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VIA ELECTRONIC TRANSMISSION

November 7, 2022

The Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

RE: RIN 0938–AU00; CMS-2421-P

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 Women's Law Center appreciates the opportunity to comment on the above-referenced proposed rule. Since 1972, we have striven to protect and advance the progress of women and their families in core aspects of their lives, including health, income security, employment, education, and reproductive rights, with an emphasis on the needs of low-income individuals and those who face multiple and intersecting forms of discrimination. To that end, we have long worked to ensure that all people, including women of color, disabled women, low-income women, and LGBTQI+ people, have meaningful access to health care, including through Medicaid and other insurance affordability programs.

We strongly support the proposals to streamline to eligibility, enrollment, and renewal, and we provide the following comments to further strengthen the rule. Medicaid applicants and enrollees, who are disproportionately women,[1] often face an administrative labyrinth that prevents or delays their access to care. The resulting barriers to enrollment and retention are particularly exacerbated for women of color, immigrant women, and disabled women. We therefore appreciate the Department's efforts to reduce the burdens on applicants and enrollees. We urge the Department to implement these changes with speed, particularly if the COVID-19 continuous coverage requirement is not extended beyond the Public Health Emergency period, in order to reduce coverage losses when states recommence coverage redeterminations.

[1] Kaiser Family Foundation, *Medical Enrollment by Sex*, www.kff.org/medicaid/state-indicator/medicaid-enrollment-by-sex (accessed Nov. 1, 2022).

I. Improve transitions between Medicaid, CHIP, and BHP agencies

The ACA promises to provide seamless transitions between insurance affordability programs—a promise that remains critical for people with low incomes. In practice, however, agencies often fail to transfer newly-ineligible people to other insurance affordability programs, causing disruptions in their coverage.

For example, under current policy, if a Medicaid agency learns from a third party that an enrollee is potentially ineligible and the enrollee does not respond to the agency's request for additional information, the agency is not required to transfer the account. There are many reasons why enrollees do not respond to requests for information. In some cases, they do not receive the request, especially if they are experiencing housing instability or homelessness. Others might not fully understand the notice—sometimes due to barriers related to disability, literacy, or language—or may face barriers to gathering the requested documentation. And some enrollees do not respond when they know they are no longer eligible for Medicaid, particularly if they do not receive information about the option to be transferred to other insurance affordability programs.

We therefore support the Department's proposal to improve coordination between insurance affordability programs, including Medicaid, CHIP, BHP, and exchange coverage. In particular, we agree that Medicaid agencies should transfer accounts when they determine that an applicant is no longer eligible for Medicaid but may be eligible for another program, regardless of whether the agency receives a response from the enrollee. Additionally, we support improving coordination between Medicaid and CHIP, including by requiring Medicaid and CHIP agencies to accept each other's eligibility determinations. This policy would reduce disruptions in coverage for children as their family income and other circumstances change.

II. Simplify citizenship verification

Under current policy, when an applicant's citizenship cannot be verified using Social Security Administration (SSA) data alone, agencies undertake a two-step process: They first verify citizenship using another data source, and then separately verify identity. This process requires enrollees to submit additional documentation, creating yet another barrier in the Medicaid application. As a result, people whose status cannot be verified through SSA data—typically naturalized citizens—may face delays in getting coverage. It is likely that women are overrepresented among Medicaid-eligible naturalized citizens affected by this policy: Most naturalized citizens are women,[2] and foreign-born women as a whole (including naturalized citizens) are more likely to face economic insecurity than men.[3]

We therefore support the proposal in § 435.407 to simplify the process for verifying citizenship. The proposed rule would expand the sources of data used for one-step citizenship and identity verification to include vital statistics systems and data from Department of Homeland Security, in addition to SSA data. It further clarifies that states must use these sources for citizenship verification before requiring additional documentation from applicants. This streamlined process would reduce burdens on applicants and lower the risk of coverage delays or application denials.

III. Define "family size" for Medicaid Savings Program eligibility

Currently, there is no standardized definition of "family size" for the purpose of determining Medicaid Savings Program (MSP) eligibility. In the absence of a national standard, many states include only

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[2] American Community Survey, B05003: Sex by Age by Nativity and Citizenship Status, 2021 ACS 1-Year Estimated Detailed Tables.

