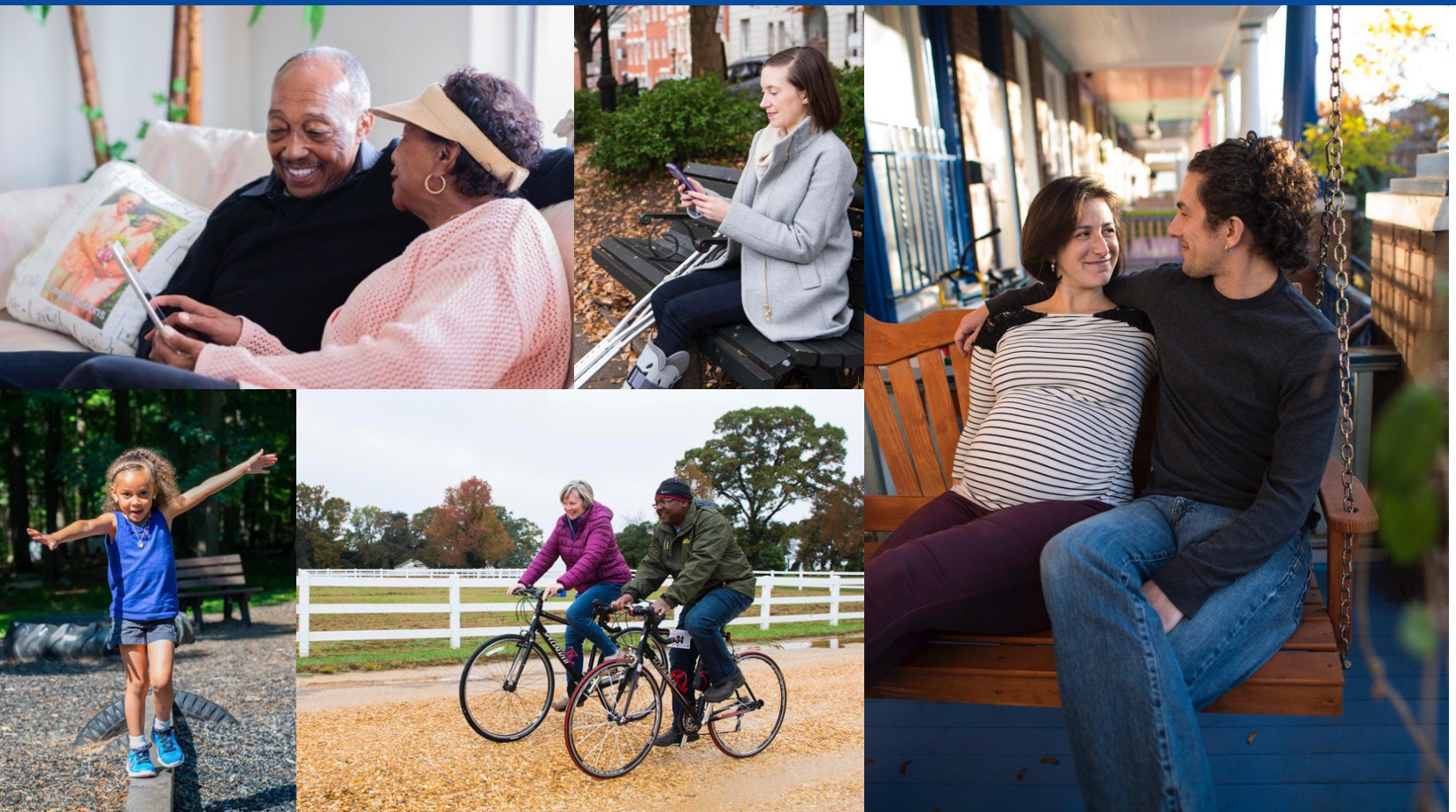
Streamlining Enrollment and Renewal Processes in Medicaid and CHIP (CMS-2421-P)



