



November 7, 2022

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2421-P, Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically via [regulations.gov](https://www.regulations.gov)

Re: Comments on Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes (CMS 2421-P)

The Consortium for Constituents with Disabilities (CCD) is the largest coalition of national organizations working together to advocate for Federal public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society free from racism, ableism, sexism, and xenophobia, as well as LGBTQ+ based discrimination and religious intolerance.

We appreciate the opportunity to provide comments on the above-referenced Notice of Proposed Rule Making (NPRM). The undersigned members of the CCD Health and Long Term Supports and Services (LTSS) taskforces strongly support the proposed streamlining of eligibility, enrollment, and renewal processes in these proposed regulations. Our comments specifically address elements of those proposals affecting older adults and persons with disabilities and the impact the changes would have on the individuals that our organization serves.

1. Facilitate Medicare Savings Program (MSP) Enrollment Through Medicare Part D Low-Income Subsidy (LIS) “Leads” Data.

Medicare Savings Programs (MSPs) provide critical financial assistance to low-income older adults and people with disabilities who are eligible for Medicare. However, the number of eligible but unenrolled individuals in MSPs remains unacceptably high. For example, a 2017 Urban Institute study showed just under half of Medicare enrollees eligible for an MSP were not enrolled.¹ Roughly one out of every six Supplemental Security Income (SSI) recipients (16%) eligible to enroll in Medicare are not enrolled in

¹ Kyle J. Caswell and Timothy A. Waidmann, The Urban Inst., *Medicare Savings Program Enrollees and Eligible Non-Enrollees*, 1 (June 2017), <https://www.macpac.gov/wp-content/uploads/2017/08/MSP-Enrollees-and-Eligible-Non-Enrollees.pdf>.

the Qualified Medicaid Beneficiaries (QMB) group.² We generally support the important provisions in this proposed rule to streamline enrollment for MSPs and urge the Department of Health and Human Services (HHS) to go further.

CCD strongly supports the proposed standards around using leads data, including requiring states to initiate an MSP application using leads data sent by the Social Security Administration (SSA). As the Notice identified, states are already required to start MSP applications using leads under the Medicare Improvements for Patients and Providers Act (MIPPA) but many states have not effectively implemented the statute. HHS must enforce its authority under MIPAA to ensure states comply with the statute to help the over one million LIS recipients eligible for but not enrolled in MSP.³ Given that states have yet to comply with MIPPA requirements, we support HHS's timeline for compliance as 30 days following the publication of the final rule to ensure prompt implementation. States should already have a system in place to accept leads data since MIPPA was enacted over a decade ago. There is no excuse to allow states additional leeway to skirt their statutory obligations for enrolling new MSP beneficiaries.

We also strongly support the proposed requirement that states accept self-attestation for certain kinds of income and assets and take on the responsibility to determine the cash value of life insurance policies. Individuals eligible for MSP are, by nature of being dually-eligible, older adults or people with disabilities. MSP eligible beneficiaries are also disproportionately people of color, have limited income and assets, and higher rates of housing insecurity and less access to transportation. For these reasons, MSP eligible persons face additional burdens trying to complete paperwork and provide additional documentation.

Given the long history of bureaucratic barriers to verification and review, we believe that individuals should have as much time as possible to provide documentation post-enrollment. Churn for avoidable administrative reasons causes needless financial harm for older adults and people with disabilities, as well as for states, and causes gaps in coverage that can lead to negative health outcomes. We recommend providing individuals at least 90 calendar days after notice to provide additional documentation in those states that implement the option to do post-enrollment verification.

Having states automatically initiate the MSP application and accept the SSA data as verified would eliminate two huge barriers to MSP enrollment. Further, MSP applicants are more likely than other Medicaid groups to have fixed incomes like Social Security. By applying for LIS, they already have their incomes verified by SSA, making additional verifications redundant apart from the small differences between LIS and MSP eligibility in states that don't align those categories.

Regarding assets, the proposed rule noted that MSP applicants have great difficulty determining the face value of their life insurance policies given the complexities of the insurance market, and that many life insurance policies were purchased decades before

² 87 Fed. Reg. 54771.

³ 87 Fed. Reg. 54764.

an LIS application was submitted, making it extremely difficult for applicants to track. For this reason, we agree with the proposed rule's claims that state agencies are better equipped to determine the cash value of life insurance policies, and support the proposal to put that responsibility on the state instead of the applicant.

Finally, HHS requests comment on the value of extending these MSP-related policy changes – particularly in the verification of interest and dividend income, but also the rules for burial funds, in-kind support, and life insurance value – across all non-MAGI eligibility groups. There are excellent reasons to mandate these policies across the non-MAGI categories and we strongly support this proposal. First, it avoids unnecessary delays in processing applications by applying more uniform standards across categories. Second, uniform standards reduce potential confusion and duplicative administrative burden for State Medicaid agencies. Third, mandating more uniform standards will increase the number of eligible individuals who are enrolled in Medicaid, which helps fulfill the clear purpose of the Medicaid program – to provide medical assistance to eligible individuals.⁴ Every step we take to make it easier for otherwise eligible people to enroll is a step in the right direction.

