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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 (CMS 2421-P)

Dear Secretary Becerra and Administrator Brooks-LaSure:

As advocates for older adults, people with disabilities, and their families, we appreciate the opportunity to comment on this Notice of Proposed Rulemaking (NPRM) focused on "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes."

The National Academy of Elder Law Attorneys (NAELA) is the only professional, non-profit association of attorneys that conditions membership on a commitment to the Aspirational Standards for the Practice of Elder and Special Needs Law Attorneys. Extending beyond the benchmark set by the American Bar Association's Model Rules of Professional Conduct, these standards recognize the need for holistic, person-centered legal services to meet the needs of older adults, people with disabilities, and their caregivers. Supporting the dignity and independence of these vulnerable populations is at the center of what we do.

This letter reflects the subject matter expertise of our members, particularly the Federal Advocacy Committee and Board. NAELA strongly supports the proposed streamlining of eligibility, enrollment, and renewal processes in the regulations proposed in the above-referenced NPRM. We offer comments below on specific elements of these proposals that are focused on older adults and persons with disabilities. Additionally, we outline areas where CMS could take additional action to ensure fairness in eligibility and enrollment processes, and further protect applicants and beneficiaries.

We request that the full text of our comments, along with the full text of the supporting materials cited, be considered part of the formal administrative record for purposes of the Administrative Procedure Act. If CMS is not planning to consider these materials part of the record as we have requested here, we ask that you notify us and provide us an opportunity to submit copies of the studies and articles into the record.

Section A: Facilitating Enrollment

We support finalization of the policies in Section A of the proposed rule, which are focused on facilitating enrollment for beneficiaries who are dually eligible for both Medicare and Medicaid, eligible for Medicare Savings Programs, and eligible through medically needy pathways. These include:

- Facilitate Enrollment Through Medicare Part D Low-Income Subsidy "Leads" Data.
- 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.
- Automatically Enroll Certain SSI Recipients into the Qualified Medicare Beneficiaries Group.
- Facilitate Enrollment by Allowing Medically Needy Individuals to Deduct Prospective Medical Expenses.

In particular, we support the proposal to expand the deduction of prospective expenses for medically needy eligibility. We fully agree with CMS that this policy would make it easier for some low-income people with catastrophic medical costs to enroll and stay enrolled. We urge CMS to finalize this policy and include in the regulatory text as specific examples the following predictable expenses:

- Medications
- Direct therapies, therapy consults (physical, occupational, speech, respiratory, etc.)
- Personal care attendants
- Adult foster care
- Nursing, home health aides
- Day programs
- Transportation
- Job coaching
- Medical food and supplies (G-tube formula, Pedialyte, TPN, syringes, feeding pump, etc.)
- Treatments (oxygen, c-pap, bi-papa, suction)
- Rental of medical equipment (wheelchairs, standers, suction, oxygen, infusion, seating - other, etc.)

We also urge CMS to provide states the flexibility to allow additional predictable expenses, beyond those specified in text.

In addition to our own comment on Section A of the proposed rule, we refer you to the comments submitted by our colleagues at Justice in Aging. We thank them for their thoughtful work in responding to these proposals and would like to align ourselves with their comments.[1]

Section B: Promoting Enrollment and Retention of Eligible Individuals

We are generally supportive of the policies outlined in Section B of the proposed rule, which include a wide range of improvements in enrollment, renewal and redetermination procedures for individuals eligible for non-modified adjusted gross income (MAGI) Medicaid (including Aged Blind and Disabled Medicaid). In our view, current program rules place too much emphasis on ensuring that ineligible individuals do not enroll or remain enrolled, and too little on ensuring that eligible individuals *are* able to enroll and remain enrolled. The provisions of the proposed rule take important steps to balance those interests.

