November 7, 2022

The Honorable Xavier Becerra  
Secretary of Health and Human Services  
U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Washington, DC 20201

The Honorable Chiquita Brooks-LaSure  
Administrator Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Washington, DC 20201

Re: Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes; Proposed Rule - CMS-2421-P

Dear Secretary Becerra and Administrator Brooks-LaSure,

The Colorado Children’s Campaign appreciates the opportunity to comment on, “Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes Proposed Rule - CMS-2421-P,” hereinafter referred to as the “proposed rule.”

The Colorado Children’s Campaign is a nonprofit, nonpartisan advocacy organization committed since 1985 to realizing every chance for every child in Colorado. We advocate for the development and implementation of data-driven public policies that improve child well-being in health, youth success, family economic prosperity, and early childhood. We do this by providing Coloradans with trusted data and research on child well-being and organizing an extensive statewide network of dedicated child advocates. The Children’s Campaign recognizes access to quality, affordable, and continuous health coverage as a pillar for a child’s mental and physical well-being.

We support CMS finalizing the 2022 Proposed Rule as proposed, subject to the comments below, with 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 retaining coverage for people who continue to be eligible. The proposed rule would make improvements that would specifically benefit children who have been historically and/or systemically disadvantaged by the current system. This includes children, who often experience delays in coverage when enrolling in CHIP or gaps when moving between Medicaid and CHIP; the proposed rule will lessen this enrollment volatility, which disproportionately harms Black, Hispanic, American Indian...
and Alaskan Native children. 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.

I. Medicaid Eligibility Determination and Redetermination Processes

Overall, we support the proposed rules relating to Medicaid eligibility determination and redetermination processes. The proposed rule would establish minimum response times that states must allow applicants and enrollees to provide requested information to determine or redetermine eligibility, as well as more detailed timeliness standards for different types of eligibility determinations. It would align many aspects of application and renewal process rules for modified adjusted gross income (MAGI)-exempt populations (disabled and dual eligibles) with rules put in place for MAGI groups (children, pregnancy coverage, parents, and other adults) with implementation of the Affordable Care Act (ACA).

The rule would also require states to take specific actions to resolve returned mail. However, it would be helpful to expand the proposed process steps to other types of requests for information. The proposed rule establishes a new section (§ 435.919) that provides specific rules for how states process changes in circumstances based on the source of the information and streamlines certain aspects of verifying citizenship. These proposed changes and additions to the Medicaid eligibility regulations will continue to build on the vision of the ACA to foster a streamlined, data-driven system that reduces administrative barriers, increases efficiency and timeliness, and promotes enrollment and retention.

Response times and timely determination and redetermination of eligibility (§§ 435.907 and 435.912)

We appreciate the proposed changes at § 435.907 that would allow adequate time for beneficiaries to provide requested information for new applications – 15 days for MAGI and 30 days for MAGI-exempt applications.

The proposed rule at § 435.912 would maintain the maximum timeliness standards of 45 days for MAGI applications and 90 days for MAGI-exempt applications but it also broadens timeliness standards to include redeterminations at renewal and for changes in circumstances. State Medicaid plans will now need to detail the state’s timeliness standards within the maximum timeliness framework for different types of determinations or redeterminations. The proposed rule incorporates additional time for states to process renewals and redeterminations depending on when information is received from the enrollee or if the state determines the enrollee is no longer eligible on the current basis and the agency is considering eligibility on another basis.

We support these additional standards to ensure that all applicants and enrollees have adequate time to provide information and receive a timely determination or redetermination. However, the expanded timeliness standards and exceptions, along with proposed changes establishing minimum response times for applicants and
enrollees to provide needed information, set up a variety of complicated scenarios that will require additional guidance for states to properly adopt and implement to make these processes more streamlined.

Changes in circumstances (§ 435.919)

The proposed rule specifies new standards (§ 435.919) for processing changes in circumstances if such changes result in ineligibility. Importantly, the proposed rule differentiates between changes reported by the beneficiary, received from a third party (i.e., data exchanges), and those that can be anticipated (i.e., when a child ages out). The rule would also address changes that may result in additional benefits or lower premiums or cost sharing with a key provision that the state may not disenroll the individual if a request for information (RFI) is not returned. The proposed rule would establish RFI response times of 30 days, for all types of changes, aligning with current policy allowing enrollees 30 days to respond when the state is unable to make a renewal determination using data available to the state (also known as ex parte). The proposed rule also specifies that the 90-day reconsideration period applies to procedural terminations following a change in circumstances.

We support the addition of procedures and standards for processing changes in circumstances, particularly allowing enrollees 30 days to respond to an RFI. However, we are not in agreement with § 435.919(b)(2)(iii) relating to changes received from a third party. The proposed rule requires the state to determine the reliability of the information § 435.919(b)(2)(f), but it does not require the state to act on reliable data. If the enrollee does not verify the information, the state may not terminate coverage, but it is not required to provide additional benefits or lower cost-sharing. We support the prohibition on termination but if the state has “reliable” information, it should be required to act on that information in the same manner as required for ex parte renewals.

