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November 6, 2022

VIA ELECTRONIC TRANSMISSION

The Honorable Xavier Becerra
Secretary
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: RIN 0938-AU00
Streamlining the Medicaid, Children's Health
Insurance Program, and Basic Health Program
Application, Eligibility Determination, Enrollment
and Renewal Process

Dear Secretary Becerra and Administrator Brooks-LaSure:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. For over fifty years, we have educated, advocated and litigated to advance health equity for all. We appreciate the opportunity to comment

on the Centers for Medicare & Medicaid Services' proposed rule, Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment and Renewal Processes (hereinafter "2022 Proposed Rule").¹

Overall, we strongly support the Proposed Rule, subject to the comments below, and recommend HHS finalize it and establish compliance dates as soon as is practicable. Finalizing the rule will help simplify eligibility determinations. Current program rules put too much emphasis on making sure that ineligible individuals do not enroll or remain enrolled, and the proposed rule tries to balance that interest with the goal of enrolling and retaining coverage for people who continue to be eligible. As the COVID-19 Medicaid continuous coverage requirement comes to an end, these are particularly important changes that could help reduce coverage losses as states begin acting on eligibility redeterminations for millions of people.

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

Our specific comments on the provisions of the 2022 Proposed Rule are as follows.

§§ 435.4, 435.601, 435.911, and 435.952 Facilitating Enrollment in Medicare Savings Programs

Medicare Savings Programs (MSPs) provide critical financial assistance to low-income older adults and people with disabilities who are eligible for Medicare. However, the

¹ U.S. Dept. of Health and Human Srvs., *Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes*, 87 Fed. Reg. 54760 (Sept. 7, 2022), <https://www.govinfo.gov/content/pkg/FR-2022-09-07/pdf/2022-18875.pdf> (hereinafter "2022 Proposed Rule" or "Proposed Rule").



number of eligible but unenrolled individuals in MSPs remains unacceptably high. For example, a 2017 Urban Institute study showed just under half of Medicare enrollees eligible for MSPs were not enrolled.² Roughly one out of every six SSI recipients (16%) eligible to enroll in Medicare are not enrolled in the Qualified Medicare Beneficiary (QMB) group.³ The proposed rule makes a number of changes aimed at rectifying these dismal statistics on MSP under enrollment. We generally support the important steps in the Proposed Rule to streamline non-MAGI eligibility, particularly in relation to MSPs, and urge HHS to go further, as MSPs are essential to the health and economic well-being of low-income Medicare enrollees.

We strongly support the provisions that codify longstanding requirements that have not been adequately implemented by state Medicaid agencies. Since 2010, states have been required to treat data they receive from the Social Security Administration (SSA) related to an individual's eligibility for Low-Income Subsidy (LIS) in Medicare Part D as an application for an MSP. But some states still do not use the data to automatically initiate an MSP application, and other states inappropriately send the individual a blank application. We commend the decision to codify this requirement into federal regulations and encourage HHS to enforce it fully.

We also support the changes to better align income and asset counting methodologies across LIS and MSP programs. This will reduce churn by eliminating the need for individuals to provide additional documentation of income or resources in order to enroll in an MSP. The best option would be for a state to use its authority under § 1902(r)(2) of the Social Security Act to fully align eligibility for these two categories, thus allowing the state to determine MSP eligibility without additional information from the applicant beyond the citizenship and residency check. But in the absence of compelling states to align eligibility for these programs that reduce out-of-pocket health care costs, HHS should require states to accept beneficiary self-attestation of income and resources. Treating SSA "leads" data as already verified, as proposed at § 435.911(e)(5), will help increase the share of LIS enrollees who get enrolled in an MSP as well.

² Kyle J. Caswell and Timothy A. Waidmann, The Urban Inst., *Medicare Savings Program Enrollees and Eligible Non-Enrollees*, 1 (June 2017), <https://www.macpac.gov/wp-content/uploads/2017/08/MSP-Enrollees-and-Eligible-Non-Enrollees.pdf>.

³ 87 Fed. Reg. 54771.



HHS requests comments on the length of time states should give enrollees to provide information needed for any post-eligibility verification of income and assets such as interest and dividend income, non-liquid resources, burial funds, in-kind support, and the cash value of life insurance policies. Given the long history of bureaucratic barriers to verification, we believe that individuals should have as much time as possible to provide necessary documentation post-enrollment. Churn for avoidable administrative reasons causes needless financial harm for older adults and people with disabilities, as well as for states. Such gaps in coverage can lead to negative health outcomes. We recommend providing individuals at least 90 calendar days after notice to provide additional documentation in those states that implement the option to do post-enrollment verification.

We support the proposed change to require state Medicaid agencies to help individuals obtain information about their life insurance to ease the burden on applicants. The language at § 435.952(e)(4)(iv)(A) requires the agency to “assist the individual with obtaining this information and documentation by requesting the name of the insurance company, the policy number, and to authorize the release of information.” We do not think any eligible individuals should fail to enroll in Medicaid just because it is too challenging to document the cash surrender value of life insurance. In those cases where an individual has a significant life insurance policy, states should take extra steps to try to calculate the surrender value without forcing applicants to do that complicated legwork. The state should also explain to applicants its reasons for requesting insurance policy details and state protections to safeguard applicant data. For those individuals who refuse to provide the basic policy information to the state, we believe that 15 calendar days is too short a turnaround time for an individual to collect and submit the insurance surrender value themselves. It often takes several days for notices to get to individuals, and they may not have time to respond in that short window. Many life insurance policies were purchased decades before an LIS application was submitted, which can make it even more difficult for applicants to track down the needed information. Respecting the balance that HHS has tried to strike between processing applications within the 45-day limit and still providing individuals ample opportunity to respond to requests for additional information, we recommend a more realistic 30-day window to provide additional documentation in these circumstances. Above all else, however, we do not want the 45-day application processing time to be extended.



Finally, HHS requests comment on the value of extending these MSP-related policy changes – particularly in the determination of interest and dividend income – across all non-MAGI eligibility groups. There are excellent reasons to mandate these policies across the non-MAGI categories and we strongly support this proposal. First, it avoids unnecessary delays in processing applications by applying more uniform standards across categories. Second, uniform standards reduce potential confusion and duplicative administrative burden for state Medicaid agencies. Third, mandating more uniform standards will increase the number of eligible individuals who are enrolled in Medicaid, which helps fulfill the clear purpose of the Medicaid program – to provide medical assistance to eligible individuals.⁴ Every step we take to make it easier for otherwise eligible people to enroll is a step in the right direction.

For this same reason, we also support HHS's proposal that all MSP applicants also get screened for full Medicaid eligibility across the various MAGI and non-MAGI eligibility categories.⁵ Such screening should be routine. However, if the final regulation does not require states to extend the MSP income and resource counting methods to non-MAGI categories, we are concerned that HHS's efforts to streamline the administrative process could be thwarted unless HHS clarifies that the full Medicaid screen is separate from the MSP enrollment process.

We are concerned that as part of the full Medicaid screen, states with different verification rules for other non-MAGI categories may routinely request additional documentation from MSP applicants and wait to process the MSP application until the applicant provides additional documentation. This would undermine the whole purpose of implementing these proposed changes to boost MSP enrollment by reducing documentation barriers.

We suggest HHS extend the proposed MSP policies for interest and dividends, non-liquid resources, burial funds, in-kind support and maintenance, and life insurance cash value to other relevant non-MAGI categories. The proposed changes do not increase state eligibility thresholds but rather, alter the verification process. By accepting self-attestation and offering states the option to conduct post-enrollment verification, HHS would help standardize a wickedly complicated eligibility process and increase the

⁴ 42 U.S.C. § 1396.

⁵ 87 Fed. Reg. 54766.



number of eligible individuals who get access to Medicaid coverage without causing harmful delays or incomplete eligibility determinations. It would also ease the administrative burden to process Medicaid applications and redeterminations.

At § 435.601, HHS proposes to define “family of the size involved” for MSP eligibility using at least the individuals included in the definition of the LIS family size. We urge HHS to go even further, and extend this aligned minimum definition of family size across non-MAGI categories to the extent possible. Maintaining multiple definitions of family size across non-MAGI eligibility categories engenders confusion and frustration for applicants, requires additional documentation, and increases administrative costs for states to process applications and renewals.

Moreover, using a broader, more standardized definition of household also strengthens equity. Definitions that limit family size to just a spouse instead of all family members who depend on the applicant’s income create disproportionate burdens for marginalized communities. People facing difficult economic challenges often turn to living in multigenerational households to lower housing costs and to provide more opportunities for informal family supports like child or adult caregiving.⁶ This trend increased during the COVID-19 pandemic, as the share of Americans living in multigenerational households increased from 22% in 2019 to 26% in 2022.⁷ Overall, Asian, Latinx, and Black households were much more likely to include multiple generations than white families.⁸ Medicaid’s eligibility rules should be sensitive to these cultural and economic realities. Arbitrary and overly restrictive family size definitions in MSP and other non-MAGI categories ignore the financial realities of applicants who cannot afford Medicare premiums or other forms of health insurance.

If HHS is not willing to use its authority under § 1902(a)(4) of the Act to require the proposed streamlining of income and asset verification rules and family-size across

⁶ Rakesh Kochhar and D’Vera Cohn, Pew Research Center, *Fighting Poverty in a Bad Economy, Americans Move in with Relatives* (Oct. 2011), <https://www.pewresearch.org/social-trends/2011/10/03/fighting-poverty-in-a-bad-economy-americans-move-in-with-relatives/>.

⁷ Stephanie Firestone and Donna Butts, *Changing the Narrative on Multigenerational Living* (June 2021), <https://generations.asaging.org/changing-narrative-multigenerational-living>.

⁸ *Supra* note 6.



non-MAGI categories, then at least it should clarify that screening MSP applicants for potential eligibility in other Medicaid categories should in no way impact or delay the processing of their enrollment in an MSP.

§§ 435.909 Facilitating Enrollment in QMB for Individuals Who Enroll In SSI

Other provisions would change existing practice to better align enrollment in the Medicaid SSI/209(b) mandatory category with enrollment in the QMB category that pays for Medicare premiums and cost sharing. In a more perfect world, SSI eligibility would automatically confer Medicaid eligibility alongside QMB eligibility for every SSI beneficiary entitled to Medicare, whether or not they qualify for premium-free Part A. We realize that historical complexities have led to exemptions and state-specific approaches like 209(b) and Part A group payer agreements that introduce extra eligibility steps for low-income individuals and lead to under enrollment and the poor health and financial consequences it can cause. Where possible, federal policies should always encourage, if not compel, states toward a simpler approach.

