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November 7, 2022

Administrator, Chiquita Brooks-LaSure  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue, SW, Room 445-G  
Washington, DC 20201

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

Dear Administrator Brooks-LaSure,

Thank you for the opportunity to provide comment on the proposed rule: Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes (CMS-2421-P). Bi-State Primary Care Association (Bi-State) supports the proposed changes in this rule that seek to break down barriers to accessing health coverage insurance by reducing administrative burden for patients and aligning requirements in Medicaid and CHIP, which will positively impact patients.

Established in 1986, Bi-State is a nonpartisan, nonprofit 501(c)(3) charitable organization that advances access to comprehensive primary care and preventive services for all, with special emphasis on those most in need in New Hampshire and Vermont. Bi-State works with federal, state, and regional health policy organizations, foundations, and payers to develop strategies, policies, and programs that provide and support community-based primary health care services in medically underserved areas. Bi-State represents all of the federally qualified health centers in New Hampshire and Vermont, as well as Area Health Education Centers in both states, Planned Parenthood of Northern New England, Vermont's Free & Referral Clinics, and Community Health Action Network.

As trusted members of their communities, our members provide each patient with an individual assessment to determine their eligibility for health insurance, striving to connect the most vulnerable patients with the most affordable and comprehensive coverage. Many of our patients are underinsured or uninsured and our practices employ dedicated staff, such as health navigators, outstation, and enrollment workers, to help consumers understand and enroll in health insurance coverage such as Medicaid and CHIP. Bi-State applauds CMS for taking steps to alleviate the patient burden, while proposing policies that promote increased access to comprehensive health care services that over 1400 health centers provide nationwide and 21 serving New Hampshire and Vermont.

We appreciate CMS considering our comments. We have divided them into four main sections: I. Key provisions affecting seniors, dual eligibles, and people with disabilities; II. Aligning eligibility, renewals, and continuity of coverage; III. Eliminating access barriers and benefit caps for children enrolled in CHIP; and IV. Modernizing record-keeping requirements to ensure proper documentation of eligibility and enrollment.

**I. Key provisions affecting seniors, dual eligibles, and people with disabilities**

## **Bi-State supports CMS' proposals to better align enrollment and renewal requirements for most individuals in Medicaid.**

Currently, all adult Medicaid applicants are required, per §435.608, to apply for any benefits they are eligible for to keep or receive Medicaid coverage. While most beneficiaries already take advantage of applying for other benefits, such as pensions, retirement, and disability benefits, foregoing an application can unfairly penalize already vulnerable populations who may choose not to or are unaware of all benefits for which they qualify. Across the country, health centers serve 1 in 5 Medicaid patients and help connect patients to other benefits services besides health insurance. Health centers in New Hampshire serve 15% of Medicaid enrollees, while health centers in Vermont serve 37% of Medicaid enrollees. Bi-State supports the removal of this requirement, which will help ensure Medicaid applicants are not potentially unjustly denied Medicaid eligibility on account of a technicality.<sup>1</sup>

Bi-State also supports eliminating the requirement of an in-person interview as part of the application and renewal process, per §§435.907(d) and 435.916(b), and limiting renewals to once a year (§435.916(b)(1)). No such provision exists for regular Medicaid beneficiaries and only had been applied to non-traditional applicants. A requirement for an in-person interview to determine eligibility places an unnecessary burden on patients with disabilities and lower-income, above 65 seniors. Our health centers are located in medically underserved areas and serve some of the hardest to reach patients who could be experiencing homelessness or unreliable transportation schedules. An in-person requirement can result in coverage denials to these patients.

