

November 3, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS-2421-P P.O. Box 8016
Baltimore, Maryland 21244-8016

Dear Administrator Brooks-LaSure:

I write to comment on the proposed rule, “Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Process” RIN 0938-AU00.¹ The underlying presumption of the proposed rule is that applying for public benefits, with a value of (tens of) thousands of dollars per recipient, is an unwarranted burden and intrusion on individuals. CMS proposes to place further restrictions on the Medicaid eligibility system acting on information provided by applicants and beneficiaries and available data matches without explaining how states will be able to improve the accuracy and timeliness of information that is available to them or giving them new tools to obtain missing information.

The proposed rule makes references to section 1902(a)(19) of the Social Security Act relating to the simplicity of administration and the “best interests of recipients.” Whether the proposed rule would achieve either of those objectives is debatable. The accompanying financial impact analyses of the rule clearly shows federal savings by delaying or preventing enrollment into private insurance coverage provided through the Federal Marketplace. Whether Medicaid coverage or private insurance coverage serves the “best interest” of individuals is an important and worthwhile discussion that deserves greater transparency than being confined to the federal administrative rulemaking process. If CMS believes that being covered by Medicaid rather than private insurance is in the long-term best interest of the nonelderly, nondisabled adults and children to be the case, further explanation and data to support its conclusion should be given.

Significant changes must be made prior to issuance of a final rule. Reliance on President Biden’s three Executive Orders cannot justify the promulgation of regulations that conflict with statutory delegations to the states or that put the states at greater risk for a loss of federal funding for improper payments.

The proposed rule would inject further confusion and complications into policies and procedures related to eligibility that are already overly complex. New policies are not based on hard data or evidence. It is unlikely to achieve the stated goals of “simplification” because policies cannot truly be “aligned.” The proposed rule would turn current options for states into mandates. Overall, as currently drafted, the proposed rule should be withdrawn.

¹Centers for Medicare & Medicaid Services, “Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes,” Proposed Rule, September 7, 2022, 87 FR 54760-54855.

Background

Each of the three programs that are the subject of this proposed rule are jointly funded by the federal government and the states and are administered by the states under a statutory framework that includes federal requirements and state options. Consequently, in each of these three programs a state may face the loss of federal financial participation (FFP) if it is not in compliance with federal rules.

In the case of Medicaid, the state's cost of administering the program is financed separately from program benefits, with different match rates. In general, states and the federal government share ongoing administrative costs of personnel on a 50/50 basis and 75/25 for skilled professionals (clinicians).

Section 1903(a)(3) of the Social Security Act requires states to maintain "mechanized claims processing and information retrieval systems." The federal government provides enhanced match rates for Medicaid Enterprise Systems (MES) which consist of its Medicaid Management Information System (MMIS) and Eligibility and Enrollment (E&E) system. The federal government will provide a 90/10 match rate for the development, design, and installation (DDI) of new IT systems and a 75/25 match rate for operations of the MES that is certified by the Centers for Medicare & Medicaid Services (CMS).² In 2021, the federal government and states spent nearly \$32 billion to administer the Medicaid and State Children's Health Insurance Program (CHIP), including \$8 billion for eligibility systems and \$4.5 billion for MMIS.³

The investments into these new systems have produced quantifiable results. CMS has recently reported on how long it takes state agencies to conduct all final MAGI determinations. According to the report, "[m]ore than half (52%) of all MAGI determinations at application were processed in under 24 hours; about two-thirds of all MAGI determinations at application were within seven days."⁴ Clearly, states are processing applications efficiently and timely.

The eligibility determination and redetermination processes for these programs serve two purposes: 1) ensuring that eligible individuals are enrolled; and 2) preventing enrollment of ineligible individuals. States are evaluated for their compliance and performance with respect to the accuracy of their eligibility systems under the Medicaid Eligibility Quality Control (MEQC) Program and the Payment Error Rate Measurement (PERM) Program.⁵

The Affordable Care Act (ACA) resulted in significant changes to eligibility for Medicaid and CHIP as a result of its provisions requiring the adoption of the Modified Adjusted Gross Income (MAGI) methodology for determining eligibility for children and non-disabled, non-elderly adults, who collectively account for approximately 80 percent of the Medicaid population. The MAGI methodology simplified eligibility rules. The ACA also added Section 1943, "Enrollment Simplification and Coordination with State Health

² In some states, the eligibility and enrollment processes are administered at the county level.

