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November 7, 2022

Chiquita Brooks-LaSure  
Administrator  
U.S. Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

Re: CMS-2421-P

Dear Administrator Brooks-LaSure,

On behalf of ADvancing States, I am writing to provide comments on “Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Process” (CMS-2421-P). ADvancing States is a nonpartisan association of state government agencies that represents the nation’s 56 state and territorial agencies on aging and disabilities. We work to support visionary state leadership, the advancement of state systems innovation, and the development of national policies that support home and community-based services for older adults and persons with disabilities. Our members administer a wide range of services and supports for older adults and people with disabilities, including overseeing a wide range of Medicaid-funded home and community-based services (HCBS). Together with our members, we work to design, improve, and sustain state systems delivering long-term services and supports (LTSS) for people who are older or have a disability and for their caregivers.

We appreciate the opportunity to provide comments on the proposed changes and, in general, we are supportive of establishing regulations that reduce the administrative burden on states and that also simplify the eligibility process for applicants. We agree that there are opportunities to improve the timeliness and ease of determinations. Below we provide general overarching comments about the rule as well as specific comments about provisions directly applicable to LTSS.

#### **Timeline for Rule Implementation**

CMS proposes providing states with up to twelve months of time to implement certain non-statutory changes within this regulation and seeks comment on several different options for the deadline to enact changes. We agree with CMS’ proposed approach to make new options available to states 30 days after the publication of the final rule and to provide a longer glide-path to finalize required changes. We encourage CMS to provide states with as much time as possible – no less than twelve months and preferably longer – to implement the regulatory requirements. Although this rule is incremental, we note that

the changes would take place in the context of a number of other stressors placed on state eligibility agencies.

States are already struggling to implement the necessary processes to prepare for unwinding of the COVID-19 public health emergency (PHE). Due to the continuous coverage requirements of the Families First Coronavirus Response Act (FFCRA), every state must enact changes to their eligibility and enrollment IT systems, as well as revert to prior Medicaid policies and procedures upon the end of the PHE. States must also dedicate significant resources to perform renewals and determinations based on changes in circumstances once the unwinding period begins.<sup>1</sup> Further, CMS released a separate notice indicating that the agency is considering implementing further changes to the continuous coverage requirements in the FFCRA (CMS-9912-N). Those changes would require further administrative efforts to implement, particularly if CMS elects to require states re-establish previous coverage for individuals who transitioned between Medicaid eligibility groups or from full Medicaid to a Medicare Savings Plan (MSP).

Because of all these stressors, there is already a backlog of IT change requests for state eligibility systems. Many of the proposed regulations would require additional IT modifications. We believe that twelve months is the minimum timeline for implementing the required modifications. Further, eligibility staff are strained with existing requirements. Though we recognize that the changes will potentially reduce burden on staff, the necessary changes to procedures will require new policy development and staff training. Ample lead time is needed to effectuate these changes in the midst of extremely high workloads on staff.

### **Annual Redeterminations for ABD Groups**

CMS proposes to modify 42 C.F.R. § 435.916 to require that states renew eligibility for all Medicaid beneficiaries annually, rather than current practice that allows states to establish more frequently. It appears that this requirement would only apply to the financial eligibility redeterminations and would not impact the flexibility of states to establish a more frequent reevaluation period for institutional level of care (LOC) contained at 42 CFR § 441.302. We encourage CMS to explicitly clarify that states retain autonomy to establish schedules for LOC redeterminations more frequently than once a year. This will be particularly important in LTSS programs that focus on post-acute rehabilitation.

### **MSP Eligibility Changes**

Proposed changes at 42 C.F.R. § 435.952 would require a state to accept self-attestation of certain income and resources for MSP applicants, such as dividend and interest income, burial funds, and the value of a life insurance policy. CMS is further requesting feedback on whether to extend these requirements to all aged, blind, or disabled (ABD) eligibility categories. If CMS finalizes these new requirements, it must ensure that all Federal audit protocols incorporate procedures that exempt states from penalties for errors related to self-attestation. States should not be punished for eligibility errors based upon applicant-attested information when Federal regulations require them to accept the self-attestation.

We also note that a state retains the obligation to verify the value of nonliquid assets if it has information that is not reasonably compatible with the participants' attestation. This verification would only be performed after enrollment in the MSP program and we assume the process would be the same if CMS extends this policy to other ABD eligibility categories. If an individual is determined ineligible based upon a

<sup>1</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/covid-19-unwinding-faqs-oct-2022.pdf>

state determination that the self-attested values were inaccurate, we request clarification regarding whether outlays during the eligibility period should be recouped. Further, we request clarification regarding whether the individual would be treated as “enrolled” in Medicaid for purposes of the FFCRA continuous eligibility requirements, or any subsequent continuous eligibility requirements that may be implemented.

CMS also encourages states to apply income and asset disregards to align Medicaid eligibility with LIS eligibility criteria. These disregards are available as a state option under section 1902(r)(2) of the Social Security Act. We recommend that CMS provide a draft State Plan Amendment preprint that includes all the applicable income and/or asset disregards to easily facilitate the alignment of these eligibility criteria for those states that elect this option.

