November 7, 2022

Chiquita Brooks-LaSure
Administrator
The Center for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Brooks-LaSure,

On behalf of the nation's Medicaid Directors, the National Association of Medicaid Directors (NAMD) is writing in response to the Center for Medicare and Medicaid Services' (CMS) proposed rule, Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes [CMS-2421-P].

This rule represents a major federal effort to streamline access to and retention of Medicaid and CHIP coverage. While many states support these goals, some states have differing philosophies regarding the role of Medicaid in their health care systems. CMS should be mindful of these dynamics in any final rulemaking. Further, even where there is alignment between state and federal objectives for eligibility policy, the sweeping changes proposed here will require significantly more implementation time than the 12 months CMS contemplates, particularly as states navigate the end of the COVID-19 Public Health Emergency (PHE).

NAMD is a bipartisan, nonprofit, professional organization representing leaders of all Medicaid agencies across the country. NAMD represents, elevates, and supports state and territorial Medicaid leaders to deliver high value services to the millions of people served by Medicaid and CHIP so they can achieve their best health and thrive in their communities.

Key Messages

NAMD offers four overarching areas for consideration as CMS advances this rule. These broad areas inform the more specific operational feedback we offer on the rule's policy proposals.

1. **Implementation of significant eligibility and enrollment changes must not overlap with the post-PHE redetermination period.** State eligibility and systems teams are wholly focused on preparations for the major redetermination efforts that will come when the PHE ends. CMS has closely collaborated with states on a myriad of topics related to the PHE unwinding and has a keen awareness of the immensity of the tasks coming over the next year. It is imperative that CMS's priorities for broader eligibility policy do not detract from

the critical work of managing the post-PHE redetermination period. States will not have the capacity to simultaneously manage this work and plan for major changes to their broader eligibility environment. CMS must set implementation timelines that reflect this dynamic.

2. **Significant implementation timelines will be necessary for states to successfully execute on the rule's proposals.** CMS's proposed 12 month implementation period upon publication of a final rule is insufficient for states to implement most, if not all, policies contemplated in this proposal. State capacity to implement systems changes, develop new state legislative and regulatory constructs, and hiring and training eligibility staff on new rules and procedures requires significantly more time. NAMD recommends CMS provide at least three years of implementation time for most policies in the rule, with options for states to request extensions when specific barriers cannot be addressed within this timeframe.
3. **CMS should avoid being overly prescriptive in its rulemaking to ensure states maintain the flexibility to implement effective systems and processes.** States have significant variation in their systems functionality, business processes, and existing eligibility practices. Core eligibility functions may reside with a sister state agency or within county agencies. While CMS may see value in bringing more standardization to aspects of eligibility and enrollment policy that currently lack such standardization, NAMD cautions against being overly prescriptive in federal regulation such that state flexibility to account for these factors is inhibited. Should CMS inadvertently codify processes that prove burdensome or have unintended consequences for states or Medicaid members, rectifying them will take additional federal rulemaking. Instead, CMS should identify its goals and provide a regulatory framework that gives states the flexibility necessary to meet those goals in a manner that is administratively streamlined and meets states where they are.
4. **Several proposed changes will have fiscal impacts on states.** Virtually all states will need to make systems changes to comply with the rule's proposals. CMS should make state access to enhanced systems match as streamlined as possible to support this work. More fundamentally, compliance activities and ongoing, increased expectations for state eligibility staff will require significant administrative resources. CMS should work with states to identify mechanisms to access enhanced match or other funding opportunities to support these efforts. Lastly, CMS's emphasis on promoting easier pathways to eligibility and retention of eligibility will likely lead to increased program enrollment, which will have impacts on state budgets.

Specific Feedback

A. Facilitating Medicaid Enrollment

1. Medicare Savings Plan Enrollment Using "Leads" Data

In this rule, CMS proposes to codify the requirement that states maximize the use of "leads" data to establish eligibility for Medicaid and Medicare Savings Programs (MSPs). Although NAMD supports CMS' goal of streamlining enrollment in MSPs, there are operational challenges associated with implementing this provision.

States report that effectuating this provision would require time-intensive systems changes. These changes would be particularly challenging because they require systems interfaces with the Social Security Administration (SSA) and other agencies. If CMS moves forward with this provision, they should provide states with technical assistance on implementing these systems changes and engage with the SSA to ensure data feeds are working properly.

States report that the information contained in Low Income Subsidy (LIS) program "leads" files is generally not sufficient to complete eligibility determinations for the MSPs or for full Medicaid benefits. This means that states typically need to request additional information from members, such as verification of citizenship or immigration status. Some states report that they do not currently have the capability to request this information or process these applications through their eligibility systems, so would either need to bring on additional staff to conduct these processes manually or seek funds to make extensive systems changes. CMS should provide technical assistance on these issues.

