

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

November 7, 2022

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Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2421-P
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Submitted electronically via [regulations.gov](https://www.regulations.gov)

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

Justice in Aging appreciates the opportunity to provide comments on the above-referenced Notice of Proposed Rulemaking (NPRM).

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income enrollees and populations that have been marginalized and excluded from justice such as women, people of color, people with disabilities, LGBTQ individuals, and people with limited English proficiency.

Justice in Aging strongly supports the changes proposed in this rulemaking. Taken together, they will substantially improve access to Medicaid benefits for those who need them most. The work of streamlining procedures is highly technical but hugely important and we appreciate that CMS has taken on these important tasks.

Our comments will focus on those aspects of the rulemaking that most directly impact low income older adults.

A. Facilitating Medicaid Enrollment

1. Facilitate Enrollment Through Medicare Part D Low-Income Subsidy “Leads” Data.

Justice in Aging strongly supports the proposed regulations setting specific standards for use of leads data. We believe that the need for more vigorous regulatory oversight of states’ compliance with their obligations under the Medicare Improvements for Patients and Providers Act (MIPPA) is urgent. The proposed regulations are well within CMS’s mandate and, in fact, CMS has an affirmative obligation to increase its oversight in light of over a decade of partial to total noncompliance by many states.

As discussed in the NPRM at p. 54,763, over one million LIS recipients are not enrolled in Medicare Savings Programs (MSPs) despite the vast majority of those individuals qualifying for MSP coverage.

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Moreover, as CMS has [documented](#), the percentage of individuals who receive LIS but are not enrolled in an MSP varies widely among states, from a low of 2% to a high of over 24%. Setting very specific requirements will give states clarity about their obligations and will bring more uniformity among states in handling applications, an important step in erasing the inequities among state residents.

With MSPs, states are acting primarily as administrators of a premium support program for the federal Medicare benefit. Because MSPs are not like other Medicaid programs that provide access to Medicaid services, local conditions and other factors that account for variability in other state Medicaid programs simply are not applicable. Thus, there is no good policy justification for the fact that, for example, residents of New Jersey, Wyoming and Virginia have significantly less access to MSPs than those living in Colorado, Florida and Oregon. Yet that is the situation today and variability in the handling of leads data is a significant factor contributing to these statistics.

Compliance date: We strongly agree with CMS that, with respect to regulations implementing current statutory requirements for state use of Low-Income Subsidy (LIS) leads data, CMS has an obligation to make both the effective date and deadline for compliance 30 from publication of the final rule. Pursuant to MIPPA, states have had an obligation since 2010 to treat applications for LIS as MSP applications. Twelve years later, many states still have not fully complied with those requirements, despite repeated guidance, technical assistance, and admonitions by CMS. That guidance began with a [State Medicaid Director Letter in February 2010](#) and continued through an [Informational Bulletin](#) in 2021.

We expect that some states will continue to assert that they need more time to modify data sharing systems and state procedures and that they do not have the resources to move quickly. CMS, however, cannot allow delays of over a decade to continue further. State Medicaid programs must not be permitted to continue to burden low income individuals who qualify for and urgently need assistance with their Medicare costs by failing to meet statutory requirements. If states cannot timely implement permanent adjustments to their data systems, then they need to develop temporary workarounds in the meantime. But one way or the other, the time has come for compliance with the clear mandates of the statute. State delays and partial measures must end. And CMS must use its compliance authority to ensure that enrollment procedures mandated by MIPPA are fully available to beneficiaries in all states.

Compliance Authority: The persistent noncompliance of states with their obligations under MIPPA raises a broader issue that goes beyond this single regulation. CMS has both the authority and the obligation to ensure that states provide Medicaid benefits in a manner that is consistent with statutory and regulatory requirements so that eligible individuals receive the benefits to which they are entitled and that their access is timely. We appreciate that CMS always offers technical support to states to achieve compliance and works with states to overcome obstacles to meeting program requirements. However, it is our experience that in situations—whether related to timeliness, procedural deficiencies, or quality oversight—where there is persistent noncompliance, CMS has rarely exercised its authority to impose sanctions. Nor has CMS clearly communicated to states and to other stakeholders which levers it would use in which situations. We recognize the importance of not imposing sanctions that would further disadvantage beneficiaries already negatively affected by state action or inaction. This fact, however, is all the more reason for CMS to be more specific and transparent (and, where needed, more muscular) in its approaches to state noncompliance across the board.

Legal Authority for MSP regulations: We agree with CMS that its regulations with respect to states' use of leads data fall squarely within the agency's authority under Section 1902(a)(4). Further, given the failure of many states to conform to the clear mandate of the statute, CMS not only has the authority, but also has an affirmative obligation to exercise stronger oversight and ensure state compliance with MIPPA dictates.

The primary requirements of the proposed regulations closely track the statute. They do not impose new obligations on states. Moreover, CMS has repeatedly reminded states of these requirements and, very specifically in November 2021, told states that they must come into compliance.

In this regard, we note further that Section 1602(a)(8) of the Act requires that a state plan must "provide that all individuals wishing to make application for aid or assistance under the plan shall have opportunity to do so, and that such aid or assistance shall be furnished with reasonable promptness to all eligible individuals." States are not complying with that requirement when their failure to properly process an application interferes with the opportunities of eligible individuals to apply for MSPs using the mechanism dictated in the MIPPA statute.

The rest of the proposed regulations that do not simply repeat the requirements of the statutes clearly address efficient operation of the program and are well within Section 1902(a)(4). As discussed in the NPRM at p. 54,764, CMS has gathered information indicating that procedural barriers are a significant factor causing under-enrollment in MSPs. Moreover, the proposed streamlining methodologies, once introduced, will reduce administrative burdens on states, rather than impose greater obligations. In addition, CMS has emphasized to states that they have the option of fully conforming their MSP requirements with LIS so that they could automatically determine eligibility, thus greatly reducing administrative burden. Fully aligning MSP and LIS requirements would lead to less paperwork for both the state and individuals, faster MSP enrollment and receipt of benefits and protections, and increased capacity for states to administer other Medicaid programs.

Importantly, the streamlining and simplification in this set of regulations are a matter of equity, not just efficiency. Collecting paper records is an unpleasant and difficult task for anyone. But for low income individuals, who disproportionately have unstable housing, low literacy, limited access to and proficiency in internet usage, limited proficiency in English, and who live with disabilities and chronic conditions, it can be overwhelming. This group may also rely on other public assistance programs and are continuously and frequently asked to collect and file paper records and complete lengthy applications to prove and reprove eligibility. The result is that they are too often denied access to benefits for which they qualify because they cannot manage the paperwork. Yet these life circumstances that make meeting documentation requirements so difficult are the very reasons that they are most in need of the benefits they are seeking.

