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November 7, 2022

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

Submitted electronically via https://www.regulations.gov/commenton/CMS-2022-0134-0002

Re: Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes (87 F.R. 54760, published September 7, 2022)

Dear Administrator Brooks-LaSure:

On behalf of the National Association of Social Workers (NASW), I submit comments on the notice of proposed rulemaking (NPRM) addressing streamlining application, eligibility determination, enrollment, and renewal processes for the Children's Health Insurance Program (CHIP), Medicaid, and Basic Health Program (CMS-2421-P).

Founded in 1955, NASW is the largest membership organization of professional social workers in the United States, representing more than 110,000 social workers. The association works to enhance the professional growth and development of its members, to create and maintain professional standards, and to advance sound social policies.

Social workers play an essential role in serving CHIP and Medicaid enrollees. In keeping with NASW's mission to advance sound social policies, we are committed to advancing equity in all health programs and activities.

NASW strongly supports the streamlining of eligibility, enrollment, and renewal processes in the NPRM. Our comments address the following topics:

- facilitating Medicaid enrollment, particularly for people eligible for Medicare Savings Programs (MSPs) and people who use home and community-based services (HCBS)
- streamlining Medicaid and CHIP enrollment and renewal processes to maximize retention and continuity of health insurance coverage

FACILITATING MEDICAID ENROLLMENT

MSPs increase health care access and affordability by covering part or all of beneficiary costs for Part A and Part B deductibles, coinsurance, copayments, or some combination thereof. The need for MSPs is growing. Out-of-pocket spending on Medicare premiums and deductibles has increased over the past 20 years.[1] Poverty among people 65 years and older—who constituted 86.2 percent of Medicare beneficiaries in 2019[2] (the most recent data available)—grew from 8.9 percent in 2020 to 10.3 percent in 2021, an increase of 1 million older adults.[3]

Despite these trends, the number of Medicare beneficiaries of all ages enrolled in the four MSPs—Qualified Medicare Beneficiary (QMB) program, Specified Low-Income Medicare Beneficiary (SLMB) program, Qualified Individual (QI) program, and Qualified Disabled Working Individual (QDWI) program—falls far short of the number eligible.[4] Consequently, NASW supports CMS's proposals to expedite MSP enrollment.

Facilitate Enrollment Through Medicare Part D Low-Income Subsidy (LIS) "Leads" Data

The process of finding and applying for multiple programs is overwhelming for many beneficiaries, especially those with limited English proficiency (LEP). Efficient use of LIS leads data is integral to smooth enrollment in MSPs. The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 (Pub. L. No. 110-275)[5] requires states to accept as verified the information sent by the Social Security Administration (SSA) to the state. The statute also specifies that states, upon receipt of leads data, must initiate an application for MSPs. If a state needs more information to process the application, it should send a prepopulated application to the beneficiary solely to gather missing information; the beneficiary should not be required to complete the entire application.

Although MIPPA has mandated these procedures for more than 10 years, most states have not fully implemented them. Social workers frequently encounter beneficiaries enrolled in LIS who are not enrolled in (or even familiar with) MSPs. Some LIS enrollees receive blank application forms for MSPs rather than prepopulated forms. Others struggle to ascertain information that SSA does not submit to states such as dividend and interest income, and the cash value of life insurance and nonliquid assets; some beneficiaries even give up at this stage in the application process. The equity implications of this barrier are significant. Many individuals (especially in communities of color) struggle for decades and families, for generations, to obtain nonliquid assets. Policies that penalize individuals with low incomes for possessing such assets perpetuate economic disparities.

Given these access challenges, NASW supports the following proposals by CMS:

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[1] Kaiser Family Foundation. (2022). *The facts about Medicare spending.* https://www.kff.org/interactive/medicare-spending/

[2] Tarazi, W., Welch, P., Nguyen, N., Bosworth, A., Sheingold, S. De Lew, N., & Sommers, B. D. (2022). Medicare beneficiary enrollment trends and demographic characteristics. https://aspe.hhs.gov/reports/medicare-enrollment

[3] Creamer, J., Shrider, E. A., Burns, K., & Chen, F. (2022). *Poverty in the United States: 2021* (Report Number P60-277). U.S. Census Bureau. https://www.census.gov/data/tables/2022/demo/income-poverty/p60-277.html

[4] National Council on Aging. (2022). *Take-up rates in Medicare Savings Programs and the Part D Low-Income Subsidy.* https://www.ncoa.org/article/take-up-rates-in-medicare-savings-programs-and-the-part-d-low-income-subsidy

[5] Medicare Improvements for Patients and Providers Act of 2008, Pub. L. No. 110-275, 122 Stat. 2494 (2008).

- Require states to process MSP applications based on beneficiary attestations regarding the cash value of dividend and interest income and the cash value of life insurance and nonliquid assets.
- Require that assistance be provided to MSP applicants in obtaining life insurance information from insurers.

