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President and CEO

November 7, 2022

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

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

Dear Administrator Brooks-LaSure,

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

We are writing to express our general support for the Centers for Medicare & Medicaid Services (CMS) taking steps to streamline and improve the enrollment processes for the Medicaid program, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) and ensure Americans who are eligible for these programs have easy access and simple processes by which to apply and qualify. CMS notes that as of May 2022, nearly 89 million individuals were enrolled in Medicaid and CHIP. These programs offer a critical health care safety net for some of the most vulnerable seniors, disabled, poor, and children across the country.

CMS also notes that enrollment in Medicaid and CHIP declined from 2017 through 2019, and is concerned that restrictive state enrollment policies contribute to coverage disruptions and create churning as people lose their Medicaid or CHIP coverage and then re-enroll within a short

period of time. Issues were noted with beneficiary enrollment in the Medicare Savings Programs (MSPs), which provide Medicaid coverage of Medicare premiums and/or cost-sharing for lower income Medicare beneficiaries. A 2017 study estimated that only about half of eligible Medicare beneficiaries were enrolled in MSPs. The agency has identified other policies or regulatory gaps that create unnecessary administrative burden as well as barriers to enrollment and retention of coverage for eligible individuals. For example, there are no regulations that link enrollment in other federal programs with the MSPs even though it is likely that individuals in such programs are eligible for the MSPs.

The COVID-19 public health emergency (PHE) and the continuous enrollment requirement have disrupted routine eligibility and enrollment operations for Medicaid, CHIP, and BHP. When the PHE concludes and routine operations resume, states will provide coverage for a significantly larger pool of enrollees than ever before.

The stated goal of this rulemaking is to address these issues and streamline the Medicaid and CHIP eligibility and enrollment processes. CMS seeks to reduce administrative burden on states and enrollees, increase enrollment and retention of eligible individuals, and improve program integrity of Medicaid and CHIP.

### **Facilitating Enrollment Through Medicare Part D Low-Income Subsidy “Leads” Data**

Of the four MSP eligibility groups, the three primary groups are Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), and Qualifying Individuals (QIs). Under the MSP, payment is made for some or all of an individual’s cost-sharing for Medicare covered items and services based in part on their income and in part on their resources.

The *Medicare Improvements for Patients and Providers Act of 2008* (MIPPA) addressed barriers to accessing MSP coverage by adding requirements for states to leverage the Medicare Part D Low-Income Subsidy (LIS) program to help enroll likely-eligible individuals in MSPs. Under MIPPA, the Social Security Administration (SSA) must transmit data from LIS applications (referred to as “leads data”) to State Medicaid agencies. States must accept leads data and act upon it in the same manner and under the same deadlines as if the data were an MSP application submitted by the individual.

CMS proposes to codify the statutory requirements for states to maximize the use of leads data to establish eligibility for Medicaid and the MSPs in its regulations because some states may have been unaware or unclear of the steps required to meaningfully use the leads data to streamline eligibility and enrollment in the MSPs. Leads data would be defined to mean data from an individual’s application for Part D LISs that the SSA electronically transmits to the appropriate State Medicaid agency. CMS also proposes to codify clearly delineated steps that states must take upon receipt of leads data from SSA. ***The FAH supports this policy and the streamlined approach for Medicare beneficiaries to qualify for Medicaid coverage and the MSP.***

## **Automatically Enroll Certain SSI Recipients Into the QMB Group**

Supplemental security income (SSI) recipients usually qualify for other federal and state programs, including under the Medicare or Medicaid programs. Receipt of SSI is a mandatory basis for Medicaid eligibility in most states. Other mandatory SSI group states apply the SSI program's income and resource methodologies and disability criteria but require individuals to submit a separate application to the State Medicaid agency. Additionally, eight states do not cover the mandatory SSI group, and they apply more restrictive financial methodologies and/or disability criteria for eligibility determinations.

Most Medicare-eligible SSI recipients meet the QMB eligibility requirements. Every state has a buy-in agreement with CMS, which requires them to pay the Part B premiums for certain Medicaid beneficiaries, including individuals enrolled in the QMB group and those receiving SSI; this is referred to as the "Part B buy-in." Citing data from 2022, CMS states that over 500,000 or 16 percent of SSI recipients who are eligible to enroll in Medicare are not enrolled in the QMB eligibility group. CMS proposes to require states to deem those individuals eligible for the QMB group the month the state becomes responsible for paying the individual's Part B premiums under its buy-in agreement. *The FAH supports this proposal to ease eligibility enrollment in the QMB program.*

## **Aligning Non-MAGI Enrollment and Renewal Requirements With MAGI Policies**

Many state Medicaid policies differ between those whose eligibility is based on modified adjusted gross income (MAGI) and non-MAGI individuals such as those whose eligibility is based on being aged (age 65 or older), having blindness, or a disability. CMS proposes changes to both the application and renewal requirements for MAGI-excepted applicants and beneficiaries, to align with the requirements for non-MAGI-based populations.

