SUMMARY:

Streamlining the Medicaid, CHIP, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes (Proposed Rule)

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EXECUTIVE SUMMARY

On August 31, 2022, CMS announced a proposed rule for Streamlining Eligibility and Enrollment. CMS notes that the provisions set forth in this rule are intended to provide greater ease for applicants seeking Medicaid, CHIP and Basic Health Plan coverage by reducing administrative burden through a simpler application, verification, enrollment, and renewal process. CMS purports that the changes proposed would remove barriers to enrollment and increase the number of eligible individuals who obtain coverage and are continuously enrolled in Medicaid and CHIP. The proposed rule would ease the application and verification processes by aligning requirements across Medicaid and CHIP; simplifying transitions between programs; providing timeliness standards across renewals and redeterminations of eligibility; promoting greater access by eliminating premium lock-out periods, waiting periods, and benefit limitations; and leveraging modern technologies to standardize recordkeeping.

The provisions within the proposed rule will require careful evaluation by states due to the volume of the changes and the impact the proposals may have on state policies, processes, information systems, and administrative capacities. CMS has requested feedback from stakeholders on implementation timeframes as well as the rationale for the recommended timeframes and views related to the impact that the changes may have on state efforts to resume eligibility and enrollment policies, processes, and procedures during the public health emergency unwinding period. Some states may also require changes in state laws and regulation to meet the provisions within the proposed rule, which could have a substantial impact on the ability to quickly make proposed changes. There is 60-day comment period for stakeholders, with comments due on November 7, 2022.

The impending rule includes substantial changes and adjustments in six specific areas to restructure eligibility and enrollment within Medicaid and CHIP, including:

A. Facilitating Medicaid Enrollment
B. Promoting Enrollment and Retention of Eligible Individuals
C. Eliminating Barriers to Access in Medicaid
D. Recordkeeping
E. Streamlining Enrollment and Promoting Retention and Beneficiary Protections in CHIP
F. Eliminating Access Barriers in CHIP

Below is a summary of the proposed regulations which we identify as having a specific impact on health care and human services providers, payers, and other stakeholders.

STREAMLINING APPLICATION AND ENROLLMENT

SECTION A: FACILITATING MEDICAID ENROLLMENT

Summary

To facilitate a simplified enrollment process that will reduce administrative burden and delays, CMS proposes the following changes:

1. Facilitate Enrollment through Medicare Part D Low-Income Subsidy "Leads" Data

- Clarifies how Low-Income Subsidy (LIS) applications ("leads data") can and cannot be used to make eligibility determinations, and more clearly delineates the steps states must take upon receipt of the leads data.
- As it relates to streamlining methodologies, the proposed rule:
    - Allows states that have aligned eligibility requirements between Medicare Savings Programs (MSPs) and LIS to use leads data to make a determination of MSP financial eligibility without requesting additional information from the individual.
    - Requires states adopt non-MAGI Medicaid MSP enrollment simplification policies related to self-attestation of income and resources that are counted in determining MSP, but no LIS, eligibility to use the leads data more efficiently.
    - Prohibits states from requesting documentation of dividend and interest income prior to making a determination of MSP eligibility (unless the state information differs from the applicant's self-attestation). The state retains the ability to conduct post-enrollment verification. Should a state elect to perform post-enrollment verification, it must allow individuals at least 90 calendar days to respond to requests for documentation.
    - Requires states to accept applicants' attestation of the value of non-liquid resources (unless the state information differs from the applicant's self-attestation). The state retains the ability to conduct post-enrollment verification. States may conduct post-enrollment verification but must allow individuals at least 90 calendar days to respond to requests for documentation.
    - When determining eligibility for the MSP, requires that states allow individuals to self-attest that a portion of their resources and their spouse's are set aside as burial funds in a separate account and are not countable for MSP determinations. States may conduct post-enrollment verification but must allow individuals at least 90 calendar days to respond to requests for documentation.
    - Requires that when documentation of the cash surrender value of a life insurance policy is required, the state must assist the individual with obtaining the relevant information/documentation. If the individual does not provide basic information about the policy, the state may require that the individual provide documentation of the cash surrender. The applicant must have at least 15 days to provide such documentation.

2. ***Define "Family of the Size Involved" for the Medicare Savings Program Groups Using the Definition of "Family Size" in the Medicare Part D Low-Income Subsidy Program***

    - Requires that the term "family of the size involved" be defined to include at least the individuals included in the definition of "family size" in the LIS program.

