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Newly Proposed Rule Would Help Kids, Seniors, and Others Get and Stay Enrolled in Medicaid and CHIP

By Allison Orris

The Centers for Medicare & Medicaid Services (CMS) recently released a proposed rule to make it easier for people who are eligible for Medicaid and the Children’s Health Insurance Program (CHIP) to get and stay enrolled in coverage.¹ The proposed rule marks CMS’ first major update to rules governing the process to determine Medicaid eligibility since finalizing rules that simplified eligibility and enrollment under the Affordable Care Act (ACA), during the Obama Administration.² The newly proposed rule is critical because as of 2021, of about 28.9 million uninsured people in this country, 7.3 million were eligible for but not enrolled in Medicaid.³ And many people who are eligible regularly “churn” in and out of coverage, a barrier to accessing care that the rule seeks to minimize.⁴

The rule identifies and proposes to close gaps in the regulatory framework that currently governs Medicaid and CHIP eligibility and enrollment policies, proposing to eliminate burdensome provisions that make it harder to gain or keep coverage. For example, the current eligibility rules that

¹ Centers for Medicare & Medicaid Services (CMS), “Biden-Harris Administration Proposes to Make Health Care Enrollment Easier for Millions of Americans,” August 31, 2022, <https://www.cms.gov/newsroom/press-releases/biden-harris-administration-proposes-make-health-care-enrollment-easier-millions-americans>.

² CMS, “Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes,” 87 Fed. Reg. 54760 (September 7, 2022), <https://www.govinfo.gov/content/pkg/FR-2022-09-07/pdf/2022-18875.pdf>.

³ Kaiser Family Foundation, “Distribution of Eligibility for ACA Health Coverage Among the Remaining Uninsured,” 2021, <https://www.kff.org/health-reform/state-indicator/distribution-of-eligibility-for-aca-coverage-among-the-remaining-uninsured/?dataView=1¤tTimeframe=0&selectedDistributions=medicaidother-public-eligible-tax-credit-eligible--ineligible-for-financial-assistance-due-to-affordable-marketplace-plan-available--ineligible-for-financial-assistance-due-to-offer-of-employer-coverage--ineligible-for-financial-assistance-due-to-citizenship--in-medicaid-coverage-gap--total&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

⁴ Jennifer Wagner and Judith Solomon, “Continuous Eligibility Keeps People Insured and Reduces Costs,” CBPP, May 4, 2021, <https://www.cbpp.org/research/health/continuous-eligibility-keeps-people-insured-and-reduces-costs>. For more information on churn, see Dorothy Rosenbaum, “Lessons Churned: Measuring the Impact of Churn in Health and Human Services Programs on Participants and State and Local Agencies,” CBPP, March 20, 2015, <https://www.cbpp.org/research/lessons-churned-measuring-the-impact-of-churn-in-health-and-human-services-programs-on>.

were issued after the ACA was enacted applied some streamlined eligibility and enrollment policies only to certain groups of Medicaid applicants and recipients (namely those whose income is determined using Modified Adjusted Gross Income, or MAGI). These simplifications did not apply to adults 65 and older or to people with disabilities (the so-called non-MAGI groups).

While the proposed rule includes changes to improve the eligibility process for all who are covered by Medicaid, the updates would especially help older adults and people with disabilities who did not benefit from eligibility simplifications adopted to implement the ACA, as well as children eligible for CHIP.

Rule Proposes Welcome Reductions in Administrative Burden

Despite prior CMS rules implemented after the ACA, which dramatically simplified the eligibility and enrollment process, people still encounter challenges getting enrolled, staying enrolled when they are eligible, and moving to other coverage when their incomes or other circumstances change.

In some cases, current regulations still permit burdensome eligibility processes for some or all populations; CMS' proposed rule seeks to address these barriers by refreshing the existing rules, applying rules that have streamlined eligibility and redetermination processes for some Medicaid populations to all Medicaid eligibility groups, and developing new standards to address Medicaid and CHIP enrollment challenges identified over the last decade. Some of the proposed simplifications are already allowed but not required; the rule would create new national standards that reflect eligibility, enrollment, and retention best practices.

In 2018, before the COVID-19 continuous coverage requirement prohibited Medicaid agencies from terminating coverage for most enrollees during the public health emergency (PHE), 1 in 10 Medicaid or CHIP beneficiaries disenrolled and re-enrolled in less than one year.⁵ Such churning is associated with disruptions in physician care and medication adherence,⁶ increased administrative costs for providers, Medicaid managed care organizations, and states,⁷ and in some cases higher health care costs when delayed care results in more expensive health care needs.⁸

Research shows that administrative burdens, such as requiring people to return forms rather than relying on electronic data and verification, reduce the number of people who enroll and can prevent

⁵ Bradley Corallo *et al.*, "Medicaid Enrollment Churn and Implications for Continuous Coverage Policies," Kaiser Family Foundation, December 14, 2021, <https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/>.

