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The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

RE: CMS-2421-P, Medicaid, CHIP, and Basic Health Program Eligibility and Enrollment

We, The Enrollment Coalition, write in response to the Proposed Rule on Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes. The Enrollment Coalition is a group of organizations across the health care community, including consumer advocates, patient advocates, health plans, health care providers, employers, and technology and data organizations. Our mission is to collaboratively identify, develop, and advance actionable policy recommendations for federal policymakers aimed at improving enrollment data, systems, and processes to foster the enrollment of uninsured Americans under age 65 into existing health coverage plans and programs for which they are otherwise eligible.

The Enrollment Coalition appreciates CMS's dedication to ensuring Medicaid beneficiaries do not unnecessarily lose coverage due to administrative barriers during the redetermination and renewal processes. As indicated in the proposed rule, a loss of coverage can occur without the knowledge or intent of the eligible beneficiary to terminate their benefits and when that person loses coverage, they are less likely to receive necessary care.

The Enrollment Coalition has previously recommended that CMS support states in streamlining enrollment processes: (1) including waiving requirements for an interview (in-person or via telephone); (2) synching enrollment and renewal processes, as appropriate, with Supplemental Nutrition Assistance Program (SNAP) to assist in verifying eligibility; (3) using pre-populated renewal forms for non-MAGI populations; (4) allowing renewals by phone and internet; (5) accepting self-attestations coupled with post-enrollment verification of specific eligibility requirements in a timely manner; and (6) extending the timeframe for returning renewals forms from 30 days to 60 days, as well as extending timeframes for resolving discrepancies arising from a change in circumstances.[1] The Enrollment Coalition appreciates that CMS has taken action on these recommendations, many of which involve the application of current federal law.

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[1] Enrollment Coalition Letter to CMS RE: RE: Planning for the Resumption of Normal State Medicaid, CHIP, and BHP Operations Upon Conclusion of the COVID-19 Public Health Emergency https://www.enrollmentcoalition.org/_files/ugd/460f85_4f9f87615dcb43b886bfa5426737361d.pdf.

The Enrollment Coalition also provides the following comments on provisions of the eligibility and enrollment proposed rule:

Outreach Using Multiple Modalities

The Enrollment Coalition supports CMS's proposal to require that states conduct outreach using multiple modalities, including text messaging and phone calls in addition to traditional paper mail, which is still important for many enrollees, including both those who lack access to or comfort with technology and those who gain comfort from the imprimatur of an official agency letter. Contacting beneficiaries solely through traditional mail risks missing many people, due to changes in address, delays in mail delivery, and failure to notice and promptly open envelopes lost in a flood of junk mail. Importantly, multiple renewal notices are needed to provide enrollees enough time to complete renewal processes.

When used to remind enrollees of renewal requirements and health care appointments, aid with navigating plan benefits, and provide fundamental health education, text messaging is a low cost and promising method of communication for individuals with Medicaid. Ninety-two percent of adults earning less than $30,000 own a mobile phone,[2] and 97 percent of low-income phone owners use text messaging.[3] These phone owners indicated that 89 percent would prefer communicating by text,[4] for reasons including more flexibility and privacy in situations like working in hourly positions that limit taking personal calls. Importantly, text messaging can reduce coverage churn in Medicaid. In one example from an Enrollment Coalition member, after using text messaging, retention rates improved from 72 percent retention prior to using texting and 87 percent retention after implementing text messages.

The Enrollment Coalition also recommends CMS take action to remove barriers to communicating with enrollees. The Telephone Consumer Protection Act (TCPA) continues to be a barrier to reaching vulnerable Americans through their preferred communication methods. The Enrollment Coalition appreciates CMS' efforts in coordination with the Federal Communications Commission to provide clarity on this topic. We also encourage CMS to issue a letter to State Medicaid Directors noting a best practice of including consent language in Medicaid and CHIP applications affirming the beneficiary may be contacted through automated calls and text by the state or Managed Care Organization (MCO) and any relevant contractors.

Utilizing Third Party Data to Evaluate Eligibility and Facilitate Renewals

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[2] Eileen Cianciolo, "3 Member Engagement Pitfalls Health Plans Should Avoid," Fierce Healthcare, 3/3/2019, https://www.fiercehealthcare.com/payer/industry-voices-3-member-engagement-pitfalls-health-plans-shouldavoid.

[3] Aaron Smith, "U.S. Smartphone Use in 2015," Pew Research Center, 4/1/2015, https://www.pewresearch.org/internet/2015/04/01/us-smartphone-use-in-2015/.