All Tribes Webinar

October 26, 2022

Agenda

- Notice of Proposed Rulemaking (NPRM) Context
- Overview of NPRM Requirements
  - Streamline Application and Enrollment Processes
  - Improve Retention Rates at and between Renewals
  - Remove Access Barriers for Children
  - Enhance Program Integrity
- Implementation Timeframe
- Request for Comments
- Questions

Notice of Proposed Rulemaking

NPRM Publication Date: **September 7, 2022**

https://www.federalregister.gov/d/2022-18875

Comment Period: **September 7 - November 7, 2022**

Backdrop to NPRM

- Presidential Directives
  - Executive Order on Strengthening Medicaid and the Affordable Care Act (January 2021)
  - Executive Order on Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage (April 2022)
- Affordable Care Act (ACA) Accomplishments
  - Streamlined application and renewal processes (e.g., increased reliance on electronic data sources and use of pre-populated forms)
  - Focus on MAGI-based populations

Important ACA simplifications not required for eligibility determinations and renewals based on age (65+) or having blindness or a disability

Backdrop to NPRM

- Enrollment Declines
  - Following a period of steady growth attributed to the ACA, enrollment in Medicaid and CHIP declined from 2016 through 2019
  - Evidence suggests the economy was the primary driver of this decline
  - We also know that more restrictive State enrollment policies contribute to coverage disruptions and create churning
- Program Integrity Concerns
  - Medicaid and CHIP recordkeeping regulations are both outdated and lacking in specificity
  - Insufficient documentation is a major driver of eligibility-related improper payments

NPRM Objectives

1. Streamline application and enrollment processes
2. Improve retention rates at and between renewals
3. Remove access barriers for children
4. Enhance program integrity

Objective 1:
Streamline Application and Enrollment Processes

Facilitate Enrollment in the Medicare Savings Programs Using Part D Low-Income Subsidy Data (42 CFR §§ 435.4, 435.601, 435.911, and 435.952)

- Current: Most individuals eligible for the full-subsidy Low-Income Subsidy (LIS) for Medicare Part D meet the eligibility requirements for a Medicare Savings Program (MSP) eligibility group, but over 1 million LIS recipients are not enrolled in the MSPs
- Proposed: Streamline enrollment for individuals in LIS into the MSPs
  - Codify statutory requirement that states initiate MSP applications using LIS application data
  - Encourage states to adopt targeted income and resource disregards, to fully align LIS and MSP financial methodologies, including:
    - Dividend interest and income
    - Value of non-liquid resources
    - Burial funds
    - Cash value life insurance

Facilitate Enrollment in the Medicare Savings Programs Using Part D Low-Income Subsidy Data (§§ 435.4, 435.601, 435.911, and 435.952)

- Proposed: Streamline LIS enrollment into the MSPs (cont.)
  - Require states to accept Social Security Administration's verified findings and deem full-subsidy LIS recipients as eligible for MSPs if income resource and methodologies are aligned
  - Accept self-attestation of income and resources not counted in determining LIS eligibility, with an option to conduct post-enrollment verification
  - Define family size in MSPs to be no less than the LIS definition: generally, the applicant, the applicant's spouse, and certain other financially-dependent relatives living in the same household

Facilitates alignment of LIS and MSP eligibility and enrollment and maximizes assistance with Medicare premiums and cost-sharing

Automatically Enroll Certain Supplemental Security Income Recipients into the Qualified Medicare Beneficiary Group (§ 435.909)

- Current: Supplemental Security Income (SSI) beneficiaries are always financially eligible for the Qualified Medicare Beneficiary (QMB) MSP eligibility group, but nearly 500k are not enrolled
- Proposed: Require states to automatically enroll most SSI beneficiaries into the QMB group
  - **Exception**: Automatic enrollment would be optional for states that do not have a Part A buy-in agreement with CMS ("group payer states")

Facilitates enrollment of individuals known to be eligible for the MSPs

Facilitate QMB Enrollment by Making the QMB Effective Date Earlier in Group Payer States (§ 406.21)