### **Low-Income Subsidy (LIS) and MSP Application**

The rule proposes to add language that reiterates the statutory requirement that States use Leads data to begin an application for MSP. We agree that there is opportunity for simplification, particularly when it comes to strategies to accept Leads data from the Social Security Administration (SSA) and establish MSP eligibility. Though we recognize that this is implementing a statutory requirement, we encourage CMS to be flexible with states that need to make additional IT changes to automatically accept and begin processing this information. As described above, such changes will likely be part of a substantial queue of IT modifications and states may not be able to enact them immediately.

CMS also proposes to establish a minimum definition for MSP family size and align it with the LIS definition. We note that states have flexibility to define different family sizes for certain Medicaid eligibility categories and want to stress that this flexibility should be maintained. It does not appear that CMS intends to apply the mandated family size beyond the MSP program; however, if CMS elects to extend other proposed rule changes, such as accepting self-attestation of certain asset values, to ABD eligibility categories, states should maintain the flexibility to create their own family size definitions depending upon the nature of the eligibility group.

### **Clarifying QMB effective date for individuals who have a Part A premium**

CMS proposes to codify existing policy, beginning in January 2023, that QMB coverage starts the month premium Part A entitlement begins or a month later than Part A begins (depending on when the State determines the person is eligible for QMB). These policies resolve a challenge that would otherwise occur if an individual must first pay the Part A premium in order to enroll and qualify for QMB and receive premium assistance but cannot afford the payment. Conditional eligibility for Part A MSP enrollment is a complex part of the program and can lead to unnecessary coverage gaps. We support the CMS changes to streamline this process and hope that it makes the program more available and accessible to participants. We note that this type of policy complexity is one of the reasons that the State Health Insurance Assistance Programs (SHIPs) and Aging and Disability Resource Centers are so crucial for participants. We encourage CMS to seek ways to augment support for those entities as part of enrollment simplification and streamlining efforts.

### **Allowing Medically Needy Individuals to Deduct Prospective HCBS Medical Expenses**

Current medically needy income eligibility regulations permit institutionalized individuals to deduct their anticipated medical and remedial care expenses from their income to establish medically needy eligibility. The existing regulation recognizes that institutional expenses are predictable and can be projected forward

to demonstrate that an individual will meet the necessary spend down amount. This can have several benefits, such as establishing continuity of eligibility for the participant and aligning their monthly rate with the Medicaid payment amount. However, because this option is only available in institutions and not the community, it creates an institutional bias within medically needy eligibility groups.

CMS proposes extending the prospective deductions for medically needy eligibility to those expenses that can be considered reasonably constant and predictable. CMS clarifies that this includes but is not limited to, services identified in a person-centered service plan developed under a Medicaid HCBS service plan projected to the end of the budget period at the Medicaid reimbursement rate. While we appreciate that CMS recognizes the expenses are not limited to those options, we are concerned that the regulatory language may be inadvertently interpreted to limit these deductions to expenses contained within a Medicaid-approved service plan. If the language focusing on a Medicaid HCBS plan of care remains as written, we are concerned that it would limit the projection option to those individuals who have already established Medicaid eligibility and have an approved plan of care.

We support this change to provide more flexibility and address one of the lingering institutional biases in medically needy eligibility policy. We encourage CMS to explicitly provide states with the option to expand the prospective HCBS deductions to individuals with private-pay receipts or who have received support from a qualified entity (such as an ADRC) to develop a service plan.

#### **New Minimum Timelines for Participant Return of Information**

CMS proposes requiring state agencies to provide at least 15 calendar days (from the date of postmark or electronic request) for most enrollees to respond to requests for additional information. For applicants whose Medicaid eligibility is being considered on the basis of a disability the agency would be required to provide the applicant with at least 30 calendar days. CMS proposes the different timelines due to complexity of disability and resource documentation that is required for ABD groups and not for MAGI groups. We agree that there is need to provide additional time due to the complexity of securing documentation needed for application to ABD groups, particularly those that require documentation of disability or require level of care certification.

#### **Removing Requirement for Individuals to Apply for Other Benefits**

Longstanding Medicaid policy requires that, in order establish eligibility for Medicaid, an individual must “take all necessary steps to obtain other benefits to which they are entitled, unless they can show good cause for not doing so.” Due to several changes in the Medicaid program and its eligibility standards since this requirement was created, CMS proposes removing this requirement. CMS requests feedback on this proposal, as well as a proposed alternative that would exempt individuals receiving SSI or enrolling in a MAGI group from the requirement but would maintain it for other ABD categories

Given that individuals who apply for SSI must already apply for other available benefits, we support the proposal to streamline state eligibility verification processes. We believe that state flexibility should be maximized in this proposal and we therefore recommend that states should not be required to impose the benefit application mandates on their ABD eligibility populations but should be provided with the option to do so. We also note that there are opportunities to better align eligibility and enrollment processes across Medicaid and other health and human services programs. We encourage CMS to work with states to



identify ways to better streamline ABD eligibility across various programs to facilitate, but not require, eligibility across different health and human services.

We appreciate the opportunity to comment on this important topic. If you have any questions regarding this letter, please feel free to contact Damon Terzaghi at [dterzaghi@advancingstates.org](mailto:dterzaghi@advancingstates.org).

Sincerely,

A handwritten signature in blue ink that reads "Martha Roherty".

Martha Roherty  
Executive Director  
ADvancing States