

CMS Proposed Rule on Medicaid and CHIP Eligibility, Enrollment, and Renewal: Implications for States

Manatt Health

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Questions? Email Heather Howard at heatherh@Princeton.edu.

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Housekeeping Details

All participant lines are muted. If at any time you would like to submit a question, please use the Q&A box at the bottom right of your screen.

After the webinar, the slides and a recording will be available at **www.shvs.org**.

Agenda

- **Level-Setting**

- **Review of the Centers for Medicare & Medicaid Services (CMS) Notice of Proposed Rulemaking (NPRM) & Implementation Timing**

- **Discussion**



Level-Setting





Webinar Objectives



- Provide an overview of the CMS eligibility and enrollment (E&E) NPRM, *“Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes.”*
- Discuss timing and operational process/IT systems implementation considerations of the final rule at the same time states are preparing to implement or implementing unwinding of the federal continuous coverage requirements.

Overview of the CMS E&E NPRM

Released on August 31, 2022, the proposed rule seeks to strengthen existing eligibility, enrollment, and renewal operational processes to close gaps and extend best practices identified by CMS and states in preparing for the end of the public health emergency (PHE). CMS has identified the following goals that it seeks to achieve with the E&E NPRM:

-  **Streamline application and enrollment processes**
-  **Improve retention rates at and between renewals**
-  **Remove access barriers for children**
-  **Enhance program integrity**

Comments on the proposed rule are due no later than November 7, 2022.

Source: CMS, [Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes](#); and SHVS/Manatt Health, [CMS Proposed Rule on Medicaid and CHIP Eligibility, Enrollment, and Renewal](#).

Provisions of the Proposed Rule to be Reviewed During The Webinar

- ✓ Medicaid and Children's Health Insurance Program (CHIP) Verification Processes
- ✓ Process Requirements at Application and Changes in Circumstances
- ✓ Returned Mail
- ✓ Transitions Between Medicaid, CHIP, and Basic Health Plan (BHP) Agencies
- ✓ Non-Modified Adjusted Gross Income (MAGI) E&E Changes
- ✓ CHIP Enrollee Protections
- ✓ Required Content of Records and Documentary Evidence
- ✓ Facilitated Enrollment Processes into Medicare Savings Programs (MSPs)

CMS has requested comments from states on a reasonable implementation timeline for each requirement, recognizing state workforce and IT systems capacity limitations, but understanding that many of the proposals could help mitigate coverage loss during unwinding. CMS is considering adopting an effective date of 30 days following the publication and separate compliance dates (e.g., 90 days, six months, and/or 12 months following the effective date), by requirement.



We are interested in your feedback on implementation timeline feasibility in light of PHE unwinding and will be conducting anonymous polling throughout the webinar.

Source: CMS, [Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes](#); and SHVS/Manatt Health, [CMS Proposed Rule on Medicaid and CHIP Eligibility, Enrollment, and Renewal](#).



Review of NPRM and Implementation Timing

Medicaid and CHIP Verification Processes

The proposed rule seeks to reduce barriers to eligibility by expanding sources of verification for citizenship, expanding opportunities to provide appropriate documentation, and eliminating requirements for individuals to apply for other benefits.

- ✓ **Expanding Citizenship and Identity Verification.** Expands the forms of allowable standalone verification to include verification of birth with a state vital statistics agency or of citizenship via the federal Systemic Alien Verification for Entitlement (SAVE) Program.
- ✓ **Removing the Option to Limit the Number of “Reasonable Opportunity Periods” to Establish Citizenship or Immigration Status.** Removes state option to limit opportunities within a coverage year for consumers to provide appropriate documentation.
- ✓ **Eliminating the Requirement for Individuals to Apply for Other Benefits.** Reinterprets underlying statute to no longer require that individuals apply for benefits for which they may be entitled. Current rules were promulgated in 1978 when Medicaid was closely linked to cash assistance programs.
- ✓ **Non-MAGI Applicants: Permitting Electronic Verification and Reasonable Compatibility Standards for Resources.** Clarifies that states are not permitted to request additional information from a non-MAGI applicant if their resource information is reasonably compatible with information the state received from an electronic data source.
- ✓ **Medically Needy Spenddown: Option to Use Prospective Medical Expenses for Non-Institutional Individuals.** Adds state option to allow individuals to deduct predictable *non-institutional* anticipated medical and remedial care expenses from their income in order to become eligible under the optional Medically Needy eligibility group.

Source: 42 C.F.R. § 435.407; 42 C.F.R. §§ 435.956 and 457.380; 42 C.F.R. § 435.608; 42 C.F.R. § 435.952; 42 C.F.R. § 435.831.