- Current: In group payer States, QMB coverage for individuals who enroll in conditional Part A during the Medicare general enrollment period (January through March) can begin as early as July 1 of the calendar year
- Proposed: QMB coverage for individuals who enroll in conditional Part A during the general enrollment period in 2023 or later years could begin as early as the month after conditional Part A enrollment

Maximizes assistance with Medicare premiums and cost-sharing and aligns with the Consolidated Appropriations Act of 2021

Facilitate Medically Needy Enrollment by Allowing Individuals to Deduct Prospective Medical Expenses (§ 435.831)

- Current: Medically needy individuals permitted to deduct from income their prospective institutional expenses, but ***not*** non-institutional expenses, in order to establish medically needy eligibility
- Proposed: Enable medically needy individuals to deduct predictable non-institutional medical or remedial expenses, such as:
  - Cost of HCBS included in a section 1915(c), (i), (j), or (k) plan of care
  - Prescription drug expenses included in a patient's pharmacy profile

Supports goal of rebalancing home and community-based services with institutional services for Medicaid beneficiaries

Facilitate Medically Needy Enrollment by Allowing Individuals to Deduct Prospective Medical Expenses: Example

Example Scenario:

Individual countable monthly income	$1,200
State's medically needy income level (MNIL)	$700
Difference between countable monthly income and MNIL	$500 ($1,200 - $700 = $500)
State budget period	3 months
Individual's spenddown for budget period	$1,500 ($500 x 3 = $1,500)
Individual's reasonably constant and predictable expenses (*e.g.* drugs prescribed to treat a chronic condition, or services in the individual's 1915(c) plan of care).	$600 per month

Current:

- Individual is not eligible at start of budget period
- Medicaid eligibility starts only after $1,500 in expenses is incurred (partway into 3rd month of budget period)
- Individual experiences gap in coverage and cycles on and off Medicaid each budget period

Proposed:

- Individual is eligible at start of budget period using projected expenses at Medicaid rate ($600 x 3 = $1,800; $1,800 > $1,500)
- Individual does not experience gap in coverage caused by cycling on and off Medicaid each budget period

Apply Reasonable Compatibility Standards to Electronic Verification of Resource Information (§§ 435.952 and 435.940)

- Current: States are required to verify financial assets (for individuals subject to a resource test) using an Asset Verification System
  - Regulations do not explicitly address relationship of AVS to other documentation in verifying assets
- Proposed: Clarify that "reasonable compatibility" rules at § 435.952 apply to verification of resources
  - Information obtained from an electronic data source, such as AVS, considered reasonably compatible with attested information if both are either above or at or below applicable resource standard
  - States may apply different reasonable compatibility thresholds for income and resources
  - If attested asset information is not reasonably compatible with electronic data, state must seek additional information from the individual

Supports streamlining enrollment for individuals applying on a non-MAGI basis and decreases burden for both States and beneficiaries

Verification of Citizenship (§ 435.407*)

- Current: Individuals whose US citizenship is verified with a State's vital statistics agency or DHS' Systematic Alien Verification for Entitlements (SAVE) Program must also provide separate proof of identity
- Proposed: Treat verification of citizenship with a State vital statistics agency or SAVE as stand-alone evidence of U.S. citizenship, not requiring separate proof of identity

Recognizes data match effectively verifies identity and reduces administrative burden on individuals and State Medicaid/CHIP agencies

*This provision applies to CHIP through cross references at §§ 435.956 and 457.380

Remove Requirement to Apply for Other Benefits (§§ 435.608)

- Current: Require all Medicaid applicants and beneficiaries, as a condition of eligibility, to apply for certain other benefits to which they are entitled (such as annuities, pensions, retirement, disability, and unemployment benefits)
  - Presents an unnecessary barrier to Medicaid eligibility, particularly when some of these benefits are not counted toward financial eligibility, such as when an individual is screened for an eligibility group to which an income test is not imposed or the particular benefits an individual might receive would not be counted under the financial methodology used to determine their eligibility