In the experience of direct service organizations serving low-income individuals, it is not uncommon for eligible Medicare enrollees to struggle for weeks if not months in gathering documentation of income and assets that could be easily verified electronically through third-party sources. We are told, for example, that some programs routinely require applicants to get a letter from SSA verifying their monthly benefit amount. Without the assistance of an advocate, many applicants do not even understand let alone manage to comply with the requirements at all.

The procedures and policies that create these unnecessary struggles directly interfere with the purposes of the Medicaid program. They cause serious harm to individuals who are qualified to receive Medicaid benefits but whose access is denied, delayed or discontinued because of state procedures that have nothing to do with their underlying eligibility. For CMS to adopt measures to correct this harm, documented by CMS in the NPRM and observed daily by advocates working with low income individuals in need of Medicaid coverage, is squarely within the agency’s authority—and mandate—under Section 1902(a)(4) to establish rules that are “necessary for the proper and efficient operation” of the state’s Medicaid program.

Accepting LIS leads data as an MSP application. We strongly support these regulations as proposed. Although the statutory requirements of MIPPA are clear in themselves, many states have not complied. Reiterating the statutory requirements in regulations and spelling out in detail how states must implement those requirements provide CMS with an additional basis for ensuring that states finally comply. We appreciate that CMS has provided extensive technical assistance to states in the handling of leads data and encourage the agency to continue to do so. Along with assistance, however, it is time for CMS also to enforce the statute. As noted in the NPRM, millions of individuals who qualify for MSPs are not enrolled, even though both eligibility and administration of MSPs are easier than many other more complex Medicaid programs, particularly if states adopt the flexibilities that CMS has been encouraging in its prior guidance as well as in the NPRM.

Screening for all Medicaid eligibility. We support the requirement that states screen applicants coming through leads data for all Medicaid eligibility categories. This is particularly important for the most marginalized low-income older adults and persons with disabilities who may not be able to separately navigate the Medicaid process. A “no wrong door” approach streamlines and accelerates review of program eligibility, and thus improves the process both for beneficiaries and for state agencies. Further, without this requirement, individuals who apply through the MIPPA leads process are disadvantaged compared to those who apply for Medicaid on the basis of MAGI. Under current regulations, individuals using the MAGI route must be screened for other programs, including all non-MAGI Medicaid. Without a similar requirement for older adults and persons with disabilities who apply using the MIPPA process, the MIPPA process becomes in fact a “wrong door,” resulting in discriminatory impact on those individuals.

We ask CMS, however, to carefully work with states to develop procedures that do not cancel out the simplification of the beneficiary experience that conformance with the MIPPA process should produce. While we do not urge any procedure that would substantially delay review of eligibility for other Medicaid programs, we recognize the difficulties in structuring a communication that, besides asking questions on the relatively few items for MSP eligibility that have not already been verified by SSA, also asks every question needed to screen for every Medicaid program.¹ An important objective of the MIPPA leads process is to avoid intimidating or overwhelming the beneficiary with information requests. We ask that CMS work with states to test different approaches with consumers and develop best practices that minimize beneficiary burden and optimize beneficiary response to mailings or other

¹ We are concerned that such a screening questionnaire could not only overwhelm applicants because of its length, but also confuse them about program parameters. For example, state disclosures about estate recovery in a consolidated mailing could lead individuals to believe estate recovery provisions apply to MSPs, making them fearful of moving forward with their MSP application.

outreach. In light of the variations in state Medicaid programs, we expect that a single model communication procedure would be inappropriate, so ask instead that CMS allow states to use different approaches, but make such approaches subject to CMS review to ensure that they are consistent with both the streamlining policies in these regulations and the need to ensure review for all Medicaid eligibility categories.

We also ask that CMS clarify that SSA leads data received through the MIPPA process must also be accepted as verified when a state, in accordance with its obligations under proposed Section 435.911(e)(6), is reviewing the same applicant for other Medicaid programs. Thus, the individual should not simply be sent a blank application for other non-MAGI Medicaid programs but instead should only be asked for information the state has not already received from SSA.

Streamlining Methodologies. Justice in Aging strongly supports the proposal of CMS to require streamlining of income and asset review processes. Over many years, advocates have reported that procedural hurdles, particularly with asset verification, are among the primary reasons that their eligible clients fail to complete enrollment. Further, even if they eventually manage to enroll, the delays in starting benefits have significant economic and health care consequences for low-income beneficiaries.

We support the approach of allowing an individual to attest to income, including dividend income, with an opportunity for the state to verify later if warranted. We believe this makes particular sense since SSA has already verified most of the underlying assets that, if they exist, would be generating the interest and dividend income to which the applicant would attest. Thus, states would have a good idea of whether the attestation accurately reflects the likely income from those investments. Allowing attestation for non-liquid resources prevents unnecessary delays because of difficulties in obtaining documentation.

The procedures proposed in the NPRM would be a welcome antidote to issues advocates see on the ground. For example, Medicaid agencies sometimes request verification of non-liquid resources or dividend income, but provide few details of the source or financial institution related to the item of concern. Individuals are left to guess the specific income or non-liquid resources the agency is referring to. Further, as the NPRM notes, dividend amounts often are inconsequential. Advocates have reported instances where, for example, an individual was required to provide dividend verification based a report from the IRS of a total annual dividend of under \$5.00 on a single share of stock of a former employer worth less than \$50. The agency required documentation verifying both the value of the asset and the amount of the dividend. The process of clarifying the source of the dividend at issue and then obtaining documentation of the share, its current value, and the dividend payment history for the last year took several months, even with the assistance of an advocate, delaying significantly completion of the application and receipt of benefits.

The most difficult documentation for applicants to acquire, as the NPRM notes, is evidence proving the face value and current cash value (if any) of life insurance. Getting a precise calculation requires the cooperation of the insurer, and a requesting individual cannot control the timing of a report. Advocates report that obtaining a letter from the insurer providing cash value takes weeks, and often longer. Further, over the last few decades of insurance industry consolidation, many insurers have closed their businesses or merged or transferred portions of their insurance portfolios to other companies. Since life

insurance policies often were purchased decades ago, just finding the trail to the current insurer can itself be an arduous pursuit. Advocates report that the process of identifying the current insurer alone can typically require hours on the phone, much of that time on hold. Many individuals simply give up due to the herculean effort and meticulous records an individual must keep to track down the holder of this documentation.