Use the LIS Definition of "Family Size" in Determining MSP Eligibility

CMS currently allows states to define family size for the purpose of counting income for MSPs. Many states define *family* to include only a spouse living in the same household as the beneficiary. This narrow definition excludes many family members who might live with and rely financially on a beneficiary or the beneficiary's spouse, including adult children with disabilities, grandchildren and other family members receiving kinship care, and parents. Therefore, NASW strongly supports CMS's proposal to set a national definition of family size for MSP eligibility that would include not only the spouse, but also all relatives, by blood or marriage, who reside in the household and depend on the applicant or spouse for at least half of their financial support. This proposed change is consistent with the LIS definition of family size and would expand income eligibility to reflect the financial realities of cohabiting extended families and multigenerational households. Such living arrangements are especially common in communities of color, in which both intergenerational interdependence and family care partnerships are valued highly. Moreover, for people of any race and ethnicity who have limited incomes, the ability to pool resources within a household enhances the economic security of all individuals therein.

Automatically Enroll Certain Supplemental Security Income (SSI) Enrollees in QMB

All Medicare beneficiaries who are enrolled in SSI also meet the income and eligibility limits for QMB. However, many of these beneficiaries are not enrolled in QMB because of state-level procedural and technical barriers, including a requirement to enroll separately in Medicare Part A. Multiple factors can confuse beneficiaries: the number of programs available, the connection between Medicaid and MSPs, variations in Medicaid program names, and navigation of multiple application systems. Procedures need to be as automated as possible to minimize beneficiary burden.

Consequently, NASW supports CMS's proposal to require states to deem SSI enrollees into QMB. We recognize that CMS has not proposed to mandate deemed QMB enrollment for SSI enrollees in the 14 group payer states that do not have a Medicare Part A buy-in option for SSI enrollees without premium-free Part A; rather, CMS has proposed easing of restrictions by allowing, but not requiring, any group payer state to enroll the SSI enrollee in Part A without the individual having to file a "conditional" Part A application. NASW encourages CMS to require group payer states to allow SSI enrollees to enroll in MSPs without filing conditionally for Part A.

Allow Individuals Using HCBS to Deduct Prospective Medical Expenses

Many individuals who live in institutional settings (such as nursing homes) and who have predictable, consistently high medical costs are allowed to project those costs and are deemed Medicaid eligible on the first day of the month. This "medically needy" enrollment pathway is not currently available to people who use HCBS, however; these individuals are not deemed to meet Medicaid eligibility until their share of cost is incurred. This discrepancy decreases access to HCBS, exacerbates institutional bias within Medicaid, and is contrary to the integration mandate of *Olmstead v. L.C.*,[6] the Americans with

[6] Olmstead v. L.C., 527 U.S. 581 (1999).

Disabilities Act (Pub. L. No. 101-336),[7] and Section 504 of the Rehabilitation Act of 1973 (Pub. L. No. 93-112).[8]

Therefore, NASW strongly supports CMS's proposal to allow individuals who use HCBS and who have predictable, consistently high costs to project costs for medical expenses through the medically needy enrollment pathway. Medical costs incurred may include supplies (such as those used for incontinence), durable medical equipment, medication, transportation to medical appointments, and services provided by aides and other direct care workers. Removing the burdensome and inequitable requirement that individuals using HCBS document their medical spending each month before activating Medicaid would promote continuity of care and services, thereby improving health outcomes and program efficiency.

Furthermore, NASW encourages CMS to enable individuals using HCBS to receive retroactive coverage to the Medicaid application date, as is currently allowed in nursing facilities. People who leave the hospital or postacute care often must wait months while a service plan is established before they can obtain Medicaid coverage for HCBS.[9] They have no choice but to enter a nursing facility, where retroactive Medicaid coverage prompts rapid admissions.

PROMOTING ENROLLMENT AND RETENTION OF ELIGIBLE INDIVIDUALS

Aligning Non-MAGI Enrollment and Renewal Requirements with MAGI Policies

NASW supports provisions in the proposed rule to simplify enrollment and renewal processes for Medicaid and CHIP coverage. Too often coverage is lost due to administrative burdens and lack of communication with beneficiaries rather than changes in eligibility. These administrative barriers disproportionately affect people of color who are more likely to rely on Medicaid.[10] To achieve the aims of the Medicaid and CHIP programs and advance health equity, states should leverage flexibilities to maximize coverage for eligible individuals and families.

NASW supports the proposal to conduct redeterminations no more than every 12 months, as 12 months of continuous eligibility can reduce churn.[11] NASW supports eliminating the in-person interview requirement as a part of the renewal process. In-person interviews are barriers for maintaining health insurance coverage particularly for individuals with high social needs, less economic resources, families with caregiving responsibilities, individuals with disabilities, and others. NASW fully supports CMS efforts to include pre-populated information in renewal forms and provide beneficiaries with adequate time (at least 30 days) to receive and respond to notices. Implementing a 90-day

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[7] Americans with Disabilities Act of 1990, 42 U.S.C. § 12101.