³ Medicaid and CHIP Payment and Access Commission, "Exhibit 31. Total Medicaid Administrative Spending by State and Category, FY 2021," *MACStats: Medicaid and CHIP Data Book*, December 2021, <https://www.macpac.gov/wp-content/uploads/2022/08/EXHIBIT-31.-Total-Medicaid-Administrative-Spending-by-State-and-Category-FY-2021-millions-1.pdf>

⁴ Centers for Medicare & Medicaid Services, "MAGI Application Processing Time Snapshot Report: January - March 2022," September 1, 2022, <https://www.medicaid.gov/state-overviews/downloads/magi-app-process-time-snapshot-rpt-jan-mar-2022.pdf>

⁵ See: Centers for Medicare and Medicaid Services, "PERM Error Rate Findings and Reports," at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/PERMErrorRateFindingsandReport>

Insurance Exchanges” to Title XIX of the Social Security Act. Regulations implementing those statutory changes, were subsequently finalized in 2012 and 2013.⁶ While regulations prior to the ACA gave significant flexibility to states in adopting procedures to redetermine eligibility for the MAGI groups at least once every 12 months, final rules prohibited states for redetermining eligibility more than once every 12 months. Also relevant to this proposed rule was the 2017 “PERM rule,” which revised regulations related to the states’ obligations to identify, measure, report and address improper payments in their Medicaid and CHIP programs.⁷ The “PERM rule” has a direct connection to the processes used to determine and redetermine eligibility.

The federal-state structure already provides for federal sanctions if states are not processing applications accurately or timely. The proposed rule provides no data that demonstrates states are not adequately performing their eligibility functions based on the information in applications that are available to them. However, the Government Accountability Office (GAO) issued a report in January 2020 that summarized key findings from 47 federal and state audits that examined the accuracy of states’ Medicaid eligibility determinations.⁸ The GAO found states that were:

- Not conducting income checks for individuals reporting no income;
- Not terminating the enrollment of individuals who had moved out of state or died;
- Enrolling individuals who did not provide required information (such as proof of citizenship) on a timely basis;
- Months or years behind schedule in conducting required eligibility redeterminations; and
- Not acting on—or not having adequate systems in place to detect—changes in enrollees’ circumstances that could affect eligibility, such as changes in income or household income.

GAO also pointed out that due to implementation of the ACA, CMS did not publish an updated national Medicaid improper payment rate from 2015 to 2018. CMS used the most recent PERM rule for the first time in 2019. The rates published by CMS in a given year reflect three previous cycles, and cycles are staggered among the states. Thus, the 2019 rate reflected state data for FY 2016, FY 2017, and FY 2018. The 2019 eligibility error rate was 8.36%. the 2020 rate (FY 2017, Review Year 2019, and Review Year 2020) was 14.94%, and the 2021 rate (2019, 2020, and 2021) was 16.62%.⁹ Those figures indicate that the amount of improper payments grew from \$36.25 billion in 2018 to \$98.72 billion in 2021, or by 272% over four years. The GAO report is an argument for greater data sharing among the Medicaid agency and other state and federal agencies and more frequent reviews of eligibility.

⁶ Centers for Medicare and Medicaid Services, “Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010,” Final Rule, March 23, 2012, 77 FR 17144-17217, and “Medicaid and Children’s Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment,” Final Rule, July 15, 2013, 78 FR 42160-42322.

⁷Centers for Medicare and Medicaid Services, “Changes to the Medicaid Eligibility Quality Control and Payment Error Rate Measurement Programs in Response to the Affordable Care Act,” Final Rule, July 5, 2017, 82 FR 31158-31188.

⁸ U.S. Government Accountability Office, “Medicaid Eligibility Accuracy of Determinations and Efforts to Recoup Federal Funds Due to Errors,” January 2020, <https://www.gao.gov/assets/gao-20-157.pdf>.

⁹ CMS “PERM Error Rate Findings and Reports.”

As GAO observed, “[d]etermining whether individuals are eligible for Medicaid is a complex process that is vulnerable to errors.”¹⁰ GAO found more errors in failing to disenroll individuals who were no longer eligible than errors for failing to enroll individuals who were eligible. GAO reported that “Unresolved income discrepancies” is one of the most frequent accuracy issues. It is likely that a state will have to receive additional information from an applicant or an enrollee in the case a redetermination to resolve such income discrepancies.

Accordingly, CMS should take care not to convey or imply that requests for additional information will be rare. On the contrary, people must expect further requests for information so they will be appropriately prepared to review any communication from the state agency immediately and respond immediately.

The proposed rule would revise §435.940 to reference Section 1940 of the Social Security Act, and describes the four-part challenge states face in making eligibility determinations:

Nothing in the regulations in this subsection should be construed as limiting the State’s program integrity measures or affecting the State’s obligation to ensure that only eligible individuals receive benefits ... or its obligation to provide for methods of administration that are in the best interest of applicants and beneficiaries and are necessary for the proper and efficient operation of the plan ...¹¹

Improving accuracy is in everyone’s best interests. Balancing the state’s responsibility to adopt program integrity measures (which are not to be constrained) with potentially conflicting obligations (to ensure only eligible individuals receive benefits and to ensure the “proper and efficient operation” of the state’s plan), provide the context for the following comments.

1. Compliance Dates

In the preamble, CMS solicits comments with respect to setting compliance dates.

The proposed rule is primarily about process and operations. In response to a final rule, states will need to file state plan amendments, promulgate their own conforming rules (which require public comment periods), modify their IT systems and operations, and revise budgets to account for new costs for both benefits and administration. States may also need to enact legislation, and some existing waivers will need to be modified as well.

