Issue Brief

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Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes

The Centers for Medicare and Medicaid Services (CMS) have released a proposed rule intended to simplify applications, verifications, enrollment, and renewals for health care coverage through Medicaid and the Children's Health Insurance Program (CHIP).

A copy of the 301-page display version of the rule is currently available at: https://public-inspection.federalregister.gov/2022-18875.pdf. The proposal is scheduled for publication on September 7, 2022. A 60-day comment period is provided ending November 7.

CMS says it "projects that these provisions would increase Medicaid enrollment by 2.81 million by 2027, and would increase total Medicaid spending by $99,290 million from 2023 through 2027. Of that amount, we estimate that $60,280 million would be paid by the Federal government and $39,010 million would be paid by the States. We expect the majority of the additional enrollment and cost to be provided for older adults and persons with disabilities. We also estimate that CHIP enrollment would increase by 0.12 million by 2027, and that total CHIP expenditures would increase by $1,690 million from 2023 to 2027 ($1,170 Federal and $520 million State costs)." The following table shows the net impacts for Medicaid and for CHIP.

Impact of Proposed Provisions on Medicaid and CHIP Expenditures and Enrollment (expenditures in millions of dollars, enrollment in millions of person-year equivalents)

Medicaid	2023	2024	2025	2026	2027	2023-2027
Enrollment	1.34	2.70	2.74	2.78	2.81	
Total Spending	10,620	21,640	21,950	22,340	22,740	99,290
Federal Spending	6,440	13,160	13,330	13,550	13,800	60,280
State Spending	4,180	8,480	8,620	8,790	8,940	39,010
CHIP	**2023**	**2024**	**2025**	**2026**	**2027**	**2023-2027**
Enrollment	0.06	0.12	0.12	0.12	0.12	
Total Spending	180	370	370	380	390	1,690
Federal Spending	120	250	260	260	280	1,170
State Spending	60	120	110	120	110	520

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Below are some of the proposed requirements adopted from the rule's accompanying fact sheet.

Streamlining Application and Enrollment

"The proposed rule, if finalized, will make the process of applying and enrolling easier through (among other updates) the following changes related to application and enrollment:

- Modify medically needy regulations to allow for the use of projected predictable medical expenses incurred by people living in the community for purposes of deducting these expenses from the applicant's income when determining financial eligibility. Examples of these expenses include home care and prescription drugs.
- Eliminate the requirement to apply for other benefits as a condition of Medicaid eligibility to ensure eligible individuals, particularly those without an income test, are not facing unnecessary administrative hurdles.
- Ensure automatic enrollment, with limited exceptions, of Supplemental Security Income (SSI) recipients into the Qualified Medicare Beneficiary (QMB) group.
- Clarify the effective date of QMB coverage for an individual who enrolls in conditional Part A during the General Enrollment Period (GEP); such coverage may begin as early as the month Part A entitlement begins.
- Require use of low-income subsidy (LIS) "leads" from Medicare Part D to:
    - Initiate applications for the MSP eligibility groups;
    - Deem LIS recipients as eligible for MSP coverage to the maximum extent possible; and
    - Accept attested information (with an option to conduct post-enrollment verification) to reduce documentation burden and streamline enrollment of eligible LIS recipients into MSP.

Improving Retention Rates at and Between Regular Renewals

"The following proposals would reduce the number of individuals who are eligible but not covered.

- For individuals who are exempt from the Modified Adjusted Gross Income (MAGI) income counting rules, including those whose eligibility is based on being 65 or older, blindness, or disability, the proposed rule would require states to:
    - Conduct renewals no more than once every 12 months (with limited exception);
    - Use prepopulated renewal forms;
    - Provide a minimum 90-day reconsideration period after termination for failure to return information needed to redetermine eligibility;
    - Eliminate required in-person interviews; and
    - Limit requests for information on a change in circumstances to information on the change.
- Establish a clear process to prevent termination of eligible beneficiaries who should be transitioned between Medicaid and CHIP when their income changes or when the beneficiary appears to be eligible for the other program, even when the beneficiary fails to respond to a request for information.
- Establish specific guidelines for states to check available data prior to terminating eligibility when a beneficiary cannot be reached due to returned mail.
- Provide options for states to use available information to update addresses when beneficiaries move within the same state.
- Require that there be sufficient time for beneficiaries to provide the documentation needed to retain enrollment.

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Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

- Clarify that states are permitted to establish an optional eligibility group for all or a reasonable classification of individuals under age 21 whose eligibility is excepted from use of the MAGI-based methodology (e.g., those living with a disability), or whose MAGI-based eligibility is not otherwise described, and for which such coverage is not already permitted in regulation.

Removing Barriers Specific to CHIP Enrollment

"This rule would:

- Allow CHIP beneficiaries to remain enrolled or re-enroll without a lock-out period for failure to pay premiums.
- Remove the option to allow a waiting period as a substitution of coverage prevention strategy in CHIP.
- Prohibit annual and/or lifetime limits on benefits in CHIP.

Enhancing Integrity of Medicaid and CHIP

"CMS has proposed important steps to update Medicaid and CHIP recordkeeping regulations and enhance the integrity of Medicaid and CHIP.

- Clearly define the types of eligibility determination information and documentation to be maintained by states.
- Remove references to outdated technology and require records to be stored in an electronic format.
- Require Medicaid and CHIP records and case documentation be retained for the time the case is active plus three years thereafter.
- Revise timeliness standards to apply expressly at renewal as well as application.
- Propose specific timelines for states to complete Medicaid and CHIP renewals, including guidelines to ensure beneficiaries who return information late are properly evaluated for other eligibility groups prior to being terminated."