MEDICARE RIGHTS CENTER
Getting Medicare right

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VIA ELECTRONIC SUBMISSION

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-2421-P
P.O. Box 8016, Baltimore, MD 21244-8016

Re: RIN 0938-AU00: 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 Medicare Rights Center (Medicare Rights) appreciates this opportunity to comment on the **Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes** proposed rule. Medicare Rights is a national, nonprofit organization that works to ensure access to affordable and equitable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to over three million people with Medicare, family caregivers, and professionals.

On our national helpline, we receive many calls annually from people who are struggling to enroll in coverage and access Medicare. In 2020-21, calls related to enrollment and affordability comprised 52% of Medicare Rights' total helpline questions, a 21% increase over 2019.[1] While enrollment questions are always common, COVID-19 brought a new urgency to the topic. There was an increase in inquiries about enrollment as we fielded calls from beneficiaries who were suddenly out of work who needed financial assistance, specifically the Qualified Medicare Beneficiary (QMB) program. The most generous of the Medicare Savings Programs (MSPs), QMB helps enrollees cover Medicare costs, including Part B premiums and cost-sharing. In 2020, 74% of Medicare Rights' low-income program inquiries and

[1] Medicare Rights Center, "Medicare Trends and Recommendations: An Analysis of 2020-2021 Call Data from the Medicare Rights Center's National Helpline" (May 2022), https://www.medicarerights.org/policy-documents/2020-2021-medicare-trends-and-recommendations.

referrals were QMB-related, while 68% were in 2019. There are over 12 million people dually eligible for Medicare and Medicaid or enrolled in an MSP who will need to recertify benefits when the federal public health emergency declaration ends.

As we work to connect people with Medicare financial assistance, we often find that state eligibility rules and administrative systems are woefully outdated, leaving many who need comprehensive Medicaid or an MSP with nowhere to turn. For example, the QMB program has restrictive income and asset limits in most states, leaving far too many beneficiaries who need help just outside of the eligibility range. The program's overly burdensome administrative apparatus[2] forces those who do qualify to jump through hoops, including complex rules, onerous application processes, and confusing communications. Once enrolled, they face unnecessarily frequent redeterminations which cause churn and stress. At their core, these current processes overemphasize the risks of ineligible people receiving benefits and underemphasize the need for people with lower incomes to access high-quality care.

As the Centers for Medicare & Medicaid Services (CMS) notes in the proposed rule MSP uptake remains far too low, with only about half of eligible Medicare beneficiaries enrolled.[3] This leaves many without affordable coverage, which is especially troubling given their likely need for care: in 2017, the Medicaid and CHIP Payment and Access Commission (MACPAC) estimated that around 55% of eligible non-enrollees reported limitations in at least one activity of daily living (ADL) or an instrumental activity of daily living (IADL).[4]

In addition, as the COVID-19 pandemic has amply demonstrated, lack of care can affect not only the individual but the entire population, and inequity in health care continues despite years of effort to mitigate the impact of systemic racism and discrimination. As the public health emergency winds down, and people are again subject to Medicaid redeterminations and disenrollments, ensuring easier access to coverage through Medicaid's many offerings—including MSPs—becomes even more vital.

Because of these factors, Medicare Rights strongly supports streamlining all eligibility, enrollment, and renewal processes in Medicaid and other programs. We are particularly encouraged by the proposals that affect individuals who are dually eligible for Medicare and Medicaid.

Further, we note our continued objection to the use of default enrollment where important protections, including processes to ensure correct eligibility determinations, are not in place. This includes in instances when the state Medicaid agency has no system or process in place to determine non-Modified Adjusted Gross Income (MAGI) eligibility within the prescribed 60-day timeframe.[5] Default enrollment

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[2] Centers for Medicare & Medicaid Services, "Journey Map: Navigating the Medicare Savings Program (MSP) Eligibility Experience" (last accessed November 7, 2022), https://www.cms.gov/files/document/navigating-medicare-savings-program-msp-eligibility-experience-journey-map.pdf.
[3] 87 Fed. Reg. 54760, 54761.
[4] Kyle J. Caswell & Timothy A. Waidmann, "Medicare Savings Program Enrollees and Eligible Non-Enrollees" (June 2017), https://www.macpac.gov/wp-content/uploads/2017/08/MSP-Enrollees-and-Eligible-Non-Enrollees.pdf.
[5] Centers for Medicare & Medicaid Services, "Default Enrollment FAQs" (February 2019), https://www.integratedcareresourcecenter.com/sites/default/files/HPMS%20Level%201%20Memo%20-%20Default_Enrollment_FAQs_2-25-19.pdf.

may benefit some, but it creates burdens and confusion for others, and eliminates informed decision-making for all. By increasing education and outreach, as well as simplifying and streamlining enrollment, we neutralize the arguments for default enrollment.