We strongly agree with CMS that, if a state believes it needs documentation of the cash value of a life insurance policy, the state is much better equipped to efficiently obtain the information. Placing that entire burden on the applicant is onerous and creates an unfair obstacle to access to a needed benefit. Administratively, because this is a very targeted regulation and only applicable to those beneficiaries with particular types of life insurance, the burden on the state will be limited.

The NPRM asks for comments with respect to possibly extending these streamlined methodologies to other information besides the specific items in the proposal. We encourage CMS to do so. One area to consider is documentation for segregation of burial funds. As noted above, the simplest approach to this requirement would be for a state to harmonize its rules with LIS and not require that funds be in a separate account. We ask that CMS require, rather than request, such harmonization.

If, however, the agency believes it does not have authority to make that requirement, we ask that CMS at least require states to add flexibilities for applicants when an applicant has not established a segregated burial funds account at the time of application. Specifically, the state should be required to accept an attestation by the applicant that the applicant will open a segregated account. Further, the state would have the option of requiring that, within 90 days of the attestation, the applicant provide proof that the segregated account has been opened.

Many individuals new to Medicaid do not anticipate the technical and relatively obscure requirement for a separate account. Further, low-income individuals are disproportionately “unbanked” and those who do have accounts are unlikely to have independently decided to segregate funds, particularly if a separate account could incur additional charges. Though still significantly more cumbersome than fully aligning burial funds rules with LIS, the proposed procedure would offer a measure of relief so that the application process is not delayed. We also note that \$1,500 is a set amount that does not increase with inflation and does not begin to cover the cost of even the most modest of funerals. Requiring low-income individuals to jump through any procedural hoops just to document that they wish to set aside even this small amount strikes us as inconsistent with broader agency goals. In many contexts, CMS rightly assesses policies by including consideration of how the policies support—or deny—the dignity of the individuals who rely on Medicare or Medicaid benefits.² It is important for the agency to look at application and redetermination procedures, including this one, through the same lens.

We also ask that CMS require states to apply streamlining requirements to all non-MAGI applications, not just those for MSPs. If a state accepts self-attestation for MSPs but does not do so when screening for other Medicaid program eligibility, the result is confusion for the individual and extreme administrative complexity for the state. Advocates report that individuals face the same difficulties in

² See, e.g., [CMS Announces New Federal Funding for 33 States to Support Transitioning Individuals from Nursing Homes to the Community | CMS](#), and [CMS Encourages States to Use Medicaid Payments to Nursing Homes to Drive Better Health Outcomes for Residents, Improve Staffing | CMS](#).

collecting data on dividends, interest, cash value of life insurance and the rest when applying for other non-MAGI programs as they do for MSPs. Particularly for ABD Medicaid, the need to streamline procedures is just as acute.

Finally, the NPRM asks the broader question of whether the shift in burden from the beneficiary to the states in the proposed streamlining of methodologies is appropriate. Our answer is that, yes, it most certainly is appropriate. As CMS data show, current procedures are not mere nuisances; they are serious impediments to enrollment for people who, by income and assets, qualify for programs that they need. These are people who, as CMS has documented in the NPRM and elsewhere, disproportionately have lower health literacy, are more likely to have limited proficiency in English, and are more likely to have multiple chronic conditions than other Medicare enrollees. To lift some documentation burdens from these struggling individuals, many of whom are easily overwhelmed by paperwork, and transfer responsibility to state programs, staffed with trained professionals with technical resources and access to broad databases is not only appropriate, it is sensible, equitable, and promotes the purposes of the Medicaid program. We also are confident that, once implemented, the changes proposed in the regulations will not, in fact, add a burden to states but will instead lighten their administrative load.

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

Justice in Aging supports the proposed regulation. The leeway that CMS has given states in setting their own definition has created difficulties and uncertainty, and has engendered lawsuits. States would benefit from a clear and uniform definition. We also note that in [2009 Guidance to States on the Low-Income Subsidy](#) at 30.6, CMS has provided additional guidance that “related to” includes, besides the spouse, “[a]ny persons who are related by blood, marriage, or adoption, who are living with the applicant and spouse and who are dependent on the applicant or spouse for at least one half of their financial support.” We ask that CMS consider including this more specific definition in either the final new regulation or in guidance to the states or, at least, in commentary to the final regulation.

Harmonizing the definition with the LIS definition will limit the administrative burden on states and on beneficiaries applying for MSPs. More importantly, the broader LIS definition recognizes the complex realities families face as they live with and care for each other. It also fosters other policy goals such as making it easier for individuals to remain in the community—often with family members—as they age, and thereby avoid unnecessary institutional placement.

Moreover, the proposed change recognizes that older adults assume a critical role in supporting and caring for not only grandchildren, but nieces and nephews, adult children with disabilities and, increasingly, their own older parents. The number of grandparents taking on the role of raising and supporting grandchildren and other young family members has been on the rise for many years as a result of the drug epidemic sweeping many of our communities.³ The COVID-19 pandemic, in which

³ In 2015, 29 million children were living with grandparents who were responsible for their care. Thirty-nine percent of grandparents caring for grandchildren are over 60 and 26 percent have a disability. [How drug addiction led to more grandparents raising grandchildren | PBS NewsHour](#). See also [23 Statistics on Grandparents Raising Grandchildren – Father Matters](#).

more than 140,000 children, disproportionately children of color, lost a caregiver, has created an additional need for older adults to assume care responsibilities for family members.⁴

Particularly in communities of color, the tradition—and necessity—of diverse intergenerational households is widespread. In Latino populations, 30% live in multigenerational households with 26% of Asian households being multigenerational.⁵ Additionally, multigenerational households frequently struggle financially. A survey of “grandfamilies” nationwide revealed that 38% percent are unable to pay, or are worried about paying, their mortgage or rent.⁶ Program eligibility requirements should be supporting rather than penalizing multigenerational caregiving arrangements so as to strengthen our families and communities.

We also appreciate that CMS explicitly allows states to create broader definitions of “family” for purposes of MSP income eligibility. It is not uncommon for individuals to live together as a family for decades despite one or more of them not being related by blood or by any formal, legal relationship to the others. Cultural norms in different communities also may define kinship and family differently. Giving states the flexibility to expand the definition allows them to respond to the particular circumstances and family patterns in their state.