On top of that, there are also two practical considerations. First, only a limited number of vendors can perform the work needed to modify state program IT systems, and the states will all be simultaneously seeking their services. Second, all but four states budget on a July 1 to June 30 fiscal year. State agencies are already deep into preparing SFY 2024 budgets in advance of their next legislative sessions, which in most states will convene in early January.

Consequently, even were CMS to immediately finalize this rule at the close of the comment period, it will not be possible for states to accurately factor this rule into their SFY 2024 budget cycle.

¹⁰ GAO p.25

¹¹ “Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes,” proposed 45 CFR §435.940.

While the foregoing considerations would all be relevant were this rule being promulgated in the context of normal conditions, in fact, normal conditions do not currently apply.

Specifically, the Families First Coronavirus Response Act (FFCRA) provided states with a 6.2 percentage point increase in their FMAPs on the condition that they maintain eligibility for all individuals enrolled in their programs on or after the date of enactment (March 18, 2020) until the end of the quarter in which the Covid public health emergency (PHE) terminates.¹² On October 13, 2022, the Secretary renewed the Covid PHE declaration for another 90 days (until January 11, 2023).¹³ Thus, the enhanced funding and associated restrictions in the FFCRA will remain in place through, at least, the end of the first quarter of calendar year 2023.

States will have to complete an enormous volume of work to return their programs to normal operations once the PHE eventually ends. Based in part on the challenge of the workload on states, CMS issued guidance for a 12 month “unwinding period.”¹⁴

Expecting states to undertake the work associated with the unwinding of the PHE while simultaneously implementing the changes to enrollment and eligibility set forth in the proposed rule, is completely unrealistic. The compliance date for the proposed rule needs to be delayed until after the unwind has been completed and sufficient data has been collected to re-set the baseline for measuring the timeliness and accuracy of eligibility determinations and re-determinations.

- Consequently, CMS should set the compliance date no sooner than 24-months after the final rule is published.

2. Facilitate Enrollment Through Medicare Part D Low-Income Subsidy (LIS) “Leads” Data (§§ 435.4, 435.601, 435.911 and 435.952)

This provision refers to enrolling individuals into Medicaid via the Medicare Savings Program (MSP). CMS proposes to require states to accept Medicare Part D Low-Income Subsidy (LIS) data as a Medicaid application for the MSP.¹⁵

The preamble references a 2017 study conducted by the Urban Institute for the Medicaid and CHIP Payment and Access Commission (MACPAC) which “...estimated that only about half of eligible Medicare beneficiaries were enrolled in MSPs.”¹⁶ That study found “almost” 9 million low-income seniors and people with disabilities were enrolled in MSP. However, more recent data shows that Medicaid currently spends approximately \$20 billion (federal and state) to pay for Medicare premiums, deductibles, and coinsurance on behalf of more than 12 million “dual eligibles.”

¹² Pub. L. 116-127 § 6008.

¹³ Administration for Strategic Preparedness and Response, “Renewal of Determination that a Public Health Emergency Exists,” October 13, 2022, <https://aspr.hhs.gov/legal/PHE/Pages/covid19-13Oct2022.aspx>

¹⁴ For the most recent summary of that guidance, see: Centers for Medicare and Medicaid Services, “COVID-19 Public Health Emergency Unwinding Frequently Asked Questions for State Medicaid and CHIP Agencies,” October 17, 2022, <https://www.medicare.gov/federal-policy-guidance/downloads/covid-19-unwinding-faqs-oct-2022.pdf>

¹⁵ Ibid. p. 54763.

¹⁶ Ibid. p. 54761.

LIS subsidies are available to individuals with income up to 150% of the Federal Poverty Level (FPL). However, the MSP program for individuals not in the workforce stops at 135% FPL. The Medicare Payment Advisory Commission (MACPAC) and the Medicaid and CHIP Payment and Access Commission (MACPAC) produced a joint “Data Book on Beneficiaries Dually Eligible for Medicare and Medicaid” in February 2022 which generally used 2019 as a “snapshot.” It reported that “Most dual-eligible beneficiaries (71) were eligible for full Medicaid benefits,” and that, “The majority (62 percent of dual-eligible beneficiaries were ages 65 and older.”¹⁷ Dual-eligible beneficiaries totaled 19 percent of the Medicare population in 2019 but accounted for 34 percent of Medicare spending.”¹⁸

The Congressional Budget Office (CBO) estimates 13 million Medicare beneficiaries receive the so-called “Extra Help” additional subsidies to pay for Part D drug coverage.¹⁹ In an August 13, 2018 Report, “Medicare Part D Prescription Drug Benefit,” the Congressional Research Service (CRS) explains that “... dual-eligible beneficiaries are already enrolled.”²⁰ Medicare beneficiaries who *automatically* qualify for LIS and who receive full subsidies for their Part D coverage are those who have:

- a) Full Medicaid benefits
- b) Medicare Savings Program (MSP) assistance
- c) Supplemental Security Income (SSI)

States and the Social Security Administration (SSA) are already using data matches to enroll individuals who qualify for full subsidies into LIS. CMS uses a “facilitated enrollment” process to auto-assign these beneficiaries into a Part D plan.