3. ***Automatically Enroll Certain SSI Recipients into the Qualified Medicare Beneficiaries Group***

    - Requires states to deem an individual enrolled in the mandatory SSI or 209(b) group eligible for the QMB group the month the state becomes responsible for paying the individual's Part B premiums under its buy-in agreement.
    - When a 1634 State receives from CMS the Part B buy-in enrollment for an SSI recipient who is entitled to premium-free Medicare Part A, an individual will automatically be enrolled in both the mandatory SSI group and the QMB group without requiring individuals to submit a separate application to determine eligibility for the QMB group.
    - Limits retroactive QMB coverage for individuals in the mandatory SSI or 209(b) group to the same period for retroactive Part B premium liability (a period of no greater than 36 months prior to the date of the Medicare enrollment determination).
    - Incorporates the longstanding practice of providing FFP for state payments of the first month of an individual's Part A premium for individuals who are eligible for the QMB group based on conditional enrollment in Part A.
    - Requires Part A buy-in states to deem those individuals who are determined eligible for the mandatory SSI or 209(b) groups as eligible for the QMB group and initiate their enrollment into Medicare Part A, pursuant to their buy-in agreement, the month they are enrolled in Part B buy-in.
    - Creates a state option for deeming individuals eligible for the QMB group. Specifically, to allow, but not require, group payer states to directly initiate Medicare Part A enrollment for individuals who are not entitled to premium-free Part A without first sending them to SSA to apply for conditional Part A enrollment.

4. ***Clarifying the Qualified Medicare Beneficiary Effective Date for Certain Individuals***

    - Codifies existing coverage policy for individuals who enroll in actual or conditional Medicare Part A during the General Enrollment Period (i.e., coverage starts the month of or a month later than the month their Medicare Part A premium begins).

5. ***Facilitate Enrollment by Allowing Medically Needy Individuals to Deduct Prospective Medical Expenses***

    - Allows noninstitutionalized individuals, under certain settings, to deduct their anticipated medical and remedial care expense from their income for purposes of medically needy eligibility determinations.
    - Specifies types of expenses that are constant and predictable (and thus deductible).
    - Provides states the flexibility to identify additional expenses that meet the criteria of being constant and predictable. Specifically, CMS proposes to allow projection of medical or remedial expenses for the HCBS that are included in a plan of care (care plan) for an individual receiving a section 1915(i), 1915(j), or 1915(k) benefit or participating in a section 1915(c) HCBS waiver.

- Permits states to project the expenses of section 1915(c), (j), (k) and (i) services and prescription drug services, as well as other expenses in calculating whether an individual meets their spenddown, where the state has determined that such services are constant and predictable. States would still need to reconcile the projected amounts with the actual amounts incurred at the end of the budget period.

6. Application of Primacy of Electronic Verification and Reasonable Compatibility Standard for Resource Information

- Currently, states are required to determine or renew eligibility based on the information provided by an individual, provided the information supplied by an individual is "reasonably compatible" with the information obtained by the state from an electronic data source. The proposed rule clarifies that this approach applies to resource verification as well as income verification.

7. Verification of Citizenship and Identity

- Establishes that verification of birth with a state vital statistics agency or verification of citizenship with the U.S. Department of Homeland Security Systematic Alien Verification for Entitlements (SAVE) Program would be considered stand-alone evidence of citizenship; unlike under current regulations, separate verification of identity would not be required.

CMS Seeks Public Comment on:

- Extending the enrollment simplification policies in proposed paragraph (e) to § 433.952 to all individuals seeking eligibility on a non-MAGI basis (as proposed, the enrollment simplification policies do not apply to individuals applying for non-MAGI eligibility groups other than MSPs) (Related to sections 42 §§ 435.4, 435.601, 435.911, and 435.952).
- Extending the proposal relating to verification of dividend and interest income to individuals seeking eligibility based on MAGI, as well as whether there are additional income or resource types to which the proposals below could be extended for all individuals (Related to sections 42 §§ 435.4, 435.601, 435.911, and 435.952).
- Usefulness of post-enrollment verification of interest and dividend income and whether it results in unnecessary procedural denials of eligible individuals (Related to sections 42 §§ 435.4, 435.601, 435.911, and 435.952).
- Proposal to require states provide individuals with at least 90 calendar days to respond to requests for additional information (e.g. proof of interest and dividend income and burial funds) and whether states should be required to provide, at a minimum, a shorter period of time, such as at least 30 or 60 calendar days (Related to sections 42 §§ 435.4, 435.601, 435.911, and 435.952).
- Whether 15 days or a longer minimum period is appropriate for the applicant to provide documentation of the cash surrender value of a life insurance policy (Related to sections 42 §§ 435.4, 435.601, 435.911, and 435.952).
- Whether shifting the burden of documenting the cash surrender value of life insurance to states is appropriate or whether an alternative approach would be preferable (Related to sections 42 §§ 435.4, 435.601, 435.911, and 435.952).
- Whether obtaining documentation to rebut the one-third presumption poses a barrier to eligibility (Related to sections 42 §§ 435.4, 435.601, 435.911, and 435.952).