In addition, we urge CMS to consider applying the LIS definition of family size to all non-MAGI Medicaid programs, not just MSPs. As just discussed, the LIS definition more realistically reflects the realities of American families and supports low-income households. Having a single definition also removes complexity for both states and individuals. For dually eligible older adults with MSPs, having different definitions of family size is particularly problematic and complex. The majority of QMBs, for example, are also eligible for full-scope ABD Medicaid. Using different family size definitions both for initial determinations and for renewals is confusing and highly burdensome for individuals and unnecessarily taxes state systems as well.

Finally, in addition to the definition that is the subject of this proposed rule, we ask CMS to review and clarify in regulation the steps that states must take in applying the definition to MSP applicants. Our specific concern is the [process](#) adopted by New Mexico’s MSP program that first evaluates the individual’s income alone.⁷ If that income is above the limit for MSP consideration, the application is denied and spousal income is not even considered. Only if the individual’s income is below MSP limits is spousal income reviewed. This backward interpretation of the statute means that, in all cases, income of the family, which New Mexico limits to the spouse, is only used to deny coverage and never to award

⁴ [NIH, More than 140,000 U.S. children lost a primary or secondary caregiver due to the COVID-19 pandemic \(Oct. 2021\).](#)

⁵ Around 30% of Latino households, 30% of non-white households, 26% of Asian households, and 24% of Black households identified as multigenerational. [Map: COVID put America’s multigenerational homes at higher risk | The Center for Public Integrity.](#)

⁶ [Grandfamilies and COVID-19: Families of Unique Origins Face Unique Challenges](#) | Robert J. Wood Johnson Foundation, October 21, 2021.

⁷ New Mexico Intradepartmental Memorandum MAD-GI: 18-02, Clarification of Medicare Savings Programs (MSP) Calculations When the Applicant/Recipient Lives with an Ineligible Spouse (Feb. 26, 2018), available at <https://www.hsd.state.nm.us/wp-content/uploads/files/Looking%20For%20Information/General%20Information/Procedures/MAD%20-%20GIs/GI-18-02-for-MSP-Calculation.pdf>.

benefits. We do not know whether any other states are currently using this methodology, which is contrary to the plain requirements of the statute, but we ask CMS to address this issue with a clear directive to all states so that the benefits of the family size definition are not swallowed up by procedural sidesteps.

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

Justice in Aging strongly endorses the much-needed improvements in the proposed regulations to automatically enroll SSI recipients into the QMB program. SSI recipients are the lowest income and highest need portion of low-income older adults and among those least able to navigate enrollment issues, a fact recognized by the special statutory provisions governing their enrollment in Medicaid. It is particularly noteworthy that, as the NPRM observes, only one-third of SSI recipients are entitled to premium-free Part A. Without enrollment in the Qualified Medicare Beneficiary (QMB) program, many SSI recipients have no opportunity to fully participate in the Medicare program and its benefits.

When thinking about streamlining for SSI beneficiaries, it is important to never lose sight of exactly how disadvantaged many SSI-eligible individuals are. For example, one advocate told us about a Black transgender client who had been receiving SSI benefits all of her adult life because physical abuse she suffered as a child left her cognitively unable to learn to read. She relied on her benefits, but life experiences made her distrustful and fearful every time she received a notice about them. She frequently misinterpreted notices (relying on friends to read them to her), including particularly the notices she received from Medicare and the state Medicaid program about the start of her Medicare coverage when she turned 65. Explaining the notices to her and assuaging her fears, and then convincing her to separately apply for QMB and shepherding her through the process took months and a great deal of one-on-one assistance. While her particular facts may be unique, the combination of trauma, overlapping marginalized identities, and physical or cognitive or behavioral disabilities is common and often compounded further by housing instability. With all these challenges, any procedural barriers put in the way of SSI-eligible individuals have an outsized impact on their ability to access the benefits that they so clearly both need and qualify for.

SSI Recipients Who Have Premium-Free Medicare Part A

In our view, requiring 1634 states and Criteria states to enroll SSI recipients who have premium-free Part A in QMB simply puts into regulation a process that should have been happening all along. Since states have little cost and their SSI enrollees have much to gain from QMB enrollment, we believe that the state requirements for SSI individuals to apply separately for the QMB program often have developed out of administrative convenience rather than as a result on any policy choices.

In California, for example, automatic mandatory SSI-linked enrollment in Medicaid comes through centralized systems, bypassing county offices that hold the files for Medicaid enrollees and handle MSP enrollments. As a result, we have seen a large number of SSI individuals not automatically enrolled in QMB even though the state's policy is to enroll eligible individuals in all programs for which they qualify.

While state system failures or complexity may be the reason for the failure to enroll SSI individuals in QMB, they should not be an excuse. Nothing in the statutory requirement to enroll SSI individuals in Medicaid allows states to exempt QMB enrollment from that mandate. It is only reasonable that the

statutory intent was to enroll SSI individual in all Medicaid programs for which they qualify. Individuals who qualify for SSI are the lowest income individuals of all Medicaid groups, and for those age 65 and older, are more likely to be women, people of color, and have lower education levels.⁸ These individuals would benefit the most from QMB's financial assistance and its broad protection against improper billing for Medicare co-insurances and deductibles.

SSI Recipients Eligible for Premium Part A

We strongly support the proposal to permit group payer states to enroll SSI individuals in QMB without requiring them to first apply to the Social Security Administration for conditional Part A enrollment. Advocates in group payer states consistently report that the conditional Part A enrollment process is extremely difficult for all individuals with premium Part A. Many fail to understand the concept—which certainly is not intuitive—and become confused about what they should be asking for. Advocates report that individuals may ask Medicaid agency staff or advocates to provide a sheet of paper with “conditional Part A” written on it so they have confidence they will sufficiently communicate their goals when approaching SSA field office personnel. Advocates also report that, even though clearer POMS instructions have been developed, they hear with some frequency of SSA field office personnel providing incorrect information about the process or failing to properly enroll individuals who are trying to conditionally enroll. Advocates frequently feel the need to arm their clients with a copy of the relevant POMS in order to ensure the correct enrollment.

For individuals with SSI, who are among those least able to navigate application processes, these complexities present almost insurmountable obstacles to QMB enrollment. Getting lost in the process is the rule rather than the exception, particularly if they do not have the assistance of an advocate. For limited English proficient (LEP) populations or those with low literacy, the hurdles are high. The fact that the opportunities of those living in group payer states are limited to the General Enrollment Period further complicates the process and, as significantly, delays QMB enrollment even if these individuals make it through the enrollment gauntlet. Bypassing this procedure will provide significant relief.