1. Aligning Non-MAGI Enrollment and Renewal Requirements with MAGI Policies (§§ 435.907 and 435.916)

The ACA and implementing regulations streamlined eligibility determinations and renewals for people whose eligibility is determined using MAGI rules. By comparison, eligibility determinations and renewals for people who are over age 65 or who are blind or have a disability (i.e., the non-MAGI groups) in many states continue to be done in a manner that is unnecessarily burdensome for applicants and enrollees, as well as for state eligibility workers. The failure to streamline eligibility rules for non-MAGI groups has resulted in higher rates of procedural denials, even though older adults and people with disabilities are more likely to have stable incomes.

Therefore, we strongly support CMS's proposed changes to promote equity across all enrolled people by eliminating barriers to application, enrollment, and renewal for the non-MAGI groups. These include:

- Conduct renewals no more than once every 12 months (with limited exception);
- Use prepopulated renewal forms;
- Provide a minimum 90-day reconsideration period after termination for failure to return information needed to redetermine eligibility;
- Eliminate required in-person interviews; and
- Limit requests for information on a change in circumstances to information on the change.

These provisions, when deployed for MAGI populations, have all proven possible to implement and effective at reducing churn on and off Medicaid, and should be extended to non-MAGI groups.[2]

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[1] Comments submitted by Justice in Aging on Streamlining Eligibility & Enrollment Notice of Propose Rulemaking.
[2] See "Eligibility, Enrollment, and Renewal: Case Study Findings," Medicaid and CHIP Payment and Access Commission (MACPAC). https://www.macpac.gov/wp-content/uploads/2018/11/Eligibility-Enrollment-and-Renewal-Case-Study-Findings.pdf. See also "An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP," MACPAC. https://www.macpac.gov/wp-content/uploads/2021/10/An-Updated-Look-at-Rates-of-Churn-and-Continuous-Coverage-in-Medicaid-and-CHIP.pdf.

2. Acting on Changes in Circumstances Timeframes and Protections (§§ 435.916, 435.919, and 457.344)
We strongly support changes that CMS is proposing to current regulations on changes in circumstances; the changes should be finalized to help reduce coverage losses for procedural reasons. In particular, we support the proposed requirement that agencies may not take adverse action if an enrollee doesn't respond to a request for information to verify a change reported by either the individual or a reliable third party that would qualify the enrollee for more favorable coverage. Enrollees' lives are often complicated, and they may not receive the request for additional information or be able to gather the appropriate documents in a timely manner (discussed further below). Defaulting to keep someone enrolled, especially when there is no evidence of ineligibility, is most beneficial for continuity of coverage and this must be preserved in the case of any adverse actions.

Additionally, rather than give states flexibility to either act on reliable third-party information that could result in an increase to the amount of coverage or assistance to which a beneficiary is entitled, or to contact the beneficiary to determine whether the information received is accurate, we recommend *requiring* action on such information from a reliable source as that would be in the best interest of beneficiaries.

As noted above, we also support the proposed changes to require states to accept reports of changes in circumstances through all modalities listed in § 435.907(a), a 30-day period to verify changes in circumstances, a new 90-day reconsideration period for individuals who are terminated for failure to return requests for information about changes in circumstances, and clarifications about when the agency may and may not rely on third-party sources of information reporting changes in circumstances. All of these proposed changes appropriately balance CMS's dual interests in assuring that individuals who are ineligible for Medicaid do not remain enrolled in coverage for which they are not eligible and in retaining coverage for individuals who continue to be eligible.

3. Timely Determination and Redetermination of Eligibility (§§ 435.907 and 435.912)
As CMS notes, there is currently no guidance providing clear and consistent timeframes for applicants and beneficiaries to return information needed to determine eligibility, or for states to process and act upon information received. This leads to unnecessary delays in processing applications and renewals, some individuals being denied services for which they are eligible, and some ineligible individuals retaining coverage.

We support proposed changes to §§ 435.907 and 435.912, which are intended to ensure that applicants and enrollees have adequate time to furnish all requested information and that states complete initial determinations and redeterminations of eligibility within a reasonable timeframe at application, at regular renewals, and following changes in circumstances. However, there are several areas where we urge CMS to take further action to protect applicants and beneficiaries.