CMS proposes to expand regulatory references so that the following would also be required by states for non-MAGI beneficiaries, as well as MAGI beneficiaries:

- No state option to require in-person interviews as part of an application or renewal;
- Renewals scheduled only once every 12 months (which is different than intervening redeterminations based on changes in circumstances);
- Renewals must first be attempted based on available information (ex parte);
- If ex parte renewal is not possible, states would be required to use the following set of streamlined procedures:
  - Send the beneficiary a pre-populated renewal form;
  - Provide the individual with at least 30 days to sign and return the form, along with any requested information; and
  - Reconsider eligibility for an individual terminated for failure to return the renewal form or other needed information if it is returned within 90 days after the termination date.

*The FAH supports these policies to streamline enrollment and re-enrollment for MAGI individuals.*

## **Optional Group for Reasonable Classification of Individuals Under 21 Who Meet Criteria for Another Optional Group**

Prior to the implementation of MAGI in the ACA, states had tremendous flexibility to use income disregards as a means to extend Medicaid eligibility to higher income individuals. States can no longer use income disregards to expand eligibility to higher income individuals in MAGI-based pathways. While no further disregards were permitted for MAGI-based individuals, states with higher income levels than in the ACA had those levels grandfathered up to December 31, 2013.

States may still use income and resource disregards for individuals in MAGI-excepted pathways—for example, for eligibility on the basis of being aged, blind, or disabled, or medically needy or HCBS-related pathways. The Medicaid statute permits states to provide optional coverage to certain categorical populations who meet the requirements of an optional pathway. The categorical populations include individuals “under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose”. Generally, states used this flexibility to expand coverage to 19- and 20-year-olds not otherwise eligible for Medicaid.

In 2016, CMS finalized regulations placing this pathway—optional eligibility for reasonable classifications of individuals under age 21—as subject to MAGI. In this rule, CMS proposes to create separate optional eligibility for reasonable classifications of individuals under age 21 through a MAGI-excepted pathway. *The FAH supports this proposal that allows states to make such an optional pathway available to reasonable classification(s) of individuals under age 21, with flexibility to disregard certain levels of assets and income, which would effectively expand income eligibility.*

### **Eliminating Access Barriers in CHIP**

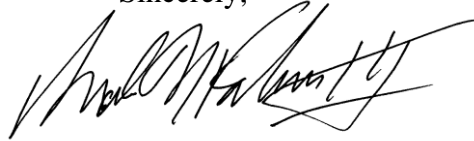
CHIP was enacted in 1997 to provide additional federal funding for states to cover low-income children with family income above a state’s Medicaid eligibility levels. CHIP included flexibility to implement policies not permitted in Medicaid, such as requiring a waiting period before children are able to enroll, annual or lifetime limits on benefits, or locking out children from coverage for a period of time because their families did not pay premiums timely. Since then, the ACA has expanded coverage to higher-income individuals, including through subsidized exchange coverage, which does not have waiting periods (but does have a limited annual enrollment window, unlike Medicaid or CHIP) and prohibits annual or lifetime limits.

In this rule, CMS proposes to eliminate state flexibility to use premium lock-out periods and waiting periods in CHIP. CMS acknowledges that, following passage of the ACA, it had left these flexibilities in place. Because such policies pose a barrier to obtaining and retaining coverage for CHIP beneficiaries who otherwise meet the state’s eligibility requirements, CMS now proposes to eliminate each of these state options. *The FAH supports these policies to improve coverage by eliminating premium lock-out periods and waiting periods for children eligible for CHIP.*

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The FAH appreciates the opportunity to support and comment on this regulation that will improve Americans' access, enrollment, and coverage under the Medicaid and CHIP programs. If you have any questions or would like to discuss further, please do not hesitate to contact me or a member of my staff at (202) 624-1534.

Sincerely,

A handwritten signature in black ink, appearing to read "William M. Bennett", written in a cursive style.