For this same reason, we also support HHS's proposal that all MSP applicants also get screened for full Medicaid eligibility across the various MAGI and non-MAGI eligibility categories.⁵ Such screening should be routine. However, if the final regulation does not require states to extend the MSP income and resource counting methods to non-Modified Adjusted Gross Income (MAGI) categories, we are concerned that HHS's efforts to streamline the administrative process could be thwarted unless HHS clarifies that the full Medicaid screen is separate from the MSP enrollment process.

We are concerned that as part of the full Medicaid screen, states with different verification rules for other non-MAGI categories may routinely request additional documentation from MSP applicants and wait to process the MSP application until the applicant provides additional documentation. This would undermine the whole purpose of implementing these proposed changes to boost MSP enrollment by reducing documentation barriers.

In sum, if HHS is not willing to use its authority under § 1902(a)(4) of the Act to require the proposed streamlining of income and asset verification rules and family-size across non-MAGI categories, then at least it should clarify that screening MSP applicants for potential eligibility in other Medicaid categories should in no way impact or delay the processing of their enrollment in an MSP.

⁴ 42 U.S.C. § 1396.

⁵ 87 Fed. Reg. 54766.

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

We strongly support defining “family size involved” for MSP using at least the LIS definition of family size. We urge HHS to go even further and to expand this aligned minimum definition of family size across non-MAGI categories to the extent possible. Maintaining multiple definitions of family size across non-MAGI eligibility categories engenders confusion and frustration for applicants, requires additional documentation, and increases administrative costs for states to process applications and redeterminations.

Moreover, using a broader, more standardized definition of household also strengthens equity. Definitions that limit family size to just a spouse instead of all family members who depend on the applicant’s income create disproportionate burdens for marginalized communities. People facing difficult economic challenges often turn to living in multigenerational households to lower housing costs and to provide more opportunities for informal family supports like child or adult caregiving.⁶ This trend increased during the COVID-19 pandemic, as the share of Americans living in multigenerational households increased from 22% in 2019 to 26% in 2022.⁷ Overall Asian, Latine, and Black families were much more likely to include multiple generations than white families.⁸ Medicaid’s eligibility rules should be sensitive to these cultural and economic realities. Arbitrary and overly restrictive family size definitions in MSP and other non-MAGI categories ignore the financial realities of applicants who cannot afford Medicare premiums or other forms of health insurance.

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

All SSI beneficiaries are eligible for QMB, yet as the NPRM identifies, over 500,000 SSI recipients are not enrolled in QMB due to technical barriers surrounding Part A enrollment.⁹ In a more perfect world, SSI eligibility should automatically confer Medicaid eligibility alongside QMB eligibility for every SSI recipient entitled to Medicare, whether they qualify for premium-free Part A or not. We realize that historical complexities have led to exemptions and state-specific approaches like 209(b) and Part A group payer agreements that introduce extra eligibility steps for low-income individuals and lead to QMB under-enrollment and the poor health and financial consequences it can cause. Where possible, federal policies should always encourage, if not compel, states toward a simpler approach. For this reason, we support HHS’ proposal that would require states to

⁶ Rakesh Kochhar and D’Vera Cohn, Pew Research Center, *Fighting Poverty in a Bad Economy, Americans Move in with Relatives* (Oct. 2011), <https://www.pewresearch.org/social-trends/2011/10/03/fighting-poverty-in-a-bad-economy-americans-move-in-with-relatives/>.

⁷ Stephanie Firestone and Donna Butts, *Changing the Narrative on Multigenerational Living* (June 2021), <https://generations.asaging.org/changing-narrative-multigenerational-living>.

⁸ *Supra* note 6.

⁹ 87 Fed. Reg. 54771.

deem any SSI recipient determined eligible for the mandatory SSI (or 209(b)) Medicaid group also eligible for QMB if they are entitled to premium free Medicare Part A.

While most Medicare beneficiaries qualify for premium-free Medicare Part A and are automatically enrolled, a large number of SSI recipients do not receive premium-free Part A and thus do not benefit from full Medicaid and Medicare benefits, despite being a very high needs group. This also poses challenges to state finances since Medicare would be primary payor for most of their claims, easing states' Medicaid dollars. We support HHS's resolution for the legal catch-22 some SSI recipients face where they would have to pay the first month's Medicare Part A premium before they can qualify for QMB coverage that would pay for those premiums. We agree with HHS's interpretation that this creates a substantial financial hurdle that is wholly inconsistent with the purpose of QMB, and we support the proposal to codify HHS's longstanding practice to provide Federal Financial Participation (FFP) to cover the first month of Part A premiums (and any late fees) in states that have Part A buy-in agreements with HHS.

