may make it easier for beneficiaries to remember, so when they get a communication with an action item from the Medicaid agency, they are aware of exactly how much time they have to respond with the needed information.

Agency Action on Returned Mail. CMS is concerned that when a beneficiary's mail is returned to the state Medicaid agency, some states rely on that information to conclude the beneficiary cannot be located and terminate coverage without taking reasonable steps to ascertain the accuracy of the information received or attempting to locate the beneficiary and update their address.

CMS proposes that states must conduct a series of data checks and outreach attempts to locate the beneficiary and verify their address. If they're unable to do so, CMS proposes states must check available data sources for updated contact information, conduct outreach to the beneficiary using at least two different modalities, then take action based on no address or no forwarding address if the beneficiary does not respond.

AAFP Comments

The AAFP strongly supports CMS' proposal requiring states to conduct a series of data checks and outreach attempts to locate the beneficiary and verify their address in cases of eligibility determination, redetermination, or renewal. Contacting beneficiaries solely through traditional mail has proven to be vastly ineffective due to changes in address and delays in mail delivery.

In our recent comments to CMS on improving access to Medicaid, AAFP called for CMS to require states to use multiple forms of communication to reach enrollees during application, eligibility redetermination, and potential termination of coverage. We appreciate CMS heard us and included the proposal to require Medicaid agencies to use multiple forms of communication to reach enrollees to discuss their eligibility or redetermination status and/or application status. This includes text messages, phone calls, and emails, in addition to traditional paper mail, which is still important for enrollees who may not have access to technology.

Importantly, multiple renewal notices and follow-up reminders can increase the response rate to renewal requests. Outreach to enrollees is critically important, especially for hard-to-reach communities. Along with using at least two forms of communication to reach enrollees, we again urge CMS to equip states with resources to initiate targeted outreach through community partnerships to notify enrollees of potential coverage changes, obtain updated contact information, and assist with applications or renewals. These outreach strategies should be conducted with established community leaders and key stakeholders to ensure messaging is culturally competent and appropriately tailored to various groups, so it is well-received and understood by enrollees. CMS should also consider assisting states with strategies for targeted community outreach and providing funding to community-based organizations with established relationships with Medicaid populations that may face additional barriers to enrollment or redetermination. In tandem with outreach through multiple modes of communication, this is the best chance to ensure beneficiaries are reached.

Strategies may include CMS advising states with specific recommendations on how to effectively use third-party data, as referenced above, to conduct outreach to enrollees. Community-based organizations, which may also increase access to interpreters and culturally competent patient navigators for applicants, can help applicants gather the appropriate documents, discuss requirements and applications, and appropriately plan for application or renewal deadlines. Community-based organizations can help disseminate information at local churches, daycare programs, social functions, various treatment facilities, and more, in a culturally competent way.

When used to remind enrollees of renewal requirements and health care appointments, aid with navigating plan benefits and resources, and provide fundamental health education, text messaging can be an effective method of communication for individuals with Medicaid. Ninety-two percent of adults earning less than $30,000 own a mobile phone and 97 percent of low-income phone owners use text messaging.[xiii, xiv] Communicating by text can give enrollees more flexibility and privacy in situations like working in hourly positions that limit taking personal calls.

The AAFP appreciates the existing guidance CMS has issued promoting the use of text messaging to reduce coverage losses amid unwinding of the PHE. In the guidance, CMS recommended states use text messages to encourage consumers to apply for other health coverage if they are determined to no longer be eligible for Medicaid or CHIP and encouraged states to request that managed care plans use additional modalities, including text, to conduct outreach to beneficiaries to encourage them to complete renewal forms. The AAFP supports these recommendations but is concerned the Telephone Consumer Protection Act (TCPA) continues to be a barrier to outreach as many health care entities will not conduct text outreach out of fear of violating the TCPA. CMS should work with the Federal Communications Commission (FCC) to develop guidance to states to assure health care entities can conduct outreach to applicants and enrollees beyond the end of the PHE without violating the TCPA.