[3] *See, e.g.,* American Immigration Counsel, *The Impact of Immigrant Women on America's Labor Force* (Mar. 8, 2017), https://www.americanimmigrationcouncil.org/research/impact-immigrant-women-americas-labor-force.

spouses, potentially leaving out many household members who depend on the applicant's income. This practice particularly disadvantages people who live in multigenerational homes—disproportionately Asian, Black, and Latine people and low-income families.[4] In many cases, families turn to multigenerational households to mitigate high housing costs or make it easier to get caregiving support from family, a trend that has become even more common since the start of the COVID-19 pandemic.[5]

The proposed rule would require states to define "family size" for MSP eligibility using a standard at least as expansive as the Low-Income Subsidy (LIS) standard. This definition would include all relatives, by blood or marriage, who live in the household and depend on the applicant or the applicant's spouse for at least half of their financial support. We urge the Department to adopt this definition.

IV. Remove requirement to apply for other benefits

Originally promulgated in 1978, § 435.608 requires applicants to apply for other benefit programs as a condition of their Medicaid eligibility. But the intervening years have seen substantial changes in Medicaid eligibility, such as delinking Medicaid and cash assistance programs. This provision therefore has long been outdated, and currently serves only to create hurdles for individuals seeking Medicaid coverage. Many people are not aware of the full range of additional programs for which they may be eligible, and the process for applying for other benefits can be burdensome and inaccessible.

Additionally, as a result of this requirement, people eligible for Social Security may have to forgo substantial benefits: They may be forced to apply for Social Security benefits at age 62, even though their benefits would greatly increase if they delayed their retirement. This is particularly harmful for women, who are more likely to rely on Social Security, but receive lower benefits than men. [6] Women generally and women of color in particular are at greater risk for poverty as they age,[7] and the further reduction in their Social Security benefits may represent a severe loss at a financially precarious time.

We support the Department's proposal to remove the requirement to apply for other benefit programs. We recommend that it remove the provision in its entirety and reject the more cumbersome alternatives outlined in the proposed rule, such as applying the requirement to certain applicants or making its enforcement a post-enrollment activity.

V. Expand deductions of prospective costs for "medically needy" enrollees

Under existing regulations, people applying through the Medically Needy enrollment pathway can deduct only a narrow range of prospective costs to determine their Medicaid eligibility: namely, costs of care provided in institutional settings. Meanwhile, people receiving care outside of institutional settings cannot deduct their medical expenses and are not considered Medicaid-eligible until they actually incur their share of costs. As a result, many are forced into a "spenddown period" before they can enroll in Medicaid, during which they may experience a lapse in coverage and consequent delay in receiving critical services. Others are driven into institutional settings to get the care they could otherwise receive at home, further exacerbating Medicaid's institutional bias.

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[4] D'Vera Cohn & Jeffrey S. Passel, *A Record 64 Million Americans Live in Multigenerational Households* (Apr. 5, 2018), https://www.pewresearch.org/fact-tank/2018/04/05/a-record-64-million-americans-live-in-multigenerational-households.

[5] Stephanie Firestone & Donna Butts, *Changing the Narrative on Multigenerational Living* (Jun. 2021), https://generations.asaging.org/changing-narrative-multigenerational-living.

[6] National Women's Law Center, *Women and Social Security* (Apr. 1, 2019), https://nwlc.org/resource/women-and-social-security.

[7] National Women's Law Center & Justice in Aging, *Supporting the Economic Security and Health of Older Women of Color* (2021), https://nwlc.org/resource/supporting-the-economic-security-and-health-of-older-women-of-color.

This limit on expenses that can be prospectively deducted may particularly harm women, who make up the majority of those who use in-home services.[8] Women generally have higher medical expenses, especially as they age. For example, a woman who is 65 years old will spend approximately $47,000 more in retirement for health care expenses than a man of the same age.[9] Black women in particular are most likely to experience chronic diseases, including heart disease, stroke, diabetes, and cancer, incurring higher medical costs.[10] When they are not permitted to account for these costs in advance, they may face a significant financial burden during the spenddown period or they may have little choice but to receive their care in an institution.