For this reason, we support HHS' proposal that would require states to deem any SSI recipient determined eligible for the mandatory SSI (or 209(b)) Medicaid group also eligible for QMB if they are entitled to premium free Medicare Part A.

Similarly, we support HHS's resolution for the legal catch-22 some other SSI recipients face when they have to pay the first month's Medicare Part A premium before they can qualify for QMB coverage that would pay for those premiums. We agree with HHS's interpretation that this creates a substantial financial hurdle that is wholly inconsistent with the purpose of QMB, and we support the proposal to codify CMS's longstanding practice to provide FFP to cover the first month of Part A premiums (and any late fees) in states that have Part A buy-in agreements with CMS for SSI beneficiaries who do not qualify for premium free Part A.

For the 14 states that use group payer agreements in lieu of a Part A buy-in, the proposed solution is frustratingly limited. SSI recipients with premium Part A in group payer states face significant unnecessary burdens due to the requirement to apply for conditional Part A enrollment through SSA in order to enroll in QMB. Advocates in group payer states report significant confusion and unnecessary delays in coverage due to the conditional enrollment requirement. Requiring an extremely low-income, high needs



group like SSI recipients to apply for conditional Part A through a completely separate agency is unrealistic and unfair. Moreover, as stated above, delays in Part A enrollment increase costs to the state because Medicaid covers the full cost of services (with a state match) until the individual is enrolled in Medicare.

Therefore, while we support the agency's proposal to allow states to enroll SSI recipients in QMB without a conditional Part A application, we urge HHS to go further. HHS should require group payer states to deem SSI recipients eligible for QMB without having to undergo the cumbersome conditional enrollment process for Medicare Part A. If HHS does not compel group payer states to take up this deeming process, we ask HHS to provide states with detailed information to highlight how each state could reduce costs by avoiding processing conditional enrollment and by saving money when enrollees are also covered by Medicare.

§ 435.831 Projecting Spending for HCBS and Other Services to Stabilize Medicaid Spend Down Eligibility

We support the extension of the process of projecting expected expenses for recurrent services beyond institutional care to include other relatively predictable medical costs – such as an individual's medications for some chronic conditions, or the costs of receiving certain recurrent and everyday HCBS services.

We appreciate HHS's request for examples of other types of services that individuals may receive on a constant and predictable basis, for which a state could project consistent costs. We believe there are several services that fall under the general umbrella of "home and community based services" that are provided via state plans, and not via § 1915 waivers, that should be included in the examples.

First, we recommend including certain behavioral health services that individuals with mental health disabilities receive on a regular schedule. Many of these services, like those authorized via § 1915(c), (j), (k), and (i), are essential home and community based services that help individuals with serious mental illness remain in the community. Like §1915(c), (j), (k), and (i) services, which are written into person-centered service plans, these mental health services are often written into treatment plans, require prior authorizations, and are delivered at regular intervals. Thus, like



person-centered service plans, these behavioral health services can be projected over a specific budget period.

These services include, at a minimum:

- Outpatient individual and group therapy, including specific therapies authorized by the state, such as trauma-focused therapy;
- Day services and intensive day services; and
- Medication management services, particularly for such services that require frequent medical monitoring or cannot be self-administered.

The main difference between the above-listed services and the existing list of services is not in the character of the services, but rather that they are authorized via the state plan instead of under waivers.

We also recommend including state plan personal care services, authorized via 42 U.S.C. § 1396d(a)(24). The majority of states offer this service, and individuals typically have a set number of hours assigned based on their needs, therefore making the cost of such services predictable and easy to project over the course of a given budget period.

As a general matter, the list proposed by HHS is overly restrictive because it is defined not by the service provided, but rather by the funding mechanism. For example, an individual may receive 20 hours of personal care services a week. In a state with state plan personal care services, those needs may be covered without a person centered plan developed pursuant to § 1915(c), (j), (k), or (i). In a state without state plan services, those would be covered by a § 1915(c), (j), (k), or (i) waiver and included in a person centered plan. Yet another state may use a § 1115 waiver to provide personal care services. Regardless of what authority is used to provide the service, the need for services remains the same and the cost of the 20 hours of services is equally predictable for each *individual*. Therefore, we encourage an approach that includes examples of specific services that are generally delivered in a manner that facilitates reliable budgetary projection, instead of limiting the list to services provided via specific § 1915 waivers and state plan options.



We recognize the somewhat limited scope of this proposed change to eliminate Medicaid's institutional bias. In many states, people who have to spend down for Medicaid eligibility would have so little income left over that they would not be able to pay for basic living expenses needed to stay in the community. This leaves institutional care as their only option if they want to use the MN pathway, since institutions cover room and board. Alongside its proposal to allow projected expenses for more community-based services, HHS should ask states to revisit and modernize their Medically Needy Income Levels (MNIL) to ensure they leave people with enough income to pay for basic community expenses like food, rent, transportation, and utilities. The review could recommend policy changes that allow people living in the community to set aside some of their income to pay those non-health expenses so they can more realistically use the Medically Needy eligibility category while staying in their homes.

§ 435.407 Verification of Citizenship and Identity

This provision would allow verification of birth with a state vital statistics agency or verification of citizenship with U.S. Department of Homeland Security SAVE data, allowing a match to serve as stand-alone evidence of citizenship, thus eliminating the need for separate verification of identity. We support this simplification and agree that it would reduce the burdens on individual applicants as well as the agency, without increasing the risk of erroneous eligibility determinations.

§§ 435.907 and 435.916 Aligning Non-MAGI Enrollment and Renewal Requirements With MAGI Policies

The ACA and implementing regulations streamlined eligibility determinations and renewals for the MAGI population. By comparison, many states continue to conduct eligibility determinations and renewals for people who are over age 65 or who are blind or have a disability (*i.e.*, the non-MAGI population) 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.⁹ Research shows that procedural denials also

⁹ Farah Erzouki & Jennifer Wagner, Ctr. on Budget and Policy Priorities, *Unwinding the Medicaid Continuous Coverage Provision: What States Can Do Now to Keep Eligible*



disproportionately impact people of color.¹⁰ There is a higher volume of denials because these groups are more likely to lack transportation, have health-related barriers to responding to requests for documents, and have challenges gathering income verifying information from administrative agencies. Moreover, as HHS acknowledges, a larger proportion of non-MAGI beneficiaries who lose coverage do so for procedural reasons.¹¹

HHS makes several proposals to align non-MAGI enrollment and renewal requirements with MAGI policies. These include limiting the frequency of redeterminations for most eligibility categories to no less than twelve months, requiring pre-populated renewal forms, prohibiting in-person interviews, and providing an adequate response time to request additional information from enrollees and applicants, and establishing a new reconsideration period. We strongly support these changes.

To simplify the application process for older adults and people with disabilities, we support HHS' proposal to apply the requirement that individuals must be able to apply through all modalities currently specified in § 435.907(a). Data from Covered California tracking insurance affordability programs shows while online applications and renewals are the most used mode, a significant portion of beneficiaries and applicants rely on the telephone.¹² Many applicants and beneficiaries prefer initiating their applications and renewals through direct contact, either in-person or over the phone, even as a precursor to online applications. For example, studies show that Latinx people prefer and seek telephone or in-person assistance, and those who do experience higher rates of

People Covered 4 (Mar. 23, 2021), <https://www.cbpp.org/sites/default/files/3-23-21health.pdf>.

¹⁰ Suzanne Wikle, et. al., Ctr. on Law and Social Policy & Ctr. on Budget and Policy Priorities, *States Can Reduce Medicaid's Administrative Burdens to Advance Health and Racial Equity* (Jul. 19, 2022), <https://www.cbpp.org/sites/default/files/7-19-22health.pdf>.

¹¹ 87 Fed. Reg. 54781.

¹² Covered California & California Dept. of Health Care Svcs., *California Eligibility and Enrollment Report: Insurance Affordability Programs For the Reporting Period April 2017 through June 2017*, Appx. A, Insurance Affordability Programs Applications Received Through CalHEERS, by Submission Channel, https://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/ABX1_1CA_Eligibility_Enroll_Data_April-June2017.pdf.



enrollment.¹³ HHS's own training materials for ACA navigator programs recognize the reluctance or inaccessibility of online enrollment for Latinx communities and emphasize the importance of in-person assistance.¹⁴ States must continue to offer all modalities for applications and renewals.

We also support prohibiting an *in-person* interview requirement for the non-MAGI population. Requiring in-person interviews imposes an undue burden on applicants, particularly older adults and persons with disabilities.

A recent review of the Washington D.C. Health Care Alliance, a program for low income persons in the District of Columbia who do not qualify for Medicaid, documents how in-person interviews and six month renewals unnecessarily burden beneficiaries and cause many to lose health coverage, despite being eligible.¹⁵ A 2014 report by the D.C. Legal Aid Society and D.C. Fiscal Policy Institute found long lines and wait periods for Alliance enrollees, as well as Medicaid applicants and beneficiaries in both MAGI and non-MAGI categories, leading to unlawful loss of coverage.¹⁶

¹³ U.S. Dept. of Health and Human Svcs., Office of the Asst. Sec. for Planning and Evaluation, *Health Insurance Coverage and Access to Care Among Latinos: Recent Trends and Key Challenges* 11 (Oct. 8, 2021), https://aspe.hhs.gov/sites/default/files/documents/68c78e2fb15209dd191cf9b0b1380fb8/ASPE_Latino_Health_Coverage_IB.pdf.

¹⁴ Ctrs. for Medicare & Medicaid Svcs., Office of Communications, *Marketplace Outreach: Best Practices for Outreach to Latino Communities* (Dec. 12, 2018), <https://marketplace.cms.gov/technical-assistance-resources/outreach-latino-communities.pdf>.

¹⁵ Nina Yamani, et al., American University, *The DC Health Care Alliance is a model public insurance program. But its burdensome requirements cause many eligible residents – and their health – to lose out*, Prince of Petworth (May 16, 2019), <https://www.popville.com/2019/05/the-dc-health-care-alliance-is-a-model-public-insurance-program-but-its-burdensome-requirements-cause-many-eligible-residents-and-their-health-to-lose-out/>.

¹⁶ Wes Rivers, et al., *Closing the Gap Between Policy and Reality: Preventing Wrongful Denials and Terminations of Public Benefits in the District of Columbia*, DC Legal Aid Society & DC Fiscal Policy Inst. (May 22, 2014), <https://www.dcfpi.org/all/closing-the->



Renewing eligibility no more frequently than every twelve months, sending a pre-populated renewal form, giving enrollees thirty 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 the MAGI population; therefore, we support extending these policies to the non-MAGI population. 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 the non-MAGI population.