Additionally, the AAFP is concerned about the barriers people who are experiencing unstable housing or homelessness face during enrollment and when the state Medicaid agency is attempting to contact them. Identity verification is largely reliant on addresses and other documentation that is particularly difficult for people experiencing unstable housing or homelessness to access and appropriately document. Additionally, many of these individuals may not receive the appropriate notices, claims, or denial letters when only sent via mail. Black, Hispanic, and indigenous populations are more likely to experience homelessness, and transgender people experiencing homelessness are more likely to be unsheltered compared to their cisgender peers.[xv, xvi]

Enrollment applications, as well as the pre-populated renewal forms referenced in this rule, should include options to indicate when an individual is experiencing unstable housing to alert states that these individuals must be contacted through methods besides mail. As CMS considers requiring that states contact beneficiaries using at least two different modalities of communication, the AAFP recommends CMS share these unique considerations with states and provide them with resources and technical assistance to ensure they are equipped to communicate with beneficiaries experiencing homelessness, including via text messaging. In reference to those experiencing homelessness, CMS may consider requiring states to ensure their outreach using at least two different modalities is in addition to traditional mail for this specific population.

Transitions Between Medicaid, CHIP and BHP Agencies. CMS notes that, in some cases, states do not transfer an individual's account to the state CHIP agency after determining they are ineligible for Medicaid. Many individuals in this case may be eligible for CHIP coverage but are unaware. CMS proposes to require state Medicaid agencies to ensure the agreement between Medicaid and CHIP agencies includes procedures for the seamless transition of eligibility between programs, accepting determinations of Medicaid eligibility made by a CHIP agency, making determinations of CHIP eligibility and transferring eligible individuals to a CHIP agency, and providing for the issuance of a combined notice to an individual who is determined ineligible for one program but eligible for the other.

AAFP Comments

The AAFP supports CMS' proposal to require seamless transition of eligibility determinations between Medicaid, CHIP, and BHP agencies, along with the issuance of a combined notice to individuals who may be in this situation. The AAFP previously showed appreciation for a similar initiative in the context of eligibility redeterminations after the conclusion of the COVID-19 PHE: CMS' recent guidance to state health officials on the requirement for states to transfer to the Marketplace the electronic accounts of beneficiaries who lose Medicaid coverage and are potentially eligible for coverage through the Marketplace, including all eligibility-related information available to the state.

We agree with this CMS proposal to institute a similar policy for transitions between Medicaid, CHIP, and BHP. The Patient Protection and Affordable Care Act (ACA) gives states the option of creating a BHP, a coverage program for low-income residents who have incomes higher than the Medicaid eligibility cutoff but may not be able to afford coverage from a qualified health plan (QHP) in the Marketplace.[xvii] States considering offering BHPs can benefit from reduced churning between Medicaid and Marketplace plans and giving consumers more affordable coverage than they may be able to get through the Marketplace.[xviii] The integration of systems that would occur from this will improve administrative efficiency by consolidating eligibility determinations and facilitate information sharing across these programs to verify eligibility and renewals. Seamless transition of a beneficiary's case between Medicaid, CHIP, and BHP agencies will reduce burden on agency employees and beneficiaries.

As mentioned, in addition to encouraging states to facilitate transitions from Medicaid to CHIP and vice versa, CMS should take steps to help applicants understand what transitions mean for them. This could include CMS developing and releasing informational materials for state Medicaid and CHIP agencies to send to enrollees, along with the combined notice referenced in this proposed rule, with detailed information on any change in the beneficiary's benefits, premium level, cost sharing, and related information. CMS may consider using navigators to work with enrollees who need to undergo renewal to submit the appropriate information for the renewal form and/or understand the transition to Medicaid from CHIP and vice versa.

Eliminating Barriers to Access in Medicaid

Remove Optional Limitation on the Number of Reasonable Opportunity Periods. A reasonable opportunity period (ROP) in the Medicaid program is used for individuals who have attested to citizenship or satisfactory immigration status but the state is unable to verify the attestation when the individual meets all other eligibility requirements. During the ROP, states must continue efforts to complete verification of the individual's citizenship or satisfactory immigration status and must furnish Medicaid benefits to individuals who meet all other eligibility requirements. States currently have the option to limit the number of ROPs that a given individual may receive for individuals who re-apply for coverage after they have been determined to be ineligible for Medicaid due to failure to verify citizenship, U.S. national status, or satisfactory immigration status during the ROP provided in connection with a prior application. CMS proposes to remove the state option to limit the number of ROPs an applicant may receive after re-applying for benefits.