In the Background section, CMS proposes an effective date for a finalized rule of 30 days following publication and a separate compliance date, which may vary by requirement, with full compliance no later than 12 months following the effective date of the final rule.[6] We urge CMS to set compliance dates for each requirement as soon as practicable. In some cases, as with the Low-Income Subsidy (LIS) "leads" data, states have had many years to comply with federal requirements but have failed to do so.[7] In such cases, compliance and enforcement dates should be soon, to ensure the maximum number of people gain, and retain, life- and health-saving access to care.

II. Provisions of the Proposed Regulations

A. Facilitating Medicaid Enrollment

1. Facilitate Enrollment through Medicare Part D Low-Income Subsidy "Leads" Data

We greatly appreciate CMS encouraging states to bring all of their eligibility rules into alignment with, or be more generous than, the LIS rules. If states did align their rules, they would no longer need to reach out to applicants for financial information but could rely on the information SSA provides. We hope states will take this opportunity to reduce burden on applicants and state enrollment workers.

CMS proposes to codify in regulation the statutory requirements for states to maximize the use of LIS leads data to establish eligibility for Medicaid and the MSPs. We support this proposal.

In addition, CMS proposes to require states to accept leads data, to treat receipt of the leads data as an application for Medicaid, and to determine MSP eligibility without requiring submission of a separate application to the extent possible given mismatched information needs. We strongly support these proposals. In our experience, some states react to receipt of leads data, if at all, by merely sending blank MSP applications to LIS applicants or enrollees or continuing to ask for information already present in the leads data. This inappropriately burdens beneficiaries; inevitably suppresses enrollment; and duplicates work for states, as it results in their re-collecting income and asset information they already have. These additional steps and barriers almost certainly delay enrollment—and access to affordable care.

As mentioned above, states ideally would align their MSP eligibility rules to match or be more generous than those for LIS. We recognize such a mandate is beyond current CMS authority. Therefore, we urge you to require states to send out an application that is prepopulated with information from the leads data and other data sources and only ask for missing information or an attestation.

[6] 87 Fed. Reg. 54760, 54763.
[7] 87 Fed. Reg. 54760, 54764.

CMS recommends that when states do request additional information from individuals, they include information on how to contact the local State Health Insurance Assistance Program (SHIP) for assistance. We support this recommendation and urge consumer testing of any such materials.

CMS's proposals would prohibit states from requiring individuals to attest or otherwise provide documentation to establish information contained in leads data. We strongly support this proposal.

CMS also proposes requiring states to collect any additional information they may need to determine Medicaid and MSP eligibility. We support this proposal. However, we urge thoughtful consideration of how states can best convey denial for one program and acceptance for another. For example, it is not uncommon for individuals to be eligible for a MSP, but not full Medicaid. A request for additional information for MSP could easily be overlooked because the request was buried behind a Medicaid denial notice. To prevent recipients from dismissing the notice after reading about a Medicaid denial, we strongly recommend that CMS's final rule include a provision that requires states provide a separate notice if they are eligible for the MSP.

To more closely align LIS and MSP methodologies, CMS proposes to require that states adopt a number of enrollment simplification policies. This includes requiring states to accept self-attestation rather than requiring documentation in several categories: dividend and interest income, the value of any non-liquid resources, claims that up to $1,500 of their resources and up to $1,500 of their spouse's resources are set aside as burial funds, and claims that they have a life insurance policy with a face value below $1,500. CMS notes that such self-attestation would not suffice if the state agency has information that is not reasonably compatible with the applicant's attestation. Additionally, states would retain the option to verify the information after the individual has been enrolled. We support these proposals. Requiring states to allow self-attestation and to make an initial determination without other documentation allows quicker access to MSP coverage. The use of additional information if it is not reasonably compatible with the attestation protects the state from improper enrollment.