The incidences and harms from churn are widespread and well documented. The HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) last year released a comprehensive examination of Medicaid churn, finding that coverage disruptions are common and lead to adverse effects on health outcomes.¹⁷ The Medicaid Access and Payment Commissioner (MACPAC) found that 8% of full time Medicaid and CHIP beneficiaries disenrolled and then re-enrolled with a twelve-month period, with churn rates higher for Black and Latinx persons.¹⁸ Another study found that churn not only leads to worse health outcomes, but higher health care costs.¹⁹ Without question, reducing churn is a win-win for state Medicaid and CHIP programs and beneficiaries alike.

[gap-between-policy-and-reality-preventing-wrongful-denials-and-terminations-of-public-benefits-in-the-district-of-columbia/](#).

¹⁷ U.S. Dept. of Health and Human Srvs., Office of the Asst. Sec. for Planning and Evaluation, *Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic* (Apr. 12, 2021), <https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf>.

¹⁸ Medicaid Access and Payment Commission, *An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP* 5 (Oct. 2021), <https://www.macpac.gov/wp-content/uploads/2021/10/An-Updated-Look-at-Rates-of-Churn-and-Continuous-Coverage-in-Medicaid-and-CHIP.pdf>.

¹⁹ Jennifer Wagner & Judith Solomon, Ctr. on Budget and Policy Priorities, *Continuous Eligibility Keeps People Insured and Reduces Costs* 5 (May 4, 2021), <https://www.cbpp.org/sites/default/files/5-4-21health.pdf>.



HHS observes that federal law allows states to consider eligibility for QMBs more frequently than every twelve months.²⁰ Nevertheless, we strongly urge HHS to encourage states to redetermine QMBs in not less than twelve month intervals to reduce burdening beneficiaries and leading to harmful coverage losses.

Finally, we support tracking the timelines for responses according to the date of the postmark, rather than the date on the notice. A state agency may delay mailing a printed notice, and the individual should not be penalized for this delayed processing time.

§§ 435.916, 435.919, and 457.344 Acting on Changes in Circumstances Timeframes and Protections

We strongly support changes that HHS is proposing to current regulations on changes in circumstances; the changes should be finalized to help reduce coverage losses for procedural reasons. In particular, we support the proposed requirement that agencies may not take adverse action if a beneficiary 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 beneficiary for more favorable coverage, such as additional benefits or lower premiums. Beneficiaries' lives are often complicated and they may not receive the request for additional information or be able to gather the appropriate documents in a timely manner. While it may be reasonable not to transition them to more beneficial coverage without verification, it would be harmful to penalize them by terminating their coverage altogether. 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.

²⁰ 87 Fed. Reg. 54782.



We also support HHS's proposal at § 435.919(b)(1)(iv) to require state Medicaid agencies to provide notice to beneficiaries who report changes, but experience no change in eligibility status. Requiring notice in these circumstances does not unduly burden states, but provides considerable peace of mind to enrollees who may be concerned with the status of their health care coverage. This will be particularly important during the COVID-19 PHE unwinding period, when Medicaid enrollees may not be able to contact the state Medicaid agency to confirm they received their reported changes because of long wait times and staffing shortages.

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 thirty day period for a beneficiary to obtain and submit information to verify changes in circumstances at § 435.919(c)(1), a new ninety day reconsideration period for individuals who are terminated for failure to return requests for information about changes in circumstances at § 435.919(d), 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 HHS's 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.

§ 435.907 Application

We appreciate HHS' recognition in the preamble of the need of Medicaid applicants to be permitted to provide additional information in cases where the state agency is unable to determine an applicant's eligibility based on the information provided on the application and verified through electronic data sources.²¹ We also appreciate HHS not permitting states to have more than 45 calendar days, or 90 calendar days in the case of disability, to complete applications when additional information is required. HHS astutely acknowledges an extended application processing time could result in eligible individuals delaying needed care.²² We saw in the post-ACA application delays, and

²¹ 87 Fed. Reg. 54786-7.

²² *Id.* at 54787.



other instances of state systems failing to timely process applications, that delays in application processing is very harmful to applicants and that the ability to file for fair hearing when action is not taken timely is important to accessing coverage.²³ We therefore think it is important to have clear timelines and limited, well-defined exceptions to such timelines that prioritize accessing coverage. We do not believe HHS should consider a change to the timeliness requirements for application processing, which would establish an exception to the 45-day requirement at current § 435.912(c)(3)(ii) and provide an additional 15 calendar days for a state to complete application processing when additional information is needed.

We support proposed § 435.907(d)(1)(i)(B), which would provide most applicants 15 calendar days to respond with additional information. We also support proposed § 435.907(d)(1)(i)(A) 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 described at section 1902(a)(10)(A)(ii)(X) of the Act, which would require the 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. While we would like to see the same period of time for all applicants so as to not lead to confusion or inequities, above all else we do not want the timeline for application processing to be extended, and we recognize that providing all applicants 30 calendar days to provide additional information would make it difficult for the state Medicaid agency to make a 45-day non-disability determination. Additionally, we strongly endorse codifying proposed § 435.907(d)(1)(ii), requiring applicants be permitted to provide additional information through any of the modes by which an application may be submitted at current § 435.907(a).

We also strongly endorse proposed § 435.907(d)(1)(iii)(A) to require that, if the individual subsequently submits the requested information within 90 calendar days of the date the notice of ineligibility is sent (or a longer period established by the state), the state must reconsider the individual's eligibility without requiring the individual to complete and submit a new, full application. We believe the length of reconsideration period at application should align with the 90-day reconsideration period currently provided at renewal, and proposed for changes in circumstances in this rulemaking, so

²³ See, e.g., *Wilson v. Gordon*, 822 F.3d 934 (6th Cir. 2016); *Walker v. Selig*, No. 2:15-CV-00166 KGB, 2015 WL 12683818, at *19 (E.D. Ark. Oct. 30, 2015).



as to be consistent and less confusing. This will also benefit the applicants who need more time to obtain and provide the information and do not want to start over and submit a new application. The timeline should be consistent because the challenges faced at application and redetermination are substantially similar in that the state is asking for additional information, which can sometimes be hard to understand, locate, and submit. This is especially true considering the limitations many applicants and beneficiaries experience in terms of time, transportation, and resources as well as the difficulties -- such as long wait times, incorrect information, language and accessibility barriers, or confusing answers -- many face in trying to get clarifying information from Medicaid call centers or local offices. The longer reconsideration period also benefits Medicaid agencies who will be able to more quickly process the existing application on file and avoid the administrative cost or burden of processing an entirely new application.

We also agree a state should have adequate time to complete the determination of eligibility when requested information is submitted during the reconsideration period. However, we think proposed § 435.907(d)(1)(iii)(B), which would provide the state with an additional 45 calendar days (or 90 calendar days for disability-related determinations) to complete the eligibility determination in accordance with proposed § 435.912(c)(3), is too long. Instead, we think this “new clock” should be no longer than 30 days for all determinations.

In addition, we strongly agree that the effective date of coverage should continue to be determined in accordance with the date upon which the original application was submitted, as described at proposed § 435.907(d)(1)(iii)(C), in order to protect the needs of applicants and ensure they have coverage as of the date they intended and were eligible. We do not believe the effective date should be based on the return of additional information that would effectively constitute a new application with a new effective date of coverage. This would certainly not be in the best interest of the applicant and would not protect them from unexpected bills for services accessed after the initial application date and might further discourage their use of necessary health care services. Additionally, to restart the application date would also particularly harm applicants in states where there is limited or no retroactive coverage available and subject them to additional medical debt. Further, states could misuse the resetting of the application date and requests for additional information as functional waiting periods for



enrollment or otherwise forestall enrollment, which is contrary to the Medicaid statutory requirements.²⁴

RECOMMENDATION: Amend § 435.907(d)(1) as follows:

(d)(1) If the agency needs to request additional information from the applicant to determine and verify eligibility in accordance with § 435.911, the agency must—

...

(iii)

- (A) In the case of an individual who is denied eligibility for failure to submit requested information and who subsequently submits the requested information within ~~the period allowed by the agency~~ ***ninety (90) calendar days, and*** in accordance with paragraph (d)(1)(ii) of this section, reconsider eligibility without requiring a new application;
- (B) ***Notwithstanding*** ~~For purposes of the application timeliness standards at § 435.912(c)(3) of this subpart, the date of application for individuals described in paragraph (d)(1)(iii)(A)(iv)(A) of this section, is considered the date upon which the individual submits the additional information requested by the agency;~~ ***the state shall only be given 30 calendar days from the date the individual submits the additional information to process the application;*** and
- (C) For purposes of the effective date of eligibility under § 435.915 of this subpart, the date of application for individuals described in paragraph (d)(1)(iii)(iii)(A) of this section is ***the*** date on which the original application was submitted.

...

§ 435.912 Timely Determination and Redetermination of Eligibility

We support HHS' proposal to revise the definition of "timeliness standards" in § 435.912(a) to specify that these standards must include not only the maximum time period in which every applicant is entitled to a determination of eligibility at application in accordance with § 435.907, but also the maximum period of time in which the agency must redetermine eligibility at renewal in accordance with § 435.916 and when an

²⁴ See, e.g., 42 U.S.C. § 1396a(a)(8), (19).



anticipated or known change in circumstances occurs in accordance with proposed § 435.919(b)(3). Such clarity about state's time limits are important and should be communicated to the beneficiary. We also support defining the "performance standards" in current § 435.912(a) to make set standards for renewing and redetermining eligibility in a timely and efficient manner across a pool of beneficiaries.

We further support the proposal to expand the requirement in current § 435.912(b)(2) to establish timeliness and performance standards to include final determinations of eligibility for CHIP (in addition to existing determinations of eligibility for Medicaid and assessments of potential eligibility for other insurance affordability programs). We support proposed § 435.912(b)(1) to require the agency to establish performance and timeliness standards for determining Medicaid eligibility for individuals who submit an application to the Medicaid agency, as well as determining eligibility for CHIP when an individual is determined ineligible for Medicaid (in accordance with proposed changes discussed in section II.B.5. of the preamble) and determining potential eligibility for insurance affordability programs available through the Exchanges as described at proposed § 435.1200(e).

