National
MLTSS
Health Plan Association

November 7, 2022

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2421-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244

Re: Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes

Dear Administrator Brooks-LaSure:

The National MLTSS Health Plan Association (MLTSS Association) appreciates the opportunity to provide comments on the Center for Medicare and Medicaid Services (CMS) Medicaid Eligibility and Enrollment Proposed Rule, published in the Federal Register on September 7, 2022.[1]

The MLTSS Association represents managed care organizations (MCOs) that have Medicaid managed care contracts with one or more states and take risk for long-term services and supports (LTSS) provided under Medicaid.[2] Our members assist states in delivering high-quality LTSS at the same or lower cost as the fee-for-service system with a particular focus on ensuring beneficiaries' quality of life and ability to live as independently as possible. Our members currently cover the majority of all enrollees in MLTSS plans and integrated plans, including national plans and regional and community-based plans. Furthermore, relevant to the changes proposed within the rule, beneficiaries enrolled in member plans are often dually eligible for both Medicare and Medicaid and have ongoing care needs, which increases their risk for poor health outcomes stemming from otherwise avoidable gaps in coverage.

We broadly support the intent and changes CMS proposes to streamline Medicaid and CHIP eligibility and enrollment. These changes better ensure beneficiaries can acquire and retain their Medicaid coverage. We support CMS' proposals to better facilitate enrollment for dually eligible beneficiaries, align non-MAGI and MAGI enrollment policies, enshrine certain application and renewal timelines, and outline more structured beneficiary information gathering processes. Our comments that follow include further rationale of our positions on CMS' proposals, as well as important caveats for CMS to consider as it moves towards implementation.

[1] 87 Fed. Reg. 54,760 (Sept. 7, 2022).
[2] Members include Aetna, AmeriHealth Caritas, Elevance Health, CareSource, Centene Corporation, Commonwealth Care Alliance, Inclusa, LA Care Health Plan, Molina Healthcare, UPMC Community HealthChoices, and VNS Health.

Timelines

The MLTSS Association implores CMS to work with its state partners in determining appropriate timelines for compliance with rule provisions. Currently, states are critically short-staffed and must also jointly prepare for conducting redeterminations once the COVID-19 Public Health Emergency (PHE) ends. Consequently, we generally recommend policies proposed in this rule to not overlap with the 14 months following the end of the PHE. This allows states ample time and focus to leverage limited staff to prioritize the redetermination process before then moving to implementation of the provisions outlined in this rule. However, we do stress that there are certain exceptions that warrant shorter time frames. In particular, we believe it is reasonable to shorten timeframes for proposals that would facilitate redeterminations at the end of the COVID-19 PHE.

Examples of these proposals include certain provisions related to renewals and information gathering. These proposals can help streamline processes and minimize gaps in care that are likely to occur after the end of the PHE and the maintenance of effort requirement (MOE) ends. In addition, several of these provisions are already optional authorities states can elect to use during the PHE, as described in CMS' March 2022 guidance.[3] Specifically, we recommend CMS, in consulting with states, consider maintaining a 60 to 90-day compliance requirement the following provisions:

- Alignment of non-MAGI and MAGI Enrollment Policies: Many of these flexibilities, including limiting non-MAGI renewals to once annually, use of prepopulated renewal forms, a 90-day reconsideration period, and elimination of the in-person interview requirement, are already available to states or as a State Plan Amendment during the PHE. As explained in further detail below, these provisions help maximize the ability for non-MAGI populations to enroll and maintain Medicaid coverage and minimize potential gaps in care.
- Agency Action on Returned Mail: Establishing a structured outreach process to attain beneficiary contact information will help assure states are working with their MCO partners and leveraging third-party data sources to update beneficiary contact information and using multiple methods of outreach. However, as explained below, we recommend states exercise caution in the information sent to beneficiaries when using a new forwarding address without first contacting the beneficiary. We also recommend CMS exercise discretion on a case-by-case basis, depending on outreach methods outlined in a state's unwinding operational plan.