⁶ Ben Sommers *et al.*, "Insurance Churning Rates for Low-Income Adults Under Health Reform: Lower than Expected But Still Harmful for Many," *Health Affairs*, Vol. 35, No. 10 (2016): 1816–1824, <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.0455>.

⁷ Katherine Swartz *et al.*, "Evaluating State Options for Reducing Medicaid Churning," *Health Affairs*, July 2015, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4664196/>.

⁸ Anthem Public Policy Institute, "Continuity of Medicaid Coverage Improves Outcomes for Beneficiaries and States," June 2018, https://www.communityplans.net/wp-content/uploads/2019/04/13_Report_Continuity-of-Medicaid-Coverage-Improves-Outcomes-for-Beneficiaries-and-States.pdf.

people from staying enrolled.⁹ These administrative burdens disproportionately impact people of color, who are disproportionately likely to qualify for Medicaid for their health coverage.¹⁰ Therefore, reducing administrative burdens — as the new proposed rule seeks to do — could significantly lower uninsured rates among Medicaid-eligible people and is critical to achieving health and racial equity.¹¹

Finalizing the changes proposed by CMS would help ensure that millions of people who meet Medicaid and CHIP eligibility criteria but who are not enrolled in coverage can get and stay enrolled, as Congress intended when it enacted the ACA and, earlier, the 2008 Medicare Improvements for Patients and Providers Act (MIPPA). Once finalized, implementing the rule will take time and resources for states; the federal government would reimburse some of these costs at enhanced administrative matching rates. And finalizing the rule could help reduce some of the administrative costs of processing new applications for individuals who churn in and out of coverage.

Overall, the rule would help fully realize the vision of the ACA by streamlining eligibility and renewal processes for eligible individuals in recognition of the gaps and burdens that CMS, states, and stakeholders have identified since the ACA was implemented. It is essential to refresh the rules and build on existing state systems to further streamline eligibility and retention, ultimately creating more efficient processes both for states and for individuals.

Key Provisions Would Streamline Eligibility, Renewal, and Retention of Coverage

The rule proposes multiple changes that would make it easier for people to enroll and stay enrolled, addressing existing gaps in the Medicaid and CHIP regulatory framework. These program-wide provisions include:

- **Bolsters timeliness standards for state agency actions.** The rule proposes changes to existing timeliness standards to require that states complete initial determinations as well as renewals and redeterminations in a timely way when people experience changes that could affect their eligibility. CMS explains in the rule that it is proposing to incorporate timeliness standards related to changes in circumstances in light of the agency’s concerns that states should be doing more to promptly follow up on changes that could entitle a Medicaid or CHIP enrollee to additional financial assistance or lower premiums and/or cost-sharing; to protect against coverage losses for procedural reasons if states request additional information from an enrollee without providing sufficient response time; or to promptly redetermine eligibility for individuals who should no longer remain enrolled. The rule specifies timelines that would apply for regularly scheduled renewals and for redeterminations due to changes

⁹ Samantha Artiga and Olivia Pham, “Recent Medicaid/CHIP Enrollment Declines and Barriers to Maintaining Coverage,” Kaiser Family Foundation, September 24, 2019, <https://www.kff.org/medicaid/issue-brief/recent-medicaid-chip-enrollment-declines-and-barriers-to-maintaining-coverage/>.

¹⁰ Suzanne Wikle *et al.*, “States Can Reduce Medicaid’s Administrative Burdens to Advance Health and Racial Equity,” Center on Law and Social Policy and CBPP, July 19, 2022, <https://www.cbpp.org/research/health/states-can-reduce-medicoids-administrative-burdens-to-advance-health-and-racial>.

¹¹ Farah Erzouki, “Reducing Administrative Burdens in Medicaid is Critical to Achieving Health and Racial Equity,” CBPP, July 19, 2022, <https://www.cbpp.org/blog/reducing-administrative-burdens-in-medicoid-is-critical-to-achieving-health-and-racial-equity>.

in circumstances, with exceptions due to administrative or other emergencies beyond the state Medicaid agency's control.

The proposed rule also includes changes to ensure that applicants and beneficiaries have adequate time to furnish all requested information that states require to determine or renew eligibility and process changes in circumstances.

- **Updates standards for agency action on returned mail.** Current regulations do not clearly specify steps states must take to follow up on mail that is returned as undeliverable, even though returned mail leads to a significant number of people losing coverage, despite continuing to meet all eligibility requirements. To address this, CMS is proposing to require states to take reasonable steps to determine beneficiaries' correct addresses before terminating their coverage.

