



November 7, 2022

The Honorable Xavier Becerra  
Secretary of Health and Human Services  
U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Washington, DC 20201

The Honorable Chiquita Brooks-LaSure  
Administrator Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
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; Proposed Rule (CMS-2421-P)**

Dear Secretary Becerra and Administrator Brooks-LaSure:

The Cystic Fibrosis Foundation thanks the Centers for Medicare and Medicaid Services (CMS) for the opportunity to comment on “Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Process proposed rule. The Cystic Fibrosis Foundation is a national organization dedicated to curing cystic fibrosis (CF). We invest in research and development of new CF therapies, advocate for access to care for people with CF, and fund and accredit a network of specialized CF care centers.

Cystic fibrosis is a life-threatening genetic disease that affects close to 40,000 children and adults in the United States. CF causes the body to produce thick, sticky mucus that clogs the lungs and digestive system, which can lead to life-threatening infections. As a complex, multi-system condition, CF requires targeted, specialized treatment and medications. If left untreated, infections and exacerbations caused by CF can result in irreversible lung damage, and the associated symptoms of CF lead to early death, usually by respiratory failure. Approximately 42 percent of all people with CF and 52 percent of children with CF under 10 years old are enrolled in Medicaid, so maintaining access to this program is essential for the management of CF.

The CF Foundation strongly supports the Agency’s effort to make it easier for patients to enroll in and maintain coverage through Medicaid and the Children’s Health Insurance Program (CHIP). We provide the following comments and recommendations:

### **Eliminate Enrollment Barriers and Benefit Caps in CHIP**

The proposed rule eliminates waiting periods and enrollment lockouts following nonpayment of premiums in CHIP. CHIP waiting periods require a child to be uninsured during a waiting period prior to coverage. The CF Foundation strongly supports the removal of waiting periods, as this policy results in children going without health insurance and/or low to moderate income families fighting through red tape to get their children enrolled. Furthermore, the proposed rule would eliminate premium lockouts in CHIP. Lockouts, like waiting periods, create a forced coverage gap for children during which they may miss needed care and families may incur large medical bills. Premiums and lockouts pose a barrier to coverage, and for children with CF, regular access to care is especially critical. Finally, this rule would eliminate annual and lifetime dollar limits in CHIP. These limits are particularly burdensome for individuals with chronic conditions like CF, who are more likely to need high-cost care. Annual and lifetime limits are not allowed in Medicaid or the private Marketplace coverage, and we strongly support CMS' decision to remove these limits in CHIP.

### **Improve Coordination of Eligibility between Medicaid and CHIP**

Streamlining enrollment and redetermination processes benefits states and Medicaid enrollees by reducing administrative burn and churn. The CF Foundation supports the proposed regulation requiring Medicaid programs in states with separate CHIP programs to make CHIP eligibility determinations and transfer files to CHIP. We also support the proposed provision to require states to move forward with CHIP determinations and transfers regardless of whether individuals have confirmed reliable data.

### **Align Non-MAGI Process with MAGI-based Processes**

CMS is proposing a number of improvements in enrollment, renewal, and redetermination procedures for individuals eligible for non-MAGI Medicaid. The proposed rule would align MAGI-exempt processes with many of the streamlining and simplification requirements adopted for MAGI groups under the Affordable Care Act (ACA), including: routine renewal to once every 12 months, requiring use of pre-populated forms, and allowing at least 30 days for response and 90-day reconsideration period. States would also be prohibited from requiring in-person interviews. Moreover, CMS is proposing detailed multi-step requirements for how states should handle returned mail in order to limit unnecessary terminations in coverage. We strongly support these provisions which will reduce barriers to enrollment and renewal for people with CF, and make it easier for applicants, agency staff, and other stakeholders to understand the rules.

### **Improve Enrollment and Participation in the Medicare Savings Program**

Individuals with CF who are dually eligible for Medicare and Medicaid are routinely affected by the administrative burden of submitting repetitive paperwork to access benefits. We are pleased CMS seeks to address this issue.

The Medicare Savings Program (MSP) provides coverage of Medicare premiums and in some cases, cost-sharing, through the Medicaid program. Individuals who are eligible for MSP are also eligible for Medicare's low-income subsidies (LIS) for prescription drug coverage. These programs provide critical financial assistance for low-income seniors and people with disabilities also eligible for Medicare; however, participation in these programs is very low.<sup>1</sup> We agree with the Agency that the enrollment process is overly complex and provide the following support and recommendations to simplify enrollment and participation in MSP.

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<sup>1</sup> Medicare and CHIP Payment and Access Commission, "Report to Congress on Medicare and CHIP," June 2020, <https://www.macpac.gov/publication/june-2020-report-to-congress-on-medicare-and-chip/>.

When an individual applies to the Social Security Administration (SSA) for the Part D LIS and is not already enrolled in MSP, SSA sends the application data to the state. The state must then accept the verified information sent by SSA and must initiate an application for MSPs. If the state needs more information to process the application, it should send out a prepopulated application to the Medicare enrollee that only asks for what has not already been provided. These procedures have been required for more than a decade; however, states have not fully implemented them. The CF Foundation supports the proposed rule which would codify the statutory requirements for state Medicaid programs to accept and act on LIS data to initiate the MSP application, including numerous requirements to ensure states do not request additional information from applicants unnecessarily and give applicants enough time to respond to valid requests for information. This would result in an influx of individuals gaining MSP coverage.

In addition, the proposed rule would require states to deem Supplemental Security Income (SSI) recipients as Qualified Medicare Beneficiaries (QMB). Currently, though SSI individuals eligible for SSI meet the income and eligibility limits for QMB, many states fail to enroll them because of procedural and technical barriers. The one situation where CMS would not mandate deemed QMB enrollment is in group payer states for SSI recipients without premium-free Part A. In those states, CMS is proposing to ease the current restrictions by allowing, but not requiring, the group payer state to enroll the SSI recipient in Part A without the individual having to first file a conditional Part A enrollment with SSA. We support these provisions, as they would allow almost all SSI recipients access to QMB balance billing protections and premium coverage for both Part A (when needed) and Part B. We encourage CMS to require this policy for all states, including group payer states.

#### **Allowing Medically Needy Individual to Deduct Prospective Medical Expenses**

“Medically needy” enrollees qualify for Medicaid, despite being over the income limits, because they have large medical expenses that reduce their countable income below the income limits. The proposed rule would allow individuals who have consistently high predictable costs, including prescription drugs, to project costs for medical expense through the Medically Needy enrollment pathway. We strongly support this new provision as it will improve continuity of care and reduce administrative burdens for the state and enrollees.

#### **Clarify Recordkeeping Requirements for States to Avoid Payment Errors**

The Payment Error Rate Measurement (PERM) shows elevated “eligibility errors” in Medicaid. However, these are often not actually eligibility errors; they are situations where states have not retained all the required data to officially confirm eligibility for the PERM review. The proposed rule would help clarify the type of data states must retain and the duration for retention.

The CF Foundation supports this provision, as it will reduce the PERM error rate and the inaccuracy that ineligible individuals are enrolled in Medicaid.

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The CF Foundation appreciates the opportunity to provide comments on the proposed rule. We look forward to working with CMS on these critical issues to ensure access and affordability for people with CF.

Sincerely,

A handwritten signature in black ink, appearing to read 'Mary B. Dwight', with a stylized flourish at the end.

Mary B. Dwight  
Chief Policy & Advocacy Officer  
Senior Vice President, Policy & Advocacy  
Cystic Fibrosis Foundation