Finally, CMS requests input on the use of calendar or business days in the new timelines outlined for several provisions. We recognize that in certain circumstances the use of business days would be helpful to beneficiaries' coverage determinations (e.g., extending redetermination timeframes) whereas in others the use of calendar days may be more justified (e.g., our recommendation of a 30-day compliance period for renewal and information gathering). Moreover, existing Medicaid regulations already vary between calendar day (e.g., 42 C.F.R § 431.70 uses a 30-calendar day timeframe for updates to provider directories) and business days (e.g., 42 C.F.R. § 438.10(c)(6) requires certain enrollee disclosures to be available within

[3] https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf

5 business days). Given the variability of business and calendar days under current regulations, we do not recommend use of one over the other. Instead, the use of business or calendar days should depend on the specific policy under discussion.

Facilitating Medicaid Enrollment

The MLTSS Association supports CMS' proposals to streamline the enrollment and eligibility determination processes for Medicaid and the Medicare Savings Programs (MSPs) and promote greater policy alignment between the Social Security Administration (SSA) and Medicaid. By reducing burden on beneficiaries and states, the proposals will create a more seamless experience for beneficiaries to apply for and enroll in Medicaid and MSPs, thereby increasing their enrollment and access to cost-sharing benefits for Medicare.

Use of Medicare Part D Low-Income Subsidy (LIS) "Leads" Data

By requiring States to maximize the use of LIS leads data to establish eligibility for Medicaid and MSPs, this proposal will alleviate beneficiaries of the unnecessary burden of applying for benefits for which States can already determine eligibility using existing data. This proposal would also standardize across States the steps they must take upon receiving LIS leads data from SSA, including treating the receipt of leads data as an application for Medicaid, asking applicants only for additional information needed for eligibility determination, providing information to the applicant on the local State Health Insurance Assistance Program (SHIP), and taking the opportunity to determine whether such individuals are eligible for Medicaid in any other eligibility groups, including other non-MAGI and MAGI-based groups. This policy change may be particularly impactful for historically marginalized populations with cultural and language barriers that may deter them from knowing about or applying for these programs that they stand to benefit from.

The MLTSS Association also supports CMS' proposal to require States to adopt certain enrollment policies related to the income and resources counted towards determining MSP eligibility, including requiring states accept self-attestation for interest and dividend income, non-liquid resources, up to $1,500 in burial funds, and up to $1,500 in life insurance. These changes may also disproportionately help historically marginalized populations who may have more difficulty demonstrating the value of their assets. While the current proposals are limited to the MSP non-MAGI eligibility group, we recommend that CMS apply the proposals to other non-MAGI eligibility groups as well, as they would also benefit from more simplified policies around determining their income and assets.

Aligning the MSP Definition of "Family Size" with LIS Definition

Currently, States have flexibility in how they define "family size" for the purpose of determining eligibility for the MSP groups. Many states only include a spouse living in the household in their family size definition. CMS proposes to set a national definition of the ''family of the size involved'' to include at least the individuals included in the definition of ''family size'' in the LIS program. In the LIS program, ''family size'' is defined to include the applicant, the applicant's spouse (if the spouse is living in the same household with the applicant), as well as all other individuals living in the same household who are related to the applicant and dependent on the applicant or applicant's spouse for one-half of their financial support.

Overall, the MLTSS Association supports any proposals to better align definitions between LIS and MSPs, which will help to simplify beneficiaries' understanding of what they qualify for as well as the States' eligibility determination processes. Furthermore, setting a standardized national definition of "family size" that is broader than how some states are currently defining it will help expand eligibility for applicants with dependent adult children, parents, grandchildren, etc. living with them. This may be particularly relevant for low-income Medicare enrollees with non-traditional family arrangements due to cultural differences or supports needed to remain in the community.

Auto-Enrollment of Certain SSI Recipients into the Qualified Medicare Beneficiaries (QMB) Group

CMS proposes to require States to deem an individual enrolled in the mandatory SSI or 209(b) group eligible for the QMB group the month the State becomes responsible for paying the individual's Part B premiums under its buy-in agreement. QMB coverage would start the month after the State deems an individual eligible for the QMB group and starts paying the individual's Part B premiums.

The MLTSS Association supports this proposal, as it would help to reduce churn and increase enrollment of individuals in the QMB group, thereby increasing their access to affordable, consistent care. While all individuals eligible for SSI already meet the income and eligibility limits for QMB, many states fail to enroll them because of procedural and technical barriers. Automating the enrollment process will mitigate these existing barriers and reduce the burden on beneficiaries to navigate a complex and duplicative application process.