These steps include checking available data sources for updated contact information, including the agency's own data systems, contracted managed care plans, and one or more reliable third-party data sources (such as agencies that administer the Supplemental Nutrition Assistance Program or the Temporary Assistance for Needy Families program, the Department of Motor Vehicles, or the postal service's National Change of Address database). To verify a forwarding address, states would have to try to reach the enrollee using both mail (to the old and new addresses) and multiple attempts via at least one other modality, like phone, email, or text message. Under the proposed rule, when states receive an updated in-state address from the post office or a managed care contractor, the state would have to accept the new in-state address and update the enrollee's account accordingly as long as the state doesn't receive a response from the enrollee that it's incorrect. If mail is returned with an out-of-state forwarding address and the state is unable to confirm the current address using the steps above, the state must provide advance notice of termination and fair hearing rights.

CMS is seeking comment on whether states should be permitted or required to update enrollee contact information received from a reliable third party without first attempting to contact the enrollee and providing them with an opportunity to verify or refute the new contact information; some states have secured this authority during the COVID-19 public health emergency (PHE) and CMS appears interested in exploring its continuation after the PHE ends.

- **Smooths transitions between Medicaid and CHIP.** Recognizing that many people lose coverage when they transition between Medicaid and CHIP, despite ACA rules designed to ease such transitions, the proposed rule would require Medicaid and CHIP agencies to determine eligibility for the other program, to electronically transfer accounts, and to accept a sister agency's determination. The proposed rule would smooth transitions between Medicaid and CHIP by seamlessly transitioning individuals when available information indicates an individual is eligible for the other program; under the current rules, people who do not submit requested information at renewal or upon a redetermination due to a change in circumstances may lose coverage because Medicaid and CHIP agencies are not required to transition otherwise-eligible individuals when beneficiaries have not provided requested information to confirm or dispute third-party data. To alleviate confusion that sometimes occurs when both the Medicaid and CHIP agency send notices to individuals losing coverage in one program and gaining coverage in another, the proposed rule would require states to

issue a combined eligibility notice explaining both the termination of eligibility for Medicaid and the determination of eligibility for CHIP or vice versa, how to appeal, and any additional requirements that may be imposed (e.g., requirement to pay premiums for CHIP).

Other changes would positively affect eligibility and enrollment for seniors, people with disabilities, and individuals with high health care costs. For example, the proposed rule would:

- **Simplify applications and renewals for seniors and people with disabilities.** The rule would apply some of the simplified processes that were adopted for MAGI populations in the 2012 rules to non-MAGI groups, that is, seniors and people whose eligibility is based on blindness or having a disability. Under the proposed rule, states would be prohibited from redetermining eligibility for these groups more than once a year and from requiring in-person interviews, and they would have to use pre-populated renewal forms to minimize burdens on beneficiaries.
- **Update Medicaid “spenddown” rules to eliminate churn for medically needy enrollees.** People who are included in Medicaid’s “medically needy” eligibility group generally have income above the Medicaid eligibility level but have significant health care needs and high medical expenses. People can qualify as medically needy if they “spend down” to a state-specified medically needy income level by incurring medical expenses, which are deducted from their income. The proposed rule would give states the option to make it easier for some low-income people with catastrophic medical costs to enroll and stay enrolled by streamlining the process by which people receiving home- and community-based services (HCBS) demonstrate their eligibility. Enrollees would be able to regularly project their anticipated medical expenses and deduct them from their income rather than wait to incur the expenses, which would help keep people continuously enrolled. This flexibility already applies to people receiving care in institutional settings; the rule is proposing to eliminate the institutional bias in the current rules by permitting states to apply the same methodology for people who receive HCBS to deduct their predictable medical expenses too. This change would help caregivers and beneficiaries retain eligibility with less paperwork, alleviating a burden on them as well as on state eligibility workers.
- **Streamline low-income seniors’ enrollment in Medicare Savings Programs.** The Medicare Savings Programs (MSPs) help cover the costs of Medicare premiums and/or cost sharing for individuals with income under 135 percent of the poverty line, or about \$18,360 per year for a single individual.¹² Despite the significant benefit of these programs in lowering seniors’ health care costs, estimates suggest that millions of people who are eligible are not enrolled.¹³ The proposed rule makes various changes to facilitate enrollment, including requiring automatic enrollment, with some exceptions, of people with Supplemental Security Income into one of the MSP groups.

¹² For more information about the Medicare Savings Programs, see Medicaid and CHIP Payment and Access Commission, “Medicare Savings Programs,” <https://www.macpac.gov/subtopic/medicare-savings-programs/>.

¹³ Kyle J. Caswell and Timothy A. Waidman, “Medicare Savings Program Enrollees and Eligible Non-Enrollees,” Urban Institute, June 2017, <https://www.macpac.gov/wp-content/uploads/2017/08/MSP-Enrollees-and-Eligible-Non-Enrollees.pdf>.

