Proposed CMS rule would reduce administrative barriers that keep people from enrolling in and keeping their health coverage

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The Affordable Care Act (ACA) made significant strides in making it easier for people to apply for, enroll in, and maintain their health coverage through Medicaid and the Children's Health Insurance Program (CHIP). Some things were left undone, however, and technological advances have made further streamlining possible. Currently, as many as 7 million people – about one-quarter of all people without insurance — are eligible for Medicaid or CHIP but not enrolled, many of them because of difficulty enrolling or remaining enrolled. The programs are rife with eligibility "churning": thousands of people each month lose coverage because of a failure to meet an administrative requirement, only to re-enroll a short time later, having sacrificed the continuity of their health care and some peace of mind. (In 2018, 5.6 million Medicaid and CHIP enrollees – 8 percent of all enrollees – lost their coverage and then re-enrolled within 12 months.) In many cases, people who are eligible may not even apply because of the complicated process involved.

Taking a major next step in this area, the Centers for Medicare and Medicaid Services (CMS) has proposed new rules for streamlining eligibility, enrollment and renewal processes for people covered by Medicaid and CHIP. CMS is accepting comments on the proposed rule until November 7, 2022. A CMS summary of the proposed rule is posted here.

Important improvements

The proposed change addresses longstanding administrative barriers that particularly affect people of color, older adults, people with disabilities, children and people with high health care expenses.

People aged 65 and older and people with disabilities will benefit

The ACA streamlined processes for many people applying for Medicaid, but the improvements did not extend to everyone. People who qualify for Medicaid because they are over age 65, are blind or have a disability still deal with complicated processes that make their enrollment and re-enrollment overly difficult and leave many confused and without coverage. This group is known as the "non-MAGI" population, because their eligibility is not determined using Modified Adjusted Gross Income, or MAGI, unlike other Medicaid applicants.

The proposed rule will simplify the process for older adults and people with disabilities to apply for coverage. If the rule is approved, people in these populations will be able to use a more streamlined Medicaid application and skip the in-person interview, an arduous requirement that only exacerbates racial inequities in health coverage. These changes are long overdue, not only because they will allow more people access to affordable health coverage, but also because, administratively, it's unlikely that people with disabilities and older adults will see changes in their eligibility and these changes will prevent unnecessary loss of coverage.

The proposed rule will also make it easier for older adults and people with disabilities to remain enrolled. State Medicaid programs would be required to renew eligibility no more frequently than every 12 months and states would no longer have the option to require an in-person interview for renewal.

The rule reinforces the idea that states should gather and use information from other sources before requesting additional documentation from the person applying, partially shifting the burden of verification away from individuals. This would benefit people aged 65 and older and people with disabilities in important ways. For older adults enrolled in Medicare prescription drug (Part D) plans, state Medicaid programs would be required to consider eligibility for a low-income subsidy (LIS) for Part D as an application and documentation for Medicare Savings Programs (MSP), in which Medicaid covers the premiums and out-of-pocket costs of low-income Medicare enrollees. The LIS data could also be used to support an application for full Medicaid eligibility. Further, states would be required to automatically enroll into and MSP people with disabilities who are eligible for Supplemental Security Income (SSI), using data from that program (with some exceptions).

Being cut off from health care coverage is more than an inconvenience for the one-fifth of Medicaid members who are older adults or people with disabilities; it can be dangerous or life-threatening. This is especially the case with Medicaid, which covers many long-term services and supports (such as home care and personal care assistance) that are not part of Medicare or most other health insurance. The proposed rule focuses attention on these groups and should ease the path for eligible people to get and stay enrolled.

Less volatility for children's coverage

The rule proposes to streamline enrollment for CHIP programs administered separately from Medicaid (which most states offer, at least in part) that aligns with proposals for Medicaid. The rule also requires strengthening the coordination between CHIP and Medicaid processes, to enable "seamless" transitions between the two programs. As of now, when a child's family income changes or they age out of CHIP, many children lose eligibility, at least temporarily. The proposed changes would strengthen coordination between Medicaid and CHIP, preventing eligible children from losing coverage. The current unnecessary gaps in coverage disproportionately harm Black, Hispanic, and American Indian and Alaskan Native children.