For the 14 states that use group payer agreements in lieu of a Part A buy-in, HHS's proposed solution is frustratingly limited. SSI recipients with premium Part A in group payer states face significant unnecessary burdens due to the requirement to apply for conditional Part A enrollment through SSA in order to enroll in QMB. Advocates in group payer states report significant confusion and unnecessary delays in coverage due to the conditional enrollment requirement. Requiring an extremely low-income, high needs group like SSI recipients to apply for conditional Part A through a completely separate agency is unrealistic and unfair. Moreover, as stated above, delays in Part A enrollment increase costs to the state because Medicaid covers the full cost of services (with a state match) until the individual is enrolled in Medicare.

Therefore, while we support the agency's proposal to allow states to enroll SSI recipients in QMB without a conditional Part A application, we urge HHS to go further. HHS should require group payer states to deem SSI recipients eligible for QMB without having to undergo the cumbersome conditional enrollment process for Medicare Part A. If HHS does not compel group payer states to take up this deeming process, we ask HHS to provide states with detailed information to highlight how each state could reduce costs by avoiding processing conditional enrollment and by saving state Medicaid match once enrollees are also covered by Medicare. Without outreach, we suspect that some group payer states will not correct this egregious enrollment barrier.

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

CCD strongly supports extending projected share of costs for certain medical expenses to individuals living in the community. Currently, individuals living in institutions can use their projected institutional costs over a budget period to deem themselves eligible through the Medically Needy eligibility pathway from day one. This practical approach avoids frequent churning on and off the program that can complicate access to care for the Medically Needy. However, individuals living outside institutions who have predictable medical costs, like home and community-based services (HCBS) or

prescription medications for chronic conditions, must actually incur those costs before becoming eligible during a budget period. This disrupts their care continuity and can cause payment delays and other issues for their providers. The proposal to allow states to include in projected expenses:

expenses for services that the agency has determined are reasonably constant and predictable, including, but not limited to, services identified in a person-centered service plan developed pursuant to § 441.301(b)(1)(i), § 441.468(a)(1), § 441.540(b)(5), or § 441.725 and expenses for prescription drugs, projected to the end of the budget period at the Medicaid reimbursement rate.¹⁰

Previously, only institutional costs were permitted to be projected. Adding this will help reduce institutional bias in Medicaid. Allowing projected costs of HCBS and other predictable expenses to count for Medicaid eligibility is consistent with the integration mandate under the American with Disabilities Act, Section 504 of the Rehabilitation Act, and *Olmstead v. L.C.*, 527 U.S. 581 (1999).

We appreciate HHS's request for examples of other types of services that individuals may receive on a constant and predictable basis, for which a state could project consistent costs. We believe there are numerous constant and predictable medical costs, such as dialysis, diabetes testing supplies, oxygen therapy, and other medical services (beyond HHS's example of prescription drugs) that meet the definition. We also believe that, in addition to HCBS provided through § 1915 programs, several services that fall under the general umbrella of HCBS provided via state plans should be included in the examples.

First, we recommend including certain behavioral health services that individuals with mental health disabilities receive on a predictable schedule. Many of these services, like those authorized via § 1915(c), (j), (k), and (i), are essential home and community based services that help individuals with serious mental illness remain in the community. Like § 1915(c), (j), (k), and (i) services, which are written into person-centered service plans, these mental health services are often written into treatment plans, require prior authorizations, and are delivered at regular intervals. Thus, like person-centered service plans, these behavioral health services can be projected over a specific budget period.

In addition to those services included in § 1915(c), (j), (k), and (i), we suggest including in the examples the following services that may be provided via stat plan services:

- Outpatient individual and group therapy, including specific therapies authorized by the state, such as trauma-focused therapy;
- Day services and intensive day services; and
- Medication management services, particularly for such services that require frequent medical monitoring or cannot be self-administered.

¹⁰ 87 Fed. Reg. 54842.

The main difference between the above-listed services and the list of services in the proposed rule is not in the character of the services, but rather that they are authorized via the state plan instead of under waivers.

We also recommend including state plan personal care services, authorized via 42 U.S.C. § 1396d(a)(24). The majority of states offer this service, and individuals typically have a set number of hours assigned based on their needs, therefore making the cost of such services predictable and easy to project over the course of a given budget period.