In 2018, there were approximately 300,000 who qualified for partial LIS subsidies, who would be above MSP but below 150% FPL. Their “leads” would not result in MSP eligibility. Conversely, there likely are low-income Medicare beneficiaries who potentially may be eligible for LIS and MSP, but if they have not applied to states or SSA, then this proposed rule will have little effect.

The projected fiscal impact of this provision provided in Table 3 confirms that the impact is likely to be rather modest, increasing enrollment by just 0.48 million of person-years equivalents.²¹ Using data leads to start an application is the beginning, but states must know where it ends if the necessary information to complete the application is never provided. The preamble acknowledges that the MSP group consists of different eligibility categories. It also acknowledges that the state may require information that is not available through the LIS data. Further, the preamble acknowledges that “...individuals eligible for the LIS program may be eligible for full Medicaid benefits.”²²

¹⁷ Medicare Payment Advisory Commission and Medicaid and CHIP Payment and Access Commission, “Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid,” February 2022, p. 27, https://www.medpac.gov/wp-content/uploads/2022/02/Feb22_MedPAC_MACPAC_DualsDataBook-508-FINAL_SEC.pdf

¹⁸ Ibid. p. 30.

¹⁹ Congressional Budget Office, “Paying for Drugs in Medicare Part D Under Current Law and Under Proposals to Redesign the Program,” November 2021, <https://www.cbo.gov/system/files/2021-11/57461-PartD.pdf>

²⁰ Congressional Research Service, “Medicare Part D Prescription Drug Benefit,” August 13, 2018, p.2, <https://crsreports.congress.gov/product/pdf/R/R40611/15>

²¹ “Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes,” p.54834.

²² Ibid. p. 54766.

In fact, the LIS leads data will not be sufficient to establish eligibility for full Medicaid benefits. Full benefits include long-term services and supports (LTSS) which may be provided as a state plan service for institutional nursing facility or Home and Community Based Services (HCBS) that are typically provided under 1915(c) waiver authority. In both cases, the state will require additional information about the individual's medical condition and a functional assessment.

CMS acknowledges this part of the rule will end a state option and turn it into a mandate:

"However, the differences in income and resource methodologies prevent LIS enrollees from being seamlessly enrolled into the MSPs unless the State has elected to align the MSP methodologies by adopting certain income and resource disregards under section 1902(r)(2) of the Act."²³

"... we are proposing at § 435.952(1)(i) and (ii) to prohibit States from requesting documentation of dividend and interest income prior to making a determination of MSP eligibility, except when the agency has information that is not reasonably compatible with the applicant's attestation."²⁴

There are many instances in which the state never receives a completed application because the additional information could not be verified through data matching. This is particularly true when the Medicaid eligibility criteria includes an asset test and information about the individual's resources is required. Simply leaving an application open longer does not improve accuracy.

In the final rule, CMS needs to:

- explicitly define the timeframe and circumstances in which a state may close a case because the required information was not received in a timely manner.
- clarify whether states:
 - a. Should proceed to use the LIS leads data as an application to determine eligibility only for premium assistance to pay for the Medicare premium, deductible, and coinsurance and make a determination which would be the quickest way to begin financial relief to the individual; *or*
 - b. Wait to make a determination as a "full dual" after additional information regarding medical need and functional assessment has been submitted which would delay financial relief and may or may not approve the person's eligibility for additional benefits.

3. Automatically Enroll Certain SSI Recipients into QMB Program (§435.909)

Individuals who are eligible for the Supplemental Security Income (SSI) program are also eligible for Medicaid.

States have three options for providing Medicaid coverage based on SSI eligibility:

1. "209(b) states" use at least one eligibility criterion more restrictive than federal rules for SSI eligibility.

²³ Ibid.

²⁴ Ibid. p. 54767.

2. “SSI Criteria States” make their own SSI determinations and thus, Medicaid determination as well.
3. “1634 state” enter into a “1634 agreement” with the Social Security Administration (SSA) to make the SSI determination. However, the state, not SSA, issues Medicaid denial notices to individuals who do not meet Medicaid-only eligibility factors which include those who refuse to assign their rights to third party medical payments or provide third-party liability information or who appear to have a Medicaid trust.²⁵

States may also choose to provide eligibility for “medically needy programs.” These programs are designed to provide coverage for individuals whose income exceeds the state’s Medicaid eligibility limits. Medicaid pays for services during a budget period (1 to 6 months) in which an individual’s incurred or anticipated medical expenses exceed their income (“spend down”).

SSI, QMBs, and “medically needy” are different programs within the Medicaid program with their own statutory authorities. Without substantial evidence, CMS “believes” requiring a separate application is to blame for not enrolling more individuals into the QMB program.

Table 4 estimates an increase in enrollment of nearly 1 million person-years equivalents at a cost of \$5.66 billion in 2024 and a total cost of \$25.7 billion for the five years 2023 through 2027.²⁶ These costs will be concentrated among the “1634 States.” CMS acknowledges that states can currently choose an option that adopts the same methodology for two different eligibility groups, but they have not done so. The proposed rule would require states to use the same methodology, which means it would eliminate state choice.