Because the current procedure is so burdensome for individuals with SSI, we recommend that CMS move further and make bypassing SSA conditional enrollment mandatory for group payer states. While a state might choose not to enter into a Part A buy-in agreement for administrative reasons, experience has shown that those decisions have created a nearly impenetrable barrier to a vitally important substantive benefit. This administrative decision made by 14 states over 30 years ago⁹ is directly interfering with the substantive right of SSI individuals to access benefits to which they are entitled. Individuals with SSI living in group payer states end up with unequal access to QMB benefits relative to those residing in other states. Mandating a bypass of SSA conditional enrollment would correct this outsized impact on the most marginalized Medicaid population while leaving the administrative Part A payment option for group payer states intact.

⁸ [A Profile of Supplemental Security Income Recipients: 2017](#) | United Census Bureau, May 2021.

⁹ Part A buy-in became available starting January 1, 1990. See SSA POMS [HI 00801.140](#).

Further, we ask CMS to consider whether it can mandate states to provide Part A enrollment for SSI-eligible individuals. We ask CMS, more broadly, to look carefully for authority to require Part A buy-in agreements by all states or, at least, to impose costs on those states that continue in group payer status.

In addition to the burden on individuals, the failure of group payer states to enter into buy-in agreements imposes significant administrative burdens and costs on the Social Security Administration and its staff. Staff time in enrolling individuals who could otherwise be enrolled automatically, time needed to explain to individuals how conditional enrollment works and why it is needed, directing them to return to their state Medicaid offices, printing out evidence of conditional enrollment that is often requested by states, etc., is not insignificant.

If CMS believes that it does not have the statutory authority to require Part A buy-in, we ask the agency to at least consider other levers it may have to encourage states to make the move. For example, we ask whether it would be possible for CMS to require group payer states to cover some of the extra costs of SSA processing.

States That Are Both Group Payer States and 209(b) States

In deciding whether all of the changes in these proposed regulations should be mandatory or optional for group payer states—including changes affecting SSI-eligible individuals—we ask CMS to look particularly at states where the challenges of navigating are greatest, Illinois, Missouri and Virginia, all of which are both group payer states and 209(b) states. In these states, SSI-eligible individuals have a particularly long gauntlet to run. First, they need to get their SSI in place when they become eligible. On the Medicaid side, the one glimmer of light in these states is that, since these are all Medicaid expansion states, most of those qualifying for SSI would likely have been enrolled in MAGI Medicaid and, thus, new Medicare eligibility would trigger a redetermination. However, the proposed rules requiring state acceptance of self-attestations would not apply to that redetermination because, as currently written, those rules only apply to MSP applicants. Those states, moreover, would not review these individuals for QMB unless and until they first file a conditional Part A application with SSA. The individuals would need to make the filing at SSA and then return to the state Medicaid office to file for QMB coverage. And they could only do so during their IEP or the GEP. Under current rules the steps they must take are far too many and, moreover, it is not at all clear that they would even know that MSP eligibility was an option.

The proposed rules would give these states tools to make this process easier but does not require that they take them up. Unless CMS makes mandatory the state option to directly enroll these individuals into Part A, there is no guarantee that there will be any improvement for SSI individuals in these states. Many of these very low-income individuals, usually with limited education, chronic conditions and often experiencing housing instability, will continue to be lost in the thicket without full access to the benefits for which they qualify. In its discussion of redeterminations (NPRM at p. 54,781), CMS addresses the value of promoting “equity across enrolled populations.” We urge CMS to also use its authority for equity among populations in different states who are eligible for the QMB benefit.

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

We appreciate this codification of existing practice, which provides that the effective date for QMB enrollment of individuals who have filed conditional Part A applications is the month premium Part A

entitlement begins. We have heard from advocates that, in some states, they saw QMB enrollment that should have started July 1 delayed until August 1. We hope that with the recently finalized additional Special Enrollment Periods for Medicare enrollment and the change in effective dates for enrollment during the General Enrollment Period and the Initial Enrollment Period, some of these issues will disappear. We note, however, that when multiple changes like these are effectuated, it is not uncommon for errors to occur as state systems adapt. We ask CMS to be prepared for these eventualities so that it can move swiftly with states to retroactively correct enrollment dates and ensure that relevant benefits are protected, e.g. refunds of deductibles or co-insurance that a QMB has paid during a month in which the benefit should have begun.

More generally, we are excited about the potential of the regulations proposed in this rulemaking and the new rules coming out of the BENES Act. We look forward to working with CMS to make sure that they are understood and utilized to their maximum to expand enrollment. We expect there will be a need for significant clarification for states and advocates on how the new SEPs will work. Detailed explanations of the interaction of conditional Part A effective dates and QMB effective dates will be helpful in group payer states. Reinforcement of other basics, like assurance that conditional enrollment in Part A never leads to payment liability, would be helpful. We hope that CMS will consider creating FAQs and use other avenues to clarify the impact of these changes, particularly for SHIPs and other advocates and counselors. We note, for example, that under the old rules for the GEP, it was not urgent for an individual to apply at SSA and the Medicaid office during the same month as long as both applications were filed before the end of the GEP, since the effective date in any case would not be until July 1. Now, however, valuable months of coverage could be lost if an individual is slow in filing a QMB application after having filed a conditional Part A application.

A detailed explanation of how conditional Part A enrollment works would be especially helpful. Advocates have reported, for example, that individuals, who conditionally enrolled in Part A and ultimately did not enroll in the QMB program, receive letters from SSA about starting to pay their Part A premiums. Although we understand that the purpose of these letters is provide the opportunity to activate conditional enrollment if an individual chooses to do so, some recipients believed instead that they were liable for payment. This is an issue where a FAQ, as well as a review of what SSA sends to beneficiaries, would be helpful. We also can think of scenarios that might not be common but could occur. For example, an individual, during the GEP, files for Part A on February 27 but does not go to the Medicaid office to file a QMB application until March 2. As we understand it, although conditionally eligible for Part A on March 1, the individual would not have QMB eligibility until at the earliest April 1. If that individual, for example, had a major heart attack in early March and incurred very large hospital bills, could the individual pay the Part A premium (plus any late enrollment penalties due) in order to get premium Part A coverage for March and keep it until QMB enrollment is established? We believe that such an option would be available but would appreciate clarification.

5. Facilitate Enrollment by Allowing Medically Needy Individuals to Deduct Prospective Medical Expenses (§ 435.831)

Prospective Medical Expenses

We strongly support the proposal to allow individuals who reside in the community to project costs for medical expenses through the Medically Needy enrollment pathway (Medicaid “spend-down”). Under

current rules, individuals with a share of cost in the community are not deemed to meet Medicaid eligibility until their share of cost is incurred. Conversely, individuals residing in an institutional setting, like a nursing facility, are able to project their costs and are deemed Medicaid-eligible as of the first day of the month. This policy prevents access to care and supports in the community and drives individuals with disabilities into institutional settings to receive care they could otherwise receive at home.