Extend the Minimum Length of Time to Provide Additional Information
Proposed § 435.907(d)(1)(i)(B) would require the agency to provide most applicants with at least 15 calendar days (30 days for applicants whose eligibility is being determined on the basis of disability), from the date the request is postmarked, or the electronic request is sent, to respond with the additional information. In the proposed role, CMS notes that it is also considering a minimum of 30 calendar days for all applicants – an approach we urge CMS to take. As detailed further below, we believe that a longer timeframe of 30 days is necessary to ensure that applicants have adequate time to gather any information or documentation needed by the state to complete the determination.

People who are eligible for Medicaid are frequently denied eligibility due to procedural deadlines and requirements that are difficult, if not impossible, to meet. These issues are well-documented and are of particular concern as states prepare to resume eligibility redeterminations following the end of the COVID-19 public health emergency (PHE).[3]

There are numerous challenges to meeting short deadlines. We often see letters from state Medicaid agencies stating response deadlines with postmarks later than the deadlines. States note the issue date of such letters, but not the postmark, leaving no record of delayed mail. These issues can be exacerbated by delays and capacity challenges at the U.S. Postal Service.

Finally, it is important to note that requests for information for anyone seeking an institutional level of care can be voluminous in nature due to the five-year look-back period. Requests for information are not just for specific statements or financial records, they are often for specific check copies, documentation and explanations for transactions, transfers, and withdrawals. These requests are typically being made from the personal representatives of applicants with significant disabilities rather than the applicants themselves, whether they are over or under 65, adding another layer of difficulty.

Timeliness Standards
The requirement for state Medicaid agencies to determine eligibility within 45 days (or 90 days for applicants whose eligibility is being considered on the basis of disability) is intended to ensure that eligibility determinations are completed in a timely manner, and applicants are not left in limbo. While we can understand why CMS is considering providing states with additional time to process eligibility alongside the proposed policy to provide beneficiaries more time to return information, we urge CMS not to do so.

[3] See "Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic," HHS Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//199881/medicaid-churning-ib.pdf. See also "Comment on CG Docket No. 02-278 Relating to Enrollment in Medicaid and Other Governmental Health Coverage Programs," MACPAC. https://www.macpac.gov/wp-content/uploads/2022/05/Comment-Letter-Re-CG-Docket-No-02-278-Relating-to-Enrollment-in-Medicaid.pdf. Finally, see "States Can Reduce Medicaid's Administrative Burdens to Advance Health and Racial Equity," Center on Budget and Policy Priorities/Center for Law and Social Policy. https://www.cbpp.org/sites/default/files/7-19-22health.pdf.

Many states regularly exceed their allotted time for application processing. According to CMS's own data, even for MAGI applications, which are generally much more simple than non-MAGI applications, as many as 11% of applications are processed in over 45 days.[4] In our experience, applications for those in aged or disabled eligibility groups take even longer. Providing states with more time could needlessly further delay eligibility determinations and would not be in the best interests of beneficiaries.

At the same time, other states use these timeliness requirements as a sword to prevent eligibility all together. In our experience, states sometimes use short determination timeframes as justification to impose short deadlines for beneficiaries to respond to requests for additional information, and in turn, to deny eligibility if those deadlines are not met.

To create a fair and reasonable balance between the need to ensure eligibility is determined in a timely and accurate manner, while also ensuring that applicants cannot be denied solely because eligibility could not be determined prior to the 45- or 90-day deadline, we strongly support CMS's proposal at § 435.907(d)(1)(iii)(A) to create a reconsideration period. Under this policy, for an individual who has been determined ineligible for failure to submit additional requested information, who subsequently submits the requested information within 30 calendar days of the date the notice of ineligibility is sent (or a longer period established by the State), the State must reconsider the individual's eligibility without requiring the individual to complete and submit a new, full application.