Finally, we support the addition of new paragraphs (b)(3), (4), and (5) to § 435.912 to require states to establish specific standards for:

- redetermining eligibility at renewal in accordance with § 435.916;
- redeterminations of eligibility related to changes in circumstances reported by a beneficiary or received from a third party as described at proposed § 435.919(b)(1)&(2); and
- redeterminations of eligibility at the time of an anticipated change in circumstances in accordance with proposed § 435.919(b)(3).

However, we do ask that HHS provide more guidance that sets strong standards about how a source is deemed reliable. There have been numerous examples of how bad data matches and systems sold as reliable fraud detection systems to states have caused significant inappropriate benefit losses, especially when individuals are asked to



prove a negative or lose benefits because of failure to complete the administrative processes triggered by such unreliable change in circumstance updates.²⁵

We support revisions to § 435.912(c)(1) to specify that the timeliness and performance standards include the periods of time covered for renewals and redeterminations of eligibility (in addition to the period from the date of application, or transfer from another insurance affordability program, to the date the agency notifies the applicant of its decision or the date the agency transfers the individual to another insurance affordability program). Specifically, proposed § 435.912(c)(1)(ii) would provide that timeliness and performance standards for conducting regularly-scheduled renewals must cover the period from the date that the agency initiates the steps required to renew eligibility on the basis of information available to the agency, as required under § 435.916(a)(2) (redesignated as § 435.916(b)(1) in this proposed rule), to the date that the agency sends the beneficiary notice regarding their continued eligibility for coverage, or as applicable, terminates eligibility and transfers the individual to another insurance affordability program in accordance with § 435.1200(e).

Proposed § 435.912(c)(1)(iii) and (iv) would provide that timeliness and performance standards for conducting redeterminations of eligibility based on a change, or anticipated change, in a beneficiary's circumstances must cover the period from the

²⁵ See, e.g., Sarah Mancini, Kate Lang, Chi Chi Wu Nat'l Consumer L. Ctr. & Justice in Aging, *Mismatched and Mistaken: How the Use of an Inaccurate Private Database Results in SSI Recipients Unjustly Losing Benefits* (April 2021), <https://www.nclc.org/resources/mismatched-and-mistaken-how-the-use-of-an-inaccurate-private-database-results-in-ssi-recipients-unjustly-losing-benefits/>; Sarah Grusin, Nat'l Health L. Program, *A Promise Unfulfilled: Automated Medicaid Eligibility Decisions* (June 30, 2021), <https://healthlaw.org/a-promise-unfulfilled-automated-medicaid-eligibility-decisions/>; see generally Benefits Tech Advocacy Hub, Case Study Library, <https://www.btah.org/case-studies.html> (including problems with data matching in Michigan, Florida, and with SSI); see generally, e.g., Alice Holdbrook & Nerdwallet, *When LexisNexis Makes a Mistake, You Pay For it*, NEWSWEEK (Sept. 26, 2019) (regarding problems with the LexisNexis data matches and the difficulty people have in proving a negative). Advocates frequently report problems with helping people prove that property flagged under their name in another state that is being treated as an asset and making some ineligible is not actually the individual's.



date that the agency receives information indicating a potential change in circumstances that may affect eligibility to the date that the agency sends the individual a notice regarding their continued eligibility for coverage, or as applicable, terminates eligibility and transfers the individual's electronic account to another insurance affordability program in accordance with § 435.1200(e).

We support the proposed amendments to § 435.912(c)(1)–(3). HHS proposes to incorporate the requirement in current § 435.912(c)(1) into proposed § 435.912(c)(2) and to expand the criteria that states must take into account to reflect the broader scope of activities for which states must account for in establishing their timeliness and performance standards. Proposed revisions to § 435.912(c)(2) would add to these criteria the time needed by the agency to evaluate information obtained from electronic data sources and the time needed to provide advance notice to beneficiaries when the agency makes a determination that would result in the denial or termination of eligibility or another adverse action, since an adverse action cannot be effective until the end of the advance notice period (generally advance notice must be sent 10 days prior to the date of the action, in accordance with §§ 431.211, 431.213 and 431.214).

However, we warn that the capability of the system should never be prioritized over the needs and interests of the beneficiaries, as required by the Medicaid Act and the ACA. Critically, the capability of the system must not be used as an excuse for failing to meet due process requirements. Too often we have heard states complain that systems cannot be changed to meet minimum notice standards or other due process requirements. States are responsible for the capability of the systems and use of data sources as they put out the RFPs, contracts, and other requirements for these systems. Beneficiaries must be able to access coverage and keep it, and enforce their rights. Proposed § 435.912(c)(2) also would provide that states account for the needs of beneficiaries, as well as applicants and the complexity of their cases in establishing their timeliness and performance standards. The complexity of eligibility, including any additional time that changes to provide equal access for disability or language is well known and states must be expected to plan for such complexities and delays in their processes.

While there are several technical changes to § 435.912(c)(3) that we do not offer specific comments on, we endorse newly added paragraphs (c)(4), (5), and (6) to establish separate parameters within which states must establish timeliness standards



for the completion of regularly scheduled renewals, redeterminations based on changes in circumstances, and redeterminations based on anticipated changes. We agree with the proposed maximum timeframes in § 435.912(c)(4).

We agree with proposed § 435.912(c)(4)(i) requiring the agency to complete a redetermination by the end of the eligibility period when eligibility can be renewed based on available information or the individual returns all needed information at least 25 calendar days or more prior to the end of the eligibility period.

We support the need for the additional time of one month for the agency to complete a timely redetermination of eligibility in proposed § 435.912(c)(4)(ii) in cases where information is returned before the end of the eligibility period, but with less than 25 calendar days remaining.

We also support providing the agency with additional time, up to a maximum of 90 calendar days as proposed in § 435.912(c)(4)(iii)(A), for states to complete a redetermination of eligibility on the basis of disability (as opposed to providing the agency with 25 days to make a determination of eligibility for most beneficiaries and to send advance notice of termination if the individual is ineligible, per proposed § 435.912(c)(4)(iii)(B)). We agree that a longer 90-day period is appropriate when a determination of disability is required because of the additional complexity in making a disability determination. We note, however, that if the missing information required does not involve the disability determination itself, there is no reason a full 90 calendar days should be necessary.

We further support proposed § 435.912(c)(5), requiring states to complete redeterminations based on changes in beneficiary circumstances reported no later than the end of the month that occurs 30 calendar days from the date the state receives information, if the state has sufficient information to evaluate any potential impact and to redetermine eligibility without requesting additional information from the individual. Because most states continue coverage through the end of the month, the proposal to extend the requirement to the end of the month in which the 30th day occurs makes sense as is easier to track. If additional information from the beneficiary is needed, we agree that states will need additional time and that proposed § 435.912(c)(5)(ii) - giving States through the end of the month that occurs 60 calendar days from the date the



state receives information indicating a change in circumstances that may impact eligibility to make a redetermination of eligibility - is appropriate.

We agree with proposed § 435.912(c)(6)(i), requiring the agency to complete a redetermination of eligibility based on an anticipated change in circumstances on or before the date of the anticipated change or the last day of the month in which the anticipated change occurs. If the state receives the information needed to complete a redetermination, but does not have at least 25 calendar days to process the information, we agree proposed § 435.912(c)(6)(ii), giving states one (1) additional month to complete a timely redetermination of eligibility, is reasonable.

We agree with proposed § 435.912(c)(6)(iii), which establishes the same standards for completing a determination of another basis as that proposed at § 435.912(c)(4)(iii) for regularly scheduled renewals. While we generally support the addition of each of the standards proposed in paragraphs (c)(3) through (6), we strongly believe the existing exception to the timeliness standards, which is described in current § 435.912(e), including when the agency cannot comply with the regulatory timelines due to an administrative or other emergency beyond the agency's control, should be amended to make more specific when these exceptions are appropriate. These exceptions, as written, are far too broad and can be simply used to erode all of the timeliness standards in this section. States may try to argue that an "administrative emergency" could be a staffing shortage or IT related reason for backlog of cases. Such reasons should not be allowed. HHS should take this opportunity to ensure this provision is not abused, while making other appropriate and beneficial changes to the benefit of Medicaid applicants and beneficiaries. Further, HHS should require states to notify them of such use of "exceptions" when a state relies on (e)(2).

Finally, the technical amendments to paragraphs (d), (e), (f), and (g) of this section to clarify their applicability to applicants as well as beneficiaries and redeterminations of eligibility is appropriate because the timeliness standards in section § 435.912, as proposed to be amended, include both applications and redeterminations.

RECOMMENDATION: Amend § 435.912(e) as follows:

(e) Exceptions. The agency must determine eligibility within the standards except in ~~unusual~~ **exceptional** circumstances, **including** ~~for example~~—



- (1) When the agency cannot reach a decision because the applicant or beneficiary, or an examining physician, delays or fails to take a required action ***without good cause***, or
- (2) When there is an ~~administrative or other~~ emergency beyond the agency's control.

§ 435.919 and § 457.344 Agency Action on Returned Mail

§ 435.919(f)

Consistent with Social Security Act § 1902(a)(1), 1902(a)(4), 1202(a)(19), and in adherence to § 1902(b)(2), we support the proposed addition of § 435.919(f) requiring states to take certain actions when mail sent to a beneficiary is returned to the agency by the United States Postal Service (USPS), regardless of whether the returned mail signals potential ineligibility.²⁶ We concur with HHS that if a beneficiary has moved it does not necessarily mean the individual is no longer a state resident or ineligible on that basis. A person may simply no longer have a permanent address, which is not a requirement for Medicaid eligibility. Therefore, termination of coverage on the basis of returned mail should not be allowed, although some states nevertheless do.²⁷ We also strongly agree with HHS' concerns that returned mail results in a significant number of beneficiaries who continue to meet all eligibility requirements being inappropriately terminated from coverage and therefore, it is highly critical that states be required to take reasonable steps to locate beneficiaries who may have moved and update their address prior to taking any adverse action.²⁸ This is particularly important during the COVID-19 public health emergency unwinding, given that many beneficiaries have been displaced and/or have experienced unstable housing.²⁹ Given how frequently low-

²⁶ (b)(2) The Secretary shall not approve any plans which imposes, as a condition of eligibility for medical assistance under the plan-

... (2) *any residence requirement which excludes any individual who resides in the State, regardless of whether or not the residence is maintained permanently or at a fixed address* (emphasis added).

²⁷ 87 Fed. Reg. 54791.