- Whether states should be required to accept self-attestation from individuals who seek to rebut a presumption of the amount of in-kind support and maintenance they receive subject to post-enrollment verification (Related to sections 42 §§ 435.4, 435.601, 435.911, and 435.952).
- Proposed definition of "family of the size involved" for purposes of the MSP groups (42 § 435.601).
- Administrative and fiscal impacts of proposed automatic enrollment of certain SSI individuals into QMB groups and of other approaches, such as requiring group payer states to deem individuals determined eligible for the mandatory SSI or 209(b) groups as eligible for the QMB group once they have completed the conditional enrollment process at SSA (42 § 435.909).
- Identify any other types of services that individuals may receive on a constant and predictable basis, and for which a state could project, with a degree of relative certainty, consistent costs for an individual over the course of a prospective budget period (42 § 435.831).
- Potential implementation challenges related to the implementation of asset verification systems (and related policies), including any systems integration considerations or challenges which could impact the effectiveness and usefulness of such a data match (42 § 435.952 and 42 § 435.940).

SECTION C: ELIMINATING BARRIERS TO ACCESS IN MEDICAID

Summary

By modifying the reasonable opportunity period and requirements for applicants or beneficiaries to apply for other benefits, unnecessary barriers to enrollment and burden on states and individuals can be reduced through the following updates proposed by CMS:

1. Remove Optional Limitation on the Number of Reasonable Opportunity Periods

- Removes the option for states to impose limits on the number of reasonable opportunity periods that an individual may receive.

2. Remove or Limit Requirement to Apply for Other Benefits

- Reinterprets the requirements for Medicaid eligibility to be based on only actual income and resources within the applicant's or beneficiary's immediate control when determining eligibility (not income and resources that might be available if such individuals applied for, and were found eligible for, other benefits).
    - Under current regulations, state Medicaid agencies must require that all Medicaid applicants and beneficiaries take all necessary steps to obtain other benefits to which they are entitled (unless they can show good cause for not doing so).
- In addition to CMS's preferred proposal of eliminating the requirement that Medicaid applicants or beneficiaries apply for other benefits, CMS is weighing two other options. First, to include benefits that would count as income under the financial methodology used to determine the applicant or beneficiary's income. Second, CMS is considering exempting SSI beneficiaries from the requirement to apply for other benefits.

CMS Seeks Public Comment on:

- Possible alternatives to eliminating the requirement that applicants or beneficiaries apply for other benefits (42 § 435.608).
- How CMS can update the regulation to reduce unnecessary barriers to enrollment and reduce the burden on states and individuals.
- Experiences of applicants and beneficiaries in their compliance with the existing rule, such as whether it commonly delays favorable eligibility determinations and, by extension, access to care.

IMPROVING RETENTION RATES AT AND BETWEEN REGULAR RENEWALS

SECTION B: PROMOTING ENROLLMENT AND RETENTION OF ELIGIBLE INDIVIDUALS

Summary

To align enrollment and renewal processes for MAGI and non-MAGI eligibility types, CMS proposes the following changes:

1. Aligning Non-MAGI Enrollment and Renewal Requirements with MAGI Policies

- Application Process
    - Requires individuals to submit the single streamlined application noted in § 435.907(a)(2) of the current regulations, through all modalities specified at § 435.907(a) (internet, telephone, mail, in person, or other commonly available electronic means).
    - Requires states accept applications and supplemental forms needed for individuals to apply for coverage on a non-MAGI basis via all modalities identified in § 435.907(a).
    - Extends the prohibitions on states requiring in-person interviews for non-MAGI applicants and beneficiaries during the application and renewal process.
- Renewal Process
    - Applies the same renewal procedures afforded to MAGI beneficiaries to non-MAGI beneficiaries by revising current renewal regulations at § 435.916.
    - Requires that when a beneficiary's eligibility cannot be renewed based on available information, states follow a set of streamlined procedures which are currently only required for MAGI-based beneficiaries, not required for those excepted from MAGI. Currently, states are not required to adopt the above procedures for individuals whose eligibility is not determined on a basis other than MAGI.
    - Requires states conduct regularly scheduled renewals of eligibility once, and only once, every 12 months for all Medicaid beneficiaries, including non-MAGI beneficiaries with limited exception.
        - Note: This rule does not apply to Qualified Medicare Beneficiaries (QMBs).
    - Requires states provide all beneficiaries, including non-MAGI beneficiaries, whose eligibility cannot be renewed in accordance with proposed § 435.916(b)(1):
        - A renewal form that is pre-populated with information available to the agency;
        - A minimum of 30 calendar days to return the signed renewal form along with any required information; and
        - A 90-day reconsideration period for individuals terminated for failure to return their renewal form but who subsequently return their form within the reconsideration period.
    - Codifies longstanding policy to align enrollment requirements in the best interest of all applicants. Proposed § 435.907(c)(4) codifies longstanding policy that states accept all MAGI-exempt applications and supplemental forms provided by

applicants seeking coverage on a non-MAGI basis, through all the modalities listed in current regulations at § 435.907(a).

- Clarifies that the 30 calendar days that states must provide beneficiaries to return their pre-populated renewal form begins on the date the state sends the form, meaning that beneficiaries have 30 calendar days from the date a form is postmarked or, for beneficiaries who elected to receive electronic notices, the date the electronic form is sent instead of the date on the form.
- Specifies current CMS policy that the returned renewal form and information received during the reconsideration period serve as an application and require, via cross reference to § 435.912(c)(3) of the current regulation, that states determine eligibility within the same timeliness standards applicable to processing applications, that is, 90 calendar days for renewals based on disability status and 45 calendar days for all other renewals.
- Establishes time standards for states to complete renewals of eligibility in proposed § 435.912(c)(4) and adds a cross reference to these proposed time standards in proposed § 435.916(c).

