JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

August 12, 2019

By electronic delivery to www.regulations.gov

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–6082-NC
P.O. Box 8016,
Baltimore, MD 21244–8016

Re: CMS–6082-NC (RIN 0938-ZB54) Request for Information; Reducing Administrative Burden To Put Patients Over Paperwork

Justice in Aging appreciates the opportunity to provide comments on the above-referenced Request for Information (RFI).

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries and populations that have traditionally lacked legal protection such as women, people of color, LGBT individuals, and people with limited English proficiency.

Justice in Aging appreciates the Patients over Paperwork initiative. We are particularly pleased that in this RFI, CMS is specifically asking for suggestions around the challenges for beneficiaries who are dually eligible for Medicare and Medicaid ("dual eligibles") and suggestions for simplification of enrollment and eligibility determinations across programs. Low-income beneficiaries can find paperwork particularly challenging. Many have relatively low health literacy and face significant health challenges that limit their ability to handle documentation and timely respond to complex requests for information on income and assets or to file appeals and waiver requests.

As advocates for low-income older adults, we have seen the severe impact on beneficiaries, particularly dual eligibles, from behind-the-scenes procedures or failures that affect their access to benefits and care that they desperately need and to which they are entitled. We also see that unnecessarily complex paperwork burdens discourage beneficiaries from even applying for benefits they need. Others start the process, and then give up because they cannot understand or navigate the complexities. Many also fall on and off programs because of frequent or complicated redetermination processes, causing interruption in care. The primary impact of these problems is on the beneficiary, but the costs to states, CMS, and the Social Security Administration are also significant. Further, providers and managed care plans serving dual eligibles who churn on and off programs face unnecessary administrative and financial burdens as they deal with fluctuations in eligibility and payment source. With these considerations in mind, we offer the following suggestions for areas to be addressed by the Patients over Paperwork initiative.

WASHINGTON
1444 Eye Street, NW, Suite 1100
Washington, DC 20005
202-289-6976

LOS ANGELES
3660 Wilshire Boulevard, Suite 718
Los Angeles, CA 90010
213-639-0930

OAKLAND
1330 Broadway, Suite 525
Oakland, CA 94612
510-663-1055

Several of our suggestions would require actions by agencies other than CMS, including the Social Security Administration (SSA) and state Medicaid agencies. We recognize, however, that the impetus for the changes would have to come from CMS and urge the agency to work to facilitate changes.

Data exchange among agencies

Determining and maintaining eligibility for programs affecting dual eligibles requires regular and accurate data exchange among state Medicaid agencies, CMS, and SSA. Delays or errors in data exchange can result in delays in receiving benefits and also lead to dropping people from programs for which they qualify. Over the past decade, CMS has taken significant steps to speed up its handling of data coming from states regarding eligibility for Medicaid programs, including Medicare Savings Programs (MSPs) and related to eligibility for the Part D Low-Income Subsidy (LIS).

On the state Medicaid side, however, state programs have not uniformly taken advantage of opportunities to transmit both Part B buy-in files and MMA files daily. Delays in state transmissions can affect all applications, but are particularly important where there is some error in a file. A transposed date or SSN or a misspelled name can easily take an extra month to correct simply because of file transfer lags. CMS has proposed to enact regulations that would require states to submit these files daily, and we have supported those regulations. Those regulations, if adopted, would not take effect until 2021. We urge CMS to work with states to voluntarily move more quickly toward daily transmittals.

SSA lags in recognizing changes in Part B payments

State Medicaid programs pay the Part B premiums for Medicare beneficiaries with full Medicaid or MSP eligibility. Once an individual qualifies for state payment, SSA as a matter of policy takes two months to stop taking Part B payments from a beneficiary's Social Security or SSDI benefit. The beneficiary will eventually receive a refund for the credited months, but the burden of the delay on an individual living at or often below the poverty line can be significant. Similarly, if an individual loses eligibility for state payment of Medicare premiums, there is at least a two-month period when SSA continues to take premiums from the state and not charge the individual. After that period, the beneficiary is faced with notice that SSA will recoup the two months (at least) of back premiums as well as begin collection of Part B premiums going forward. This means that typically beneficiaries will receive a monthly benefit payment that is more than $400 short of what they usually live on. The beneficiary is suddenly without the means to pay rent, purchase food, or otherwise make it through the month. Advocates report beneficiaries arriving in their offices in tears, fearful that they will be evicted because they are unable to make their rent payment from their reduced SSA benefit.

In a time when consumers expect that banks and retailers will impose and reverse charges within 24 hours, it is difficult to justify SSA taking, at a minimum, two months to adjust Medicare premium withholding. It is particularly concerning because SSA does this as a matter of policy even when it has the technical ability to act more quickly. We urge CMS to work with SSA to eliminate the hardship caused by these unnecessary delays and to close the two-month lag.