Bi-State appreciates CMS' efforts to decrease beneficiary burden by sending beneficiaries pre-populated renewal forms with information available to the agency. Extending this to apply to all Medicaid renewals will overall ease the process for beneficiaries, removing administrative burden and encouraging agencies to leverage and share existing information. Bi-State also supports the clear mandate from CMS that States now must accept renewals via all four modalities (online, by phone, mail, or in-person), for both regular Medicaid applicants *and* non-traditional applicants. Currently, almost all states accept information by mail and in person, but fewer provide the opportunity to submit information by phone (39 states) or via online accounts (41 states).<sup>2</sup> Making this a requirement for all states will help promote continuity of coverage by giving beneficiaries the flexibility in choosing how to submit a renewal form.

Given the vulnerable populations health centers serve, any removal of barriers to renewing coverage or easing their administrative burden is crucial in helping them maintain health insurance coverage. Bi-State agrees with CMS' proposal to give enrollees 30 days to return signed renewal forms and request any information, as well as extend a 90-day grace period for individuals who were terminated for failure to return their renewal form, but subsequently returned their form within the reconsideration period. This longer period to reconsider coverage for individuals who did not send in their renewal form by the deadline takes into consideration a renewal form getting lost in the mail, or an enrollee not receiving the original notice at all. The 90-day period extends special consideration for enrollees, like health center patients, that face barriers to sending in the renewal form or sending in additional information. Barriers for our patients include those that experience homelessness, those that are managing significant medical events, lack of transportation, and food insecurity.

## **II. Aligning Eligibility, Renewal, and Continuity of Coverage**

### **Bi-State supports CMS' proposed revisions to enhance coordination between Medicaid and CHIP agencies as well as Basic Health Programs and plans through the Exchange.**

These revisions promote continuity of coverage, especially for children and families with mixed insurance coverage. Given that 1 in 5 children experience a gap moving between Medicaid and CHIP and vice versa,<sup>3</sup> streamlining

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<sup>1</sup> <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>

<sup>2</sup> <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-requirement/>

<sup>3</sup> <https://www.macpac.gov/wp-content/uploads/2022/04/Churn-and-Coverage-Transitions.pdf>

information sent to enrollees about eligibility for different programs will decrease beneficiary confusion about eligibility. The combined eligibility notice will also decrease confusion for families where individuals qualify for different insurance programs. These revisions echo the original intent behind the Affordable Care Act; there should be “no wrong door” for applicants when applying for health insurance. Information collected by agencies serving the same populations and households, like Medicaid and CHIP, should have systems that minimize burden and shift more responsibility and coordination onto agencies instead of beneficiaries. Mandating that States coordinate and combine eligibility notices with other insurance affordability programs (§457.348(a)), as well as requiring CHIP/Medicaid agencies to accept determinations by the other, per §457.348(b) and §435.1200, will mitigate the chance of preventable churn on and off insurance.

Bi-State also appreciates that this proposal extends to other forms of coverage, like BHPs or the Exchange. If an enrollee can’t be determined eligible for Medicaid/CHIP, the agency will identify them as potentially eligible for other insurance affordability programs, including Medicaid on a basis other than MAGI, eligibility for the Basic Health Program (BHP) in accordance with 42 CFR 600.305(a), or insurance affordability programs available through the Exchange, and transfer the individual’s account. Ensuring information about potential savings in the combined eligibility notice will decrease the chance of churn and prompt beneficiaries to seek more information about their coverage options.

Bi-State also recommends that proposed rules relating to automatic entitlement to Medicaid, following determination of eligibility under other programs,<sup>4</sup> be revised to apply to patients served by CHCs who have been determined to have income under 100% of poverty and who meet required Medicaid eligibility categories such as mothers, children, and the elderly. CMS can encourage states to utilize CHCs, who are well-positioned to share this information. This auto-determination recommendation fits well with CMS’ vision for more interagency collaboration in determining eligibility by taking it a step further. CMS can also work with states in promoting auto-determinations by using as much administrative data as possible through matching with databases or other means-tested assistance programs. This can alleviate the burden on the beneficiary while ensuring the states have the necessary information.