- Ensures that, prior to terminating coverage for an individual determined ineligible for Medicaid, states determine eligibility for CHIP and potential eligibility for other insurance affordability programs (that is, BHP and insurance affordability programs available through the Exchanges) and transfer the individual's account in compliance with the procedures set forth in § 435.1200(e), including proposed changes described in section II.B.5. of this proposed rule.

CMS Seeks Public Comment on:

- Administrative impact of conducting eligibility only once every 12 months for non-MAGI beneficiaries.
- Specifically, CMS is interested in:
  - Data on stability of coverage related to conducting renewals only once every 12 months;
  - Data on coverage losses among non-MAGI beneficiaries due to procedural reasons; and
  - Comments on any program integrity concerns.

2. Acting on Changes in Circumstances, Timeframes, and Protections

- Clearly defines the following specific responsibilities states have to act on changes in circumstances:
  - Must have procedures for beneficiaries to make timely and accurate reports of changes in circumstances that may affect eligibility.
  - Must accept both reported changes in circumstances that may affect eligibility and any other beneficiary reported information through the same modes for submission of application at § 435.907(a) ensuring that beneficiaries can easily report information that supports continued enrollment in Medicaid, such as updating contact information or reporting an in-state address change, even if the information would not constitute a change in circumstances that affects eligibility.

- Describes the steps that CMS believes states should be required to take in processing changes in circumstances reported by a beneficiary in between renewals of eligibility. Under the proposed regulation, states must first evaluate whether the reported change may result in ineligibility for Medicaid or a change in the amount of medical assistance for which the beneficiary is eligible (for example, a change in benefits or higher or lower premiums or cost sharing charges). If additional information is needed to determine whether the beneficiary remains eligible, the agency must redetermine eligibility based on available information, if able to do so, and if the additional information is not available to the agency, request such information from the beneficiary.
- Detailed instructions for states on how to respond to a beneficiary-reported change or third-party data such as information from a state SNAP program and how to respond if a request for information from the beneficiary is not answered.
- Provides a minimum of 30 calendar days from the date a request for information is sent to a beneficiary, which is the date the request is postmarked or the date the notice is sent electronically if the beneficiary elected to receive electronic notices, for a beneficiary to obtain and submit information needed in order for the state to redetermine eligibility based on a change in circumstances
- Provides beneficiaries whose coverage was terminated due to failure to provide information requested in accordance with proposed § 435.919(b)(1)(i) and (ii) with a 90-day reconsideration period. If a beneficiary returns requested information within 90 calendar days of termination, the state would be required to redetermine the individual's eligibility without requiring a new application.
- Removes the reference to MAGI beneficiaries in order to apply the requirement that states evaluating a change in circumstances must limit requests for additional information to such change in circumstances to both MAGI and non-MAGI beneficiaries.
- Allows states to begin a new 12-month eligibility period if the agency has enough information to renew eligibility with respect to all eligibility criteria when processing a change in circumstances, as proposed in § 435.919(e)(2).
- Makes technical changes to current § 435.916(d)(1)(ii), redesignated at proposed § 435.919(e)(2), to use the term ''eligibility period'' rather than ''renewal period'' and to remove the reference to the ''12-month'' eligibility period to align the length of the new eligibility period the state may begin for an individual consistent with the eligibility periods described in proposed § 435.916(a).
- Requires states act on anticipated changes in circumstances at the appropriate time as proposed in § 435.919(b)(3). In proposed § 435.919(b)(3), CMS modifies language in the current regulations at § 435.916(d)(2) to require states act on anticipated changes at an appropriate time and clarifies this means the state would need to initiate a redetermination consistent with timeliness standards for processing anticipated changes in circumstances as proposed in § 435.912(c)(6).

3. Timely Determination and Redetermination of Eligibility

- CMS is considering aligning the minimum time that states must provide all applicants to submit additional information or documentation requested by the state, as well as finalizing a longer timeframe for all applicants.
    - Timeframes under consideration include 15 calendar days, 20 calendar days, 25 calendar days, and 30 calendar days.
- CMS is considering 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.
- Timely Redetermination
    - Ensures that applicants and beneficiaries have adequate time to furnish all requested information and that states complete initial determinations and redeterminations of eligibility within a reasonable timeframe at application, at regular renewals, and following changes in circumstances.
    - Requires that, if 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, and it must obtain additional information from the applicant, specified requirements would need to be met. Would require the agency to provide most applicants with at least 15 calendar days, from the date the request is postmarked or the electronic request is sent, to respond with the additional information.
    - Requires the agency to provide current beneficiaries with at least 30 calendar days from the date the request is postmarked or the electronic request is sent to submit requested information.
    - Requires states provide applicants applying on the basis of disability with at least 30 calendar days, from the date the request is postmarked or the electronic request is sent, to return additional information or documentation required by the agency.
    - If an individual subsequently submits requested information within 30 calendar days of the date the notice of ineligibility is sent (or a longer period established by the state), obligates that states reconsider the individual's eligibility without requiring the individual to complete and submit a new, full application.
    - Begins a new clock for determining timeliness. This 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), beginning on the date that the requested information is submitted.
    - Establishes a 30-day reconsideration period at application.
    - Specifies expectations for the maximum time states have to complete redeterminations at regular renewals, as well as when the state learns of a change in circumstances that may impact an individual's eligibility.
    - Revises 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 anticipated or known change in circumstances occurs in accordance with proposed § 435.919(b)(3). The ''performance standards'' defined in current § 435.912(a) would also be revised to include standards for renewing and redetermining eligibility in a timely and efficient manner across a pool of beneficiaries.