The Intersection of Proposed Medicaid and CHIP Verification Processes and the PHE



Analysis:

- Of the proposed verification changes, the one that may have the biggest impact on supporting states' unwinding efforts will be the application of reasonable compatibility standards for resources.
- The remaining proposed changes will: (1) largely impact application processes not renewal processes; and/or (2) require a heavier operational/systems lift (e.g., option to use prospective medical expenses for Medically Needy eligibility.)
- Therefore, states may consider **prioritizing implementation of reasonable compatibility standard for resources** to facilitate redetermination processing at the end of the PHE.



Polling: Please review and answer WebEx questions.

Proposed Changes to Application, Renewal, and Change in Circumstance Process Requirements

The NPRM proposes new requirements to further standardize the application process and timeframes and establishes new processing timeframes for renewals and changes in circumstances.

- ✓ **Application Requirements.**
 - **Minimum timeframe to respond to requests for information:** Creates a new requirement that most individuals be given at least 15 calendar days (30 calendar days for people applying based on a disability).
 - **Reconsideration period:** Creates a new 30 calendar day application reconsideration period from the date of the notice of ineligibility (like the reconsideration process that currently exists at renewal).
- ✓ **Changes in Circumstances Requirements.**
 - **Notice requirements:** Clarifies that if the state receives information from a third party and it: (1) adversely impacts the enrollee, the agency must request information from the enrollee to verify or dispute the information; or (2) results in additional medical assistance and/or lower premium/cost sharing, the state must notify the individual of the determination. Prior to notifying the enrollee, the state may verify third party-information with the enrollee but may not terminate coverage if the enrollee doesn't respond.
 - **Reconsideration period:** Establishes a new 90-day reconsideration period for individuals terminated for not returning requests for information.
- ✓ **Renewal and Changes in Circumstances Processing Timeframes.** Establishes new processing timeframes for renewals, when individuals report a change in circumstances, and when there are anticipated changes in circumstances (e.g., a birthday that would affect eligibility). *(See next slide for detail.)*

Source: 42 C.F.R. § 435.907; 42 C.F.R. § 435.912; 42 C.F.R. §§ 435.919 and 457.344.

Proposed Processing Timeframes

Action	Processing Time Period Definition	Proposed Processing Timeframe for Medicaid/CHIP Enrollees
Application Processing	The date of application or (upon receipt of an account transfer from another insurance affordability program) until the date the agency sends the notice of eligibility determination (or the date the agency transfers electronic account).	<ul style="list-style-type: none"> • 45 days/90 days for individual enrolled on basis of disability. • (Current standard, no proposed change).
Renewals Processing	The date the agency initiates the steps to renew eligibility based on information available to the agency until the date the agency sends the eligibility determination notice.	<ul style="list-style-type: none"> • If renewal form/additional information is received: <ul style="list-style-type: none"> ○ 25+ days before the end of the eligibility period: no later than the end of the eligibility period. ○ Less than 25 days before the end of the eligibility period: no later than the end of the month following the end of the eligibility period. • If the agency determines the enrollee is not eligible on the current basis and is being determined on the basis of disability, 90 days from the date of that determination.
Changes in Circumstances Processing	The date the agency receives new information (from the enrollee or a third party) until the date the agency sends the eligibility determination notice.	<ul style="list-style-type: none"> • 30 days following the agency's receipt of information related to a change (unless the agency needs to request additional information); or • 60 days following the agency's receipt of information related to a change if the agency requests additional information from the enrollee.
Anticipated Changes in Renewal Processing	The date the agency begins the redetermination of eligibility to the date the agency sends the eligibility determination notice.	<ul style="list-style-type: none"> • If the enrollee sends requested information 25+ days before the date of anticipated change, the agency must process the determination on or before the date of the anticipated change or, at state option, the last day of the month in which the anticipated change occurs. • If the information is received < 25 days prior to the date of the change, the agency must process the determination no later than the end of the month following the end of the month in which the anticipated changes occur. • If the agency determines the enrollee is not eligible on the current basis and is being determined on the basis of disability, the determination on the basis of disability must be processed within 90 days of the initial determination.

The Intersection of Proposed Medicaid and CHIP Processing Timeframes and the PHE



Analysis:

- Establishing a minimum period of 15 days to respond to requests for information (30 days for individuals who are disabled) will give individuals more time and could result in more people maintaining coverage.
- The: (1) new processing timeframes at renewal and change in circumstances; and (2) new notice and reconsideration period at changes in circumstances will likely require a heavier operational/IT systems lift.



Polling: Please review and answer WebEx questions.

Returned Mail

Recognizing returned mail may result in eligible people being terminated from coverage, the NPRM outlines the following steps that states must take upon receipt of returned mail from the United States Postal Service (USPS).

Step 1: Check Available Data Sources for Updated Contact Information.