²⁸ *Id.*

²⁹ P. Boozang, K. Serafi, K. O'Connor, *Maintaining Medicaid and CHIP Coverage Amid Postal Delays and Housing Displacements*, Manatt Health, Sept 24, 2020, available at



income families move, known challenges accessing the postal service, and the counter-cyclical nature of Medicaid and the economy, people may be moving more frequently due to economic hardship when their need for Medicaid and continued coverage is the greatest.³⁰

Specifically, we agree with HHS that returned mail with an out-of-state or no forwarding address indicates a potential change in circumstance with respect to state residency, but that without additional follow up by the state, the receipt of returned mail alone is not sufficient to make a definitive determination whether beneficiaries no longer meet state residency requirements.³¹ We also agree that returned mail with an in-state forwarding address is not a change affecting eligibility although it is important to confirm to ensure accurate contact with the beneficiary can continue.³² Therefore, we support the specific proposed § 435.919(f) requirements that when states receive returned beneficiary mail, they must take proactive steps to verify any forwarding address provided or to otherwise locate the individual. Specifically, in the cases of returned beneficiary mail, including returned mail with an in-state, an out-of-state, or no forwarding address, the specific additional steps required in proposed §§ 435.919(f)(1) through 435.919(f)(3), to conduct a series of data checks and outreach attempts to locate the beneficiary and verify their address, are critically important to protect a beneficiary's right to coverage.

We fully concur with the requirements in Step 1 that states at a minimum check for updated mailing contact information from the agency's Medicaid Enterprise System (MES) and the agency's contracted managed care plans (if applicable in the State). A State's MES is a comprehensive state data system that includes Medicaid eligibility, enrollment and claims data and in many cases also includes state data from other public benefits programs such as SNAP or TANF or WIC, State Disability Insurance, or Unemployment offices that may be relied on to determine eligibility for Medicaid or visa versa. Similarly, individuals enrolled in a Medicaid managed care plan

<https://www.shvs.org/maintaining-medicaid-and-chip-coverage-amid-postal-delays-and-housing-displacements/#> at fn. 9.

³⁰ Markian Hawryluk, *Return to Sender? Just One Missed Letter Can Be Enough to End Medicaid Benefits*, NPR (Nov. 1, 2019), <https://www.npr.org/sections/health-shots/2019/11/01/774804485/return-to-sender-just-one-missed-letter-can-be-enough-to-end-medicaid-benefits>.

³¹ 87 Fed. Reg. 54791.

³² *Id.* at 54792.



are certainly more likely to provide their plan with updated address information given that beneficiaries more frequently contact their plan to access health care. Finally, proposed § 435.919(f)(1)(iii) requires that the state must obtain and check at least one of the following third-party data sources available to state Medicaid agencies: SNAP, TANF, the Department of Motor Vehicles, the USPS National Change of Address (NCOA) database, and other sources specified in the state's verification plan to determine if a different and more recent address is available. We agree that states should be required to check with at least one of these agencies or databases, if they are available to the Medicaid agency. But asking states to simply pick one may be insufficient as not all beneficiaries will receive these benefits or have a driver's license. Further, checking with the USPS NCOA should always be required of all agencies as that is a reliable and well known government source many people use to broadly inform others of such a change of address.

We also strongly endorse the obligations on states in proposed § 435.919(f)(2) and 435.919(g), that when a state receives a forwarding address on a piece of returned mail, the state must attempt to contact the individual to verify the forwarding address, both by mail and second modality, and provide the beneficiary with an opportunity to confirm or dispute the information. In attempting to contact the beneficiary by U.S. mail, we strongly support proposed § 435.919(f)(2) requiring the state to send notices to both the current address on file, the forwarding address (if one is provided by USPS), and any address more recent than that in the beneficiary's case records obtained pursuant to proposed § 435.919(f)(1). This is a vast improvement to the current rule. We also agree the notice must request that the individual confirm their current address and provide the individual (or family) with a reasonable period of time - 30 calendar days from the date the notice is sent to the beneficiary - to verify the accuracy of the new contact information, as proposed in § 435.919(f)(2)(i) and consistent with proposed § 435.919(c)(1). Sending notices to both (or multiple) addresses is a critical step to protect the beneficiary's right to ensure the correct information is obtained or verified. We also support proposed § 435.919(f)(3) requiring states to attempt to contact the beneficiary using at least one additional modality other than mail - such as by phone, electronic notice, email, or text message - and requiring at least two attempts with at least three business days between the first and second attempt. We also commend HHS for requiring at least one modality to be an electronic format that a beneficiary has elected as preferred by which to receive notices and communications. While we understand HHS has provided states with flexibility to use any combination of available



electronic or telephonic modalities, we believe states should be required to check any more recent telephone or email information than that in the beneficiary's case records obtained pursuant to proposed § 435.919(f)(1). We recommend that proposed §435.919(f)(3)(ii) be amended to require notice in the alternative modality also be sent to any email or phone number obtained on file through data checks in the (f)(1) rather than making such outreach optional.

A. In-State Forwarding Address

For returned mail with an in-state forwarding address, if the state is unable to locate or verify a beneficiary's address after this series of outreach attempts, we support proposed § 435.919(f)(4) which prohibits the state from terminating the beneficiary's coverage if it does not receive a response to its requests that the individual confirm their correct current address, and requires the state to accept the new in-state address and update the beneficiary's account accordingly. We believe states should be required to update a beneficiary's in-state address using more recent contact information reflected in a forwarding address from USPS or an address provided by NCOA or a managed care plan in this situation because the information is very likely more accurate and will increase the likelihood the beneficiary will receive ongoing communication. Yet we also support the proposed requirements that states attempt to contact the beneficiary with the address and other information on file to provide them with an opportunity to verify or dispute the new information.³³

B. Out-of-state Forwarding Address

³³ We acknowledge CMS has provided States with such authority under § 1902(e)(14)(A) of the Act without first attempting to contact the individual and providing them with a reasonable period of time to verify the accuracy of the new contact information, in accordance with the State Health Official Letter, Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency, (March 2, 2022) (SHO 22-001), <https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf>.

Nevertheless, we believe this proposed rule is a better approach and provides more protections to beneficiaries.



For returned mail with an out-of-state forwarding address (which indicates a potential change in circumstances based on state residency that may impact eligibility), we agree with proposed § 435.919(f)(5) that, if a beneficiary does not respond to the state's requests per proposed § 435.919(f)(1) through (f)(3) for information to verify their current address, or if information provided or available through data sources does not establish that the beneficiary continues to satisfy the state residency requirement, the state must still provide advance notice of termination and fair hearing rights consistent with 42 C.F.R. part 431 subpart E. These due process rights are essential to protect the beneficiary's rights.

C. No Forwarding Address

For cases of returned mail with no forwarding address provided or available through other data sources, HHS proposed revising and redesignating current regulation at § 431.231(d) at proposed § 435.919(f)(6) to require that, when a state receives returned beneficiary mail with no forwarding address, the state must first take reasonable steps to locate the beneficiary consistent with proposed § 435.919(f)(1) through (f)(3). We strongly endorse the additional clarity that such steps must be taken before any notice of termination, and termination of coverage, can occur. However, notwithstanding § 431.231(d) of the current regulations (redesignated at proposed § 435.919(f)(6)), we do not agree that states are not required to provide advance notice of termination in the case of a beneficiary whose whereabouts remain unknown after the efforts required to locate the individual have been taken, but are required to provide notice of fair hearing rights. Constitutional due process dictates that such advance notice be provided in a case where Medicaid benefits are denied or terminated.³⁴ Therefore, proposed § 435.919(f)(6)(i) should be amended to require States to provide advance notice of termination in the case prior to terminating coverage.

We support the addition of proposed (redesignated) § 435.919(f)(6)(ii)(A) (consistent with current regulations at § 431.231(d)), that if the beneficiary's whereabouts become known prior to the beneficiary's originally-scheduled renewal date, the state must reinstate their coverage. We strongly support the additional requirement of proposed

³⁴ *Goldberg v. Kelly*, 397 U.S. 254, 266 (1970), see, e.g., 42 U.S.C. § 1396a(a)(3). The essential elements of due process in Medicaid are an adequate written notice and the opportunity to challenge an adverse state action before an impartial decision-maker.



§435.919(f)(6)(ii)(A) that states must reinstate coverage back to the date of termination if the individual's whereabouts become known before their next regularly-scheduled renewal, without the need to verify eligibility. We believe this reinstatement back to the termination date will help avoid a break in coverage, which is critical to avoid medical bills from covered services that may have been accessed since that date. It will also reduce the burden on beneficiaries and save administrative costs to the state or local agency. We also support the newly added proposed § 435.919(f)(6)(ii)(B) for states to begin a new eligibility period (defined in current regulations at § 435.916(a), redesignated and revised at § 435.916(b) in this proposed rule) for a beneficiary whose whereabouts become known if the agency has enough information available to it to renew eligibility without requiring additional information from the beneficiary.

RECOMMENDATION: Amend § 435.919(f)(1)(iii) as follows:

(iii) ~~One or more~~ **All** of the following: the State agency that administers Supplemental Nutrition Assistance Program; the State agency that administers Temporary Assistance for Needy Families; the State Department of Motor Vehicles; the USPS National Change of Address (NCOA) database; or other sources specified in the State's verification plan described in § 435.945(j).

RECOMMENDATION: Amend § 435.919(f)(3)(ii) as follows:

(ii) The notices required under this paragraph must be sent to the contact information in the beneficiary's case record, if available, and ~~may~~ **must** be sent to other contact information obtained by the agency per paragraph (f)(1) of this section.

RECOMMENDATION: Amend § 435.919(f)(6)(i) as follows:

(i) If the agency elects to terminate or suspend coverage in accordance with this paragraph, the agency must send **advance** notice to the beneficiary's last known address or via electronic notification, in accordance with the beneficiary's election under § 435.918 of this subpart, no later than **10 days prior to** the date of termination or suspension and **include in such** notice of fair hearing rights in accordance with 42 CFR part 431 subpart E.



RECOMMENDATION: Amend § 435.919(f)(6)(ii)(B) as follows:

(B) ~~May~~ **Must** begin a new eligibility period, consistent **with** paragraph (e)(2) of this section, if the agency has sufficient information available to it to renew eligibility with respect to all eligibility criteria without requiring additional information from the beneficiary.