In addition to addressing the barriers associated with enrollment in the Part B premium buy in program and QMB coverage, we feel it appropriate to stress to CMS the barriers raised by the dichotomy created between Part A premium "buy-in" states and "group payer states."[4] In "buy-in" states (36 states), beneficiaries are able to conditionally apply for and receive Part A premium assistance at any point in the year. In "group payer states" (14 states), conditional approval for Part A premium assistance can only occur during the prescribed enrollment period. Importantly, limited access to Part A represents subsequently limited access to the broader QMB program. We recognize that participating in a Part A buy-in agreement is at the discretion of states, but we nevertheless urge CMS to consider all regulatory options to alleviate this barrier to the QMB program (and to Part A premium assistance).

Allowing Medically Needy Individuals to Deduct Prospective Medical Expenses

CMS is proposing to allow noninstitutionalized individuals to deduct anticipated medical and remedial care expenses from their income for purposes of eligibility determination through the Medically Needy enrollment pathway. Currently, individuals who reside in the community are not deemed to meet Medicaid eligibility until their share of the cost is incurred, while those residing in institutions are able to project their costs and be deemed Medicaid eligible for the first day of the month. The existing policy contributes to institutional bias in the system and creates unnecessary burden for beneficiaries who must document spending each month before their Medicaid is activated.

[4] SSA Program Operations Manual System. HI 00801.140.

The MLTSS Association strongly supports this proposal to allow States to project expenses for noninstitutional services for beneficiaries living in the community. This proposal recognizes that certain home- and community-based services are also often delivered on a constant and predictable basis and seeks to address the institutional bias that the current policy upholds in assuming otherwise. In addition to CMS' proposal to permit States to project the expenses of section 1915(c), (j), (k) and (i) services and prescription drug services, we recommend that CMS consider including in the regulatory text the following as examples of services with consistent and predictable costs: dental services, transportation services, Durable Medical Equipment (DME), and Disposable Medical Supplies.

We also recommend that CMS consider allowing expenses for technology more broadly to be counted, as there are many examples of how technology can be leveraged within individuals' homes to support outcomes and reduce the reliance of unnecessary (or unwanted) direct care professional staff. Examples of such technologies include remote patient monitoring, sensory technology to monitor when someone with cognitive limitations or memory loss leaves their bed and returns to bed in the middle of the night, or "Med Minders", which capture data on individual medication uptake and contacts a family member or neighbor when a medication has not been taken as scheduled. Furthermore, it may be beneficial to consider the cost of broadband access needed to facilitate the use of such technologies that support an individual's ability to live in a community setting.

Promoting Enrollment and Retention of Eligible Individuals

Aligning Non-MAGI and MAGI Enrollment Policies

The MLTSS Association broadly supports CMS' proposals to align non-MAGI and MAGI enrollment policies, explained in further detail below:

- Annual Renewals: More frequent renewals increase the probability beneficiaries may disenroll from coverage due to procedural or administrative reasons. Further, the income and assets of non-MAGI individuals tend to not change drastically over time to warrant more frequent renewals.

- Prepopulated renewal forms: Prepopulated forms simplify the eligibility renewal process and minimize risk for errors. In 2019, 30 states have already adopted the option to use prepopulated forms in age and disability-related pathways.[5]

- 90-Day Reconsideration Period: This reconsideration period is particularly helpful for dually eligible beneficiaries, who exhibit a high rate of churn due to administrative reasons such as providing certain documentation of income and assets. Dually eligible beneficiaries often also regain coverage within 90 days of losing it, indicating that a 90-day reconsideration period would minimize unnecessary gaps in coverage and reduce state administrative burden.[6]

[5] https://files.kff.org/attachment/Issue-Brief-Medicaid-Financial-Eligibility-for-Seniors-and-People-with-Disabilities-Findings-from-a-50-State-Survey

[6] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.0396

- Removal of In-Person Interview Requirement: The in-person interview requirement is particularly burdensome for states and can lead to gaps in coverage for beneficiaries. Interviews are time-intensive for states, minimize the ability to conduct an *ex parte* renewal for certain beneficiaries, and can increase the probability an individual loses coverage due to not being able to complete the interview. Individuals with LTSS needs may not have consistent work schedules to conduct the interview, have difficulty arranging transportation, or otherwise difficult to reach.[7] Some states, such as Washington, already incorporate flexibility in their interview requirements for LTSS, including the ability to conduct the interview by phone or waive the requirement if the client is unable to complete it due to a medical condition or because no one is available to assist the beneficiary.

