Submitted Electronically

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

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

Dear Administrator Brooks-LaSure:

On behalf of our over 5,000 members and partners including mission-driven organizations representing the entire field of aging services, 38 state associations, hundreds of businesses, consumer groups, foundations, and research centers, LeadingAge is pleased to offer comments relating to selected aspects of the proposed rule on Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment and Renewal Processes.

Facilitating Enrollment in Medicare Savings Programs Through Medicare Part D Low-Income Subsidy "Leads" Data

LeadingAge supports CMS's proposal to promote enrollment in Medicare Savings Programs (MSP) by maximizing State use of data from the Medicare Part D Low-Income Subsidy (LIS) program in alignment with the Social Security Act (the "Act").

As the preamble explains, the Act requires the Social Security Administration to transmit data from LIS applications ("leads data") to State Medicaid agencies and requires States, in turn, to accept and act upon leads data as if it constituted an MSP application submitted by the individual. We support CMS's proposal to codify the existing statutory requirements in regulation to help ensure States are aware of and clear about the steps required to make meaningful use of the leads data.

The Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual (QI) programs provide critical financial assistance to low-income older adults and people with disabilities who are also eligible for Medicare, yet data shows that MSP participation among eligible low-income Medicare beneficiaries remains relatively low. The Medicaid and CHIP Payment and Access Commission (MACPAC) has noted findings of low

participation rates across all MSPs and all age groups. According to a MACPAC report, the QMB program had the highest participation rate, at 53 percent across all age groups. Of SLMB-eligible beneficiaries, 32 percent participated, and of QI-eligible beneficiaries, 15 percent participated. When age groups are separated, the report shows that participation is lower among older adults on Medicare than those under age 65 who are eligible for Medicare due to disability. MACPAC estimated that QMB participation is 48 percent among those age 65 and older, compared to 63 percent among those age 18-64, and that SLMB participation is 28 percent among those age 65 and older, compared to 42 percent among those age 18-64.[1]

We believe CMS's proposed codification of the existing requirements would address some of the factors leading to low participation and assist more individuals who are eligible for one of these MSP programs to enroll. This additional income support will contribute greatly to the health and economic well-being of older adults, wherever they call home.

Allowing Medically Needy Individuals to Deduct Prospective Medical Expenses

LeadingAge supports the proposal to allow non-institutionalized individuals, under certain circumstances, to deduct anticipated medical expenses from their income for purposes of medically needy eligibility determinations.

Under current regulations, States have the option to project certain predictable medical institution expenses (such as the monthly cost of nursing home care calculated at the Medicaid rate) when determining the income eligibility of an individual who will be required to meet a spenddown. In other words, a State may choose to determine that an individual *will* incur the expense and, in doing so, can establish that the individual is eligible for Medicaid and grant eligibility effective on the first day of the person's budget period. No further eligibility-related determination is necessary on the front end, though States must reconcile the projected amounts with the actual amounts incurred at the end of the budget period to confirm that the individual's incurred expenses were at least equal to the individual's spenddown.

States do not have the option to project expenses for individuals residing in the community, however, which means that an individual must first incur and verify eligible expenses that meet the required income spenddown before becoming Medicaid eligible. This results in the individual cycling on and off Medicaid, with eligibility starting at some point after each new budget period begins (such periods are between 1 and 6 months, at the State's discretion), causing a gap in coverage for the individual and additional administrative work for the State.

Under the proposed rule, CMS would amend §435.831(g) to provide States the option to project certain additional services that the State can determine with reasonable certainty will be constant and predictable – such as expenses for medical or remedial services identified in a Home and Community Based Services (HCBS) care plan or expenses for prescription drugs – when determining the income eligibility of an individual. These expenses would be projected

[1] Medicare and CHIP Payment and Access Commission, "Report to Congress on Medicare and CHIP," June 2020, Table 3-3 https://www.macpac.gov/publication/june-2020-report-to-congress-on-medicaid-and-chip/.

only to the end of the budget period and calculated the applicable Medicaid reimbursement rate. States that choose to adopt this policy would need to reconcile the projected amounts with the actual amounts incurred against the required spenddown at the end of the budget period.

CMS explains in the preamble that permitting projection of the cost of care only for institutionalized individuals creates an institutional bias and notes that there are noninstitutional services that may be similarly constant and predictable. We agree, and we support the proposal to allow States the option to project certain expenses for individuals who must meet a spenddown to become income-eligible for Medicaid coverage of HCBS.

LeadingAge strongly supports policies that facilitate the process for eligible individuals to access needed services in the setting of their choosing, whether that be in a nursing home or in the community, and CMS's proposal creates an opportunity for States to adopt such policies while ensuring continued program integrity. We also agree with CMS that permitting projection of noninstitutional services would reduce some of the complexity that both State agencies and individuals seeking coverage currently experience, reduce administrative costs associated with disenrolling and reenrolling individuals, and lead to greater continuity of care.

Timely Determination and Redetermination of Eligibility

We appreciate CMS's detailed consideration of how best to ensure that applicants and enrollees have adequate time to furnish information needed to verify eligibility and that states can complete initial determinations and redeterminations of eligibility within a reasonable timeframe, all while balancing the need for both timeliness and accuracy in determinations of eligibility and ineligibility.

We defer to other stakeholders to share comments on the specific changes CMS is proposing relating to these processes, but we do wish to advocate for CMS to track and publicly report on the extent to which States complete their processing of applications within the core timelines established in current regulations: no more than 90 calendar days for determining eligibility on the basis of disability and no more than 45 calendar days for determining eligibility on all other bases.

Our provider members and LeadingAge affiliate organizations have reported that some States and their local agency partners may struggle to meet the required timelines on a consistent basis, even in situations where an applicant has provided the information necessary for a determination. Timeliness is important not only for individual beneficiaries but also for the organizations that provide services and supports to those individuals and receive payment from Medicaid. We encourage CMS to measure and report on the performance of States in some manner, so that all stakeholders may work together to identify, address, and resolve systemic delays if and where they are occurring.

Conclusion

LeadingAge is pleased to offer these comments on issues affecting older adults who rely on Medicaid for access to many needed services and supports.

The systems and processes addressed in this rulemaking process are tremendously important, especially as beneficiaries, providers, and States alike look ahead to the eventual end of the Public Health Emergency and of the COVID-19 Medicaid continuous coverage requirement. Timely and accurate redeterminations are essential, both for Medicaid beneficiaries and the providers that serve and support them.

We appreciate that CMS is seeking feedback on changes designed to streamline eligibility process and reduce coverage losses as States begin acting on eligibility redeterminations for millions of people across the country, as well as your consideration of the many complexities involved with finalizing new regulatory requirements and setting appropriate dates for implementation of the changes.

Thank you for your consideration, and please contact me (jlips@leadingage.org) if we can answer any questions or provide additional information.

Sincerely,

Jonathan Lips
Vice President, Legal Affairs