As a general matter, we suggest the list proposed by HHS is overly restrictive because it is defined not by the service provided, but rather by the funding mechanism. For example, an individual may receive 20 hours of personal care services a week. In a state with state plan personal care services, those needs may be covered without a person centered plan developed pursuant to § 1915(c), (j), (k), or (i). In a state without state plan services, those would be covered by a § 1915(c), (j), (k), or (i) waiver and included in a person centered plan. Yet another state may use an 1115 waiver to provide personal care services. Regardless of which authority is used to provide the service, the need for services remains the same and the cost of the 20 hours of services is equally predictable for each individual. Therefore, we encourage an approach that includes examples of specific services that are generally delivered in a manner that facilitates reliable budgetary projection, instead of limiting the list to services provided via specific § 1915 waivers and state plan options.

We recognize the somewhat limited scope of this proposed change to eliminate Medicaid's institutional bias. In many states, people who have to spend down for Medicaid eligibility would have so little income left over that they would not be able to pay for basic living expenses like rent, food, and utilities needed to stay in the community. This pushes them toward institutional care as their only option through the MN pathway, since institutions cover room and board. Alongside its proposal to allow projected expenses for more community-based services, HHS should ask states to revisit and modernize their Medically Needy Income Levels (MNIL) to ensure they leave people with enough income to pay for basic community expenses. The review could recommend policy changes that allow people living in the community to set aside some of their income to pay those non-health expenses while maintaining their Medicaid Needy eligibility.

We also recommend HHS further protect individuals wishing to live in integrated community settings and allow prompt and retroactive coverage for HCBS comparable to how it is provided in institutions. Currently, an individual needing LTSS could immediately be transferred to a nursing home from the hospital even before a plan of care is established, and Medicaid would cover their nursing home costs while the plan of care is being developed. However, if that individual wanted HCBS, Medicaid would not cover services until a plan of care was developed, leaving them without services for weeks if not months. Additionally, Medicaid covers their institutional care up to three

months before their date of application, while HCBS would only be covered prospectively. These delays in the onset of services, and the failure to provide retroactive HCBS coverage further pushes older adults and people with disabilities into nursing homes unnecessarily.

5. Agency Action on Returned Mail (§§ 435.919 and 457.344)

Current Medicaid and CHIP regulations do not specify steps states must take to follow up on mail that is returned as undeliverable, even though returned mail leads to a significant number of eligible people losing coverage. We support provisions in the proposed rule that would require states to take reasonable steps to determine beneficiaries' correct addresses by checking available data sources and making multiple attempts at contacting beneficiaries, through multiple methods, before terminating coverage. The proposed requirements for acting on mail returned with in-state, out-of-state, and no forwarding addresses represent reasonable approaches to ensure eligibility continuity for individuals still eligible for the program.

In addition to new procedures for acting on returned mail, we support HHS's proposal to permit states to accept information received from reliable sources, such as the post office or a managed care contractor, as long as the state does not receive a response from the enrollee that it is incorrect. We encourage HHS to go a step further and instead require states to accept this information, even if the enrollee does not respond to a request to confirm it. Requiring this is warranted given the reliability of the post office's National Change of Address database and enrollee reported/verified information shared by contracted managed care plans.

Finalizing new standards regarding returned mail will help avert coverage losses that are anticipated as the COVID-19 public health emergency comes to an end. People with disabilities have suffered major disruptions in care due to the pandemic. Many have had to move or switch providers due to workforce shortages and COVID safety protocols. Establishing strong and overlapping mechanisms to ensure that the end of the public health emergency does not lead to further disruptions or gaps in coverage for older adults and people with disabilities due to administrative issues like outdated addresses will be critical to limit negative outcomes from the PHE unwinding.

Conclusion

We appreciate that HHS has taken important steps to create a more streamlined eligibility and enrollment system for people covered through non-MAGI eligibility categories. We urge that the final rule go even further, per our recommendations, to make sure eligible individuals can easily get and maintain the coverage they are entitled to, to reduce institutional biases in Medicaid's eligibility system, and to embrace regulations and policies that help improve health equity for marginalized and underserved communities.

If you have questions about these comments, please contact David Machledt, co-chair of CCD's Health Task Force (machledt@healthlaw.org).

Sincerely,

Access Ready

American Association on Health and Disability

American Occupational Therapy Association (AOTA)

American Physical Therapy Association (APTA)

American Therapeutic Recreation Association

The Arc of the United States

Association of University Centers on Disabilities

Autistic Self Advocacy Network

Autistic Women and Nonbinary Network

The Bazelon Center for Mental Health Law

Center for Public Representation

Disability Rights Education and Defense Fund (DREDF)

Epilepsy Foundation

Family Voices

Justice in Aging

Lakeshore Foundation

Muscular Dystrophy Association

National Alliance on Mental Illness

National Association of State Head Injury Administrators

National Disability Institute

National Disability Rights Network (NDRN)

National Down Syndrome Congress

National Health Law Program

Pandemic Patients

United Spinal