  Even without the interview requirement, states and plans have many other touch points in place to interact with the beneficiary and ensure appropriate service delivery. MLTSS plans have robust care coordination procedures in place to ensure beneficiaries receive the services and providers they need through a person-centered planning approach. Care managers will often conduct ongoing periodic reassessments of a beneficiary's needs to assure care plans can be adjusted if needs change.[8] Care managers will also keep close contact with the beneficiary during a significant health event (e.g., hospitalization) and when there are changes in formal/informal supports (e.g., switching providers, losing a caretaker).

Acting on Changes in Circumstances, Timeframes, and Protections

CMS proposes to require states to have procedures in place for processing beneficiary changes in circumstance that impact eligibility. CMS describes steps that states should take, including 1) evaluating whether the change may impact eligibility 2) determining if additional information is needed, 3) providing advance notice of disenrollment if beneficiary is eligible for other programs, and 4) acting on information obtained from third party, such as SNAP. CMS proposes states to have 90 days for the beneficiary to submit additional information, and an additional 90-day reconsideration period after the beneficiary is disenrolled.

The MLTSS Association supports these processes and time periods proposed and recommends that CMS consult with states on the feasibility of these time periods as well. These guardrails allow beneficiaries to provide additional information and maintain their coverage, while balancing the need for states to disenroll individuals who may no longer be eligible for the Medicaid program. Notably, these changes reduce the propensity for churn within the Medicaid program, which can result in higher administrative costs and less predictable state expenditures. Churn can also contribute to delayed care, less preventive care, less filling of prescriptions, and higher emergency department use, all leading to increased health care costs.[9]

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[7] https://www.cms.gov/files/document/navigating-medicare-savings-program-msp-eligibility-experience-journey-map.pdf

[8] https://www.macpac.gov/wp-content/uploads/2018/06/Managed-Long-Term-Services-and-Supports-Status-of-State-Adoption-and-Areas-of-Program-Evolution.pdf

[9] https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/199881/medicaid-churning-ib.pdf

Timely Determination for New Applicants and Redetermination of Eligibility

New Applications: CMS establishes new timelines for the timely determination of new applicants, including 15 days (30 for those applying based on disability) for beneficiaries to provide additional information requested, a 30-day reconsideration period, and a 45-day period for the state to complete an application based on new information received (90 for those applying based on disability).

The MLTSS Association supports the revised timelines CMS has set out for determining eligibility and time for beneficiaries to respond to additional information requests. However, we recommend CMS provide 45 days, rather than 30, for individuals applying based on disability to respond to an information request from the state.

Determining eligibility for LTSS can be a complex, involved process for state Medicaid agencies. States must first determine if individuals meet certain state-defined income eligibility criteria, and then determine whether the individual meets certain state-defined functional eligibility requirements, which are assessed using a variety of different functional assessment tools. The functional assessment is a labor-intensive process, often consisting of a face-to-face interview in an individual's home. If the individual is eligible for more than one LTSS program, multiple assessment tools may be needed. Further complicating eligibility determinations is the patchwork of HCBS waivers that exist in states – each waiver with its own eligibility criteria. Consequently, we believe additional time is needed to ensure that beneficiaries applying on the basis of disability have sufficient time to respond to state requests for additional information.

Redeterminations: CMS proposes expanding timeliness and performance standards to also govern the redetermination process and when a change in circumstances occurs. We support the expansion of additional criteria for the state to consider in establishing standards, including the time needed by the state to evaluate the information from electronic data sources, as well as the time needed to provide advance notice to beneficiaries. We also support the exception of providing 90 calendar days for redeterminations based on disabilities, rather than just 25 calendar days before the end of the eligibility period. As previously noted, LTSS eligibility can be a relatively more complex and involved process, and states need additional time to collect the information necessary to conduct the redetermination.

Agency Action of Returned Mail

CMS proposes a series of steps when beneficiary mail is returned to the state, including checking available data sources for updated contact information, conducting outreach using at least two different modalities, and taking a corresponding action based on whether a new forwarding address obtained. CMS proposes that states must use a new address obtained, even if not confirmed, disenroll the beneficiary with advance notice if an out of state address is found, or take reasonable steps to find the address if no address is found, and then disenroll the beneficiary.