Allowing for costs to be projected for Medicaid eligibility in the community would address this institutional bias and, further, would advance the integration mandate required by the Americans with Disabilities Act and Section 504—consistent with the Administration’s inclusion of the integration mandate in the proposed Health Care Rights law (Sec 1557).

As an example, a 51-year-old woman in Virginia is diagnosed with early onset dementia. She is enrolled in Virginia’s medically needy program. She clinically meets an institutional level of care and is eligible for “community-based care,” known as CBC. If she were in a nursing facility, she would be found eligible for Medicaid on the first of the month. Medicaid would pay the provider for that month and the provider would collect her share of cost (the patient liability). In the community, however, she is not deemed Medicaid-eligible until she provides evidence to the Medicaid agency that she has incurred her share of cost for that month. In this scenario, once she pays the CBC agency her share of cost, Medicaid will then pay the provider the remainder of the cost of her care for that month, but not until the next month. Advocates report that the practical impact of this policy is that there are few home and community-based services (HCBS) agencies that are willing to provide care because of the delay in payment and uncertainty each month of whether Medicaid will pay at all.

The administrative record reflects that the current provision on projectable costs was proposed in 1983 and ultimately finalized in 1994. CMS’s discussion of what expenses could be considered projectable in the administrative record focused on “institutional costs” because they were “long term, constant, and predictable” while conversely, at that time, non-institutional costs and costs in acute care could not be projected because they were short-term and unpredictable.¹⁰

We agree with CMS that, as currently provided, HCBS are a form of care that is just as long-term and predictable as institutional care. As a result, HCBS costs should be projectable for the purpose of qualifying for Medicaid spend-down in the community in the same way as the cost of care is in an institution. In fact, CMS has already allowed for the projection of HCBS costs under its 1115 waiver demonstration authority. In California, individuals with a share of cost receiving specific HCBS were deemed Medicaid-eligible for enrollment in the state’s Medicare and Medicaid plans under the financial alignment initiative. For example, enrollees in the state’s Multi-Purpose Senior Services Program (MSSP) were deemed to meet their share of cost on a routine basis.¹¹

Accordingly, we support the proposal to allow for the projection of medical or remedial expenses for HCBS included in a plan of care for an individual receiving a 1915(i), 1915(j), or 1915(k) benefit or enrolled in a 1915(c) HCBS waiver. We, however, strongly urge CMS to specify that HCBS offered

¹⁰ See 2148 Fed. Reg. 39959-01, 1983; 59 Fed. Reg. 1659-01, 1994; additional guidance can be found in the State Medicaid Manual, Chapter 3, Section 3628.4.2.

¹¹ Memorandum of Understanding Between CMS and California, available at <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CAMOU.pdf>.

through a state plan, including personal care, and HCBS provided through all waiver authorities, be added to the list of specific types of expenses that meet the criteria of being constant and predictable.

For example, California has a robust personal care benefit, In-Home Supportive Services, offered through both the Medicaid state plan and 1915(k) waiver authority. These HCBS expenses, whether under the state plan or under 1915(k) waiver authority, are equally constant and predictable and should be treated alike. Similarly, California also offers an adult day benefit, Community-Based Adult Services, through 1115 waiver authority. The state also offers a myriad of other HCBS through its 1915(b) waiver under CalAIM, all of which are authorized by managed care plans through an approved plan of care. Again, these HCBS would meet the criteria of being constant and predictable, and should be included in the list of specific expenses that can be projected. The regulation should avoid enumerating specific waiver authorities and instead employ a blanket referral to all the authorities under which states are offering HCBS, including the growth in offering HCBS through managed care.

In addition to HCBS, there are other types of services that would be constant and predictable that CMS should consider identifying as specific, qualifying examples for states, including:

- **Routine Transportation.** Many individuals who have chronic conditions require transportation to and from medical appointments and services on a routine and constant basis. For example, individuals who require dialysis must travel to and from dialysis centers three times a week.
- **Prescriptions.** Individuals with chronic conditions, such as diabetes, may be prescribed newer, more effective forms of medication that their available Part D plans do not cover. The enrollee may therefore be forced to pay out of pocket for more effective medication.
- **Durable Medical Equipment and Supplies.** Individuals with chronic conditions incur costs for monthly durable medical equipment and supplies including, for example, diabetic supplies, incontinence supplies, feeding tubes and supplies, and oxygen.

Prompt Coverage

We also strongly urge CMS to address in this rulemaking an even more consequential policy that currently reinforces the institutional bias in Medicaid and acts as a barrier to HCBS. Today, federal Medicaid policy allows for Medicaid covered services to be rendered immediately and subsequently reimbursed retroactively to the date of application and up three months prior as long as the individual meets all eligibility requirements. Yet while CMS permits this retroactive reimbursement for nursing facility care, it does not do so for HCBS. As a result, persons who would otherwise be able to live at home with HCBS often are forced to move into nursing facilities.

Assume an 85-year-old woman is hospitalized after a stroke. She needs assistance to return home but, under current federal policy, Medicaid coverage for HCBS cannot begin until approval of a plan of care -- a process that often requires several weeks to several months. As a practical matter, she will not be able to stay at the hospital for several weeks to await Medicaid approval of HCBS. It is likely instead that she will be forced to transfer to a nursing facility for care, because a nursing facility can be reimbursed by Medicaid for all days of her stay, even if her Medicaid application is not approved until weeks or even months after admission. Once in the nursing facility, she may find it very difficult to arrange for a return home. For example, she may lose her month-to-month lease on her apartment in the community

because of the uncertainty of whether or when she would ever get the HCBS services that would make her return possible.¹²

This is not a hypothetical barrier. In California, for example, individuals who apply for the state’s Home and Community-Based Alternatives (HCBA) waiver and the Assisted Living Waiver (ALW) wait months to be assessed to receive services. In one recent instance reported by an advocate, an individual already living in an assisted living residence who had been on the waitlist for years and finally became eligible for an ALW slot, has waited six months to be assessed while her family continues to pay privately out of pocket and who will not be reimbursed. Meanwhile, advocates in Washington DC engaged in years long advocacy with the Medicaid agency to speed up assessments for the Services My Way Program that were taking up to six months to finalize. The receipt of HCBS should not be contingent on the current and fluctuating capacity of the Medicaid agency and its contractors to complete an assessment for services. The failure to provide prompt coverage for HCBS is contrary to the Medicaid statute, creates inequities in access, and undermines the goals of *Olmstead*.