Another key proposed change is designed to ensure compliance with MIPPA, which requires states to use Medicare Part D Low-Income Subsidy (LIS) program data to enroll eligible low-income seniors who get financial assistance with prescription drug costs under Part D into MSPs, too.¹⁴ This would save enrollees an estimated \$170 a month in their Medicare Part B premiums, helping these seniors with low incomes meet their other needs. Given shared income-eligibility thresholds, low-income Medicare beneficiaries likely are eligible for both LIS and one of the MSP programs. CMS is proposing to require that states treat eligibility for LIS (which is determined by the Social Security Administration and transmitted to states daily as “leads data,” pursuant to MIPPA) as an application for the MSPs as well. In other words, states would be required to accept leads data and could no longer require individuals to initiate a new application for MSP coverage, although states could request additional information needed to determine eligibility if the information is not contained in the leads data or in the existing case file. Other proposed changes would align MSP resource and household size standards with LIS rules to further simplify MSP eligibility determinations.

Finally, key changes in the rule would help eligible children access CHIP, including:

- **Facilitating children’s enrollment in CHIP.** The rule proposes to eliminate waiting periods (or required periods of uninsurance prior to enrollment) and lock-outs for children whose eligibility is terminated for non-payment of premiums. Some states that operate their CHIP programs separately from Medicaid include such policies, which are not permissible in Medicaid or marketplace coverage and can serve as a barrier to coverage.¹⁵
- **Eliminating annual or lifetime caps on CHIP benefits.** Medicaid and plans in the ACA marketplaces cannot impose annual and lifetime limits on benefits, but some CHIP programs limit benefits for enrolled children. The rule proposes to prohibit aggregate annual and lifetime dollar limits on all benefits as well as annual and lifetime dollar limits on specific benefits. States can still limit the number of services (e.g., physical therapy visits) consistent with other federal requirements, but CMS argues that dollar limits can impede access to services that children need, noting especially a concern with how limits have impacted access to dental care for low-income kids.

Proposed Rule Would Promote Program Integrity

CMS proposes other changes designed to promote program integrity. For example, the rule updates recordkeeping requirements to define the types of eligibility determination documentation that states must retain and proposes that states retain records for three years after an applicant or enrollee’s case is no longer active. It also would require records to be stored electronically and removes references to outdated technology.

¹⁴ For more information about the Medicare Low Income Subsidy, or “Extra Help,” see Social Security Administration, “Understanding the Extra Help with Your Medicare Prescription Drug Plan,” February 2022, <https://www.ssa.gov/pubs/EN-05-10508.pdf>.

¹⁵ See Table 2 in Tricia Brooks *et al.*, “Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey,” Georgetown University Center for Children and Families and Kaiser Family Foundation, March 2020, <https://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility,-Enrollment-and-Cost-Sharing-Policies-as-of-January-2020.pdf>.

If finalized, in addition to the recordkeeping requirements, the entire proposed rule would advance program integrity by promoting proper and efficient administration of Medicaid and CHIP. As the rule recognizes, program integrity goes beyond ensuring that Medicaid is not covering ineligible people. It also encompasses whether individuals who are eligible for coverage receive it.¹⁶

This is critical because if program requirements and practices mean that eligible individuals are unable to successfully enroll, stay enrolled, and transition to other forms of coverage when their situations change, then the program is not meeting its mission of providing coverage to those who are eligible and is exacerbating uninsurance rates. The various changes that the proposed rule includes to advance simplicity of administration for states and beneficiaries would help ensure that eligible people are able to enroll in coverage and protect their enrollment by reducing barriers in the eligibility and enrollment process, including excessive paperwork, inadequate communication, and other factors.

What's Next

CMS is accepting comments on the proposed rule through November 7. As CMS goes through the process of considering comments and finalizing the rule next year, states will begin undertaking the “unwinding” process of reviewing their enrollees’ eligibility for Medicaid, once the PHE ends, as is expected sometime next year.¹⁷

In light of states’ important responsibility to redetermine eligibility for people at the end of the PHE, the preamble to the proposed rule seeks comment on reasonable implementation timelines, signaling openness to provide a longer compliance timeline before many of the requirements go into effect so that states can stay focused on resuming routine eligibility and enrollment operations. Of course, states can begin to implement some of the proposed simplifications before unwinding to reduce agency workload and client burden and help eligible people stay enrolled.

¹⁶ Testimony of Judith Solomon, Senior Fellow, Before the Senate Finance Subcommittee on Health Care, October 30, 2019, <https://www.cbpp.org/research/health/medicaid-compliance-with-eligibility-requirements>.

¹⁷ Suzanne Wikle *et al.*, “Unwinding the Medicaid Continuous Coverage Requirement, Frequently Asked Questions,” Center for Law and Social Policy and CBPP, March 9, 2022, <https://www.cbpp.org/research/health/unwinding-the-medicaid-continuous-coverage-requirement>.