- Proposed: Eliminate requirement

Removes barriers to coverage

Remove Optional Limitation on the Number of ROPs (§§ 435.956 & 457.380)

- Current: States permitted to establish limits on the number of reasonable opportunity periods (ROP), if needed to ensure program integrity and approved by CMS
  - No State currently elects this option

- Proposed: Eliminate State option

Ensures access to services for otherwise eligible individuals and better aligns with the statute

Objective 2:
Improve Retention Rates at and Between Renewals

Aligning MAGI and Non-MAGI Application and Renewal Requirements (§§ 435.907, 435.916)

- Current: For MAGI-based beneficiaries, in-person interviews may not be required at application and renewal, and States must provide at renewal:
  - **Renewal form prepopulated** with available information needed to renewal eligibility
  - Minimum of **30 calendar days to return** prepopulated form
  - Minimum **90 day reconsideration period** to reconsider eligibility without requiring a new application when coverage is terminated at renewal for failure to return form but individual subsequently returns completed form

  These policies are currently optional for non-MAGI beneficiaries

- Proposed: Require streamlined application and renewal processes for *all* Medicaid and CHIP beneficiaries, except as specifically allowed under statute*

Facilitates continued enrollment of eligible individuals

*Section 1902(e)(8) of the Act allows States to renew eligibility for QMBs no more frequently than once every 6 months

Acting on Changes in Circumstances (§§ 435.919, 457.344)

- Current: Regulations are silent on expectations for processing redeterminations based on changes in circumstances
- Proposed:

1. Codify required steps for redetermining Medicaid and CHIP eligibility based on changes in circumstances for all beneficiaries:
   - Check available sources before requesting information from the beneficiary
   - Reach out to the beneficiary before taking adverse action
   - Maintain coverage in certain circumstances when a beneficiary does not respond
2. Require **minimum 30 calendar days** for all beneficiaries to respond to requests for information needed for a redetermination following a change in circumstances
3. Provide **90 day reconsideration period** for all beneficiaries terminated for failure to provide needed information without requiring a new application, similar to that currently provided at renewal

Supports timely processing of redeterminations, improves continuity of coverage, and reduces churn

Required Actions When Beneficiaries Address May Have Changed (§§ 435.919 and 457.344)

- Current: Regulations do not prescribe proactive steps states must take when obtaining information indicating that a beneficiary's address may have changed
- Proposed: Require proactive steps when beneficiary mail is returned or State obtains other information indicating a potential address change:
  - Leverage a standard set of data sources to obtain updated contact information (returned mail only)
  - Conduct outreach by mail, and via alternative modalities, to try to locate the beneficiary
  - *If still unable to locate the beneficiary*, require specific actions based on whether the beneficiary is in-state, out-of-state*, or whereabouts unknown

Promotes continuity of coverage by reducing procedural terminations

*If a State's separate CHIP coverage is not available statewide, and the updated address lies outside geographic areas in which CHIP coverage is provided, State would follow the same steps proposed for out-of-state addresses

Facilitating Transitions Between Medicaid and CHIP (§§ 435.1200, 457.348, 457.350)

- Current: In States with a separate CHIP, transfer beneficiaries between Medicaid and CHIP when potential eligibility for the other program can be determined
  - When a State receives data indicating a change in eligibility and the beneficiary neither confirms nor denies the change, coverage may be terminated without a transition
- Proposed: In States with a separate CHIP:
  - The Medicaid agency will determine eligibility for CHIP
  - The CHIP agency will determine eligibility for Medicaid
  - Each agency will transition eligible individuals to the other agency and accept eligibility determinations made by the other agency
  - The agencies will issue a combined notice of eligibility

Prevents gaps in coverage for eligible children

Objective 3: Remove Access Barriers for Children

Eliminate CHIP Waiting Periods (§§ 457.805, 457.810)