Given that the statutory construction vests authority with the states to design the eligibility rules for the affected populations it is likely that one or more states will challenge this mandate.

- This provision should be removed from the rule and CMS should instead administer a pilot with interested states to determine the underlying causes of individuals not applying for benefits for which they may be eligible.
- CMS should clarify that this provision does not change the criteria a state uses to determine eligibility for its medically needy program.

4. Other Provisions to Facilitate Medicaid Enrollment (§§ 406.21, 435.407, 435.952 and 435.940)

These provisions include the definition of family size, conforming the effective date of QMB coverage, and the use of electronic verification of citizenship and identity. The accuracy, and therefore validity, of electronic verification of citizenship and identity have vastly improved. Although these changes should be noncontroversial, states will still have to make systems and procedural changes. Presumably, states will use their current IT vendors to make conforming changes.

²⁵ For a list of identifying which states use 209(b), SSI criteria, or 1634 criteria and whether the state has a medically needy programs for aged, blind, and disabled individuals, see: Social Security Administration, “List of State Medicaid Programs for the Aged, Blind and Disabled,” <https://secure.ssa.gov/apps10/poms.nsf/lnx/0501715020>

²⁶ “Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes,” p. 54835.

- CMS needs to provide firm dates for when it would apply “corrective action plans” for noncompliance and when it would apply financial sanctions for noncompliance.
- Also, with respect to the systems and procedural updates states will have to make to accommodate these changes, CMS needs to clarify whether states will have to file Advanced Planning Documents (ADP), and the applicable match rate for the associated administrative costs.

5. Define “Family of the Size Involved” for the Medicare Savings Program Groups in Using the Definition of “Family Size” in the Medicare Part D Low-Income Subsidy Program (§435.601)

The determination of Medicaid eligibility is based on the federal poverty level (FPL) which are updated annually by income and family size.

While the purpose of this section is “[t]o further facilitate alignment of methodologies used to determine eligibility for the Medicare Part D LIS and MSP groups”, the proposed language added to 435.601(f) is confusing as it includes both mandatory language (“must”) and permissible language (“unless the agency chooses the option”; “the agency may apply “ “or”; “except that”).²⁷

- The final rule should clarify that states will still have authority to adopt different methodologies between the MAGI and non-MAGI groups.

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

Medicaid is the largest source of paid care for Long Term Services and Supports (LTSS). There is widespread agreement that the “institutional bias” in the Medicaid statute itself should have been reconciled by Congress long ago. Instead, it is left up to the states to navigate through a thicket of eligibility and services options. There are multiple pathways to Medicaid coverage of Home and Community Based Services (HCBS) which are nonmedical in nature but are necessary to help an individual live safely in the community. Because states have adopted the various options available to them in terms of eligibility and services, HCBS expenditures account for more than half of LTSS expenditures. According to the “Medicaid LTSS Expenditures Report: FY 2019,” Medicaid expenditures for LTSS totaled \$162.1 billion, of which \$95 billion (58.6 percent) were for HCBS.²⁸

The language used in the heading of this subsection and in the description of the provision are unnecessarily confusing and even misleading. It implies the rule is allowing the *individual* the right to make this change. But the rule itself merely allows the *state* the option to make changes in projecting what expenses will be allowable in the calculation of “spend down.” As such, it describes an option that states may adopt that is already an option to them.

²⁷ “Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes,” p. 54770 and proposed §435.601(f).

²⁸ Centers for Medicare and Medicaid Services, “Medicaid LTSS Expenditures Report: Federal Fiscal Year 2019,” December 9, 2021, <https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures2019.pdf>

The proposed rule refers to “services identified in a person-centered service plan.” A person-centered service plan (PCSP) is unique to HCBS services. A PCSP comes *after* eligibility has been established. Not everyone living in the community would have a PCSP. HCBS rules also bring their own set of requirements including Independent Assessment and conflict-free case management which should be applied to this group as well

- The provision is unnecessary and should be deleted. If CMS chooses to maintain it, the rule must be amended to include:
 - In the heading, substitute a more accurate description such as “Allowing States to Count Projected HCBS Expenditures in Determining Eligibility for the Medically Needy Group”
 - Confirm that the noninstitutional expenses will be added to the projected spending *only if* the state chooses to do so. In other words, the state can continue to administer the program as it currently exists.
 - Remove the inappropriate and confusing reference to PCSPs.
 - Add the requirement for an Independent Assessment in determining eligibility and for conflict-free case management.

7. Promoting Enrollment and Retention of Eligible Individuals: Aligning Non-MAGI Enrollment and Renewal Requirements with MAGI Policies (§§ 435.907 and 435.916)

Collectively, the series of “Promoting Enrollment and Retention” provisions described in the following sections will cost \$48.2 billion over the five-year period. The title of these provisions describes all of the individuals impacted by these proposals as “eligible” individuals. This is misleading as the provisions include delays in disenrolling individuals who are no longer eligible.