In Colorado, the amount of time a Medicaid enrollee or applicant receives to respond to an RFI depends on the information requested. The receipt of an income discrepancy letter allows people 30 days to respond to an RFI, yet upon receipt of a verification checklist, which is sent to members either following an application if more information is needed or during the renewal process if the member needs to complete an additional task, the member is only given 10 days. Families with children may experience disruptions or delays in receiving coverage if they do not respond to these verification needs in time. Allowing 30 days for members to respond to an RFI in all communications would help ensure families have an adequate time respond without losing their health coverage.

Returned mail

We are enthusiastic about the proposed rule requiring states to follow-up on returned mail. We support the process which would require states to check various sources for updated mailing addresses and other contact information, mail a notice to both the old and new addresses, and then make at least two attempts to follow up with the individual via non-
mail communication modes. Importantly, the rule disallows states from terminating coverage for an individual who does not respond to the notice when mail is returned from the U.S. Postal Service with an in-state forwarding address.

We support the requirements for states to follow-up on returned mail. We believe these processes will promote retention of eligible individuals, reduce procedural disenrollments, avoid churn, and accelerate the pace at which states are adopting efficient, cost-effective, and timely enrollee communications using non-mail modes. Therefore, we recommend that follow-up requirements be added when information is needed to determine eligibility at application, renewal or when there is a change in circumstances.

In Colorado, Medicaid and Colorado’s CHIP program (Child Health Program Plus) insure approximately 1.6 million Coloradans. All these individuals will have to be redetermined for their health coverage when the public health emergency ends. Despite Colorado developing and implementing an “Update Your Address” Campaign in hopes of mitigating the loss of coverage due to returned mail, parents and other caregivers with children, especially those experiencing housing instability, are often already under extreme amounts of stress to the point that updating their address is not their top priority. The proposed rule’s requirements for following up on returned mail would help ensure that more Colorado children are able to maintain their health coverage without disruption as the public health emergency unwinds.

90-day reconsideration period

As noted above, we support allowing enrollees a 90-day reconsideration period if disenrolled for procedural reasons when a change in circumstances is processed (§ 435.919(d)). However, it is not clear why 90-day reconsideration is limited to disenrollment for procedural reasons. There is clear evidence that temporary fluctuations in income, which are more frequent for low-income wage earners, drive churn. Expanding the 90-day reconsideration period to all types of disenrollments would promote smooth re-enrollment for individuals regardless of why they lost coverage and potentially lower the volume of fair hearings requested when the beneficiary disagrees with the state’s decision.

We recommend striking the language that limits of the 90-day reconsideration period to termination “for failure to submit the renewal form or necessary information” at renewal (§ 435.916(a)(3)(iii)) and “for not returning the requested information” at (§ 435.919(d)).

Alignment of certain renewal processes for MAGI-exempt groups as required for MAGI eligibility (§ 435.916)

The proposed at § 435.916 would align non-MAGI processes with many of the streamlining and simplification requirements adopted for MAGI groups under the ACA, including: disallowing a requirement for an in-person interview, conducting renewals only once a year, sending pre-populated forms, providing 30 days to return renewal information,
accepting renewals through the four modalities, and providing a 90-day reconsideration period if information is returned after a procedural disenrollment.

We support this alignment of processes and believe it will promote retention in non-MAGI Medicaid while making processes consistent will make it simpler for eligibility and call center workers, enrollees, assisters, and other stakeholders to understand the rules. We also support requiring states to accept information obtained through an electronic data match as reasonably compatible if both are above, at or below the application resource standard to facilitate verification of resources.

Verifying citizenship (§§ 435.407 and 435.956)

Under current law, when an applicant’s citizenship cannot be verified using data from the Social Security Administration, a two-step process is required: first verifying citizenship and then identity. The proposed rule would amend § 435.907 to allow two additional data sets, state vital statistics systems and data from the Department of Homeland Security (DHS), to be used as "standalone" proof of citizenship in addition to Social Security Administration data. This change would simplify the process because applicants would no longer have to provide separate proof of identity, reducing burden on applicants and increasing administrative efficiency.

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. The proposed rule would remove this option at § 435.956.

We support these changes. Requiring separate proof of identity when a state vital statistics system or DHS has already verified citizenship is redundant and inefficient. With respect to ROPs, some applicants such as survivors of domestic abuse and people experiencing homelessness are more likely to have difficulty with electronic data matches, making it harder for them to enroll. Allowing states to limit the number of ROPs could disproportionately impact these communities, widening health disparities.

II. CHIP

Following passage of the ACA, CMS made notable gains in establishing a streamlined and coordinated eligibility and enrollment system across all health coverage programs. However, some CHIP administrative barriers, including waiting periods, remain in place that are not allowed in Medicaid and other insurance affordability programs. We support continuing to align CHIP to Medicaid and ending outdated practices as described in the proposed rule.