- Agency's Medicaid Enterprise System;
- Contracted managed care plans; and
- One or more of: SNAP agency, TANF, DMV, USPS NCOA database, or other in verification plan.

Step 2: Conduct Outreach Using at Least Two Different Modalities.

- To address on file and from available data sources.
- Two notices by one or more modalities other than mail (e.g., electronic notice, email, text messaging)

Step 3: Take Action.

- Accept in-state forwarding address.*
- Send advance notice of termination for out-of-state forwarding address.*
- No forwarding address: take steps to locate and terminate, suspend, or move to fee-for-service.

**If the agency does not receive a response from the enrollee that the address is incorrect.*

Source: 42 C.F.R. §§ 435.919 and 457.344. **Acronyms:** SNAP = Supplemental Nutrition Assistance Program; TANF = Temporary Assistance for Needy Families; DMV = Department of Motor Vehicles; and NCOA = National Change of Address.

The Intersection of Proposed Returned Mail Processes and the PHE



Analysis:

- Implementing the proposed returned mail processes will help to mitigate coverage loss for eligible individuals during the PHE unwinding but will likely require a heavier operational/IT systems lift for states.



Polling: Please review and answer WebEx questions.

Alignment of Non-MAGI and MAGI Enrollment and Renewal Requirements

The NPRM extends simplified MAGI processes to non-MAGI populations, who are more likely to live on fixed-incomes and thus remain financially eligible for Medicaid, and who are more susceptible to administrative barriers to continuity of coverage due to age or disability.

- ✓ **Application Requirements:** Clarifies that states must allow non-MAGI populations to submit applications through all modalities (online, by telephone, by mail, or in-person). Also eliminates the state option to require an in-person interview as part of the non-MAGI application process.
- ✓ **Renewal Requirements:** Eliminates the state option for an in-person interview for non-MAGI populations at renewal. Establishes that renewals may not be more frequent than every 12 months. Also requires states to send a prepopulated renewal form to non-MAGI populations if eligibility cannot be verified through ex-parte.

Per the NPRM, six states require regularly scheduled renewals for at least some non-MAGI enrollees more frequently than every 12 months (e.g., every six months).

Source: 42 C.F.R. §§ 435.907 and 435.916.

The Intersection of Non-MAGI Processes and the PHE



Analysis:

- While the proposed changes could significantly support individuals renewing coverage who are in the non-MAGI eligibility group, implementing the proposed non-MAGI processes will likely require a heavier operational/IT systems lift for states.



Polling: Please review and answer WebEx questions.

CHIP Enrollee Protections

The NPRM includes sweeping enrollment changes that would have a considerable impact on ensuring continuity of coverage for CHIP-enrolled children.

- ✓ **Premium Lock-Outs:** Eliminates premium lock-out periods in CHIP under the rationale that lock-out periods (1) are not required by statute; (2) are not permitted in Medicaid; and (3) can impact continuity of coverage for low- and moderate-income children.
- ✓ **Waiting Periods:** Eliminates waiting periods in CHIP. States will still be required to monitor for when families substitute CHIP for private insurance (aka “crowd-out”).
- ✓ **Annual and Lifetime Limits on Benefits:** Eliminates annual and lifetime limits for CHIP-enrolled children.

14 states currently have premium lock-out periods.

11 states currently have waiting periods: nine states have a 90-day waiting period, one state has a two-month waiting period, and one state has a one-month waiting period.

12 states place an annual dollar limit on at least one CHIP benefit, and six states place a lifetime limit on at least one benefit; the most common benefit where limits are placed is on dental and orthodontia coverage.

Source: 42 C.F.R. §§ 457.570 and 600.525(b)(2); 42 C.F.R. §§ 457.65, 457.340, 457.350, 457.805, and 457.810; 42 C.F.R. § 457.480.

The Intersection of CHIP Enrollee Protections and the PHE



Analysis:

- Implementing the proposed changes to CHIP will likely have a significant, positive impact on access to coverage during the PHE unwinding.



Polling: Please review and answer WebEx questions.

Transitions Between Medicaid and CHIP

The NPRM seeks to improve transitions for children between Medicaid and CHIP for states with a separate CHIP.

- ✓ **Establishing Procedures to Accept Determinations Across State/Federal Agencies:**
 - Medicaid agencies would be required to accept determinations of MAGI-based Medicaid eligibility made by a separate CHIP agency and complete determinations of CHIP eligibility for individuals who are determined ineligible for Medicaid based on third party data.
 - CHIP agencies would be required to accept determinations made by Medicaid agencies.
 - CHIP Agencies—like Medicaid agencies—will be required to complete MAGI-based determinations for Medicaid and screen for potential non-MAGI Medicaid, as well as eligibility for BHP and insurance affordability programs through the Exchange.
 - Both Medicaid and CHIP agencies would be required to transfer the account of an individual if they have been found eligible for Medicaid or CHIP and potentially eligible for Exchange coverage, even if the enrollee has not responded.