Congress specifically created the Modified Adjusted Gross Income (MAGI) under the Affordable Care Act (ACA) for the nonelderly and nondisabled adults and children and chose not to apply MAGI enrollment and renewal requirements to the elderly and disabled adults and children. There are numerous differences between the MAGI and non-MAGI groups including:

- Asset tests for the non-MAGI group
- “Look back” period for the non-MAGI group to prevent divestiture of assets
- Substantial use of LTSS, both institutional and HCBS for the non-MAGI group
- MAGI eligibility is based only on financial information; Non-MAGI eligibility includes medical and functional needs assessment as well

A single streamlined application simply cannot work for the two very different populations. It would have the opposite effect intended by Congress.

The rule also proposes to prohibit an in-person interview as part of the application process. This would make an Independent Assessment (IA) of functional needs impossible. An IA would not be accurate without an in-person assessment in the person’s own home. Because the IA is a requirement in the eligibility determination and redetermination processes, it not merely “procedural.”

Accordingly, CMS should:

- Drop the “single application” requirement as it is infeasible and contrary to the intent of Congress to create a simple, streamlined application for the MAGI group.
- Clarify that the IA remains a requirement of eligibility and does not constitute a prohibited “in-person interview.”

8. Promoting Enrollment and Retention of Eligible Individuals: Acting on Changes in Circumstances Timeframes and Protections (§§ 435.916, 435.919 and 457.344)

To be reliable for the purposes of making an eligibility determination, data must be accurate, complete and timely. In making an application, the individual (“applicant”) provides all required information under penalty of perjury. An application that is not complete cannot be approved. After approval, the individual (often referred to as “enrollee,” “beneficiary,” or “recipient”) is obligated to report any change in circumstances that may affect eligibility.

There is only one type of change in circumstances that a Medicaid would have the necessary information in its eligibility system to verify in advance of an event—the age of the enrollee. A birthday (a child turning age 21; an adult turning age 65) can affect eligibility. Through data matching with the state agency responsible for vital health statistics, the Medicaid agency can find birth and death records. The Medicaid agency can use the Public Assistance Reporting Information System (PARIS) to find if duplicate payments are made to the same enrollee in more than one state.²⁹ However, that information is reportedly only quarterly. State agencies also check for incarceration which affects eligibility. Other changes in circumstances such as, marriage, divorce, and relocation would all have to reported by the individual for the state agency to know on a timely basis.

In the meantime, the individual may (likely) have experienced other changes as well, particularly in a change in income in the last 12-18 months as people have returned to work and employers have offered incentives to attract workers. Prior to MAGI, eligibility was assessed on monthly income. MAGI is based on annualized income. The Medicaid agency verifies financial information, including wages and net earnings from self-employment through data matches with the State Wage Information Collection Agency (SWICA), the Internal Revenue Service (IRS), the Social Security Administration (SSA), and other state agencies. Financial data also may only be available on a quarterly basis that is typically accessed by the state in the second month after the quarter ends. States should request additional information from an individual adult who reports \$0 in income.

The proposed rule would require states to provide an applicant with at least 15 or 30 days (depending on the applicable eligibility category), “to respond and to provide any necessary information.” The state agency is required to provide a notice of appeal and hearing for an adverse action. This provision is unclear and should be clarified in the final rule. Specifically:

- CMS needs to clarify whether this provision would require the state agency to provide an *additional* period of appeal prior to closing the case for incomplete information.

By adding more time prior to the state agency making a final determination of eligibility, a minimum of 30 days at application [proposed 435.919(c)(1)] and 90-day reconsideration period upon changes in

²⁹ Administration for Children and Families, “Public Assistance Reporting Information System,” <https://www.acf.hhs.gov/paris/state>

circumstances [proposed §435.919(d)], the proposed rule means the states will have to act upon information that is that could be as much as 180 days old. By “freezing” information at a point in time, eligibility error rates are likely to increase as a result.

Using data from one public assistance program to determine eligibility in another is not new and has been promoted to expedite and simplify enrollment and reduce state administrative costs for more than a decade. The Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) created performance bonuses to give states incentives to adopt features such as Express Lane Eligibility (ELE) which states can use eligibility findings from other public benefit programs to establish eligibility for Medicaid and CHIP.³⁰ In an October 2016 Report, the Health and Human Services Office of Inspector General reported that 14 states had adopted ELE but 5 states had discontinued its use.³¹ According to the latest CMS data on the use of ELE, only 7 states use it for Medicaid or CHIP and only two use it for both.³² A major reason states have not adopted ELE is because of the major investments in integrated IT systems. The key to accuracy and timeliness is fresh data that is reliable.

The proposed rule adds complexity and therefore risk by adding new procedures and timelines. While it acknowledges that “...States may not take adverse action based on unreliable information,” it puts up barriers for states to obtain reliable information from the individual.³³

Medicaid is unique in that it already provides for “retroactive” eligibility for up to 90 days of coverage prior to the date of application. States already have options for extending coverage so there is no need for these provisions. Moreover, CMS already has authority to impose sanctions on states for failure to act within the respective eligibility determination deadlines.