The rule would also prohibit optional practices that block CHIP enrollment, continuous coverage, and access to comprehensive care: pre-enrollment waiting periods, annual and lifetime benefit limits, and program lock-outs for non-payment of premiums.

Relief for people with high medical expenses

If the proposed rule is enacted, it will reduce medical debt and allow people with high medical expenses to receive their care in their homes and communities, rather than the facility-based care currently incentivized in many state Medicaid programs. Our current system helps people in care facilities, like nursing homes, enroll and stay enrolled in coverage, even when otherwise administrative barriers would prevent it, by allowing

them to deduct their regular medical expenses from their income when it is too high to qualify for Medicaid otherwise. The rule change would allow people getting Home- and Community-Based Services to do the same, preventing them from skipping care or incurring medical debt.

Other steps will make it easier to get and keep coverage

Undelivered mail is a common cause of people losing coverage: important notices and requests for information do not reach their intended recipient because the program has the incorrect address or the recipient has moved. When the required information is not returned, eligibility is terminated. The proposed rule requires state agencies to do their due diligence to locate people whose mail is returned, helping to ensure continued coverage.

The problem of undelivered mail is of particular concern as the end of the COVID-19 Public Health Emergency (PHE) nears. When the PHE ends, states will gradually resume the process of periodically redetermining the eligibility for Medicaid and CHIP programs. This "unwinding," as it is known, will involve states sending official notices to millions of people and is anticipated with trepidation because undelivered mail and other administrative complications would result in many eligible people, particularly people of color, losing coverage.

Another moment when people frequently lose coverage is during transitions between programs. The ACA required that states use a single application for Medicaid, CHIP and the Basic Health Program (if they offer one), and that they coordinate eligibility determinations for the programs, making transitioning between coverage easy, but it doesn't always work this way. The proposed rule strengthens the ACA provisions – requiring more coordination across the programs in determining eligibility and in notifying people of their status – to make seamless transitions more likely and help people keep life-saving coverage.

The rule would also allow the verification of citizenship and identity of applicants using state vital statistics data or a Department of Homeland Security database without requiring the applicant to provide additional paper documentation.

Timeliness requirements: The proposed rule establishes reasonable timeframes – for both the state agencies and enrollees – for application acceptances and eligibility renewals, so that if people are eligible for coverage, they are able to get it quickly. Regarding existing timeliness requirements, compliance is inconsistent and certain states have had unsatisfactory records of timeliness in recent years. The proposed rule does not, however, address this performance, for example through stronger enforcement.

Promoting program integrity

States must meet standards for program integrity or face federal financial sanctions. Program integrity in Medicaid and CHIP means not covering ineligible people and ensuring that people who do meet eligibility requirements are covered. The focus on simplification in the proposed rule signals CMS's emphasis on the second aspect of program integrity, which has not always received the same attention as the first.

The rule also clarifies state requirements for record keeping and updates outdated regulations, which do not reflect current technology. The rule proposes that states retain records for three years after a case has been active, and that they rely on these records during that time for documentation that may be required, for example when someone reapplies for Medicaid, unless there is a reason to believe circumstances have changed.

What's next

Overall, the proposed rule represents a positive movement toward a more responsive and accountable health system that offers better coverage. It reduces administrative hassles and helps improve the likelihood that everyone who is eligible for Medicaid and CHIP enrolls and receives services. State Medicaid and CHIP administrators may resist some parts of the proposed rule and feel challenged to implement it, especially with the PHE unwinding approaching. State advocates should consider reaching out to state officials about their plans to comment on the rule and the importance of the streamlining it proposes while also highlighting the experiences of people affected by administrative barriers to enrolling in and keeping their coverage.