- Assessment of Potential Eligibility for CHIP and Other Insurance Affordability Programs
    - Requires 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).
    - Requires states to establish specific standards for redetermining eligibility at renewal in accordance with MAGI standards set forth at § 435.916.
    - Requires the establishment of specific standards for 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) and (b)(2) respectively.
    - Requires the establishment of specific standards for redeterminations of eligibility at the time of an anticipated change in circumstances in accordance with proposed § 435.919(b)(3).
    - Revises current timeliness and performance standards to specify that they also include the periods of time covered by the timeliness and performance standard adopted by the agency for renewals and redeterminations of eligibility.
    - Provides that timeliness and performance standards adopted by the agency 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, 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.
    - Provides that timeliness and performance standards adopted by the agency for conducting redeterminations of eligibility based on a change in a beneficiary's circumstances must cover the period from the 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 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).
    - Provides that timeliness and performance standards adopted by the agency for conducting redeterminations of eligibility based on an anticipated change in a beneficiary's circumstances must cover the period from the date the agency begins the redetermination of eligibility based on an anticipated change, as described at § 435.919(b)(3), to the date the agency notifies the individual of its decision or, as

applicable the date the agency terminates eligibility and transfers the individual's electronic account to another insurance affordability program in accordance with § 435.1200(e).

- Expands the criteria 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.
- Adds to the criteria for timeliness and performance standards 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. In addition, states would account for the needs of beneficiaries, as well as applicants and the complexity of their cases in establishing their timeliness and performance standards.
- Establishes 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. Additional time would be provided in such in cases a state does not receive all of the information needed to redetermine eligibility until closer to the end of the eligibility period.
- Provides 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. However, if a new determination based on disability is necessary, states would have a maximum of 90 days to complete a redetermination of eligibility on the basis of disability. The applicable time period (25 or 90 days) is measured in calendar days from the date the agency determines the individual not eligible on the basis on which he or she had been receiving coverage.
    - If an individual returns the renewal form with less than 25 calendar days remaining before the end of the eligibility period, states would be permitted to complete the renewal by the end of the month following the month in which the individual's eligibility period ends.
- Requires states to provide beneficiaries with at least 30 calendar days from the date the request is postmarked or the electronic request is sent to provide the information and that the state enables beneficiaries to do so through any of the modes of submission specified in § 435.907(a).
- Establishes requirements for redeterminations of eligibility based on anticipated changes in circumstances. The agency must determine the amount of time it needs to act on such changes and to begin the redetermination process with sufficient time to complete processing the redetermination prior to the change occurring. As such, the proposed rulemaking applies the same basic requirements at § 435.912(c)(6) for states establishing standards for redeterminations based on anticipated changes in circumstances as those described at proposed § 435.912(c)(4) for regularly scheduled renewals. At proposed § 435.912(c)(6)(i), the agency would be required 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.

- Prohibits states from using the timeliness standards as a reason for delaying termination of an individual's coverage or delaying an adverse action.
- Applies the same requirements to separate CHIP programs.

CMS Seeks Public Comment on:

- Appropriate minimum timeframe for applicants to submit requested information at proposed § 435.907(d) that will provide the greatest balance between ensuring that a state determines eligibility as quickly as possible and that applicants have adequate time to gather any information or documentation needed by the state to complete the determination.
- Whether the final rule should align the timeframe for all applicants or provide a longer period for individuals applying on the basis of disability, and whether a corresponding exception to the 45-day timeliness requirement at § 435.912(c)(3)(ii) should accompany a longer timeframe.
- Whether calendar days or business days would provide a more appropriate measure of timeliness.
- Amount of time provided for states to complete a redetermination of eligibility at a regularly scheduled renewal or based on changes in circumstances at proposed § 435.912(c)(4), (c)(5), and (c)(6), whether the regulations should allow for a longer or shorter period of time, and whether the use of business days rather than calendar days would be more appropriate.
- Whether the effective date of coverage should be determined in accordance with the application date or whether, consistent with the reconsideration period at renewal and the proposed reconsideration period following a change in circumstances (described in section II.B.2. of the preamble), the return of additional information would effectively constitute a new application with a new effective date of coverage.