[4] "Global Mobile Messaging Consumer Report," Twilio, 9/12/2016, https://www.twilio.com/press/releases/twiliostudy-finds-that-9-out-of-10-consumers-globally-want-to-message-with-brands.

We are encouraged by CMS' recommendations for states to leverage MCOs to help fill gaps in data collection to update enrollee information. MCOs may have more up-to-date contact information, compared to the state and an enrollee would most likely be responsive to correspondence coming directly from their plan, prompting them to update information in a timely manner, thus mitigating churn. In addition to MCOs, other partner organizations, such as health systems, pharmacies, non-emergency medical transportation providers, essential community providers, and other stakeholders in care coordination and delivery often have up-to-date contact information for enrollees that could be leveraged by States to facilitate renewals.

The Enrollment Coalition also supports the use of third-party data to evaluate eligibility and facilitate renewals. Using third party data can alleviate the administrative burden placed on beneficiaries and helps prevent administrative denials of those who otherwise may be eligible. Specifically, change of address data, state income tax data, and SNAP data can help provide reliable information showing continued eligibility.

In order to support states in creating data connections between public agencies that make major contributions to enrolling the eligible uninsured and preventing inappropriate coverage losses, the Enrollment Coalition encourages HHS to re-issue a previous exception to the cost allocation requirements set forth in the Office of Management and Budget (OMB) Circular A-87. Re-issuance of the exception would allow Federally funded health and human services programs to benefit from investments in the design and development of State eligibility-determination systems for State-operated Exchanges, Medicaid, and the Children's Health Insurance Program (CHIP). Providing an exception to the cost allocation requirements in OMB Circular A-87 would allow states to do more to integrate the eligibility determination and enrollment functions across health and human services programs, realizing efficiencies for States and serving individuals and families. Integrated eligibility systems would allow individuals and families to access critical safety-net services without having to complete multiple enrollment processes and without government workers repeatedly processing the same information.

States could also utilize this waiver to connect health programs to external sources of data that can verify eligibility without requiring individuals and families to complete repetitive paperwork. States could also simultaneously enroll eligible individuals into health coverage as well as other programs for which they are eligible by improving data matching, establishing more robust referral mechanisms, streamlining business processes, and notifying program participants of their potential eligibility for other benefits. By promoting more integration of IT systems across health and social services programs through the A-87 exception, HHS can encourage states to reimagine how to deliver government services for the 21st century.

Transitions of Coverage

The Enrollment Coalition appreciates that CMS has taken steps to facilitate transitions of coverage. A recent report from the Medicaid and CHIP Payment and Access Commission (MACPAC) found that only about 3 percent of all adult and child beneficiaries who were disenrolled from Medicaid and CHIP enrolled in exchange coverage within a year after

disenrolling.[5] Further, most individuals who moved from Medicaid to the exchange had a gap in coverage and these gaps were longer for racial and ethnic minorities.[6]

In order to further facilitate transitions of coverage, CMS could encourage states to leverage current MCOs to help assist beneficiaries in redeterminations and renewals or with assistance navigating disenrolled individuals' access to marketplace coverage while ensuring protections for consumer choice, or use cost-allocation agreements between Medicaid agencies and exchanges to fund integrated, one-stop systems of application and consumer assistance, with each program paying costs in proportion to the benefits it receives. Application assistance is often divided between navigator services, funded through exchange administrative resources, and consumer assistance provided to Medicaid applicants, funded through Medicaid administrative funding. CMS guidance on integrated funding streams could also remind states that whenever the consumer assistance furnished for Medicaid purposes involves a direct interaction between the application assister – whether a state employee, state contractor, or community-based organization – and the state's eligibility and enrollment system, the federal government's share of cost is 75 percent.[7]

The Enrollment Coalition also encourages CMS to consider how to improve account transfers between Medicaid and Exchanges, as well as implementation of the no-wrong-door enrollment approach so that consumers do not get bounced from program to program and asked many of the same eligibility questions by multiple government agencies.

Thank you for the opportunity to comment.

Sincerely,

Enrollment Coalition

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[5] MACPAC: Transitions Between Medicaid, CHIP, and Exchange Coverage, June 2022, https://www.macpac.gov/wp-content/uploads/2022/07/Coverage-transitions-issue-brief.pdf.

[6] MACPAC: Transitions Between Medicaid, CHIP, and Exchange Coverage, June 2022, https://www.macpac.gov/wp-content/uploads/2022/07/Coverage-transitions-issue-brief.pdf.

[7] State Medicaid Letter: RE: Mechanized Claims Processing and Information Retrieval Systems-Enhanced Funding, https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16004.pdf.