§ 435.919(g)

We support the addition of proposed § 435.919(g)(1) that requires states that obtain updated in-state mailing information from NCOA or a managed care plan contractor to treat such information as reliable. And the state must send a notice to the current address on file with the state and to the new address, and provide the individual with a reasonable period of 30 calendar days to verify the accuracy of the new contact information, as well send at least two additional notices (consistent with paragraph (f)(3)) to the beneficiary through other modalities, such as via telephone, electronic notice, email, or text message, where feasible. We also endorse the requirements in (g)(1)(vi) that if the beneficiary responds and confirms the new address, the state must update the beneficiary record with the new contact information. However, in (g)(1)(v) the state must update the beneficiary record with the new contact information, (v) and accept the in-state address as the beneficiary's new address and update the beneficiary's case record accordingly, if the beneficiary does not respond to a request to confirm their address or state residency, provided the beneficiary is given at least 30 days from the date the agency sent the notice. We recommend that states be required to update the beneficiary record with the new contact information in either case, instead of making it optional in the latter instance above.

We support the addition of proposed § 435.919(g)(2) authorizing states to use updated in-state address information from other trusted data sources in accordance with proposed paragraph (g)(1) if the state obtains approval from the Secretary. We also support the addition of proposed § 435.919(g)(3), and the process that states must follow when obtaining any address information from any sources not listed in paragraph (g)(1) or (2) of this section, including out-of-state mailing address information, requiring the agency to follow the steps outlined in § 435.919(f)(2) through (6), related to returned mail in order to confirm the address change with the beneficiary.



We believe that states should be required to update beneficiary contact information based on information obtained from an MCO, from the USPS NCOA, or other reliable data sources, such as Indian Health Care Providers, Federally Qualified Health Centers, Rural Health Clinics, Program of All-inclusive Care for the Elderly providers, Primary Care Case Managers, Accountable Care Organizations, Patient Centered Medical Homes, Enrollment Brokers, or other state Agencies (SNAP, TANF, etc.). However, we do not believe these updates should be made without first checking the available data sources outlined in § 435.919(f)(1)(i) and § 435.919(f)(1)(ii), as well as attempting to contact the individual to provide them with an opportunity to verify or dispute the new information. Even though such third-party data is very likely reliable, beneficiaries should still be given notice and the opportunity to verify or dispute it. Then if they do not respond at all after such requirements outlined in paragraphs (f)(2) through (6) have been met, related to processing out-of-state address information or address information from a source not identified in § 435.919(g)(1), then the contact information should still be updated. These additional steps required to be taken to contact or notify the beneficiary will provide the safeguards needed to respond if it is not correct.

RECOMMENDATION: Amend § 435.919(g)(1)(v) as follows:

(v) ~~May~~ **Must** accept the in-state address as the beneficiary's new address and update the beneficiary's case record accordingly, if the beneficiary does not respond to a request to confirm their address or State residency, provided the beneficiary is given at least 30 days from the date the agency sent the notice; and

§ 437.344

Finally, we recommend the same amendments to proposed changes to § 457.344 regarding the responsibilities of states administering a separate CHIP program in the event of returned mail and when they receive information from a third party about a change in address for individuals enrolled in a separate CHIP.



§§ 431.10, 435.1200, 600.330 Transitions Between Medicaid, CHIP and BHP Agencies

The ACA envisions a coordinated system of health coverage with seamless transitions between insurance affordability programs, including Medicaid, CHIP, BHP, and exchange coverage. Unfortunately, that seamless system has yet to be achieved. Many people still experience periods without insurance 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 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 do not receive information about their potential eligibility for other programs.

HHS proposes several changes to improve coordination among insurance affordability programs and facilitate coverage transitions when an individual is determined ineligible for one program. Smoothing these transitions and preventing coverage gaps will be especially challenging during the unwinding of the COVID-19 PHE and end of the continuous coverage requirement under the Families First Coronavirus Response Act (FFCRA).³⁵

As HHS notes “[d]isenrollment from health insurance coverage without a corresponding transition to enrollment in another insurance affordability program is a troubling

³⁵ Families First Coronavirus Response Act (Pub. L. 116–127) Mar. 18, 2020, <https://www.congress.gov/116/plaws/publ127/PLAW-116publ127.pdf>.



outcome.”³⁶ We agree. Losing health coverage can have harmful consequences, particularly for persons with disabilities, chronic conditions, and those with complex health care needs (see discussion on the effects of churn in comments on §§ 435.907 and 435.916).

We support the proposed changes that provide for an agreement with the separate CHIP agency to seamlessly transition beneficiaries between Medicaid and CHIP when their eligibility status changes; establish procedures to receive determinations of Medicaid eligibility completed by a separate CHIP; complete determinations of eligibility for a separate CHIP for individuals who are determined ineligible for Medicaid based on reliable third-party data; and issue a combined notice indicating ineligibility for Medicaid and eligibility for CHIP when appropriate.

HHS recognizes that “functions performed by the separate CHIP agency would be solely administrative in nature, and not reflective of a delegation of authority to make Medicaid eligibility determinations.”³⁷ However, we are concerned that the delegation of Medicaid eligibility determinations to a separate CHIP agency may, in some instances, run afoul of the Medicaid single state agency requirement.³⁸

Federal law requires participating states to designate a “single state agency” to operate the Medicaid program consistent with federal standards.³⁹ The single state agency may contract with entities to assist with program functions; however, the single state agency remains responsible for implementing the program consistent with the federal mandates.⁴⁰ However, a contractor “must not have authority to change or disapprove any administrative decision” of the single state agency.⁴¹

³⁶ 87 Fed. Reg. 54795.

³⁷ 87 Fed. Reg. 54797.

³⁸ 42 U.S.C. § 1396a(a)(5).

³⁹ *Id.*

⁴⁰ See 42 U.S.C. § 1396a(a)(5); 42 C.F.R. § 431.10 (single state agency may not delegate to others its authority to “issue policies, rules, and regulations on program matters”).

⁴¹ 42 C.F.R. § 431.10(e)(3); see *Hilburn v. Maher*, 795 F.2d 252, 261 (2d Cir. 1986) (noting reason for single state agency requirement “was to avoid a lack of accountability for the appropriate operation of the program”); *McCartney v. Cansler*, 608 F. Supp. 2d



HHS describes various scenarios in which a separate CHIP agency may make Medicaid eligibility determinations – for example, when a Medicaid agency and a separate CHIP agency share eligibility systems, as well as policies and procedures.⁴² These present no concern. We are concerned, however, where separate CHIP agencies make Medicaid eligibility determinations, but do not use the same MAGI-based methodologies and verification procedures as those used by the state’s Medicaid agency.

For example, under federal MAGI rules, states have flexibility in how they count pregnant women - as one person, as two people, or as one plus the number of children expected to be delivered.⁴³ States can choose to consider reasonably predictable increases or decreases in income, and can choose to consider either current monthly income or projected annual income when conducting MAGI redeterminations.⁴⁴ States also have flexibility under federal rules on how they determine household size and income for family planning eligibility.⁴⁵

Separate CHIP programs can make different policy choices in how they implement MAGI, or have a different verification plan. For example, Georgia’s Medicaid program

694, 701 (E.D.N.C. 2009), *aff’d*, 382 F. App’x 334 (4th Cir. 2010) (holding in Medicaid due process case that North Carolina DHHS, as the single state agency, “may not disclaim its responsibilities under federal law by simply contracting away its duties”); *Salazar v. District of Columbia*, 596 F. Supp. 2d 67, 69 (D.D.C. 2009) (“States cannot contract away to managed care organizations ... their responsibilities to Medicaid beneficiaries or the rights of Medicaid beneficiaries.”); see also *Forsyth Co. Bd. of Soc. Servs. v. N.C. Div. of Soc. Servs.*, 346 S.E.2d 414, 416 (1986) (striking state law allowing county social services departments to challenge eligibility decisions made by single state Medicaid agency, citing 42 U.S.C. § 1396a(a)(5) as prohibiting local agents from taking any action “seeking to substitute their judgment” for that of single state agency).

⁴² See 87 Fed. Reg. 54797.

⁴³ 42 C.F.R. § 435.603(b).

⁴⁴ 42 C.F.R. § 435.603(h).

⁴⁵ 42 C.F.R. § 435.603(k).



counts pregnant women as two people.⁴⁶ However, Georgia's CHIP agency counts pregnant women as one plus the number of children expected to deliver.⁴⁷

Ultimately, the Medicaid single state agency is responsible for ensuring that, when it delegates administrative authority to conduct eligibility determinations, the delegated entity (in this instance a separate CHIP agency) is following the Medicaid agency's MAGI methodologies when determining Medicaid eligibility.

HHS must ensure that the agreements between Medicaid and separate CHIP agencies specify that the CHIP agencies will adhere to the Medicaid agency policies. Enrollees and applicants should not receive different eligibility determinations because the state Medicaid and separate CHIP agencies have different MAGI methodologies. Accordingly, CMS should proactively work with states so that Medicaid and separate CHIP agencies align their policies and eligibility systems.

§ 435.223 Optional Group For Reasonable Classifications of Individuals Under 21

We support the proposed rule to create an eligibility group implementing a statutory pathway for children that is missing from the current regulatory framework. Under the Medicaid statute, states have the flexibility to extend coverage to all children (or reasonable classifications thereof) using any of the many pathways under Social Security Act § 1902(a)(10)(A)(ii). However, the current implementing regulations (at 42 C.F.R. § 435.222) only apply to two of the subprovisions on the list of statutory options and only apply to MAGI-based categories. Proposed § 435.223 would implement an eligibility pathway for the other subprovisions and non-MAGI enrollees, opening the door for states interested in structuring their coverage categories using these flexibilities.

⁴⁶ See Title XIX State Plan Amendment (SPA), GA 13-0022-MM3 (Dec. 9, 2013), <https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/GA/GA-13-0022-MM3.pdf>.

⁴⁷ Separate Child Health Insurance Program, MAGI-based Methodologies, GA-13-0016 (May 20, 2015), <https://medicaid.georgia.gov/document/publication/13-016magieligibilitymethodsgrouppdf/download>.



§ 435.956 Verification of Other Non-Financial Information

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 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. We support this change because allowing states to limit the number of ROPs would make it harder for eligible people to enroll, disproportionately impacting certain vulnerable groups, including survivors of domestic violence and people experiencing homelessness, for whom electronic verification of immigration status is difficult.