4. Agency Action On Returned Mail

- Whenever beneficiary mail is returned to the agency by the United States Postal Service (USPS), the agency must:
  - Check Medicaid Enterprise System; contracted managed care organizations (MCOs), if applicable; and, one or more of the following: state agency that administers SNAP; state DMV; USPS National Change of Address (NCOA) database; or other sources in state's verification plan.
  - Send beneficiary a notice by mail to: current address on file in case record; forwarding address on returned mail; and any address identified by agency, and provide beneficiary at least 30 days from notice date to verify contact information.
  - Send beneficiary at least two notices by one or more methods other than mail. For a beneficiary who elected to receive notices electronically, at least one communication attempt must use contact information on file via preferred electronic format; provide at least 30 days from notice for beneficiary to verify contact information. If electronic communication fails, agency may use telephonic or electronic contact information. The first and last notice must be separated by no less than three business days. If no contact information for any alternative method provided, this must be noted in beneficiary's case record.

- Where beneficiary mail is returned with an in-state forwarding address and whose current address the agency is unable to confirm, the agency: may not terminate beneficiary's coverage for failure to confirm address or state residency; must accept and update beneficiary's case record with in-state forwarding address on returned mail, address from an MCO (as verified by beneficiary), or address as obtained from USPS NCOA database.
- Where beneficiary mail returned with out-of-state forwarding address and whose current address the agency is unable to confirm, the agency must provide advance termination notice and fair hearing rights.
- Where beneficiary's whereabouts are unknown, the agency can terminate or suspend beneficiary's coverage or move beneficiary to fee-for-service, provided that notice to terminate/suspend is sent to beneficiary's last known address or electronically by beneficiary's election with fair hearing rights.
- Where the address of a beneficiary terminated/suspended because of whereabouts unknown becomes known within the beneficiary's eligibility period, the agency: must reinstate coverage back to termination/suspension date without requiring additional information to verify eligibility unless agency has information indicating the individual is not eligible; or begin a new eligibility period if sufficient information exists for renewal.

CMS Seeks Public Comment on:

- Whether states should be required to update a beneficiary's in-state address using more recent contact information provided in a forwarding address from the USPS, the USPS NCOA database or an MCO when a beneficiary has not responded to a request to verify current address.
- Whether states should be permitted or required to update beneficiary contact information based on information obtained from an MCO, the USPS NCOA database or other reliable data sources without first attempting to contact the beneficiary, and, if so, which data sources should states be permitted to rely upon without first attempting to contact beneficiaries.
- Feedback from states that received waiver authority to update beneficiary contact information from a reliable third-party without first attempting to contact the beneficiary (as described in State Health Official (SHO) letter #22-001).
- Efficacy of the requirement to send notice to a beneficiary's address on file to ensure the initial piece of returned mail was not incorrectly returned.

5. Agency Action On Updated Address Information

- Whenever the agency obtains updated in-state mailing address information from the USPS NCOA database or MCO, the agency: must ensure address from the MCO was verified by or directly received from beneficiary; must send beneficiary a notice by mail to both the address in case record and new address to verify accuracy; must send beneficiary at least two notices by one or more methods other than mail, i.e. phone, email; may not terminate beneficiary's coverage for failure to confirm in-state address change; may accept in-state address and update case record if beneficiary does not respond to request to confirm address or state residency within at least a 30-day notice timeframe; and, accept in-state address as beneficiary's new address as confirmed by beneficiary.

- If approved by HHS Secretary, the agency may treat updated in-state address information from other trusted data sources.

CMS Seeks Public Comment on:

- Whether states should be permitted or required to update beneficiary contact information obtained from an MCO, the USPS NCOA or other reliable data sources (such as Indian Health Care Providers, FQHCs, RHCs, PACE providers, Primary Care Case Managers, Accountable Care Organizations, Patient Centered Medical Homes, Enrollment Brokers, or State Human Services Agencies) **(collectively referred to as "Sources B")** without first attempting to contact the beneficiary to verify or dispute the information, and, if so, which data sources should states be permitted to rely upon without first attempting to contact beneficiaries.
- Feedback from states that received waiver authority to update beneficiary contact information based on information received from a reliable third-party without first attempting to contact the beneficiary (as described in SHO letter #22-001).
- Efficacy of the requirement to conduct at least two outreach attempts to the beneficiary using a method other than mail.
- Processing of out-of-state address information or address information from a source not identified as "Sources B," including whether CMS should consider requiring states to check the available data sources.