CMS also proposes that when documentation of the cash surrender value of a life insurance policy is required, the state must assist the individual with obtaining such information and documentation by requesting that the individual provide the name of the insurance company and policy number and authorize the state to obtain such documentation on the individual's behalf, similar to the assistance the Social Security Administration (SSA) provides Supplemental Security Income (SSI) applicants. We support this proposal.

CMS seeks comment on whether 15 calendar days or a longer minimum period, such as 20 calendar days or 30 calendar days, appropriately balances the complexity of determining and obtaining documentation of the cash surrender value with the 45-day limit for States to complete Medicaid eligibility determinations for individuals applying on a basis other than disability status. We urge the use of a 30-day timeline to ensure applicants have sufficient time to respond.

CMS seeks comment on the utility of post-enrollment verification and whether it results in unnecessary procedural denials of eligible individuals. We believe such post-enrollment verification results in

unnecessary denials as enrollees may fail to respond because they understand their application to have been approved. We urge CMS and states to minimize the use of post-enrollment verification to reduce opportunities for error.

CMS seeks comment on the proposal to require that States provide individuals with at least 90 calendar days to respond to requests for additional information for post-enrollment verification. If post-enrollment verification is permitted, we support the 90-day timeframe to allow enrollees to gather necessary information. We also urge CMS to require states to provide enrollees with details on disputing erroneous information.

CMS seeks comment on whether requiring documentation of a different amount of in-kind support to rebut the 1/3 Federal benefit rate poses a barrier to eligibility and whether it should instead require states to accept self-attestation from individuals who seek to rebut the presumption. We support requiring states to accept self-attestation. As CMS notes,[8] documenting the amount of actual in-kind support and maintenance to rebut the presumption can be difficult for applicants, creating a self-fulfilling prophecy that few will seek to rebut it.

In addition to the issues above, we strongly urge CMS to work with states to eliminate the non-LIS requirement for MSP applicants to collect all available sources of income such as being forced to take a required minimum distribution or the requirement that an individual take a reduced SSA retirement benefit at an early age as a condition of MSP eligibility. Such policies effectively create an irreversible lifetime financial disadvantage for low-income individuals since full retirement age is no longer aligned with the age for Medicare eligibility.

2. Define "Family of the Size Involved" for the Medicare Savings Program Groups Using the Definition of Family Size in the Medicare Part D Low-Income Subsidy Program

CMS proposes to define "family of the size involved" for MSP eligibility to include at least the individuals included in the definition of "family size" in the LIS program, to include the applicant, the applicant's spouse (if the spouse is living in the same household with the applicant), and all other individuals living in the same household who are related to the applicant and dependent on the applicant or applicant's spouse for one-half of their financial support. We strongly support this definition. The current mismatch between the LIS and some MSP definitions leads to unnecessary confusion and discriminates against communities that regularly use multi-generational housing.

3. Automatically Enroll Certain SSI Recipients into the Qualified Medicare Beneficiaries Group

CMS proposes to generally require states to deem an individual enrolled in the mandatory SSI or 209(b) group eligible for the QMB group the month the state becomes responsible for paying the individual's Part B premiums under its buy-in agreement. We support this proposal to ensure that SSI recipients who

[8] 87 Fed. Reg. 54760, 54769.

are definitionally eligible for QMB have its added protections against balance billing and its coverage of Medicare cost sharing and premiums.

CMS proposes to add a state option for deeming individuals eligible for the QMB group by allowing, but not requiring, group payer states to directly initiate Medicare Part A enrollment for individuals who are not entitled to premium-free Part A without first sending them to SSA to apply for conditional Part A enrollment. While we support this proposal at a minimum, we urge CMS to require this deeming of individuals instead of simply permitting it.

In addition to the issues above, we regularly hear from SSI recipients who are enrolled in Part B through the buy-in months before being added to the Part A buy-in, unnecessarily causing confusion and coordination of benefits issues.

4. Clarifying the Qualified Medicare Beneficiary Effective Date for Certain Individuals

CMS proposes to codify existing policy for individuals who enroll in actual or conditional Part A during the Medicare General Enrollment Period (GEP). As the result of legislation passed in 2020 and rules finalized this month, beginning on or after January 1, 2023, the effective date of Medicare coverage for individuals who enroll in Medicare during the GEP is the month following the month of enrollment.[9] We strongly support and enthusiastically welcome this proposal which would more fully effectuate the changes made by the Consolidated Appropriations Act of 2021.