- ✓ **Combined Eligibility Notice:**
 - An enrollee should receive a combined notice of Medicaid/CHIP eligibility.
 - An enrollee should receive a combined notice of BHP/insurance affordability programs available through Marketplaces.

Source: 42 C.F.R. §§ 435.1200, 457.340, 457.348, and 457.350.

The Intersection of Proposed Cross-Program Transition Processes and the PHE



Analysis:

- The proposed changes will significantly improve coverage transitions for children during the PHE by allowing states to rely on data sources and eligibility determinations made by another program—thereby reducing the number of procedural terminations.



Polling: Please review and answer WebEx questions.

Record Keeping Requirements

The proposed rule seeks to strengthen current regulatory requirements and respond to the U.S. Department of Health and Human Services Office of Inspector General reports and Payment Error Rate Measurement findings that Medicaid and CHIP case records sometimes lack sufficient documentation.

Per the proposed rule, the following must be maintained for each applicant or current enrollee:

- All information provided on the initial application submitted through any modality (mail, telephone, online, in-person), including signature and date of application.
- The electronic account and any information or other documentation received from program.
- The date of, basis for, and all documents or other evidence to support any determination, denial, or adverse action obtained electronically or otherwise.
- The provision of and payment for services, items, and other medical assistance, including the service or item provided, relevant diagnoses, the date that the service or item was provided, the practitioner or provider rendering or prescribing the service (including National Provider Identifier), and the full amount paid or reimbursed for such service or item, and any third-party liabilities.
- Any changes of circumstances reported by the individual and any actions taken.
- All renewal forms and documentation provided on behalf of the enrollee regardless of modality submitted.
- All notices provided to the applicant or enrollee.
- All records pertaining to any fair hearings requested, including the date of the request, complete record of the hearing decision, and final administrative action.
- The disposition of income and eligibility verification information received through data matching, including evidence that no information was returned.
- Statistical, fiscal, and other records necessary for reporting and accountability as required by the Secretary.

Source: 42 C.F.R. §§ 431.17, 435.914, and 457.965.

The Intersection of Record Keeping Processes and the PHE



Analysis:

- These new record keeping requirements will likely not help to facilitate renewals during states' unwinding efforts but will assist in the quality of information that is maintained for future renewal cycles.
- Implementing the proposed record keeping requirements may likely require a heavier operational/IT systems fix.



Polling: Please review and answer WebEx questions.

Facilitated Enrollment Into MSP Using Low-Income Subsidy (LIS) Data

The proposed rule seeks to increase the number of low-income Medicare enrollees who receive assistance with paying for their premiums and cost sharing through MSP.

- ✓ **Enrolling Individuals into an MSP:** Requires states to maximize the use of LIS data to establish eligibility for both Medicaid and the MSPs. CMS encourages states to align eligibility criteria between the LIS and MSP programs so that a state receiving LIS data can automatically make an MSP determination without requesting additional information.
- ✓ **Defining Family Size for MSP to Align with LIS Program:** Defines family size for an MSP to include at least the individuals included in the definition of family size for the LIS program.
- ✓ **Automatically Enrolling Certain Supplemental Security Income Recipients into the QMB Program:** The proposed rule would require states to deem an individual enrolled in the mandatory SSI or 209(b) group eligible for the Qualified Medicare Beneficiary (QMB) group in the month the state becomes responsible for paying the individual's Part B premiums.

Source: 42 §§ C.F.R. 435.4, 435.601, 435.911, and 435.952; 42 C.F.R. § 435.601.

The Intersection of MSP Enrollment Processes and the PHE



Analysis:

- The proposed data verification and program alignment changes would have a significant impact on improving enrollment into the MSP program, especially for individuals who aged out of Medicaid during the PHE.
- Implementing the proposed MSP processes may likely require a heavier operational/IT systems fix.



Polling: Please review and answer WebEx questions.

Discussion



Discussion Question: What technical assistance can SHVS, its technical assistance partners, and CMS provide to help states with successful implementation of the NPRM?

The slides and a recording of the webinar will be available at www.shvs.org after the webinar

Thank You

Patricia Boozang

Senior Managing Director
Manatt Health
pboozang@manatt.com

Kinda Serafi

Partner
Manatt Health
kserafi@manatt.com

Daniel Meuse

Deputy Director
State Health and Value Strategies Program
dmeuse@princeton.edu

Heather Howard

Director
State Health and Value Strategies Program
heatherh@princeton.edu