[8] Rehabilitation Act of 1973, 29 U.S.C. § 701 et seq.

[9] Carlson, E. A. (2021). *Medicaid's unfair choice: Wait months for in-home assistance—or get nursing facility coverage today*. https://justiceinaging.org/wp-content/uploads/2021/09/Medicaids-Unfair-Choice.pdf

[10] Erzouki, F. (2022). "Reducing Administrative Burdens in Medicaid is Critical to Achieving Health and Racial Equity," CBPP, July 19, 2022, https://www.cbpp.org/blog/reducing-administrative-burdens-in-medicaid-is-critical-to-achieving-health-and-racial-equity.

[11] Medicaid and CHIP Payment Access Commission, (2022). Request for Information: Access to Coverage and Care in Medicaid & CHIP, April 18, 2022, https://www.macpac.gov/wp-content/uploads/2022/04/MACPAC-comments-on-CMS-RFI-on-access-to-care-and-coverage.pdf

reconsideration period without requiring a new application would also facilitate continuity of health insurance coverage and ease administrative burdens for States.

Acting on Changes in Circumstances Timeframes and Protections
NASW supports efforts to facilitate communication between beneficiaries and state Medicaid agencies by permitting beneficiaries to report address/contact changes through the same methods allowed for application submission. States should use multiple avenues of communication with beneficiaries to ensure that time-sensitive information is received.[12] NASW recommends providing all applicants and beneficiaries a minimum of 30 days to respond to information requests. A 30-day window provides an adequate timeframe for response while also preventing processing delays at the Medicaid agency. If the eligibility of the individual or family changes, NASW agrees that states should determine other health insurance coverage options and transfer the information to the appropriate program.

Agency Action on Returned Mail
NASW encourage States to use all available data sources to verify addresses and contact information. Medicaid agencies should conduct outreach using various modes of communication to enhance accurate data collection including phone calls, emails, and text messaging in addition to mail.[13] Enhanced outreach efforts will ease burdens on beneficiaries as well as State agency staff. In addition, NASW supports States using the addresses and alternative contacts based on information received from reliable third-party sources including USPS, MCOs, State Human Service Agencies and other sources. States can leverage the availability of these data sources to minimize disruptions in coverage. Once updated information is received, agencies should send notifications to addresses to verify the new information with the individual or family.

Transitions Between Medicaid, CHIP and BHP Agencies
Social workers serve individuals and families with multiple health and social needs. Continuity of health insurance coverage is essential, which has been highlighted throughout the COVID-19 pandemic as unanticipated health and mental health needs have emerged. NASW strongly supports efforts to ease transitions between Medicaid, CHIP, and other health programs. Reducing unnecessary gaps in coverage and reducing periods of insurance are critical for low-income families served by Medicaid and CHIP.

When new information deems an individual ineligible for Medicaid coverage, Medicaid agencies should have an obligation to transfer the individual's information to another insurance affordability program as appropriate. NASW encourages Medicaid and CHIP agencies to use a single eligibility system and accept eligibility determinations without further verification. Information sharing through technology platforms at Medicaid and CHIP agencies will have an important impact on facilitating access to health care services for children in particular.

CHIP Proposed Changes
NASW supports implementing the above recommendations in both Medicaid and CHIP as appropriate including providing adequate timeframes for responding to requests for information, continuing coverage during review periods for renewals to facilitate continuity of health insurance coverage,

[12] MACPAC, (2022).
[13] Erzouki, F. (2022).

conducting outreach through multiple avenues, accepting information from third parties to update addresses and contact information, and accepting shared eligibility determinations between Medicaid and CHIP agencies and other insurance affordability programs.

Eliminating Access Barriers in CHIP

CHIP coverage is an important factor in promoting the health of children and pregnant women in low-income households. Policies that institute lock-out periods or terminations for non-payment of premiums create additional barriers to care and work against the goal of the CHIP program. Gaps in coverage and administrative hurdles to re-enroll in CHIP make it less likely that families will obtain the health insurance coverage and health care services that they need. NASW supports enhanced efforts to engage families in a culturally responsive manner to explore payment options and educate families regarding payment obligations. Employing a family-centered approach will encourage participation. Also, NASW encourages States to eliminate waiting periods for CHIP to ease gaps in care and confusion that can occur when coordinating between Exchange plans and CHIP.

NASW supports the elimination of annual and lifetime limits on benefits such as orthodontia care. There are already many barriers to receiving health care services for low-income families. Access to necessary treatment can improve health conditions before they become chronic issues with long-term implications. In addition, it makes sense to align the prohibition of annual and lifetime caps in the Affordable Care Act with CHIP policies.

Implementation of this NPRM will enhance Medicaid enrollment and retention, thereby reducing health disparities, improving health outcomes, and economic security for countless individuals and families. Thank you for your consideration of NASW's comments. Please contact me at BBedney.nasw@socialworkers.org if you have any questions.

Sincerely,

Barbara Bedney

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