The MLTSS Association supports the intent behind a structured process to ensure beneficiary contact information is up to date to assure beneficiaries are apprised of changes to their eligibility or requests for more information for renewal. In implementing any process, we caution CMS and states to appropriately

account for scenarios beyond the beneficiary's control. For example, beneficiaries may have unstable housing situations or use prepaid cell phones that run out of minutes.

We strongly support CMS' recommendation for states to work with MCOs to receive the most up-to-date contact information. MCOs, through their care management programs and relationships with providers, can have multiple points of contact with members with more up-to-date contact information. However, we recommend states exercise caution in using a new address obtained by the MCO or discovered through other means without being first confirmed by the beneficiary. Given the potentially sensitive nature of the communications between the state and the beneficiary, including personal identifiable information, there may be privacy concerns and the possibility that such information is exposed to other individuals if an unconfirmed address is used. CMS and states should only communicate non-sensitive information when using an address that has yet to be confirmed by the beneficiary. In addition, rather than updating a mailing address based on outside information, we instead recommend that states use that information as a second, alternative address, until the beneficiary can be successfully contacted.

Finally, we also support the use of at least two different methods of communication (e.g., text messaging and mail) regarding additional information. Beneficiary preference for communication can vary widely – some may prefer electronic notices, while others may opt for paper notices. Others may express a need to speak to a caseworker in person, especially if the beneficiary has additional questions. Access to technology will vary as well – some may not have access to a computer, depend on a cell phone with limited data, or live in rural areas with limited broadband access. Unique beneficiary preferences should be considered when determining the best outreach method. Further, CMS must also consider the unique accessibility issues across different modes of communication for those with disabilities.[10]

In addition to the above, we also recommend CMS consider the following to better enable plans to conduct outreach, especially once redeterminations begin after the end of the COVID-19 PHE:

- Encourage states to allow plans to initiate communications at least 30 days pre and 60 post an individual's renewal date and continue to communicate at least 60-90 days post disenrollment from Medicaid to assist with transitioning to other coverage options.
- Encourage states to allow MCOs to educate members losing Medicaid eligibility about other coverage options, including Exchange coverage offerings and the potential for employer-sponsored coverage availability. States should also be encouraged to allow "warm transfers" of individuals losing Medicaid eligibility from MCO call centers to Exchange enrollment experts.
- Work with states to expedite approval of health plan marketing materials related to redetermination. CMS could also provide pre-approved template materials to states to facilitate expedited communication.

[10] https://www.macpac.gov/wp-content/uploads/2022/01/Beneficiary-Preferences-for-Communication_MACPAC-Issue-Brief_Jan-2022.pdf

- To the extent states have data systems that denote certain SDOH-related characteristics, such as homelessness and primary language, states should leverage this data and share it with MCOs, CBOs, and providers to inform best practices to conduct outreach.

Eliminating Barriers to Access in Medicaid

Under current policy, State Medicaid agencies must require that all Medicaid applicants and beneficiaries, as a condition of their eligibility, take all necessary steps to obtain other benefits to which they are entitled (unless they can show good cause for not doing so). CMS proposes to remove this requirement by reinterpreting the meaning of "such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient" in section 1902(a)(17)(B) of the Social Security Act to encompass only the actual income and resources within the applicant's or beneficiary's immediate control (i.e., rather than the income and resources that might be available if such individuals applied for, and were found eligible for, other benefits).

The MLTSS Association supports this proposal to consider only income and resources as those within the beneficiary's immediate control for purposes of Medicaid eligibility. Eliminating this requirement for Medicaid eligibility to be contingent on applying for other benefits will help to reduce churn and burden on individuals to continually provide information on applications for other benefits they may be entitled to. While we support the removal of this requirement, CMS should encourage States to consider other creative strategies to educate beneficiaries on the other benefits they are entitled to and to maximize their enrollment in those other programs. For example, one MLTSS Association plan member is paying for its members to enroll in the Supplemental Nutrition Assistance Program (SNAP) – States could consider other policy levers to incentivize partnerships to maximize beneficiary enrollment in public benefit programs that would support their holistic health and social needs.

Conclusion

The MLTSS Association supports CMS' proposals to improve the eligibility and enrollment process for Medicaid and CHIP beneficiaries. We welcome the opportunity to work with CMS to operationalize the policy changes in this proposed rule. If you have any questions, please contact me at mkaschak@mltss.org.

Sincerely,

Mary Kaschak
Chief Executive Officer