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

§ 435.608 Remove or Limit Requirement To Apply for Other Benefits

We strongly support HHS's proposal to remove § 435.608 which requires applicants and beneficiaries to apply for other benefit programs as a condition of Medicaid eligibility. We agree that changes in Medicaid eligibility have made such a requirement outdated. Congress and the Clinton administration eliminated the Aid to Families with Dependent Children (AFDC) program and thereby delinked Medicaid eligibility for a significant number of beneficiaries. The ACA requires that states use MAGI methodologies for many Medicaid eligibility categories, which must follow IRS rules and consider taxable income actually received. As HHS correctly observes, "there is no statutory mandate for the rule in § 435.608(a) that currently requires application for other benefits by Medicaid applicants and beneficiaries."⁴⁸

Requiring individuals and families to apply for pensions, annuities, and other benefits as a condition of Medicaid eligibility impedes access to medical care, unduly burdens applicants and beneficiaries, and ultimately harms people by delaying needed care. Accordingly, we disagree with the alternative approaches HHS suggests, including

⁴⁸ 87 Fed. Reg. 54803.



making the requirement a post-enrollment activity. Such a requirement may seriously limit the amount and scope of benefits for which an individual may be eligible. For example, most adults in the United States may apply for Social Security benefits at age 62. However, delaying until age 67 or 72 can significantly increase the amount of benefits received. Medicaid applicants and enrollees should not have to forgo their full, earned Social Security benefit to access Medicaid.

**§§ 457.570 and 600.525(b)(2) Prohibit Premium Lock-Out Periods
and**

§§ 457.65, 457.340, 457.350, 457.805, and 457.810 Prohibit Waiting Periods

States are currently permitted to establish waiting periods of up to 90 days before children can enroll or reenroll in CHIP. Waiting periods are unique to CHIP – they are not permitted in Medicaid or Marketplace plans. They are also 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, and 457.810. This policy is unique to CHIP, burdening low- to moderate-income families. HHS should not simply reduce the allowable length of waiting periods to 30 days or some other time period but eliminate waiting periods altogether. Barriers to enrollment, including waiting periods and lock-outs, harm children and do little to deter crowd out.⁴⁹

Research has already proven that lockouts deter and reduce enrollment in Medicaid and CHIP.⁵⁰ Numerous studies have confirmed these effects among children with

⁴⁹ See Tricia Brooks, Georgetown Univ. Health Pol’y Inst., Ctr. for Child. & Fam., *Now is the Time to Remove CHIP Waiting Periods and Welcome Kids into Coverage* (Apr. 20, 2020), <https://ccf.georgetown.edu/2020/04/17/now-is-the-time-to-remove-chip-waiting-periods-and-welcome-kids-into-coverage/>.

⁵⁰ See, e.g., Samantha Artiga et al., Kaiser Family Found., *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings*



household income above 150% of FPL.⁵¹ Studies also demonstrate that premiums and lockouts have a disproportionate impact on Black children and children with lower household income.⁵² Given the extensive evidence about the effects of premiums, CMS

(2017), <https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/>; Brendan Saloner et al., *Medicaid and CHIP Premiums and Access to Care: A Systematic Review*, 137 PEDIATRICS e20152440 (2016), <https://cca-ct.org/wp-content/uploads/2019/02/Medicaid-and-CHIP-Premiums-and-Access-to-Care-A-Systematic-Review.pdf>.

⁵¹ See, e.g., Genevieve Kenney et al., *Effects of Premium Increases on Enrollment in SCHIP: Findings from Three States*, 43 INQUIRY 378, 380 (2006), https://journals.sagepub.com/doi/pdf/10.5034/inquiryjrnl_43.4.378 (finding that increases in premiums in CHIP reduced initial enrollment and led to substantial disenrollment); Margo Rosenbach et al., Mathematica Pol’y Research, Inc., *National Evaluation of the State Children’s Health Insurance Program: A Decade of Expanding Coverage and Improving Access* (2007), <https://www.mathematica.org/publications/national-evaluation-of-the-state-childrens-health-insurance-program-a-decade-of-expanding-coverage-and-improving-access> (noting that premiums and lockouts have been found to reduce retention in CHIP); Jill Boylston Herndon et al., *The Effect of Premium Changes on SCHIP Enrollment Duration*, 43 HEALTH SERVS. RES. 458 (2008), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2442374/> (finding that increasing premiums from \$15 to \$20 for children in families from 151-200% of FPL decreased length of enrollment); Georgetown Univ. Health Pol’y Inst., Ctr. for Child. & Fam., *Cost Sharing for Children and Families in Medicaid and CHIP* (2009), https://ccf.georgetown.edu/wp-content/uploads/2012/03/Cost_sharing.pdf (compiling research from 11 states showing that new or increased premiums reduce enrollment and/or increase disenrollment in CHIP); Salam Abdus et al., *Children’s Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children*, 33 HEALTH AFFAIRS 8, (2014), https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2014.0182?url_ver=Z39.88-202003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed (finding that a premium increase of \$10 per month reduced enrollment in Medicaid and CHIP).

⁵² See, e.g., Kenney et al., *supra* note 51, at 388 (concluding that in Kentucky “larger disenrollment effects were found for nonwhite children relative to white children,” while



recently acknowledged that allowing states to waive the limits on premiums is not likely to advance the objectives of Medicaid and is likely to exacerbate existing health inequities.⁵³

Some families face significant increased costs in addition to premiums, including higher out-of-pocket health care costs, increased utility bills, and increased expenses associated with special clothing, equipment, and food.⁵⁴ The burden of these costs is magnified when care for the child means a loss in parental income due to missed work, decreased work hours, inability to work overtime or shifts with higher pay (like swing or night shifts), or having to quit work entirely.⁵⁵ Families in rural areas may experience additional increased financial burden due to having more limited job opportunities, lower income, and limited health care access.⁵⁶

We strongly support eliminating CHIP waiting periods and premium lock-out periods. There is simply no legitimate policy rationale for denying children needed health care.

§ 457.480 Prohibit Annual and Lifetime Limits on Benefits

We strongly support this provision which would eliminate annual and lifetime dollar limits on benefits in CHIP. Current law and regulations do not permit annual or lifetime limits

in New Hampshire, disenrollment effects were concentrated among children with lower income (185-250% of FPL compared to 250-300% of FPL)); Jill Boylston Herndon et al., *supra* note 51 (finding that the effects of increasing premiums were greater among lower income children); Brendan Saloner et al., *Access to Care Among Individuals Who Experienced Medicaid Lockouts After Premium Nonpayment*, 2 JAMA NETWORK OPEN e1914561 (2019).

⁵³ See Letter from Chiquita Brooks-LaSure, Adm'r, CMS, to Caylee Noggle, Comm'r, Ga. Dep't of Cmty. Health 9 (Dec. 23, 2021), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ga/ga-pathways-to-coverage-12-23-2021-ca.pdf>.

⁵⁴ Lisa C. Lindley & Barbara A. Mark, *Children with Special Health Care Needs: Impact of health expenditures on family financial burden*, 19 J. Child & Fam. Stud. 79 (2010), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2872488/>.

⁵⁵ *Id.*

⁵⁶ *Id.*



on essential health benefits (EHBs).⁵⁷ Further, while not all group health plans are required to offer EHBs (e.g. large employer plans), when a plan does offer EHBs, they are prohibited from imposing annual or lifetime limits on those benefits.⁵⁸ Similarly, Medicaid prohibits annual and lifetime limits on benefits. However, current CHIP regulations do not expressly prohibit the imposition of annual and lifetime limits on benefits and a number of states currently place such limits on certain benefits. For example, the proposed rule notes that at least six states impose lifetime dollar limits on at least one CHIP benefit, while twelve states impose annual dollar limits on at least one CHIP benefit.⁵⁹

The proposed rule also specifies that annual and lifetime limits are most frequently applied to CHIP dental benefits, including orthodontia.⁶⁰ Research shows that low-income children are more likely to develop dental diseases and face barriers to accessing care. Studies indicate that untreated dental disease can lead to pain, infection, and may even be associated with increased risk for other health conditions such as diabetes or lung disease.⁶¹ Children with dental problems are more likely to miss school as a result of pain.⁶² Dental pain can also impair a child's ability to eat, sleep and perform other daily activities.⁶³

⁵⁷ 42 U.S.C. § 300gg-11.

⁵⁸ *Id.* Health plans subject to EHB coverage requirements include plans sold through the ACA Marketplaces, non-grandfathered individual and small group plans, as well as Medicaid Alternative Benefit Plans (ABPs). See 42 U.S.C. § 300gg-6, 42 U.S.C. § 18021(a)(1)(B), 42 U.S.C. § 1396u-7(b)(5). Although self-insured and large group plans are not required to cover EHBs, if they do, they must apply cost-sharing protections. See 42 U.S.C. §§ 300gg-6(b), 300gg-11(b), 18022(c); see also 29 C.F.R. § 2590.715-2711.

⁵⁹ 87 Fed. Reg. 54816.

⁶⁰ *Id.*

⁶¹ Medicaid & CHIP Payment & Access Comm'n, Medicaid Access in Brief: Children's Dental Services (June 2016), <https://www.macpac.gov/wp-content/uploads/2016/06/Medicaid-Access-in-Brief-Childrens-Dental-Services.pdf>.

⁶² *Id.*

⁶³ Colin Reusch and Joan Alker, Georgetown Univ. Health Insurance Inst. Ctr. Child. & Fam., *Fulfilling the Promise of Children's Dental Coverage* 1 (Sept. 2016), <https://ccf.georgetown.edu/wp-content/uploads/2016/09/FutureOfKidsDental-3-1-1.pdf>.



Given this, annual and lifetime limits on children’s dental and other services can further exacerbate already existing health disparities for low-income children. Further, health care costs typically grow faster than the economy, and inflation is soon expected to hit the health care sector especially hard, which could bring the real value of covered benefits down over time unless properly indexed.

Federal law requires CHIP plans to cover a comprehensive set of benefits.⁶⁴ We agree with HHS’s assertion that the benefits and services offered in CHIP likely fall within the EHB categories.⁶⁵ Additionally we agree that, as a policy matter, annual and lifetime limits create difficulties accessing coverage and care for low-income children with high medical needs. Given this, we strongly support HHS’s proposal to eliminate annual and lifetime limits on all services in CHIP.

To Understand the Impact of Eligibility and Enrollment Changes, HHS Must Collect Demographic Data

The changes outlined in the proposed rule will improve the health insurance enrollment process for underserved populations, increase retention in insurance affordability programs for eligible individuals, and reduce administrative burdens to access these programs -- all of which may improve health equity across HHS programs. However, to actually determine the effect of these changes on achieving health equity for underserved populations, HHS must ensure that its programs collect demographic information on applicants and participants and stratify measures of program access by the demographic characteristics collected.