- CMS should delay these provisions for 24 months after the end of the PHE and then collect actual data on how long the eligibility determination and redetermination take.
- CMS should publish, on a quarterly basis, the states that failed to meet the eligibility determination deadlines.

9. Promoting Enrollment and Retention of Eligible Individuals: Timely Determination and Redetermination of Eligibility (§§ 435.907 and 435.912)

CMS clearly defines a problem but does not offer a clear solution. In the preamble, CMS notes that, “[t]hrough this work, as well as our ongoing work with States prior to the COVID-19 PHE, we have become aware that in certain situations, redeterminations can remain incomplete for several months following

³⁰ See: Centers for Medicare and Medicaid Services, “Children’s Health Insurance Program Reauthorization Act (CHIPRA),” Fact Sheet, December 19, 2012, <https://www.cms.gov/newsroom/fact-sheets/childrens-health-insurance-program-reauthorization-act-chipra>

³¹ Department of Health and Human Services, Office of Inspector General, “State Use of Express Lane Eligibility for Medicaid and Chip Enrollment,” October 2016, <https://oig.hhs.gov/oei/reports/oei-06-15-00410.pdf>

³² See: Centers for Medicare and Medicaid Services, “Express Lane Eligibility for Medicaid and CHIP Coverage,” <https://www.medicaid.gov/medicaid/enrollment-strategies/express-lane-eligibility-medicaid-and-chip-coverage/index.html>

³³ “Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes,” p. 54785.

the end of a beneficiary's eligibility period."³⁴ CMS also notes that benefits must be continued throughout this period of uncertainty.

The proposed rule would require states to reconfigure their MES to ensure the new procedures related to checking available data sources, documenting outreach, and documenting actions on returned mail. States would no longer be able to use "returned mail" as sufficient evidence to close a case.

- The need for states to make these operational changes is another reason why CMS should not set a compliance date for these provisions before the completion of the PHE "unwind."

10. Eliminating Barriers to Access in Medicaid (§§ 435.956, 457.380 and 435.608)

The proposed rule puts states in a "Catch-22" in proposing to prohibit states from gathering information unless it has reason to do so and it cannot be based on asking the individual for the information. Simplification works only if it is clear. If it is not clear, it has not been simplified.

CMS proposes to (1) prohibit states from imposing limitations on the number of Reasonable Opportunity Periods ("ROPs") to verify citizenship, national, or satisfactory immigration status; and (2) remove or limit the requirement to apply for other benefits.

The purpose of the ROP is to reconcile inconsistent information. An individual has attested to citizenship status but the electronic verification systems states rely upon do not support the attestation. Without a limitation on ROPs, the state may be forced to accept other information on the application that is no longer accurate.

The longstanding requirement to apply for other benefits can be traced back to 1978. CMS now proposes to exercise language at 1902(a)(17)(B) that a State plan "must provide for taking into account only such income and resources as are, determined *in accordance with standards prescribed by the Secretary*, available to the applicant or recipient ..." (emphasis in original).³⁵ This is another example of tension in determining "best interest" of an individual. Should enrollment in Medicaid supersede the individual's interest in obtaining financial benefits that may be available to them? While CMS states that "[w]e are interested, for example, in whether or not it is the experience of State agencies that imposition of the existing rule commonly results in applicants or beneficiaries receiving additional eligibility-altering income."³⁶ This is precisely the type of information a federal agency should want to know prior to promulgating such a sweeping rule that removes a longstanding policy and procedures "... entirely for all Medicaid applicants and beneficiaries *to apply for other benefits to which they are entitled* (emphasis added)."

CMS projects that these two provisions will have a significant financial impact, adding \$18.48 billion in total spending to Medicaid over the first five years, \$6.69 billion of which will be additional state spending.³⁷

³⁴ "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes," p. 54786.

³⁵ Ibid p. 54802.

³⁶ Ibid p. 54804.

³⁷ Ibid Table 8, p. 54837.

CMS should:

- Clarify that in prohibiting a limitation on ROPs, it is NOT requiring states to accept self-attestation and thereby approve an application that has not been electronically verified for citizenship status.
- Amend the proposed rule to require states to close a case for which citizenship/immigration status has not been electronically verified that is more than 90 days old. This would not prohibit an individual from submitting a new application.
- CMS should withdraw the application for benefits provision and instead undertake the study and analysis it requests on how states operationalize the requirement and whether individuals would forfeit benefits to which they are entitled if the rule were finalized.

11. Recordkeeping (§§ 431.17, 435.914, and 457.965)

The proposed revisions to this subsection are consistent with the expectations of a modern Medicaid IT system. However, they still raise two issues for states: funding and compliance.

- CMS needs to clarify that all of the costs of compliance will be eligible for the 90/10 match rate for necessary DDI activities.
- Also, given the competition among states for the limited number of vendors who can perform this work, and the lengthy procurement processes that states face, CMS needs to clarify that it will not sanction states for noncompliance for at least 36 months following the effective date of the final rule.