AAFP Comments

The AAFP supports the proposal to remove the option for states to limit the number of ROPs an applicant may receive after re-applying for benefits. We agree that the ROP is integral to the Medicaid application process and ensuring prompt access to services for eligible individuals who have attested to U.S. citizenship, national, or satisfactory immigration status, but whose status cannot be promptly verified electronically.

CMS may consider extending the period of ROPs beyond the initial 90-day period, which will benefit individuals working in good faith effort to obtain documents, especially those who are working multiple jobs or in circumstances that may make it more difficult to secure documents. This will also benefit Medicaid agencies who may need more time to verify the individual's status or assist the individual in obtaining documents needed to verify their status, especially in situations where the agency may be overwhelmed with eligibility determinations and redeterminations, such as after the COVID-19 PHE concludes. This may alleviate burden on state Medicaid agencies and reduce churn if eligible individuals are determined ineligible because they were unable to obtain documents in time, lose coverage, then must reapply for coverage. We appreciate CMS suggesting states can extend their ROPs in the March 2022 guidance and recommend CMS release similar guidance on how states can maneuver additional ROPs after the option to limit the number of ROPs is removed.

Remove or Limit Requirement to Apply for Other Benefits. Currently, state Medicaid agencies must require that all Medicaid applicants and beneficiaries, as a condition of their eligibility, take all necessary steps to obtain other benefits to which they are entitled, unless they can show good cause for not doing so. These benefits include, but are not limited to annuities, pensions, retirement, and disability benefits.

CMS proposes to remove or limit this requirement to benefits the beneficiary currently has access to, not benefits they could apply for. This means that eligibility for Medicaid would no longer require that applicants and beneficiaries apply for benefits for which they *may* be entitled. CMS proposes several alternative options to ensure beneficiaries are aware of other benefits they may be entitled to while also reducing unnecessary barriers to enrollment and reducing burden on individuals.

AAFP Comments

While the AAFP is supportive of CMS removing barriers to beneficiaries accessing Medicaid benefits in a timely manner, we are concerned about potential unintended consequences if this change results in significant increases in state Medicaid spending. Historically, when state Medicaid spending increases, states have taken steps to constrain spending by reducing or eliminating benefits, reducing physician payment, and other mechanisms that create barriers to timely access to needed health care services.[xix]

The AAFP recommends CMS take steps to minimize potential negative ramifications of this proposal. CMS could also consider how to provide resources that will speed the process of application for other benefits, such as a consultation with a patient navigator to understand which additional benefits they are eligible for and what the application entails, without the requirement to apply for those benefits in order to qualify as eligible for Medicaid.

Recordkeeping

CMS proposes to require that states store their case records in an electronic format and proposes to update the types of documentation that states must retain, including the initial application, the electronic account, all forms and notices provided, and all actions taken in a beneficiary's case.

CMS also proposes to require that states maintain all records for the entire time a beneficiary's case is active plus three years after and proposes to require states to provide stored information within 30 calendar days after a request has been made.

AAFP Comments

The AAFP is strongly supportive of the requirements to maintain all of a beneficiary's case records in an electronic format for the entire time a beneficiary's case is active and for at least three years after a beneficiary's case is no longer active. Retention of these records will minimize the administrative burden on both state Medicaid eligibility employees and beneficiaries when looking for certain information, which may be particularly helpful in situations of termination and reapplication. We recommend CMS consider requiring states to also store any other data sources states use to verify eligibility, including state CHIP case records and application materials. We recommend CMS require states disclose to the beneficiary all the records that will be maintained in the system for the beneficiary's awareness and in case they may need to obtain any records from the state agency.

We caveat that if this is required, CMS must work with state agencies to ensure their IT systems can store this information in a secure, standardized, and organized way. CMS could partner with IT developers in collaboration with agency staff to prepare for the transfer to fully electronic documentation and storage of beneficiaries' case files, which should include testing of any electronic format system and training for agency employees to use it efficiently. CMS should work with states to adopt the same format across all state Medicaid agencies. If so, these standardized case files can also be beneficial if a beneficiary moves to another state, for example, the case file can be easily transferred to the other state's system to minimize any coverage loss during the application process in the other state.