- Current: States may impose up to a 90-day waiting period for enrollment in CHIP
  - Most states have eliminated their waiting period
  - In practice, states report that few children are subject to a waiting period after applying federally-required and state-specific exceptions
- Proposed: Eliminate waiting periods in separate CHIPs
  - Aligns with Medicaid and individual market Exchange plans
  - Requires states to look to other monitoring strategies to prevent substitution of group health plan coverage
  - Seeks comments on exception to permit 30 day waiting period if state demonstrates need to address crowd out

Improves access to care, such as primary and preventive care, that is particularly critical during childhood and adolescence & eliminates coverage gaps for eligible children

Remove Premium Lock-Out Periods in CHIP (§ 457.570)

- Current: States are permitted to apply a premium lock-out period for up to 90 days to prevent children in CHIP from enrolling in coverage if they have unpaid premiums or enrollment fees
- Proposed: Remove premium lock-outs and encourage CHIPs to consider other mechanisms for addressing timely payment of premiums including:
  - Generating frequent reminder notices
  - Providing multiple and convenient options for paying premiums
  - Addressing language barriers to ensure families are knowledgeable about payment policies and procedures
  - Pursuing collection of past due premiums

Improves continuity of care and more closely aligns CHIP and Medicaid state plan policies

Prohibit Annual and Lifetime Benefit Limits in CHIP (§ 457.480)

- Current: Annual and lifetime limits are prohibited only for behavioral health benefits provided through a separate CHIP due to the Mental Health Parity Act of 1996 (MHPAEA)
  - States have already taken steps to remove limits on CHIP benefits, and no state has an aggregate lifetime limit on CHIP benefits
- Proposed: Prohibit annual and lifetime limits on any CHIP benefits

Ensures continued access to coverage and aligns with Medicaid and the Marketplaces

New Optional Medicaid Eligibility Group for Reasonable Classifications of Individuals Under Age 21 (§ 435.223)

- Current: Medicaid statute permits states to cover a reasonable classification of individuals under age 21 (i.e., "children") within an optional statutory eligibility category
  - This authority is partly implemented at § 435.222, which generally authorizes states to cover an optional, MAGI-based eligibility group serving a reasonable classification of children
- Proposed: Establish a regulatory provision confirming States' authority to cover *non-MAGI*-based Medicaid eligibility groups (i.e., groups that meet a MAGI exception in § 435.603(j)) serving one or more reasonable classifications of children
  - States would be authorized to apply disregards to such groups under the authority of section 1902(r)(2) of the Act

Permits States to tailor optional coverage expansion to targeted groups of children based on specific state circumstances

Objective 4: Enhance Program Integrity

Establish Maximum Timeframes for Redetermination of Eligibility (§§ 435.912, 457.340)

- Current: States must determine eligibility at application within 45 days (90 days for applicants applying on the basis of disability), but regulations are silent on timeframes for processing redeterminations of eligibility at renewal and based on changes in circumstances
- Proposed: Establish specific timeframes for eligibility redeterminations
  - Timeframes are specific to different types of redeterminations (renewal vs. change in circumstance)
  - Longer timeframes provided for eligibility determinations on the basis of disability
  - Timeframes are extended when beneficiaries return requested information or documentation with less than 25 days remaining to provide sufficient time to check other bases of eligibility

Establishes consistent standards for all States and allows required actions to occur more quickly

Strengthen Recordkeeping Regulations in Medicaid and CHIP (§§ 431.17, 435.914, and 457.965)

- Current: Regulations on the maintenance of applicant and beneficiary case records are unclear and outdated
  - Record keeping deficiencies have been highlighted in recent Federal and State audits as well as Payment Error Rate Measurement (PERM) program reviews
- Proposed: Modernize States' recordkeeping systems
  - Require records to be stored in an electronic format
  - Delineate the types of records that must be retained as part of each applicant and beneficiary case record
  - Establish a minimum record retention period for all such records extending through the period that the case is active, plus a minimum of 3 years thereafter

