November 7, 2022

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard Baltimore, MD 21244

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 Alliance of Community Health Plans (ACHP) supports the Centers for Medicare and Medicaid Services' (CMS) efforts to promote efficiency, streamline eligibility, reduce administrative burden and advance equity across the Medicaid, Children's Health Insurance Program (CHIP) and Basic Health Program. We appreciate the opportunity to provide comments that align with the Agency's efforts to create a seamless care journey for patients through enhanced access to coverage and more efficient eligibility processes.

ACHP represents the nation's top-performing, nonprofit health plans that provide high-quality coverage and care to tens of millions of Americans across 36 states and D.C. Our member companies serve diverse populations across all lines of business, particularly in Medicaid where collectively, our members cover 3.2 million consumers nationwide.

Driven by the provider-aligned, community-based model, ACHP member companies are invested in helping consumers seamlessly transition from Medicaid to a qualified health plan following the Medicaid redetermination process. When the Public Health Emergency (PHE) ends, an estimated 15 million Americans will lose coverage and care due to Medicaid eligibility redeterminations.

ACHP member companies have developed resources to mitigate unnecessary loss of coverage. These include advertising the end of the PHE through digital banner ads, social media, print and public service announcements. Additionally, ACHP member companies are communicating with their current customers to update contact information and alerting consumers at risk of losing coverage through emails, letters, phone calls and text messages, where permissible, to share marketplace coverage options based on state regulatory processes.

We are encouraged by CMS' commitment to providing states, health plans, consumers and other stakeholders with tools and guidance to preserve and enhance access to coverage throughout the redetermination process. ACHP has identified five priorities to ensure a smooth transition:

outreach to consumers; transitions to coverage; aligning enrollment and renewal; eliminating barriers to entry; and utilizing third party data to evaluate eligibility and facilitate renewals.

Outreach to Consumers. Ensuring consumers have uninterrupted care and coverage is critical to reaching the goal of health equity. Health plans are deploying all strategies available to engage consumers throughout the PHE unwinding process. Unfortunately, marketing limitations established in the Telephone Consumer Protection Act (TCPA) have relegated health plans to solely communicate via physical mail and telephone. Health plans continue to need greater flexibility to communicate with consumers and avoid unnecessary loss of coverage. We appreciate CMS' efforts to engage the Federal Communications Commission (FCC) to clarify the permissibility of text messages and automated, pre-recorded telephone calls to individuals' cell phones to maximize outreach to consumers under TCPA. However, further action is needed on the part of the Agency to maximize consumer outreach as the end of the PHE nears.

Texting is an accessible and effective mode of communication for consumers to receive information and a powerful health equity measure to mitigate the unnecessary loss of coverage. Many Medicaid enrollees maintaining coverage through a Managed Medicaid plan may not be aware that they are enrolled in Medicaid. Receiving correspondence exclusively from a state Medicaid agency regarding the status of their Medicaid coverage will likely cause beneficiaries confusion and delay action. It is our experience that consumers will be more responsive to correspondence coming from their plan, prompting them to update information and complete renewals in a timely manner, thus mitigating churn.

ACHP recommends CMS remove barriers to communicating with consumers. The TCPA continues to be a barrier to reaching vulnerable Americans through their preferred communication methods. We appreciate that CMS and the FCC are collaborating to provide clarity on this critical issue. We also encourage CMS to issue a letter to State Medicaid Directors with best practices for states and their contracted Managed Medicaid plans regarding consent language in Medicaid and CHIP applications affirming the beneficiary may be contacted through automated calls and text by the state or Managed Medicaid plan and any relevant contractors.

Transitions to Coverage.

ACHP 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 beneficiaries disenrolled from Medicaid and CHIP were enrolled in exchange coverage within a year. Further, a report by the Department of Health and Human Services (HHS) projected that most individuals that are at risk of losing coverage during the unwinding are between the ages of 25- 34-years old. HHS data also notes that Black and Latinx consumers will be disproportionately impacted by administrative denials in eligibility.

CMS should encourage states to leverage Managed Medicaid plans to assist consumers in redeterminations and renewals or by assisting disenrolled consumers in navigating marketplace coverage. This would ensure 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.

CMS guidance on integrated funding streams would reaffirm for states that whenever direct interactions for consumer assistance involve an application assister (e.g., 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, further incentivizing enhanced infrastructure to support transitions to coverage.

Aligning Enrollment and Renewal. ACHP supports CMS' proposals to align enrollment for individuals participating in the Medicaid program via a single, streamlined application for both Modified Adjusted Gross Income (MAGI) and non-MAGI enrollees, to be renewed ***once*** every 12 months. Currently, MAGI enrollees are subjected to renewals once a year, whereas non-MAGI enrollees are subjected to renewals ***at least*** once a year. The current system has subjected those most in need of care to unfair and inconsistent processes that continue to perpetuate inequities.

These proposals will foster more equity amongst non-MAGI enrollees, who are predominantly 65 years or older, blind and/or disabled, have more predictable, stable eligibility, and this would eliminate unnecessary burden on the individual to endure multiple renewals a year. The proposal to eliminate in-person interviews for MAGI eligible enrollees would eliminate barriers to coverage for individuals who are hampered by work schedules, inability to obtain childcare or lack of transportation.

We encourage CMS to examine the impact the proposed 12-month eligibility will have on the continuous eligibility provision from the Families First Coronavirus Response Act. We appreciate that this regulation, when finalized, aims to provide states guidance that will progress along with the unwinding of the PHE. However, added guidance is needed to understand the impact of the transition from continuous eligibility to a streamlined 12-month eligibility across different populations.

Eliminating Barriers to Entry. Medicaid and CHIP enrollees face obstacles in obtaining coverage. From varying state eligibility criteria to disparate requirements to demonstrate financial need, these barriers create undue burden on individuals who need critical supports and services.

We strongly support CMS' proposals to eliminate lock-out periods for non-payment of premiums for CHIP enrollees. We also support proposals to prohibit waiting periods or periods of uninsurance, which are permissible for children transitioning from group health plans to CHIP. These proposals, along with provisions which would eliminate annual and lifetime limits on benefits will set a level playing field for children eligible for CHIP coverage. Currently CHIP enrollees are among the only demographics covered under affordability programs subjected to these requirements. These proposals will increase access to care and further improve health outcomes for young children across the country.

Utilizing Third Party Data to Evaluate Eligibility and Facilitate Renewals. Without the ability to obtain patient data directly from the patient, states are encouraged to obtain data through third-parties, such as other federal assistance programs in which the consumer may be enrolled. Managed Medicaid plans can be a vital partner in obtaining patient information and ensuring preservation of coverage.

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

ACHP 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 help prevent administrative denials of those who otherwise may be eligible. Specifically, change of address data, state income tax data, and Supplemental Nutrition Assistance Program (SNAP) data can provide reliable information showing continued eligibility.

How states, health plans and other stakeholders handle the unwinding will have a profound impact on beneficiaries, their families and the health of the nation. Large rates of uninsurance among an already vulnerable demographic will result in deferred care or higher utilization of emergency services, both of which impede timely medical intervention and result in higher medical costs. We have a critical window of opportunity to coordinate and fortify processes to ensure consumers do not lose confidence in the system due to disruptions in care and coverage and become hesitant to seek care due to potentially unexpected costs.

ACHP is committed to working with CMS to provide consumers with a seamless redetermination experience. Please contact Nissa Shaffi, ACHP's Associate Director of Public Policy, at nshaffi@achp.org or (202) 524-7773, with any questions or if we can provide further information.

Sincerely,

Ceci Connolly

Ceci Connolly
President and CEO, ACHP