CHIP Proposed Changes – Streamlining Enrollment and Promoting Retention and Beneficiary Protections in CHIP

CMS proposes to apply the same changes proposed in this rule for Medicaid, to CHIP, where applicable and relevant in timely determination and redetermination of eligibility and related reviews (with flexibility for children with special health care needs), changes in circumstances, returned mail, transitions between CHIP and Medicaid, and recordkeeping. CMS seeks comment on whether there are any special considerations applicable to CHIP that warrant adoption of a different policy for CHIP than the proposed alignments with Medicaid.

AAFP Comments

The AAFP supports applying these proposed Medicaid changes to CHIP where applicable and relevant, with the appropriate flexibilities and considerations for specific child populations. We appreciate CMS' focus on ensuring seamless transitions between CHIP and Medicaid to facilitate easy access to continuous coverage for eligible individuals.

CHIP gives states the opportunity to provide affordable health coverage to children and pregnant women in families that earn too much to qualify for Medicaid but too little to afford private health insurance. Stable health coverage is essential for a healthy childhood and development, and public health coverage is associated with improved health and reduced disability for children as they reach adulthood.[xx] Children covered by CHIP have better access to primary and preventive care, specialist care and dental care compared to uninsured children, and CHIP programs cover physical, occupational, and speech and language therapies, benefiting many children with special health care needs.[xxi] Children enrolled in CHIP benefit from these robust coverage policies, but streamlined enrollment, determination, and redetermination policies are necessary to ensure as many eligible children as possible can access these benefits. The AAFP supports any effort to accomplish this.

Eliminating Access Barriers in CHIP

CMS proposes changes to CHIP to streamline enrollment and promote retention and beneficiary protections in CHIP along with eliminating access barriers to continuous coverage. In addition to other changes similar to those proposed in this rule for the Medicaid program, CMS proposes to:

- eliminate premium lock-out periods, specified periods that a child or a pregnant individual must wait until being allowed to reenroll in the CHIP program after non-payment of premiums;
- eliminate waiting periods, or required periods of uninsurance prior to enrollment, for individuals who have recently disenrolled from a group health plan prior to allowing them to enroll in a separate CHIP; and
- prohibit annual and lifetime dollar limits on all CHIP benefits, including both aggregate annual and lifetime limits on all benefits as well as annual and lifetime dollar limits on specific benefits.

AAFP Comments

The AAFP supports CMS' proposals to eliminate premium lock-outs, waiting periods, and annual and lifetime limits on benefits for CHIP enrollees. Experts have noted that CHIP premiums are one of the biggest barriers to enrollment.[xxii] In addition to premiums themselves, lock-out periods and waiting periods result in beneficiaries losing coverage unnecessarily and are a barrier to needed care.

The AAFP supports CMS' proposal to eliminate waiting periods for CHIP to align with Medicaid, BHP, and individual market exchange plans. Like premium lock-outs, gaps in coverage from waiting periods can be harmful to continuity of coverage and as a result, creates barriers to access to care for children. Without health coverage, children have less access to medical care, are less likely to have a usual source of care, and may delay care, turn to costly emergency department visits as a last resort, or forgo care altogether.[xxiii] Delaying or forgoing health care for children is harmful to their long-term health and development, even during a waiting period or lock-out period. Eliminating or reducing the number of days in waiting periods will reduce uninsurance and improve stability of coverage.

Further, administering waiting periods is costly, inefficient, and imposes unnecessary administrative burden on state CHIP agencies.[xxiv] Research looking to determine whether waiting periods discourage crowd-out (when families drop private health insurance for public insurance) has been inconclusive and contradictory. A Government Accountability Office (GAO) study of CHIP found that

of states that shortened or eliminated waiting periods, there were no concerns that this contributed to CHIP crowd-out.[xxv, xxvi] In fact, state officials noted that reducing waiting periods eased their state's administrative burdens and eliminated gaps in children's health insurance.

The AAFP supports CMS' proposal to prohibit all annual and lifetime limits on all CHIP benefits. The AAFP's Health Care for All policy framework advocates for prohibitions on annual and lifetime caps on benefits and coverage. With several peer organizations, the AAFP has previously voiced support for the value of protections afforded by the ACA, including the ban on annual and lifetime limits on coverage.

Thank you for the opportunity to provide comments on the proposed rule. The AAFP looks forward to continuing to work with CMS to advance comprehensive, affordable health coverage and access to high-quality primary care for all. Should you have any questions, please contact Meredith Yinger, Manager, Regulatory Affairs at myinger@aafp.org or (202) 235-5126.

Sincerely,

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