Part A Buy-In

The Qualified Medicare Beneficiary (QMB) Program benefit includes payment of the Medicare Part A premium for individuals who do not qualify for premium-free Medicare Part A. The premium, which can be $437/month, is unaffordable for most low-income individuals, so the QMB benefit has significant value. In most states, called Part A buy-in states, individuals needing Part A coverage may apply for the QMB benefit at any time and will be enrolled as soon as their application is approved. However, thirteen states, called group payer states, do not have a Part A buy-in agreement with CMS. In group payer states, an individual without premium-free Part A who wishes to apply for the QMB benefit and is not in a Medicare enrollment period, must wait until the January-through-March General Enrollment Period to conditionally apply for Medicare Part A through SSA. Only after submitting that conditional application can the individual go to the state Medicaid office to apply for QMB. If the QMB application is approved, the QMB benefit will not start until July 1. Advocates report that low income individuals have tremendous difficulty navigating this complex process (described in POMS HI00801.140). Many eligible individuals lose their way and fail to complete the enrollment process. Even those who manage to navigate the maze face a long gap before their benefit begins.

The situation in group payer states is an aberration. For every other Medicaid benefit of which we are aware, Medicare beneficiaries can apply whenever they qualify and get coverage upon approval. The QMB benefit in group payer states is the only instance where low-income beneficiaries must wait, and the wait can be as long as 15 months.[1] We ask CMS to require that all states sign a Part A buy-in agreement with SSA in order to eliminate this significant barrier to access to the Medicare benefit and to needed care.

MIPPA Process for Medicare Savings Programs (MSPs)

In the so-called MIPPA process, SSA provides states with verified information on individuals who have applied for the Part D Low-Income Subsidy (LIS) so that states can review those individuals for eligibility for MSP eligibility. The process offers promise for addressing chronic under-enrollment in these important programs. Many states, however, have not fully utilized the opportunities offered by the MIPPA process. According to a 2016 survey,[2] just five states (AR, IA, NJ, OR, SD) pre-populate MSP application forms sent to those identified by SSA, so that individuals are only required to provide information that has not already been verified by SSA. Most states, however, simply send out a blank MSP application form or a blank full Medicaid form, which can be as long as 17 pages in some states. Not surprisingly, advocates report that the uptake is much higher when forms are simple and the amount of information that the individual must supply is limited.

We appreciate CMS's efforts to date to assist states in improving their processes.[3] We ask that CMS continue to work with state Medicaid programs to more effectively use MIPPA data and that CMS require, rather than merely allow, states to use verified information. We particularly ask that CMS work

[1] In the Medicare program as well, LIS and dual eligible beneficiaries have Special Enrollment Periods, a recognition of the urgency of need and lack of alternatives facing beneficiaries with low incomes.
[2] National Council on Aging, Social Security Extra Help/LIS Leads Data: Findings from a Survey of MIPPA States (2016), available at www.ncoa.org/wp-content/uploads/LIS-Leads-Data-Survey.pdf.
[3] See, e.g., State Medicaid Director Letter #18-012 (Dec 19, 2018) at Opportunity 10, available at www.medicaid.gov/federal-policy-guidance/downloads/smd18012.pdf

with states to use pre-populated forms and that the agency require that all states transition to this approach.

Harmonized LIS and MSP Eligibility Requirements

Although improvement in the MIPPA process would certainly assist with uptake for MSP enrollment, a more comprehensive simplification would be to harmonize the federally required baseline enrollment criteria for LIS and MSP eligibility, while retaining the current flexibility allowing states to set MSP requirements that are less restrictive than federal minimums. Already MSP enrollment automatically results in LIS enrollment. We urge that LIS enrollment automatically result in MSP coverage as well. This would create a "no wrong door" system giving low-income individuals a chance to enroll in both programs without excessive paperwork. We recognize that achieving this goal would likely require legislation, and we urge CMS to support such legislative change.

In the absence of this comprehensive legislative solution, we urge administrative adoption of more granular changes. The eligibility requirements for Medicare Savings Programs and for the Low-Income Subsidy are quite similar but do not match up exactly. For example, the LIS program excludes in-kind support from income counting. It also excludes the cash value of modest life insurance policies and assumes that an individual wishes to set aside $1500 for burial expenses without requiring that the beneficiary set up a separate account. For MSP coverage, in contrast, many states count in-kind support, which is often difficult to quantify; require that an individual report the cash value of insurance, a figure that many beneficiaries find hard to obtain; and require separate burial accounts, which are cumbersome and sometimes expensive for beneficiaries. We ask that CMS continue to work with states to simplify asset counting for MSPs so that methodologies mirror those used for the Low-Income Subsidy.