5. Facilitate Enrollment by Allowing Medically Needy Individuals to Deduct Prospective Medical Expenses

CMS proposes to allow noninstitutionalized individuals, under certain circumstances, to deduct their anticipated medical and remedial care expenses from their income as institutionalized individuals are permitted to do. We support this change, as it removes one layer of institutional bias that harms community-dwelling individuals who have consistently high, predictable costs. By the same logic and also to remove institutional bias, we also encourage CMS to extend retroactive Home- and Community-Based Services (HCBS) coverage and protections for individuals to the same extent it is available for institutional settings.

7. Verification of Citizenship and Identity

CMS proposes to simplify citizenship verification procedures by making verification of birth with a state vital statistics agency or verification of citizenship with the Department of Homeland Security's

[9] Medicare Rights Center, "Important Rules Implement Key BENES Act Provisions to Simplify Medicare Enrollment" (November 3, 2022), https://www.medicarerights.org/medicare-watch/2022/11/03/important-rules-implement-key-benes-act-provisions-to-simplify-medicare-enrollment; Centers for Medicare & Medicaid Services, "Medicare Program; Implementing Certain Provisions of the Consolidated Appropriations Act, 2021 and Other Revisions to Medicare Enrollment and Eligibility Rules (CMS-4199-F)" (November 3, 2022), https://www.federalregister.gov/documents/2022/11/03/2022-23407/medicare-program-implementing-certain-provisions-of-the-consolidated-appropriations-act-2021-and.

Systematic Alien Verification for Entitlements (SAVE) Program function as stand-alone evidence of citizenship with no separate verification required. This is similar to SSA's process for verifying citizenship. We support this proposal.

B. Promoting Enrollment and Retention of Eligible Individuals

1. Aligning Non-MAGI Enrollment and Renewal Requirements with MAGI Policies

CMS proposes requiring states to align non-MAGI Medicaid enrollment and renewal requirements with MAGI Medicaid standards, including by limiting regularly-scheduled eligibility renewals to once every 12 months. We strongly support this proposal. Currently, older adults and people with disabilities are subject to more barriers in gaining and retaining Medicaid coverage than MAGI populations. This proposal would significantly reduce that burden.

CMS also proposes to eliminate states' option to require an in-person interview as part of the application and renewal process for non-MAGI beneficiaries. We strongly support this proposal.

CMS proposes to clarify that the 30 calendar days that states must provide beneficiaries to return their pre-populated renewal form begins on the date the form is postmarked or electronically sent rather than the date on the form. We support this proposal as it prevents situations where the form's date does not match its sent date.

In addition, we support CMS's proposal to require states to treat the returned renewal form and other information received during the reconsideration period as a Medicaid application, and the requirement that states determine eligibility within the same timeliness standards for processing application—90 days for renewals based on disability status and 45 days for all other renewals.

2. Acting on Changes in Circumstances Timeframes and Protections

CMS proposes to require states to establish and maintain procedures for beneficiaries to report changes in circumstances that may affect their Medicaid eligibility, and to make explicit the steps states must take in processing those reported changes. We support these proposals and urge CMS to ensure the beneficiary-facing processes and communications are easy to utilize and understand.

CMS also proposes that states provide a minimum of 30 calendar days from the date a request for information is sent, which is the date the request is postmarked or the date the notice is sent electronically if the beneficiary elected to receive electronic notices, for a beneficiary to obtain and submit information needed in order for the State to redetermine eligibility based on a change in circumstances. We support a minimum time frame to ensure beneficiaries have sufficient time to respond to requests for information.

In addition, CMS proposes that states provide beneficiaries whose coverage was terminated due to failure to provide information requested with a 90-day reconsideration period without requiring a new application. We support this proposal.

We also request that CMS increase oversight, monitoring and sanctions of state Medicaid agencies that violate the federal requirement of making determinations of eligibility within 45 days of application.

4. Agency Action on Returned Mail

CMS proposes to specify the steps states must take when beneficiary mail is returned to the agency. We support creating this list of steps, which must ensure beneficiaries do not lose access to coverage just because they have changed addresses.

Conclusion

Thank you again for the opportunity to provide comment. For additional information, please contact Lindsey Copeland, Federal Policy Director at LCopeland@medicarerights.org or 202-637-0961 and Julie Carter, Counsel for Federal Policy at JCarter@medicarerights.org or 202-637-0962.

Sincerely,

Fred Riccardi
President
Medicare Rights Center