We urge CMS to finalize this proposal but lengthen the reconsideration period for initial applications to 90 days to align with the 90-day period proposed at redetermination. We further urge CMS to finalize its proposal to determine the effective date of coverage in accordance with the date upon which the application was submitted.

4. 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 modalities, 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 that individuals who are likely eligible remain so and that individuals who have moved out of state do not remain enrolled.

In addition to new procedures for acting on returned mail, we support CMS's proposal to permit states to accept information it receives 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

[4] CMS: Medicaid MAGI and CHIP Application Processing Times. https://www.medicaid.gov/state-overviews/scorecard/medicaid-magi-and-chip-application-processing-times/index.html.

that it is incorrect. We encourage CMS to go a step further and change its proposal to 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 U.S. Postal Service's National Change of Address database and enrollee reported/verified information shared by contracted managed care plans.

Finally, we urge CMS to extend these requirements to initial applicants for coverage, to the extent practicable. For example, a state that is requesting additional information from an applicant should follow the steps outlined in the proposal if that request is met with returned mail, including checking third-party data sources available to the agency, and conducting outreach using two other modalities (e.g., electronic notice, phone or text message).

Finalizing new standards regarding returned mail will help avert coverage losses that are anticipated as the COVID-19 PHE comes to an end and will further ensure that eligible individuals can enroll in coverage.

Additional Opportunities for CMS to Improve Fairness of Information Requests

While not discussed in the proposed rule, we also urge CMS to consider additional steps to ensure that information requests are fair and considered appropriately.

First, CMS should consider providing guidance around reasonable standards for information provision during the five-year lookback period. While the proposed rule would expand the extent to which beneficiaries can self-attest to income and resources, there are no similar rules for self-attestation of information gathered from the five-year lookback period. Federal rules do not provide a standard of proof, and we have found that states often use this against applicants, denying applications due to the failure to meet a sometimes-arbitrary standard of proof. Denials for failure to provide information that do not meet a certain – or worse, unclear – standard of proof are devastating to applicants and their families.

Second, CMS should consider regulatory changes that address problematic requests for information that the applicant is unable to obtain. Such requests present numerous difficulties and unfair hurdles for applicants. For example, in requesting information on cash values for life insurance policies, states will often ask for multiple monthly values to ascertain small differences in cash values. Applicants and their representatives have extreme difficulty interacting with the insurance company for those requests. It can be similarly difficult to obtain historical valuation figures for savings bonds. Further, certain banks outright refuse to give historical bank statements, even for exorbitant fees, without a subpoena. CMS should consider putting parameters around the extent to which states can hold up or deny an eligibility determination for applicants who have made a good-faith effort to obtain this information.

Implementation and Compliance Dates

Subject to our comments above, we support finalizing the Proposed Rule as proposed, with compliance dates as soon as is practicable. As the COVID-19 Medicaid continuous coverage requirement comes to an end, these are particularly important changes that could help reduce coverage losses as states begin acting on eligibility redeterminations for millions of people.

Therefore, CMS should consider the complexity of system updates when setting implementation dates and balance state workload with the overall benefit of implementing changes. Phasing compliance dates is a reasonable approach should states need additional time to come into compliance, so long as states begin system updates upon finalization of the rule.

Conclusion

We thank CMS for its commitment to ensuring that eligible individuals are able to enroll in and retain eligibility in Medicaid, and for its thoughtful consideration of the important issues discussed in the proposed rule. NAELA stands firmly in support of these proposed policies, and all additional efforts to remove barriers and facilitate enrollment.

We appreciate this and future opportunities to work with HHS and CMS. In addition to our written comments to your RFI, shared below, we welcome the opportunity to engage with you on our policy suggestions and priorities moving forward. If you have any questions or would like to set up a discussion, please reach out to Michael Knaapen, NAELA's Director of Public Policy and Alliance Development, at MKnaapen@naela.org.

Sincerely,

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