Elimination of the Asset Test for MSPs

Eliminating the asset test altogether for Medicare Savings Programs would be a more significant step in reducing paperwork burdens for beneficiaries. Nine states have done so, ranging from Mississippi, Alabama and Arizona to Vermont and New York. Eliminating the asset test has meant that these states can create applications that are as short as two pages. See, e.g., the application for New York MSPs.[4] Eliminating the asset test means that beneficiaries do not need to collect asset information, which they often find difficult, and states do not need to confirm asset values. Eliminating the asset test also significantly simplifies the transition that beneficiaries face at age 65 when they become eligible for Medicare and lose access to expansion Medicaid, which has no asset test. If the asset test were removed, most transitioning individuals could be automatically enrolled in MSPs, a process that would significantly ease the transition. Further, data do not support fears that eliminating the asset test would open the floodgates to people with significant assets who are "gaming" the system. A Kaiser Family Foundation report, for example, shows that low income and very modest assets generally go hand in hand.[5] We ask that CMS work with additional states to eliminate the MSP asset test and that the agency also consider legislative initiatives to eliminate the asset test nationwide.

---

[4] Available at www.health.ny.gov/forms/doh-4328.pdf.

[5] According to the Kaiser report, in 2016, 25% of Medicare beneficiaries had income below $15,250/yr and 25% had assets below $14,550. See, Kaiser Family Foundation, Income and Assets of Medicare Beneficiaries, 2016-2035 (Apr. 2017), available at www.kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-2016-2035/.

Redeterminations

The redetermination process, both in full scope Medicaid and in Medicare Savings Programs, is another area where simplification could significantly smooth beneficiary coverage. Medicaid law requires that redeterminations be conducted at least annually, but CMS permits more frequent redeterminations. State practice varies in both the frequency and timing of redeterminations and the amount of information required from the beneficiary.

We ask that CMS work with states to develop more uniformity and rationality in Medicaid redetermination processes across states, reduce beneficiary burden in redeterminations, and limit redeterminations to once annually. Poor older adults have relatively steady income and more frequent redeterminations are unnecessary. We also ask that CMS work with states to make the redetermination process as passive as possible. States can and should rely on information from the many sources available to them. Problems with beneficiaries falling off Medicaid because of confusion about forms are widespread and cause serious harm. Care can be interrupted and the delicate finances of a low-income beneficiary can be upturned, particularly when the SSA delays discussed above exacerbate the harm.

Another redetermination issue has been computer problems in state systems, often happening when systems changes are introduced. Recent examples include Rhode Island[6] and Georgia.[7] The result has been that many individuals have been erroneously dropped from the rolls, often facing tremendous difficulties in getting reinstated. We ask that CMS work more closely with states whenever new systems are introduced and exercise strong oversight to ensure that testing is rigorous, so these problems do not happen in the first place.

In addition, we are concerned that states are not sufficiently proactive when problems arise. For example in Georgia, where those most affected by the systems errors were enrolled in MSPs, the state only acknowledged the problem after intense news coverage and significant advocacy efforts. In Rhode Island, litigation was needed to get prompt state action.[8] We ask that CMS impose an affirmative requirement on states to immediately inform CMS when the state is aware of a computer problem that could affect beneficiary eligibility or access to care. We know and appreciate that CMS is actively engaged with the two states above, but believe there is a need for better systems to ensure that CMS is involved from the onset and that resolutions are prompt and transparent.

---

[6] See, e.g., Katherine Gregg, Rhode Island Recommits to Vendor Behind Troubled Social Services System (Providence Journal, April 17, 2018, available at www.govtech.com/computing/Rhode-Island-Recommits-to-Vendor-Behind-Troubled-Social-Services-System.html; ACLU Files New UHIP-Related Lawsuit Over Medicaid Termination Notices, available at http://riaclu.org/news/post/aclu-files-new-uhip-related-lawsuit-over-medicaid-termination-notices/; ACLU Settles Second UHIP-Related Lawsuit Over Medicaid Termination Notices, available at http://riaclu.org/news/post/aclu-settles-second-uhip-related-lawsuit-over-medicaid-termination-notices/.

[7] See, e.g., Arial Hart, State to Reinstate Medicaid Benefits to Those Who Lost Them (Atlanta Constitution, June 21, 2019, available at www.ajc.com/news/state--regional-govt--politics/state-reinstate-medicaid-benefits- georgians-who-lost-them/UqMdKQHkroZMpKBBmXNeCO/?fbclid=IwAR2Z-luI4jFB5tIIQ1Q81SYnDHf6de03610zMy-8mpWcw47r4YszDlDnkd0 ; Ariel Hart, 17,000 Georgians cut off from Medicaid face messy bureaucracy (Atlanta Constitution, June 14, 2019), available at www.ajc.com/news/state--regional-govt--politics/000-georgians-cut-off-from-medicaid-face-messy-bureaucracy/la0pcJA3lBBq5oDAQntMSJ/

[8] See *supra* note 6.