The proposal at § 435.831 represents a significant step towards reducing this burden. The proposed rule gives states the option to expand the types of expenses that can be projected through the Medically Needy enrollment pathway: It would allow them to include predictable expenses of care received outside of institutions, like home- and community-based services. We encourage the Department to define the scope of eligible services broadly, including behavioral health and personal care services.

While providing states with this option represents important progress towards eliminating Medicaid's institutional bias and meeting *Olmstead*'s integration mandate, we encourage the Department to adopt further reforms in its final rule. For example, the rule should also allow for prompt and retroactive coverage of home- and community-based services comparable to the coverage provided for institutional care. Additionally, the rule should ask states to revisit their income caps for people enrolled through the Medically Needy pathway. In many states, people who have to spend down their assets to become eligible for Medicaid have so little income left that they are unable to pay for rent, food, utilities, and other basic living expenses that allow them to stay in their community. This often leaves institutional care as their only option. For disabled and aging women, who already contend with fewer financial resources,[11] limited income caps can be especially harmful: They force them deeper yet into poverty, threatening not only their economic stability but also their health.[12] By asking states to update their income caps, the Department can help more enrollees retain sufficient income to pay for in-community expenses.

VI. Align non-MAGI enrollment and renewal with MAGI policies

Since the enactment of the ACA, eligibility determinations and renewals for MAGI groups have become increasingly streamlined. But these reforms have lagged when it comes to non-MAGI groups, including people who are over age 65, blind, or disabled. Women—who are overrepresented among people over the age of 65,[13] disabled people,[14] and Medicaid enrollees overall[15]—likely make up the majority of the non-MAGI population.

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[8] Agency for Healthcare Research and Quality, *Assessing the Health and Welfare of the HCBS Population* (2012), https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/hcbs/findings/find5.html.
[9] National Women's Law Center & Justice in Aging, *Supporting the Economic Security and Health of Older Women of Color* (2021), https://nwlc.org/resource/supporting-the-economic-security-and-health-of-older-women-of-color.
[10] *Id.*
[11] *See id.* at 2; Department of Labor, *Spotlight on Women with Disabilities* 6 (Mar. 2021), https://www.dol.gov/sites/dolgov/files/ODEP/pdf/Spotlight-on-Women-with-Disabilities-March-2021.pdf.
[12] Gretchen Borchelt, *The Impact Poverty Has on Women's Health*, 43 ABA Human Rights Magazine (Aug. 2018), https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/the-state-of-healthcare-in-the-united-states/poverty-on-womens-health.
[13] Administration for Community Living, *2020 Profile of Older Americans* 4 (May 2021), https://acl.gov/sites/default/files/aging%20and%20Disability%20In%20America/2020Profileolderamericans.final_.pdf.
[14] Department of Labor, *Spotlight on Women with Disabilities* 3 (Mar. 2021), https://www.dol.gov/sites/dolgov/files/ODEP/pdf/Spotlight-on-Women-with-Disabilities-March-2021.pdf.
[15] Kaiser Family Foundation, *Medical Enrollment by Sex*, www.kff.org/medicaid/state-indicator/medicaid-enrollment-by-sex (accessed Nov. 1, 2022).

In many states, eligibility determinations and renewals for non-MAGI groups remain burdensome, resulting in higher rates of procedural denials. These burdens are particularly concerning given the barriers that many older adults and disabled people face to responding to documentation. For example, the required paperwork and other aspects of the application process are not sufficiently accessible for people with a range of disabilities. Additionally, older adults and disabled people have less access to reliable transportation, which may prevent them from obtaining documentation or attending an interview.[16] They commonly experience poorer health, potentially limiting the time and bandwidth they have to complete paperwork.[17] Older adults and disabled people are also more likely to face housing instability and homelessness, making it more difficult for them to receive notices related to their application or renewal.[18]