6. Transitions Between Medicaid, CHIP And BHP Agencies

- State Medicaid agencies must have processes in place to collaborate with separate CHIP and Basic Health Program (BHP) agencies and State Health Insurance Exchanges (Exchange or Exchanges) to coordinate enrollment and eligibility processes.
- Adds CHIP and BHP agencies to list of entities the Medicaid agency can delegate eligibility determinations.
- Limits the Medicaid requirements a BHP agency must meet to those in § 435.1200(d), (e)(1)(ii) and (e)(3) (i.e., new application not required, accepting individual's electronic account, Exchange agreement requirements).
- Improves transitions from and to Medicaid, CHIP, BHP and the Exchange:
    - Seamlessly transitions eligibility of beneficiaries between Medicaid and CHIP when one of the agencies determines beneficiary eligible for the other program.
    - Accepts determination of Medicaid eligibility made using MAGI-based methodologies by state agency administering separate CHIP in-state by: applying MAGI-based methodologies and verification policies as those used by separate CHIP; utilizing shared eligibility service where determinations of Medicaid eligibility governed exclusively by Medicaid agency and separate CHIP only performs administrative function; entering into agreement where Medicaid agency delegates eligibility determinations to separate CHIP; or adopting other procedures approved by HHS Secretary.
    - For an individual determined eligible for Medicaid by an insurance affordability program (separate CHIP, BHA, Exchange, including appeals and review entities), the Medicaid agency must: establish procedures to receive electronic account of Medicaid eligibility determination securely; comply with § 435.911 as if application

submitted to Medicaid agency; and comply with § 431.10 to maintain oversight of Medicaid program.

- For an individual determined ineligible for Medicaid during a renewal period, or change of circumstances or per a fair hearing decision, the agency must promptly: determine eligibility for separate CHIP (if operated in the state), and if eligible, transfer the individual's electronic account securely to the separate CHIP agency and ensure the individual receives a combined eligibility notice; and, if not eligible for CHIP, determine potential eligibility for BHP (if offered in-state) and coverage through the Exchange and transfer the individual's electronic account securely to the BHP or Exchange. An individual is ineligible for Medicaid if the individual is only eligible for a limited benefit group, e.g., individuals with tuberculosis.
- The Medicaid agency must include in its agreement with a separate CHIP agency, that either the Medicaid agency or the separate CHIP agency will provide a combined eligibility notice explaining the termination of eligibility for Medicaid and the determination of eligibility for CHIP or vice versa. In addition, a combined eligibility notice would be issued in all other cases, including situations where the Medicaid agency has determined an individual to be potentially eligible for a BHP or insurance affordability program available through the Exchange, and to situations in which an Exchange, CHIP or BHP has made an assessment of potential (not final) Medicaid eligibility, including on a non-MAGI basis. Also, as currently required, when more than one individual is included on an enrollment application or renewal, Medicaid and the other insurance affordability programs are expected to provide a single combined notice for all household members to the extent possible, even if members are eligible for different programs.

CMS Seeks Public Comment on:

- Whether there are different ways states with a separate CHIP agency should be permitted to effectuate a seamless transition to Medicaid for ineligible CHIP individuals.
- Ability of the Medicaid agency to collect information on access to state employee health coverage.
- Challenges states may encounter in transitioning enrollment from Medicaid to CHIP and suggested processes for implementation that could address the challenges.
- Whether the Medicaid agency would be able to complete only a determination of potential CHIP eligibility requiring the Medicaid agency to transfer the individual's electronic account to the CHIP agency for final eligibility determination.
- Feasibility of implementing a combined notice for Medicaid and CHIP eligibility determinations along with a combined notice with determinations of BHP and insurance affordability programs available through the Exchange, both in states using a fully integrated eligibility system or shared system and in states utilizing separate systems. In addition, CMS seeks comment on the:
    - Anticipated time required for a state to implement these changes if combined eligibility notices are not currently issued by the state.
    - Whether to apply the changes designed to create seamless transitions between Medicaid and a separate CHIP to BHP.

7. Optional Group for Reasonable Classification of Individuals Under 21 Who Meet Criteria For Another Optional Group

- Allows states to provide coverage to all individuals under age 21, 20, 19, or 18 or to a reasonable classification of such individuals who meet certain requirements as specified at 42 USC 1396a(a)(10)(A)(ii).

CMS Seeks Public Comment on:

- CMS seeks no specific comment for this portion of the proposed rulemaking.

REMOVING BARRIERS SPECIFIC TO CHIP ENROLLMENT

SECTION E: STREAMLINING ENROLLMENT AND PROMOTING RETENTION AND BENEFICIARY PROTECTIONS IN CHIP

Summary

To retain alignment with Medicaid and other insurance affordability programs, CMS proposes that CHIP adopt the same proposed policies as those proposed for Medicaid, as described through the changes below:

1. ***Timely Determination and Redetermination of Eligibility and Related Reviews***
    - Gives applicants who need a disability determination at least 15 days from the date the request is postmarked and 30 days from the date the electronic request is sent to determine eligibility.
    - Allows applicants to respond through any mode of submission available.
    - Reconsiders eligibility of applicants who are denied for failure to provide needed information if it is provided within 30 calendar days.

2. ***Changes in Circumstances***
    - Specifies states must provide a minimum of 30 calendar days for beneficiaries to respond to a request for additional information needed to determine eligibility based on a change in circumstances.
    - Requires state Medicaid agencies provide beneficiaries whose coverage is terminated due to failure to provide information with a 90-day reconsideration period.