We appreciate CMS’ goal for Medicaid and CHIP agencies to work together seamlessly and see an opportunity to strengthen presumptive eligibility provisions in the Medicaid statute and regulations. We encourage CMS to expand the ability and authority of CHCs to determine that a child is presumptively Medicaid eligible for an initial period of time. In 2021, health centers provided services to nearly 4 million individuals seeking coverage<sup>5</sup>; this proven track record indicates their readiness to provide presumptive eligibility for children, which will enhance coverage access for the children they serve.

Bi-State also sees an opportunity for CMS to further streamline Medicaid eligibility, especially for certain populations. CMS should encourage states to work with CHCs to facilitate coverage for migrant farmworkers traveling to other states to work. CHCs can be important sites for assuring and, more importantly, streamlining Medicaid eligibility determination and coverage in interstate travel. Establishing a system under which people eligible for Medicaid crossing state lines to work temporarily in those states—such as migrant farmworkers and their families—is critical so that these individuals can immediately qualify for at least mandatory Medicaid services in the state where they are working. Sources estimate between 4 and 4.5 million agricultural workers currently reside in the United States.<sup>6</sup> In 2020, health centers provided care to more than 977,000 migratory and seasonal agricultural workers (MSAW) and their families around the United States. Bi-State’s member CHCs, along with the Vermont Free & Referral Clinics care for numerous agricultural workers who support the farming communities within our two states. Currently, MSAW and their families must be determined eligible for Medicaid in every state they go to, which places a significant burden on this population. Promoting Medicaid eligibility arrangements like this would fit well in CMS’ efforts to streamline eligibility.

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<sup>4</sup> 42 CFR 435.909

<sup>5</sup> <https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=ODE&year=2021>

<sup>6</sup> <http://www.ncfh.org/ag-worker-access.html>

## **Bi-State appreciates CMS creating nationwide timeliness requirements for redeterminations of eligibility in Medicaid and CHIP.**

Giving beneficiaries at least 30 calendar days from the date the request is postmarked to respond with information for changed circumstances (§435.919) will allow them enough time to come to the health center, for example, if they need help gathering documentation and submitting for redetermination. If states need to conduct additional follow-up after a redetermination, we recommend CMS implement a minimum requirement of 30 calendar days for all applicants, accompanied by 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.

While we understand CMS needs required information for redeterminations in a timely fashion, Bi-State urges the agency to provide at least 30 days for beneficiaries to seek assistance and gather additional documentation. It may take enrollees significant time—more than 15 days—to gather further requested documentation, such as electronic health record or income documents. It is important that CMS does not create additional burden through regulation based on unrealistic assumptions about the beneficiaries' capacity. The 15-day response deadline is particularly concerning for more transient individuals that reside at different addresses during a given week. Expecting a quick turnaround to submit additional information poses a significant risk to health center patients, especially if a request for information is lost in the mail. We recommend allowing beneficiaries 30 days to respond to the state in the event the state needs additional information.

If the 30-day timeframe were to be applied across the board (with additional time for people with disabilities), we encourage CMS to provide concrete guidance on how beneficiaries can access coverage while their redetermination is being processed. We understand that retroactive coverage is activated by the state starting three months from the date of application but recommend states cover patients' care during the redetermination, regardless of if their coverage is extended. Health centers provide care to anyone, regardless of their ability to pay, however for beneficiary peace of mind, explicit guidance on coverage options in the interim will be useful.

Bi-State supports CMS in holding all states accountable by creating guardrails around beneficiary communication via mail. Mandating that upon receipt of returned mail, the state must attempt to reach the beneficiary in two different ways, per §435.919(f)(2), puts more protections in place to ensure states are reaching Medicaid beneficiaries who may have housing and other issues. Bi-State encourages CMS to require states to employ multiple contact methods such as a phone call, text, or email, multiple times to reach more transient patients. States relying on responses to mailed letters will disproportionately impact people with no/unstable addresses—such as those experiencing homelessness—who are much more likely to remain eligible. CMS should encourage states to use multiple methods, like via email or phone, to reflect the increasing use and reliance by patients and providers on technology to communicate important updates.