12. CHIP Proposed Changes—Streamlining Enrollment and Promoting Retention and Beneficiary Protections in CHIP (§§ 457.340, 457.1170, 457.344, 457.960, 45.348 and 457.350) and Eliminating Access Barriers in CHIP (§§ 457.570, 457.65, 457.340, 457.350, 457.480, 457.805, 457.810 and 600.525)

Title XXI of the Social Security Act provide states with three choices for how they want to provide coverage to uninsured targeted low-income children and other classes of children:

1. Expand Medicaid and thus follow all Medicaid rules
2. Establish a separate CHIP program
3. Use a combination of Medicaid and CHIP

Section 2102(b) “General Description of Eligibility Standards and Methodology” describes the eligibility standards (including access to other health coverage), methodology for establishing and continuing eligibility and enrollment, eligibility screening and coordination with other health coverage programs, reduction of administrative barriers and non-entitlement. Section 2102(b)(4), reducing administrative barriers, provides “[s]uch procedures shall be established and revised as often as the **state** determines appropriate ... (emphasis added)”.

The proposed rule would make numerous changes to the State Children’s Health Insurance Program (CHIP) under the umbrella justification of Section 1413 of the ACA. The use of the words “align” and “alignment” in the preamble is confusing if not misleading. In the alphabet and a geometric line AB, “A” is aligned with “B” as they are next to or connected to each other. But “A” is not “B.” Section 1942

requires “coordination” between Medicaid, the State Children’s Health Insurance Program (CHIP) and State Health Insurance Exchanges but it does not require one program to become the other.

States with separate CHIP programs cannot be required to adopt Medicaid policies or even processes that reduce their authority under the Title XXI statute.

- Accordingly, CMS needs to remove from the final rule its proposed changes to the following subsections:
 - 42 CFR 457.344 Changes in circumstances.
 - 42 CFR 457.348 Determinations of Children’s Health Insurance Program eligibility by other insurance affordability programs.
 - 42 CFR 457.350 Eligibility screening and enrollment in other insurance affordability programs.
 - 42 CFR 457.480 Prohibited coverage limitations, preexisting condition exclusions, and relation to other laws.
 - 42 CFR 457.570 Disenrollment protections.
 - 42 CFR 457.805 State plan requirement: Procedures to address substitution under group health plans.
 - 42 CFR 457.810 Premium assistance programs: Required protections against substitution.

13. Inadequacy of Fiscal Impact Analysis

As acknowledged in the fiscal impact statement and supporting tables, “[t]here is a wide range of possible savings due to this effect of the proposed rule.”³⁸ The impact of government rules is supposed to be realistic, not merely a possibility. The fiscal impact of a rule should be predictable. The fiscal impact of this proposed rule is wildly unpredictable because of the PHE and the uncertainty of the unwind.

Under the rule, CMS estimates the states would be required to increase state spending by \$39.5 billion to keep people enrolled in Medicaid and CHIP longer, while the federal spending for Marketplace subsidies would decrease by nearly \$18 billion for the federal fiscal years 2023-2027.

The proposed rule almost exclusively describes situations in which states must take additional time and invest in additional procedures to avoid termination of Medicaid eligibility, and by implication, lose access to coverage. But, more precisely, the rule will *prevent* the migration to private insurance offered through the federal Marketplace. CMS assumes 60 percent of the individuals impacted by the proposed rule would have enrolled in Marketplace coverage. “The remaining 40 percent would have either received other coverage or become uninsured.”³⁹

CMS should:

- Use more recent data to estimate facilitated enrollment through LIS “Leads Data.” The preamble references a MACPAC study that undercounts current MSP enrollment.

³⁹ Ibid p. 54837.

- Provide an analysis of the cost of maintaining coverage of individuals who are found to be ineligible.
- Provide an analysis of the cost of delay in disenrollment. Due to the expansion of managed care, states pay monthly capitation rates to MMCOs. Delays in adjudication will likely add at least one month of payments to the MMCOs and potentially two months depending on the timing of taking action.

Summary

The ability of states to make a determination requires the ability of other federal and state agencies to provide necessary information about an application on a timely basis. Strengthening states' ability to gain access to updated databases would likely have a greater impact on streamlining the determination and redetermination processes than the rule itself. Delays occur because information is missing from the application. Given that states are restricted from requesting information from the applicant, the need for data sharing among federal and state partners has increased in importance. CMS should conduct an analysis of ability of the federal data systems to provide accurate and timely data including how conflicting information is resolved. For example, a state may obtain an updated address from a Supplemental Security Income (SSI) beneficiary. But the state cannot independently make the change of address for the individual. The Social Security Administration (SSA) must do so.

By slowing down the switch from Medicaid and CHIP to private insurance, the proposed rule is a missed opportunity to bring more young, healthy lives into the risk pool. It is yet another reminder that the ACA turned out to be more of a Medicaid expansion than helping to lower the cost of private coverage by adding millions of lives to the individual insurance market. The bias towards Medicaid demands a national discussion beyond the proposed rule that should be answered before it is finalized.

Dennis G. Smith
Head Coach
Medicaid Strategies

Ed Haislmaier
Senior Research Fellow
The Heritage Foundation

Nina Owcharenko Schaefer
Director, Center for Health and Welfare
The Heritage Foundation