We therefore support the proposed changes in §§ 435.907 and 435.916, which would better align non-MAGI eligibility determinations and renewals with the procedural protections that currently exist for MAGI groups. The rule would help simplify the application process for non-MAGI groups by requiring that they be allowed to apply through the same modalities as MAGI groups. The rule's prohibition on in-person interview requirements for non-MAGI groups would also remove a significant barrier. In-person interviews can be particularly difficult for people who cannot easily access transportation, afford to take time off work, or pay for caregiving and other related expense. However, we recommend that the Department prohibit *all* interview requirements, for both MAGI and non-MAGI groups. Finally, we support extending to non-MAGI groups other policies that have proven to reduce churn for MAGI groups, such as reviewing eligibility no more frequently than every 12 months, sending prepopulated renewal forms, and allowing a 90-day reconsideration period.[19]

VII. Ensure adequate response time and timely eligibility determinations

Medicaid agencies often send requests for additional information or documentation without providing applicants and enrollees with sufficient time to respond. As noted, numerous barriers can make it difficult for individuals to respond promptly. For example, some may not become aware of the deadline, particularly if it is buried in a lengthy or complex request or if they experience other barriers to understanding the notice in its entirety. Some may experience delays in receiving the request for additional information due to housing changes or instability. A range of circumstances can make it more difficult for many people to gather the requisite documentation: For example, people with low incomes, immigrants, people reentering their communities after incarceration, and transgender people are all less likely to have up-to-date identity documents or documentation related to their salary or financial history.

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[16] *See, e.g.,* Abigail L. Cochran, *Impacts of COVID-19 on Access to Transportation for People with Disabilities*, 8 TRANSPORTATION RESEARCH INTERDISCIPLINARY PERSPECTIVES 100263 (Nov. 2020), https://doi.org/10.1016/j.trip.2020.100263; Elena T. Remillard et al., *Transportation Challenges for Persons Aging with Mobility Disability: Qualitative Insights and Policy Implications*, 15 DISABILITY AND HEALTH JOURNAL 101209 (Jan. 2022), https://doi.org/10.1016/j.dhjo.2021.101209

[17] *See, e.g.,* National Council on Aging, *Get the Facts on Healthy Aging* (Jan. 1, 2021), https://www.ncoa.org/article/get-the-facts-on-healthy-aging; Centers for Disease Control and Prevention, *Disability and Health Related Conditions* (Sep. 16, 2020), https://www.cdc.gov/ncbddd/disabilityandhealth/relatedconditions.html.

[18] *See* Jaboa Lake et al., *Recognizing and Addressing Housing Insecurity for Disabled Renters* (May 27, 2021), https://www.americanprogress.org/article/recognizing-addressing-housing-insecurity-disabled-renters; Patti Prunhuber & Vivian Kwok, Low-Income Older Adults Face Unaffordable Rents, Driving Housing Instability and Homelessness (Feb. 2021), https://justiceinaging.org/wp-content/uploads/2021/02/Older-Adults-Rental-Housing-Burdens.pdf.

[19] *See* MACPAC, *An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP* (Oct. 2021), https://www.macpac.gov/wp-content/uploads/2021/10/An-Updated-Look-at-Rates-of-Churn-and-Continuous-Coverage-in-Medicaid-and-CHIP.pdf.

The barriers to gathering documentation are especially pronounced for people applying on the basis of disability, given the complex nature of the documentation required for this eligibility pathway.

We support proposed changes to §§ 435.907, 435.912, and 457.340, which would provide a minimum response time of at least 15 days for most applicants and at least 30 days for those applying on the basis of disability. The rule should also ensure that state agencies make eligibility determinations in a timely manner. In particular, it should retain the current 45- and 90-day processing timelines in order to avoid unnecessary delays, regardless of whether applicants are given additional time to respond to requests.

VIII. Facilitate enrollment in using LIS "leads" data

MSPs provide critical financial assistance for low-income older adults and disabled people who are eligible for Medicare. However, barriers to enrollment in MSPs have resulted in a large number of eligible but unenrolled individuals. One study estimated that around half of Medicare enrollees eligible for an MSP—nearly 3 million people—were not enrolled.[20] Across all types of MSPs, women make up approximately two thirds of those who are eligible but not enrolled—including QMB (67%), SLMB (66%), and QI (63%).[21]

Since 2008, the Medicare Improvements for Patients and Providers Act (MIPPA) has provided for certain standards to address the high rates of unenrollment among MSP-eligible individuals. MIPPA requires SSA to transmit eligibility data from LIS applications (or "leads" data) to state Medicaid agencies. The state agencies must in turn treat this data like an MSP application, rather than requiring individuals to submit a separate application. If an agency requires further information, it should send a prepopulated application to the individual, requesting only the information not yet provided by SSA.