Aligning CHIP to Medicaid (§§ 457.340 and 457.344)
CHIP enrollment and renewal policies generally mirror Medicaid, and the proposed rule would continue to align CHIP with Medicaid rules with some limited exceptions. We support alignment for timeliness standards, changes in circumstances, and returned mail policies, with the same recommendations noted above for Medicaid. See below for CHIP-specific recommendations.

With respect to aligning CHIP rules on returned mail and address updates to Medicaid, proposed § 457.344 directs the state to treat an in-state mailing address as if it were out of state if the new address is outside the geographic region the CHIP program serves. However, these circumstances merit different treatment because the state can do more to enroll children within the state.

We recommend that if the new address is out of the separate CHIP program region but still within the state, that CHIP proceed with determining eligibility for Medicaid, CHIP and other insurance affordability programs within the state and available in the region where the new address is located, then transferring the account and sending a combined notice, as outlined in 42 CFR §§ 435.1200(h) and 457.350(g).

III. Transitions Between Insurance Affordability Programs

Medicaid Single State Agency and Responsibilities for a Coordinated Eligibility and Enrollment Process (§ 431.10 and § 435.1200)

We support CMS’s effort to improve coordination between Medicaid and other programs, particularly CHIP. While we support most of the provisions in the regulation, we have some recommendations for improvement.

Prioritizing Minimum Essential Coverage

The proposed rule also requires that Medicaid agencies must, in addition to determining eligibility for other programs when an individual is ineligible for Medicaid, also determine eligibility when the individual is only eligible for a Medicaid benefit that is not minimum essential coverage.

We support the requirement at § 435.1200(e)(4) to require determinations of eligibility for other programs if an individual has not been found eligible for minimum essential coverage.

Medicaid Determinations of CHIP Eligibility

Regardless of the eligibility system policy, we support the proposed regulation requiring Medicaid agencies in states with separate CHIP programs to make CHIP eligibility determinations and transfer files to CHIP. We agree with the preamble to the proposed rule that Medicaid agencies have or can obtain the necessary information for CHIP
determinations. Furthermore, the proposed rule would require states to move forward with CHIP determinations and transfers regardless of whether individuals have confirmed reliable data. This policy is critical because under current regulations, even though a Medicaid agency may find that an individual is likely eligible for CHIP, the state can terminate the enrollee (without transferring their file) if the individual fails to respond to an RFI. There is no reason states should refrain from taking appropriate action when they have reliable information to move forward. Doing so would be inconsistent with maximizing enrollment and the intent of an *ex parte* process.

The preamble to the proposed regulation also requests comments on the challenges in effecting immediate CHIP enrollment (from Medicaid) in some instances, such as where a premium needs to be paid or there is a plan selection process. We believe that CMS should require states to effectuate CHIP enrollment immediately based on the Medicaid agency’s eligibility determination—with any additional steps moved to post-enrollment processes. CMS could require that the existing 30-day payment grace period apply to the first month of premiums and individuals could be passively enrolled into a plan while they have an opportunity to proactively select a plan.

*We support the requirement for Medicaid to make CHIP eligibility determinations and file transfers, and that this be effectuated when reliable information is available, regardless of whether individuals confirm the information. Second, we recommend that, in addition to unifying eligibility systems, CMS make enrollment immediately effective, and conduct other processes (such as premium payment and plan selection) post-enrollment.*

**Combined Eligibility Notice**

The proposed rule requires that individuals receive a combined eligibility notice when either the Medicaid agency determines the individual ineligible for Medicaid and eligible for CHIP or a separate CHIP agency determines the individual eligible for Medicaid and ineligible for CHIP. We support this policy, as it will reduce confusion for enrollees and ultimately promote continuity of coverage. The preamble notes that a combined notice will help families transitioning from Medicaid to CHIP learn about premium requirements or any plan selection process they need to complete; however, it is not clear the regulation requires combined eligibility notices to include this information. We recommend that CMS conform the definition of combined notices at §§ 435.4 and 457.340(f) to implement the proposed policy.

The preamble also clarifies that under current regulations Medicaid and CHIP would be expected to issue a single combined notice for all household members to the maximum extent possible. We appreciate this clarification, though we urge CMS to specify the narrow set of circumstances when a combined eligibility notice for all family members would not be possible.

*We support the requirement for Medicaid and CHIP programs to use combined eligibility notices. We recommend that CMS explicitly require such notices to specify*
any additional steps needed to effectuate coverage. We also recommend that CMS require combined notices for Medicaid, CHIP, Exchanges, and BHPs, and that CMS specify the limited scenarios where full family combined notices would not be required.

The Colorado Children’s Campaign stands firm in our belief that Medicaid and CHIP enrollees and applicants should not have to surmount numerous unnecessary obstacles to access the benefits they deserve. Streamlining the application, eligibility determination, enrollment, and renewal processes would help ensure that more families with children of low incomes both in Colorado and nationwide have equitable access to continuous health coverage.

Sincerely,
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2. Planning For the End of the Public Health Emergency - Webinar Presentation - April 15, 2022 (colorado.gov)
3. https://hcpf.colorado.gov/uya-campaign