On its face, the Medicaid Act arguably requires coverage of HCBS to start promptly based on the date of application, just as for nursing facility care. Specifically, Medicaid must provide eligibility up to three months prior to the month in which a Medicaid application is filed, for any month in which the person is determined to meet eligibility standards, regardless of when the determination is made.¹³

CMS, however, has excluded HCBS waivers from such coverage based on its narrow and self-contradictory interpretation of the statutory requirement that home and community-based services be provided “pursuant to a written plan of care.”¹⁴ CMS interprets this provision to mean that Medicaid can only cover HCBS *subsequent to approval* of a care plan. This interpretation is overly narrow because it construes “pursuant to” to necessarily mean “after,” “temporally following,” or “subsequent to,” when in fact “pursuant to” - especially in the context of law - can simply mean “in conformity with,” or “according to.”¹⁵

Further, this interpretation contradicts CMS’s application of a similar provision in the context of Medicaid long term care coverage in a nursing home. Medicaid nursing home coverage is subject to a similar statutory requirement for “a written plan of care.”¹⁶ Yet services provided in a nursing home are routinely covered by Medicaid retroactively from the approval of the care plan to the date of application.

We urge CMS to adopt an interpretation more consistent with the overall structure and purpose of the Medicaid statute: specifically, retroactive coverage cannot be authorized until after a plan of care is approved, but once approved, retroactivity would be applied. This interpretation advances, rather than hinders, compliance with the least restrictive setting requirement of *Olmstead*, which the waiver provision was designed to implement.

¹² See Justice in Aging, “Medicaid’s Unfair Choice: Wait Months for In-Home Assistance—or Get Nursing Facility Coverage Today,” Sep. 2021, available at <https://justiceinaging.org/wp-content/uploads/2021/09/Medicoids-Unfair-Choice.pdf>.

¹³ 42 U.S.C. § 1396a(a)(34).

¹⁴ 42 U.S.C. §1396n(c).

¹⁵ Merriam-Webster Dictionary, accessed Nov. 4, 2022.

¹⁶ 42 U.S.C. §1396r(b)(2).

The initial services covered prior to a completed written plan of care could be relatively basic, subject to further development when a full person-centered planning process is completed. Good authority on this concept is found in Olmstead Letter No. 3, which recommends a “provisional written plan of care which identifies the essential Medicaid services that will be provided in the person’s first 60 days of waiver eligibility, while a fuller plan of care is being developed and implemented.”¹⁷ As with the proposal to allow for projected costs for Medicaid coverage in the community, this policy fix would further the integration mandate of the ADA and Section 504 by addressing a longstanding and detrimental institutional bias in the Medicaid program.

6. Application of Primacy of Electronic Verification and Reasonable Compatibility Standard for Resource Information.

We appreciate these clarifying changes to the regulatory language and we ask that CMS set compliance timelines that, besides taking into account state concerns, also weigh heavily the fact that delays in all the streamlining changes in this rulemaking have very real consequences for individuals and their access to health benefits that they need.

7. Verification of Citizenship and Identity

We strongly support the changes and simplifications proposed for verification of citizenship and identity. The proposed changes will not have a negative impact on the accuracy of the verification process and will smooth procedures for the state and the individual.

B. Promoting Enrollment and Retention of Eligible Individuals

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

Justice in Aging strongly supports the changes aligning application and renewal practices for non-MAGI categories with practices used in the MAGI Medicaid program. As CMS has correctly noted, older adults and persons with disabilities often have significant difficulty in managing paperwork and in getting to interviews.

Electronic verification: The requirement to pre-populate forms and only ask for information not available through other channels is necessary and, when followed, significantly helps qualified individuals to get enrolled and to stay enrolled at renewal, without losing eligibility for procedural reasons.

With respect to the prohibition against requiring enrollees to produce duplicative documentation of facts that can be determined through electronic verification, we are especially concerned that group payor states are unnecessarily requiring individuals who apply for conditional Part A enrollment to produce documentation of that application as a prerequisite for their QMB application. Although states can query SSA’s State Verification and Exchange System (SVES) to verify the conditional Part A enrollment,¹⁸ we have learned from state advocates that some states require QMB applicants to provide

¹⁷ State Medicaid Director Letter, Olmstead Update 3 (Jul. 2000), available at <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd072500b.pdf>

¹⁸ See [Manual for State Payment of Medicare Premiums](#) Sec. 1.11. “When processing the conditional Part A enrollment, SSA will refer the individual to the appropriate state Medicaid office to apply for the QMB program

proof of their conditional enrollment when the state could, instead, query SSA. California, for example, created a form to be signed by SSA staff stating that the conditional application has been filed. Though it is unclear whether the form was created to be an absolute requirement, we know from advocates that county eligibility workers believe it to be so, and have told applicants they must obtain this form from SSA and file it with the state Medicaid agency in order for the agency to process their QMB application. This created particular problems during the PHE when many SSA offices were closed. We also have heard from advocates in other states that Medicaid eligibility workers routinely require a screenshot or other proof.

The discussion of electronic verification in the NPRM focuses on confirmation of income and assets and citizenship/immigration status, and does not specifically address electronic verification of Medicare eligibility, including conditional eligibility. We ask that CMS explicitly do so. Although getting a screenshot from SSA is always a good idea and confirming forms can be a helpful backup, they should not be requirements since states have SVES confirmation available to them.

Face-to-face interviews: Attending a face-to-face interview can be a heavy burden for older adults and persons with disabilities, especially because many individuals have physical or cognitive limitations and many lack transportation or find it very costly. We note specifically that the Non-Emergency Medical Transportation benefit in Medicaid does not cover these trips.

For example, a routine visit to the local Department of Human Services in the District of Columbia requires showing up at least an hour to an hour and half before the agency opens in the morning. While waiting for the agency to open, the individual must stand in line outside the building. There is no seating provided, access to public restrooms, or shelter from rain, snow, or sun. It is common for older adults or individuals with disabilities to have someone stand in line for them, while they wait in a nearby car or store until the doors open and the line slowly proceeds in. Once in the building, the individual must sit in the waiting room for many hours before being seen.