But while these requirements have been in place for over a decade, most states are not yet in full compliance, resulting in over a million people who are enrolled in LIS benefits but not in an MSP. We therefore support the proposal at § 435.911 to codify and implement MIPPA's requirements. We also support setting the compliance deadline at 30 days following the publication of the final rule: Given that states have been statutorily required to accept leads data for years, they should already have a system in place to do so, and further delays allowing them to skirt their statutory obligations are unwarranted. Finally, both through this rule and through other activities, we encourage the Department to explore stronger enforcement mechanisms to address the chronic noncompliance, such as enforcing a reporting requirement or linking financial incentives to implementation.

IX. Protect enrollees from adverse actions in changes of circumstances assessments

We generally support proposed changes that would protect individuals from unwarranted adverse actions when states act on changes in circumstances. In particular, we agree that when an agency is verifying information from a third party that would qualify an enrollee for more favorable coverage, the agency should not take adverse action if the individual does not respond to the request for additional information.

We support the requirement that agencies accept reports of changes in circumstances through a range of modalities (online, by telephone, by mail, or in person). We also agree that agencies should allow enrollees a 30-day period to verify changes in circumstances and allow a 90-day reconsideration period when enrollees are terminated for failing to provide requested information.

X. Establish required agency action on returned mail

Current policy leaves many people at risk of losing coverage because of mail that is returned as undeliverable, particularly people facing housing instability or homelessness—an experience that

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[20] Kyle J. Caswell & Timothy A. Waidmann, *Medicare Savings Program Enrollees and Eligible Non-Enrollees* 8 (Jun. 2017), https://www.macpac.gov/wp-content/uploads/2017/08/MSP-Enrollees-and-Eligible-Non-Enrollees.pdf.
[21] *Id*. at 15.

disproportionately impacts women of color. Compared to white women and men, Black, Latina, and AAPI women are substantially more likely to be cost-burdened renters, meaning that they spend more than 50 percent of their income on rent[22]; this puts their housing in a precarious position when their income or expenses fluctuate. Black women in particular are more likely than any other group to be evicted: One study found that evictions against Black women are filed at twice the rate of white women.[23] And among low-income renters, Black women are nine times as likely as white women to be evicted.[24] If mail from Medicaid agencies is returned as undeliverable as a result, they may experience coverage disruptions or terminations.

We therefore support the proposed requirement that state agencies take reasonable steps to determine correct addresses. We also agree that agencies should further make multiple efforts, through multiple modalities, to contact beneficiaries before terminating coverage.

The Department also proposes to allow agencies to accept information about address changes it receives from reliable sources, such as the post office's National Change of Address database, unless they receive a response from the enrollee indicating that this information is incorrect. We agree that this policy would reduce burdens on enrollees. However, we encourage the Department to go further and *require* states to accept this third-party information, even if the enrollee does not respond to a request to confirm it.

XI. Conclusion

We appreciate the opportunity to comment on this proposed rule and urge the Department to finalize it, subject to our recommendations above. We request that the supporting documentation that we have made available through direct links in our citations be considered part of the formal administrative record for purposes of the Administrative Procedures Act.

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[22] National Women's Law Center & National Low Income Housing Coalition, *Gender and Racial Justice in Housing* 2 (May 2021), https://nwlc.org/wp-content/uploads/2021/05/GenderRacialJusticeFSNLIHC_8pages-2.pdf.
[23] Kalyn Womack, Black Women Face Greater Risk of Eviction than Any Other Group, THE ROOT (Apr. 5, 2022), https://www.theroot.com/black-women-face-greater-risk-of-eviction-than-any-othe-1848751832.
[24] National Women's Law Center & National Low Income Housing Coalition, *Gender and Racial Justice in Housing* 4 (May 2021), https://nwlc.org/wp-content/uploads/2021/05/GenderRacialJusticeFSNLIHC_8pages-2.pdf.