Reduces auditing vulnerabilities by ensuring that eligibility and enrollment actions are properly documented

Implementation Timeframe

- In considering the timeframe for finalizing this NPRM, we:
  - Recognize ongoing State work to unwind from the continuous enrollment condition effective during the COVID-19 public health emergency
  - Seek to balance implementation of new options and requirements with the 12-14 month unwinding period
  - Are considering an effective date of 30 – 60 days after final rule publication, with a separate date (or dates varying by provision) for compliance with finalized requirements
- We seek comment on:
  - Reasonable implementation timelines for each proposed provision
  - An immediate effective date, with compliance no later than 12 months following

Submitting Public Comments

NPRM Publication Date: **September 7, 2022**

https://www.federalregister.gov/d/2022-18875

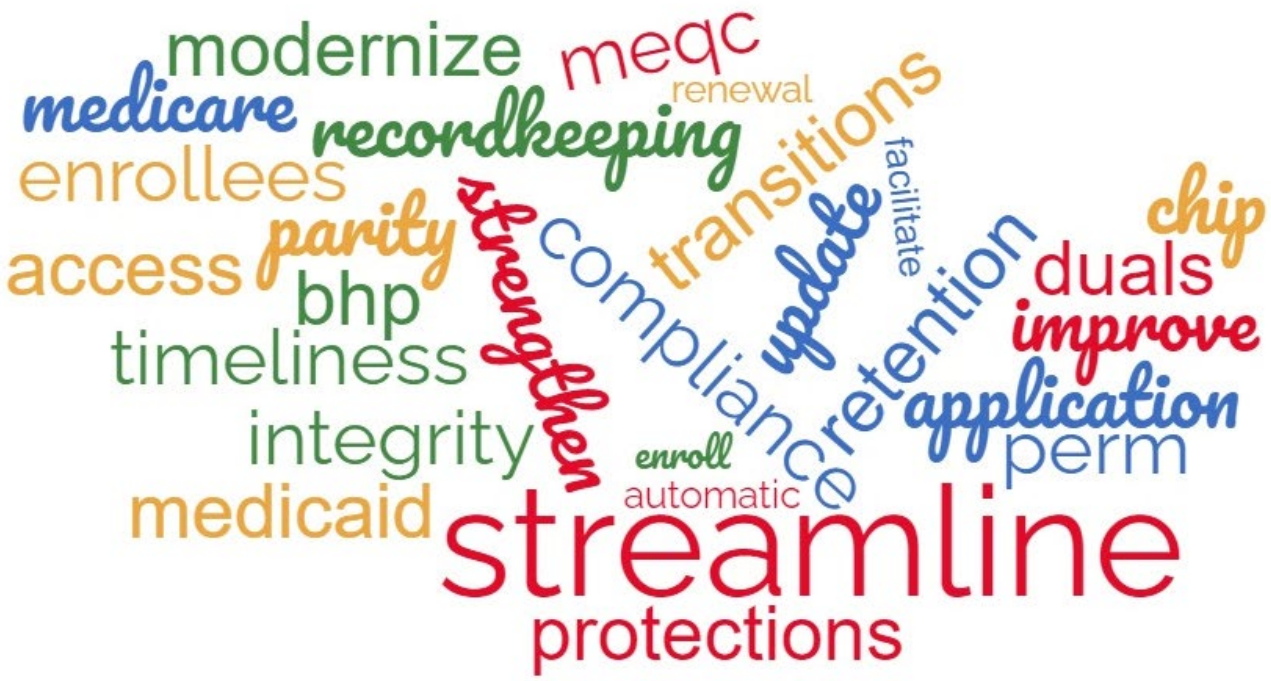
Comment Due Date: **November 7, 2022**

- Submit comments online at: http://www.regulations.gov
- Refer to file code CMS-2421-P when submitting comments

Request for Feedback

We need YOU to review and submit public comments!

Questions?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