Disparities in health care access persist based on race, ethnicity, spoken and written language, disability status, sexual orientation, gender identity, age, variation in sex characteristics, pregnancy status, and other factors.⁶⁶ HHS programs, including

⁶⁴ 42 U.S.C. § 1397-cc.

⁶⁵ 87 Fed. Reg. 54816.

⁶⁶ David Barton Smith, *Racial And Ethnic Health Disparities And The Unfinished Civil Rights Agenda*, 24 Health Aff. 317-324 (2005); Ctrs. for Medicare & Medicaid Servs., *Improving Health Care for Adults with Disabilities* (Dec. 2020), <https://www.cms.gov/files/document/federaldatadisability508.pdf>; Nat’l Acad. of



Medicare, Medicaid, and CHIP, that have some information on demographic characteristics of participants, have identified significant disparities in access by race and ethnicity.⁶⁷ Information on other demographic characteristics, such as disability, sexual orientation, and gender identity, are not uniformly collected but are needed for the same purpose.⁶⁸ While independent studies prove these disparities exist, without program-level data, HHS cannot identify the precise location of disparities, identify a baseline for health care access, or provide precise and targeted redress.

We strongly recommend that HHS collect demographic information of all program applicants. For example, HHS should require state Medicaid agencies to collect demographic data of applicants on the Medicaid and CHIP application and the Single Streamlined Marketplace application (since it is shared with state Medicaid agencies if an individual may be eligible for Medicaid or CHIP). Collecting this information at the application stage allows information to be stored in the applicant's file and shared with relevant entities, such as insurers, providers, and health facilities, for planning and accessibility purposes.⁶⁹ Having demographic information collected at the outset

Sciences, Engineering & Medicine, *Understanding the Well-Being of LGBTQI+ Populations* 289 (White, J., Sepulveda M.J., & Patterson C.J., eds., 2020), available at https://www.ncbi.nlm.nih.gov/books/NBK563325/pdf/Bookshelf_NBK563325.pdf.

⁶⁷ Medicaid and CHIP Access and Payment Commission (MACPAC), *Racial and Ethnic Disparities in Medicaid: An Annotated Bibliography* (Apr. 2021), <https://www.macpac.gov/wp-content/uploads/2021/04/Racial-and-Ethnic-Disparities-in-Medicaid-An-Annotated-Bibliography.pdf>; U.S. Dep't of Health & Hum. Servs., *HHS Initiatives to Address the Disparate Impact of COVID-19 on African Americans and Other Racial and Ethnic Minorities* (2020), available at <https://www.hhs.gov/sites/default/files/hhs-fact-sheet-addressing-disparities-in-covid-19-impact-on-minorities.pdf>.

⁶⁸ White, *supra* note 66, at 75-81.

⁶⁹ See Ruben D. Vega Perez et al., *Improving Patient Race and Ethnicity Data Capture to Address Health Disparities: A Case Study from a Large Urban Health System*, 14 *Cureus* 1 (2022) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8815799/>; Colin Planalp, State Health Access Data Assistance Ctr. (SHADAC), *New York State of Health Pilot Yields Increased Race and Ethnicity Question Response Rates*, State Health & Value Strategies (Sept. 9, 2021), <https://www.shvs.org/new-york-state-of-health-pilot-yields-increased-race-and-ethnicity-question-response-rates/>; Elizabeth



facilitates interactions with individuals who may need language access services or other communication services in order to enroll in coverage, and it removes the need for entities further down the line to ask for duplicative information. It also allows programs to track disparities not just in access to services, but in the eligibility and redetermination processes, in retention of eligible individuals and families, in utilization of services, and much more.

As in our prior comments to HHS, including our comments in response to the Proposed Rule on Nondiscrimination in Health Programs and Activities, NHeLP recommends that HHS set a standard set of demographic categories and variables to facilitate demographic data collection across its programs.⁷⁰ We believe this NPRM offers HHS the opportunity to require this on Medicaid and CHIP applications and thus offer the following recommendations for minimum variables in each demographic category:

Race and Ethnicity. HHS should ensure that its programs use the race and ethnicity variables articulated in the 2011 Data Standards.⁷¹ Although all HHS-run and HHS-funded programs are currently required to use the minimum standards given by OMB's

Lunkenen and Emily Zylla, *Exploring Strategies to Fill Gaps in Medicaid Race, Ethnicity, and Language Data*, State Health Access Data Assistance Ctr. (SHADAC) (2020), <https://www.shvs.org/exploring-strategies-to-fill-gaps-in-medicaid-race-ethnicity-and-language-data/>.

⁷⁰ Natl. Health L. Prog., Comment on Proposed Rule on Nondiscrimination in Health Programs and Activities (Oct. 3, 2022), <https://healthlaw.org/resource/nhelp-comments-on-section-1557-proposed-rule/>. We request that HHS also consider our asks on demographic data collection from our prior comments on the Proposed Rule on Nondiscrimination in Health Programs and Activities as incorporated into this NPRM.

⁷¹ The Office of Management and Budget is currently in the process of updating Directive No. 15, which sets minimum standards for federal agencies to use when collecting information about race and ethnicity. See Karin Orvis, *Reviewing and Revising Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity*, The White House: Briefing Room Blog (Jun. 15, 2022), <https://www.whitehouse.gov/omb/briefing-room/2022/06/15/reviewing-and-revising-standards-for-maintaining-collecting-and-presenting-federal-data-on-race-and-ethnicity/>.

Per 42 U.S.C. § 300kk, HHS is required to update its race and ethnicity data collection standards to align with the race and ethnicity standards given by OMB, at a minimum.



Directive No. 15, the 2011 Data Standards use more granular variables for race and ethnicity and allow for better disaggregation of data. In addition, HHS should review those standards and make recommendations on ways to further disaggregate Latinx, Asian, and Native subgroups and add variables to reflect the Middle Eastern and North African (MENA) community.⁷²

Primary Language. HHS should require programs to collect information about the primary spoken and written language used by each individual served.

Disability Status. HHS should adopt the disability status data collection methods found in the 2011 Data Standards. This six-question format, also used on the American Community Survey, captures information on a range of disabilities, including whether an individual is Deaf or hard of hearing, blind or low-vision, or has a physical, functional, mental, or emotional disability. We also recommend that HHS review and add data collection methods that capture information about an individual's communication abilities, psychological and learning disabilities, and autism.

Variations in Sex Characteristics. HHS should adopt the recommendations of the NASEM Committee in its 2022 report, *Measuring Sex, Gender Identity, and Sexual Orientation*.⁷³ Few federal data sources (including administrative data collection, clinical data, and surveys) collect information on individuals with differences in sex characteristics or intersex traits. Yet, the occurrence of individuals who have non-normative sex traits, such as differences in hormones or anatomy, is significant considering the number of individuals who may be intersex, who have had gender-affirming care, or who may have other medical conditions (such as a mastectomy for the purpose of treating breast cancer). Identifying individuals with intersex traits or variations in sex characteristics as a demographic category enables a better understanding of population health, illuminates disparities of an under-recognized and

⁷² See Victor Rubin et al., PolicyLink, *Counting a Diverse Nation: Disaggregating Data on Race and Ethnicity to Advance a Culture of Health* 24-26 (2018), available at https://www.policylink.org/sites/default/files/Counting_a_Diverse_Nation_08_15_18.pdf.

⁷³ Nat'l Academies of Sciences, Engineering, & Medicine, *Measuring Sex, Gender Identity, and Sexual Orientation* (Nancy Bates, et al., eds., 2022), available at <https://nap.nationalacademies.org/catalog/26424/measuring-sex-gender-identity-and-sexual-orientation>.



under-studied population, and bolsters the agency’s ability to protect the civil rights of this population. An anatomical or organ inventory can also provide greater utility than a simpler “sex” category in a medical setting when it comes to identifying sex traits.⁷⁴ HHS should test methods of collecting demographic information about variations in sex characteristics that can be used on applications and eligibility materials.

Gender Identity and Sex. HHS should adopt the recommendations of the NASEM Committee in its 2022 report, *Measuring Sex, Gender Identity, and Sexual Orientation*. The Committee recommends collecting two data points – the sex classification on an individual’s original birth certificate and the individual’s current gender identity – to identify both the individual’s gender and whether or not the individual is transgender. The Committee notes the low nonresponse rate – less than 1% for both sex and gender identity data points – which is consistent with past studies on gender identity data collection.⁷⁵ As discussed above, sex classification is less useful than an organ inventory for identifying an individual’s specific anatomy. However, in the context of gender identity, collecting information about an individual’s sex classification at birth in conjunction with gender identity is the most reliable proxy currently known to identify transgender individuals.

Sexual Orientation. HHS should adopt the recommendations of the NASEM Committee in its 2022 report *Measuring Sex, Gender Identity, and Sexual Orientation*. In addition, we urge HHS to develop a process to regularly review and update the response options for sexual orientation and gender identity. Sexual orientation and gender identity can be fluid, language evolves, and prevalence of certain identity labels

⁷⁴ Chris Grasso et al., *Optimizing gender-affirming medical care through anatomical inventories, clinical decision support, and population health records in electronic health record systems*, 28 J. Am. Med. Inform. Assoc. 2531-35 (Oct. 2021), <https://pubmed.ncbi.nlm.nih.gov/34151934/>.

⁷⁵ Nat’l Academies of Sciences, Engineering, & Medicine, *Measuring Sex, Gender Identity, and Sexual Orientation* 55, 80 (Nancy Bates, et al., eds., 2022), <https://nap.nationalacademies.org/catalog/26424/measuring-sex-gender-identity-and-sexual-orientation>; Sean Cahill et al., *Do Ask Do Tell: High Levels of Acceptability by Patients of Routine Collection of Sexual Orientation and Gender Identity Data in Four Diverse American Community Health Centers*, PLoS One (2014), <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0107104>.



shift over time (e.g., gay and lesbian vs. queer; the emerging understanding of pansexuality and asexuality). Regular community feedback and testing of new measures and response options can help inform inclusive language and improve the validity of responses.⁷⁶

CONCLUSION

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

Thank you for the opportunity to comment on these important issues. If you have further questions, please contact Alicia Emanuel, emanuel@healthlaw.org.

Sincerely,



Elizabeth G. Taylor
Executive Director

⁷⁶ See Nat'l Acad. of Sciences, Engineering & Medicine, *Understanding the Well-Being of LGBTQI+ Populations* 66 (White, J., Sepulveda M.J., & Patterson C.J., eds., 2020), available at

https://www.ncbi.nlm.nih.gov/books/NBK563325/pdf/Bookshelf_NBK563325.pdf.