3. ***Returned Mail:***
    - Requires states to also attempt to contact the individual using other means, such as by telephone, email, text, or other electronic notice.
    - Applies the Medicaid provision related to receipt of updated address information from returned mail, the USPS NCOA, a state's contracted MCOs, and other third-party sources equally to CHIP.

4. ***Transitions Between CHIP and Medicaid***
    - Requires the Medicaid agency to determine eligibility for CHIP when an individual is determined ineligible for Medicaid.
    - Seamlessly transitions the individual's electronic account.
    - Requires the Medicaid agency to accept the determinations of MAGI-based Medicaid eligibility made by separate CHIP agencies and enroll those eligible individuals into Medicaid.
    - Requires states to provide a combined eligibility notice for individuals determined ineligible for Medicaid and eligible for separate CHIP.
    - Requires separate CHIP agencies to complete MAGI-based eligibility determinations for Medicaid and to screen for potential non-MAGI Medicaid, eligibility for BHP and insurance affordability programs.

5. Recordkeeping

- Requires states be able to provide stored information within 30 calendar days after a request has been made.

CMS Seeks Public Comments on:

- Whether the longer time to return additional information requested by the state should be applied to children applying for CHIP if a determination that the child qualifies for Children with Special Health Care Needs (CSHCN) is required.
- Whether a minimum of 15 calendar days from the date of the state's request for additional information is generally sufficient.
- Whether states should be afforded additional time to make a determination of eligibility for applicants seeking coverage under a separate CHIP for CSHCN.
- Whether calendar or business days would be better suited as an appropriate timeliness measure.
- Whether a longer reconsideration period of 45 or 90 calendar days would be appropriate.
- Whether the requirement to determine eligibility should be applied to CHIP in cases where a state has more than one separate CHIP population and an enrollee could transition between populations.
- Whether states should be required to update an enrollee's in-state address using more recent contact information reflected in a forwarding address from USPS or an address provided by NCOA or an MCO.
- Whether states should be permitted or required to update contact information without first attempting to contact the enrollee and provide them an opportunity to verify or dispute the new information.
- The efficacy of the requirement to send a notice to an enrollee's address on file.
- Whether all states have a Medicaid Enterprise System that encompasses both Medicaid and CHIP.
- Whether any provisions should not be applied to CHIP as there may be operational challenges states may face.
- Whether states should be required to update enrollee information based on information obtained from an MCO, the USPS NCOA, or other reliable data sources without first attempting to contact the individual.
- The efficacy of the requirement to conduct at least two outreach attempts to the enrollee using a method other than mail.
- The feasibility of a contractor for the separate CHIP agency having the ability to conduct the Medicaid determination in accordance with § 435.1200(b)(4).
- Whether three years is an appropriate minimum duration of time for states to retain case records after the case is active.
- Whether any longer or shorter duration (than three years) is appropriate for certain types of information or whether the retention period should be tied to the individual or active case.
- Whether states should retain flexibility to main records in paper or other formats that reflect evolving technology.

SECTION F: ELIMINATING ACCESS BARRIERS IN CHIP

Summary

To continue securing coverage for uninsured children by eliminating barriers for children to enroll, CMS proposes the following changes:

1. Prohibit Premium Lock-Out Periods

- Permits CHIP enrollees to remain enrolled or re-enroll without a lock-out period even if premiums are not paid.

2. Prohibit Waiting Periods

Under the proposed regulation, states may not apply for a waiting period if:

- The premium paid for the coverage for the child under the group health plan exceeds 5% of household income.
- The child's parent is determined to be eligible for advance payments of the premium tax credit if the employer-sponsored insurance is determined to be unaffordable.
- The cost of family coverage exceeds 9.5% of the household income.
- The employer stopped offering coverage of dependents.
- A change in employment results in the child's loss of coverage.
- The child has special health needs.
- The child lost coverage due to the death or divorce of a parent.

3. Prohibit Annual and Lifetime Limits on Benefits

- Prohibits annual and lifetime limits, similar to individuals enrolled in QHPs through the Exchanges, or in Medicaid.

CMS Seeks Public Comment on:

- Proposal to eliminate waiting period to balance the goal of preventing coverage gaps for children while ensuring CHIP coverage does not substitute for coverage available under group health plans.
- Consideration of permitting a 30-day waiting period for states that are able to demonstrate that a high rate of substitution is a problem.

SECTION D: RECORDKEEPING

Summary

Recognizing that regulations have not been updated in the last three decades and the opportunity for improvements through modern technology, CMS proposes the following updates:

- Defines the types of eligibility determination information and documentation to be maintained by states.
- Removes references to obsolete technology.
- Requires records be stored in an electronic format.
- Establishes a retention period for Medicaid and CHIP records and case documentation.
- Revises timeliness standards for renewal and application.
- Specifies renewal timelines for states.

CMS Seeks Public Comment on:

- The proposed retention period generally.
- Whether a shorter or longer retention period should be required for certain types of records or all records.
- Whether a retention period should be tied to the individual or the active case.
- Whether states should have flexibility to keep records in paper or other formats that leverage technology.