We ask that CMS clarify that the prohibition on requiring in-person interviews extends to video interviews as well. Though perhaps somewhat easier to manage than office interviews, a video requirement also creates significant barriers and is no more necessary than an in-office interview. Access to the internet is one challenge, as many low-income older adults do not own or have access to the required technology. Further, many have difficulty in using electronic devices and understanding directions for use. All of these challenges have been [well documented](#) for telemedicine and create similar barriers to Medicaid interviews. Many disabilities that are widespread among this population, such as problems with hearing, sight, and speech, add to the challenge. Moreover, for both in-office and video interviews, many older adults and persons with disabilities are uncomfortable participating without being accompanied by a family member and, in some cases, are entirely unable to speak for themselves. Interview requirements often burden these family members, who themselves may be struggling financially, by requiring them to take time off from work or arrange for child care in order to participate.

and may give the individual a screen shot of the application to bring to the state as proof of the conditional enrollment. The state can also query SSA's State Verification and Exchange System (SVES) to verify the conditional Part A enrollment."

In light of all these factors, we strongly endorse the proposed rule changes and urge CMS to further strengthen them in light of the issues we have raised.

2. Acting on Changes in Circumstances, Timeframes and Protections

We appreciate these proposals. They give states a clear path for addressing changes in circumstances and reinforce the requirement for beneficiary protections in the case of an adverse change.

3. Timely Determination and Redetermination of Eligibility

We urge CMS to provide a period of at least 30 calendar days for all applicants. Advocates for older adults report that many of their clients put official-looking mail in a pile and do not take action until a family member or friend comes to help sort through the items, a visit that might only happen every couple of weeks, or even less frequently. This practice is especially prevalent among individuals with limited English proficiency who need assistance in understanding untranslated materials. A fifteen-day window simply does not accommodate these on-the-ground realities. Moreover, a fifteen-day timeframe, even when an individual promptly begins to work on a response, often is inadequate for the task of gathering documents, particularly when combined with mail processing times and potential delivery delays.

For all deadlines, we urge the use of calendar days. Business day counting is too complex and holidays can depend on local jurisdictions. Using calendar days is consistent with CMS practice in the Medicare program and thus is most familiar to individuals who are dually eligible for Medicare and Medicaid. When using calendar days, however, it is important to recognize that delay in receipt of notices because of holidays will happen, another reason why 15-day turnarounds are unrealistic for responses by individuals.

Looking at deadlines for agency action, we ask that 45 days for agency action be the absolute limit. That timeframe is, in fact, overly long in most cases. We propose that the deadline be 15 days from the date that all information required from the applicant is received (or the deadline for receipt of information has passed) or 45 days, whichever is earlier. We also note the obvious connection between timely review of applications and streamlined processes. If states are required to use streamlined self-attestation processes for all non-MAGI applications, those processes should speed consideration of applications considerable. Moreover, actions by states to conform their criteria to align with LIS criteria would further promote efficiency and timeliness.

Finally, enforcement of deadlines is as important as the deadlines themselves. Even with MAGI-based Medicaid applications that are less complex than non-MAGI, the history of state compliance with existing timeliness requirements has been dismal.¹⁹ When CMS regulations set deadlines—and ensures that those deadlines are honored-- those deadlines offer protection and predictability to individuals needing benefits. States should face meaningful sanctions for egregious levels of noncompliance and we urge CMS to specify such sanctions in the new rule. As noted in our earlier comment on compliance with respect to use of leads data, we believe it is important with all CMS mandates to states that the agency be clearer and more specific about the consequences of noncompliance.

¹⁹ Medicaid MAGI and CHIP Application Processing Time Report. CMS, November 7, 2019.

4. Agency Action on Returned Mail

We strongly support the proposal of CMS to require states to make more adequate investigation before terminating individuals from Medicaid coverage based on returned mail. Many Medicaid-eligible individuals face housing insecurity, a fact that may lead to more address changes than experienced by those with higher incomes. Arbitrarily cutting these beneficiaries off from needed health care because of a single piece of returned mail is bad policy and can endanger the health of high needs individuals.

We agree with CMS that an individual's managed care plan may be one of the best sources for obtaining a current address. A pharmacy or prescription drug plan also may be a good source. Because in some jurisdictions, such as California, Medicaid prescription drug coverage may be distinct from managed care, we suggest that CMS also mention prescription drug plans as an additional source of information. We further note that for dual eligible enrollees who do not need long-term services and support, connections to their Medicaid managed care plan may be more tenuous; the Medicare managed care plan or Medicare Prescription Drug Plan to which they belong may be a more fruitful avenue to pursue. Since Medicaid is a secondary payer to Medicare, the state should be able to coordinate with either the MA-PD or PDP when seeking up-to-date address information.

In light of the expected challenges in locating Medicaid beneficiaries who have changed addresses during the COVID-19 Public Health Emergency, we ask that CMS require compliance with this rule immediately upon publication or no later than 30 days thereafter. We appreciate the outreach and education that CMS has undertaken to encourage individuals to update their residence information, but know that many individuals will fall through the cracks. Prioritizing compliance with these regulations will help to limit harm during the unwinding and mitigate the potential for disruption in access to care.

Addressing Systems Issues

Although not part of this rulemaking, we ask that as CMS tries to attack the causes of churn and procedural loss of access to benefits, particularly MSPs, the agency work with states to better address responses to systems failures. While we recognize that complex computer systems sometimes go awry, it is concerning that, in our experience working with state advocates over many years, in almost all cases states did not become aware of irregular denials or disenrollments until reports surfaced of beneficiaries losing access to services. States generally do not appear to have sentinel systems or other mechanisms in place to monitor their systems for unusual denials or disenrollments. Especially for dually eligible individuals who rely on MSPs or ABD Medicaid for payment of Part B (and sometimes Part A) premiums, the result can be a cascade of service denials across both programs causing significant harm and gaps in coverage while federal and state agencies attempt to repair the error. This was evident in Georgia in 2019 when thousands of MSP enrollees were erroneously disenrolled from their MSPs and it was advocates who brought the error to the state and CMS.²⁰ Stronger preventive measures and systems testing are needed, both when changes such as those that will result from these regulations are introduced and routinely as Medicaid agencies administer their programs.

²⁰ WABE, "Report: Georgia Cutting Medicaid Assistance to Thousands," (Jun 10, 2019), available at <https://www.wabe.org/report-georgia-cutting-medicaid-assistance-to-thousands/>.

Conclusion

Thank you for the opportunity to comment in support of this important set of regulations. If any questions arise concerning this submission, please contact Georgia Burke, Director of Medicare Advocacy, at gburke@justiceinaging.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Amber Christ". The signature is written in a cursive style with a large initial "A" and a stylized "C".

Amber Christ
Managing Director for Health Advocacy