This is especially important for health centers, which serve a large transient population. In 2021, health centers provided care to 1.3 million patients experiencing homelessness and over 1 million agricultural workers. CHCs in New Hampshire and Vermont serve over 8,000 individuals experiencing homelessness. Health centers' care coordination teams work closely with case managers to help their patients experiencing homelessness coordinate their health care and ensure they are receiving and understanding important notices regarding their health insurance.

### **III. Specific CHIP Provisions**

**Bi-State supports the elimination of premium lock-out periods (§§457.570 and 600.525(b)(2)), waiting periods (§§457.65, 457.340, 457.350, 457.805, and 457.810), and annual/lifetime limits on benefits in CHIP (§457.480).**

With 1 in 8 children receiving services through health centers,<sup>7</sup> these proposed changes will positively impact the children we serve by enhancing continuity of coverage and eliminating potential cost barriers for beneficiaries seeking

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<sup>7</sup> [https://www.\(YOUR ORGANIZATION\).org/wp-content/uploads/2022/03/Chartbook-Final-2022-Version-2.pdf](https://www.(YOUR ORGANIZATION).org/wp-content/uploads/2022/03/Chartbook-Final-2022-Version-2.pdf)

comprehensive coverage. CHCs in New Hampshire and Vermont serve 21,000 and 32,000 children, respectively. Lock out periods and waiting periods impact coverage in CHIP overall, even in the short term. Lack of insurance, even temporary periods of uninsurance, deters people from seeking health care even when they desperately need it and can significantly disrupt critical preventive well child primary care services.

#### **IV. Modernizing recordkeeping requirements to ensure proper documentation of eligibility and enrollment**

Bi-State supports CMS' recommendation to ensure beneficiaries have timely access, within 30 calendar days, to all enrollment and eligibility documentation. We also appreciate the directive under §431.17(c) that states maintain all applicant or beneficiary case documents while the case is active, plus a minimum of 3 years thereafter. However, we urge CMS to direct states to move towards full electronic recordkeeping, instead of just recommending, to promote the ease of sharing documents with health centers or their patients in the event of a fair trial or hearing related to their coverage.

#### **Conclusion**

While Medicaid beneficiaries currently have continuous coverage through the maintenance of effort (MOE) requirement for the duration of the PHE,<sup>8</sup> states will begin Medicaid redeterminations once the PHE officially ends. Given that an estimated 15 million beneficiaries on Medicaid/CHIP are at risk of losing coverage due to the unwinding,<sup>9</sup> the proposed changes in this rule come at an important time. Furthermore, before continuous coverage during the pandemic, 1 in 10 Medicaid/CHIP beneficiaries experienced churn in less than one year.<sup>10</sup> Bi-State supports CMS' proposed implementation timeline of making these revisions effective 30 days after it is published with a separate compliance date, with those dates varying depending on the provision. Alignment of eligibility and enrollment for Medicaid and CHIP, along with protections for those dually eligible or receiving subsidized Marketplace coverage, will help ensure broad, more continuous coverage for the entire family. Bi-State strongly supports finalizing this proposed rule to ensure access and promote continuity of health insurance coverage.

Thank you for your consideration of these comments. If you have any questions, please contact me at [gmaheras@bistatepca.org](mailto:gmaheras@bistatepca.org) or 802-229-0002 x 218.

Sincerely,

*Georgia Maheras*

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<sup>8</sup> Families First Coronavirus Response Act (FFCRA), 2020.

<sup>9</sup> [https://aspe.hhs.gov/sites/default/files/documents/404a7572048090ec1259d216f3fd617e/aspe-end-mcaid-continuous-coverage\\_IB.pdf](https://aspe.hhs.gov/sites/default/files/documents/404a7572048090ec1259d216f3fd617e/aspe-end-mcaid-continuous-coverage_IB.pdf)

<sup>10</sup> <https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/>.