We also ask that CMS facilitate information sharing among state Medicaid programs concerning experiences with computer systems related to eligibility and redetermination. The learning from systems problems in one state and the experiences with the particular software design can be of immeasurable value for other states considering using variations of the same system or managing contracts with vendors.

Change in Overpayment Recovery Rate for LIS-Eligible Beneficiaries

Many low income Medicare beneficiaries experience overpayment situations where they must repay SSA from their usually meager benefits. One avenue available to address this burden is SSA POMS GN 02210.030(C), which provides relief for Medicare beneficiaries who qualify for the full Part D low-income subsidy. Under this provision, if an LIS beneficiary requests rate relief, SSA will allow a repayment rate of $10 per month without requiring further development of income or asset information. This provision recognizes that beneficiaries with incomes low enough to qualify for LIS need most of their monthly income to pay for necessities.

Though this provision is valuable, unnecessary barriers limit its use. Individuals must ask for the LIS-based relief and must assert their LIS status, even though SSA knows every beneficiary's LIS status. Even more problematic is the fact that the POMS is the only place where the availability of this relief is spelled out. Beneficiaries do not read the POMS. The overpayment notice sent by SSA nowhere mentions the availability of LIS-related relief. SSA Form 634, "Request for Change in Overpayment Recovery Rate" also is totally silent about the availability of the LIS-related relief and has no box to check. Further, advocates report that SSA offices generally do not alert beneficiaries to the availability of the provision.

It is hard to imagine a beneficiary who, knowing of the availability of the LIS-related relief, would not take advantage of the provision. Yet the existence of the provision is hidden from those who qualify. Further, even if they learn from advocates about the provision (although many advocates themselves are unaware of the provision), they must affirmatively apply even though all the necessary information to process the request is already in the hands of SSA.

We urge that CMS work with SSA to eliminate the current unnecessary requirements and change procedures so that anyone with 100% LIS subject to an overpayment automatically is provided overpayment rate relief. We also ask for significantly more transparency concerning the relief. Every beneficiary facing overpayment should be told of the relief—and of its automatic application-- in the original overpayment letter to the beneficiary. We ask that CMS and SSA also develop more consumer communication to LIS beneficiaries so that the provision is more widely known and understood.

Part B Premium Obligation For Incarcerated Individuals

Individuals may not receive any Medicare benefits while incarcerated.[9] Payments from the Social Security Administration are also suspended during incarceration. Yet, if an incarcerated individual becomes eligible for Medicare during incarceration, e.g., turns 65, the Initial Enrollment Period begins and, if the individual fails to enroll, late enrollment penalties can accrue. Individuals already enrolled in Medicare when they begin incarceration have a two-month grace period in which their enrollment (although not their eligibility for any benefits) continues. They are then disenrolled and late enrollment penalties can accrue in this situation as well. In both cases, when the individual is released, there is no

[9] 42 C.F.R. §411.4

Special Enrollment Period and, unless qualifying for Medicaid, the individual must wait until the next annual General Enrollment Period to enroll in Part B and must pay applicable late enrollment penalties. Further, for those individuals who had the two-month grace period while incarcerated, SSA will deduct the two months of premiums from their first Social Security benefit payment. This procedure even applies to those who have been exonerated.

This process impedes access to health care and inhibits financial security at the very time that individuals leaving incarceration most need to marshal all their resources to build their life. It most certainly is inconsistent with broader initiatives government-wide to facilitate reentry.

We urge that CMS, together with SSA, address this issue. One element of a solution would be the extension of the Part B Special Enrollment Period (SEP) and Premium Surcharge Rollback, POMS HI 00805.266, to include individuals leaving incarceration. Extending the SEP could be done administratively and would be similar to and consistent with an earlier extension (added to the SEP in 2012) that included individuals covered by national health insurance overseas. We also ask that there be an exception to the two-month grace period for Part B premiums. The grace period does not make sense in the context of incarceration, particularly because incarcerated individuals do not have access to Social Security benefits with which to pay premiums.

Conclusion

Thank you for considering our comments. Justice in Aging would be pleased to discuss any of these proposals in more depth and to provide additional information. If any questions arise concerning this submission, please contact Georgia Burke at gburke@justiceinaging.org.

Sincerely,

Jennifer Goldberg
Deputy Director