Additionally, CMS proposes enrollment simplification policies to align MSP and LIS eligibility, including requiring states to accept attestations for certain resources. Although some states report already having aligned these policies, other states report that complying with this provision would require significant systems changes and outreach to members. There are also significant operational challenges with the proposal to require states to assist individuals in obtaining documentation of the cash surrender value of a life insurance policy. States report that life insurance companies typically will not provide information to anyone but the member or their authorized representative, which limits the ability of a State Medicaid Agency to assist in this process. Requiring additional attestations may also lead to legislative complexities around program integrity concerns.

In the rule, CMS seeks comment on extending these proposals to all individuals seeking eligibility; states generally did not support extending these proposals to all individuals but did support extending the proposal related to verification of dividend and interest income to individuals seeking eligibility on a MAGI basis. States generally supported keeping post-enrollment verification at state option and requested clarification on how post-enrollment verification would interact with long-term care decisions and if a denial would trigger benefit recovery. CMS should also not require states to accept self-attestation for individuals who are seeking to rebut a presumption of the amount of in-kind support and maintenance they receive; this should be at state option.

2. Define "Family of the Size Involved" for the Medicare Savings Program Groups using the Definition of "Family Size" in the Medicare Part D Low-Income Subsidy Program

In the rule, CMS proposes to formally define "family of the size involved" for MSP eligibility as including at least the individuals included in the of "family size" in the LIS program. States generally do not report concerns about this proposal. However, some states report that they are unable to view LIS family size data if the family is larger than two people, which would make operationalizing this provision impossible. CMS should provide technical assistance on this issue.

States also report the need for clarification on how changes to household size definitions may impact income eligibility limits. NAMD is concerned that the proposed change may negatively impact some MSP enrollees; if the additional household members have income, this could raise the total household income above the MSP eligibility limit. CMS should examine these potential unintended consequences to ensure members are not negatively impacted by the change in "family of the size involved" definition.

3. Automatically Enroll Certain SSI recipients into the Qualified Medicare Beneficiaries Group

In this rule, CMS proposes to require states to deem an individual enrolled in the SSI or 209(b) group eligible for the Qualified Medicare Beneficiaries Group (QMB) the month the state becomes responsible for paying the individuals' Part B premiums. States report that implementing this option would require lengthy and expensive systems changes; in general, provisions that require interfaces with other data sources are difficult to implement.

The rule would also create limited retroactive QMB coverage for individuals in the mandatory SSI or 209(b) group to a period of no greater than 36 months prior to the date of the Medicare enrollment determination. Creating a retroactive period for this population would require significant system changes and employee trainings, resulting in a fiscal impact. Some states also report that this change would require legislative approval.

NAMD supports the option for group payer states to adopt the same streamlined QMB enrollment procedures used in Part A buy-in states. States report this option may reduce administrative burden by streamlining QMB enrollment but could lead to increased cost as more individuals would be enrolled. Given the required systems changes, this provision should be a state option and not a requirement.

4. Clarifying the Qualified Medicare Beneficiary Effective Date for Certain Individuals

In this rule, CMS proposes to clarify the effective date of QMB coverage for individuals who must pay a premium to enroll in Part A and reside in a group payer state. NAMD does not have comments on this provision.

5. Facilitate Enrollment by Allowing Medically Needy Individuals to Deduct Prospective Medical Expenses

In this rule, CMS proposes to allow certain noninstitutionalized individuals to use the same expense projections for medically needy eligibility determinations that are currently available to individuals receiving institutional care. NAMD supports this proposal; it would help address the institutional bias in Medicaid by allowing individuals who receive home- and community-based services (HCBS) to use the same spend-down flexibilities as individuals who receive institutional care. CMS could also consider adding predictable expenses like over-the-counter medications, over-the-counter medical supplies, and health insurance premiums to the final rule.

To strengthen the proposal, CMS should consider a less prescriptive approach that allows states to reasonably define what expenses can be used for projections. This should include allowing flexibility on the proposed requirement to use the Medicaid reimbursement rate for these calculations. CMS should also allow flexibility on the requirement that states reconcile the projected spend with the actual expenses incurred at the end of each budget period. States cite the administrative burden associated with this frequency of reconciliation; CMS should instead allow states to review expenses each year at renewal. A less prescriptive approach would increase state and member uptake and allow states to adapt expense projection parameters to their local contexts.

6. Application of Primacy of Electronic Verification and Reasonable Compatibility Standard for Resource Information

In the rule, CMS proposes to clarify that asset verification processes, including the application of reasonable compatibility standards, apply to resources in addition to income. Although NAMD agrees with CMS' intent to streamline enrollment, states highlight several operational concerns associated with this policy.

States report that, to implement this policy, they would need to integrate Asset Verification Systems (AVS) into their existing eligibility systems or look up each case manually. In either scenario, this would be complex, labor intensive, and redirect resources from other priorities. There are also data quality and timeliness concerns with AVS. States report that the return of data is slow (14 days on average), which can delay eligibility determinations and prevent states from meeting application and renewal processing deadlines. States also report that AVS data has quality issues; many financial institutions do not participate, and interest is often reported incorrectly. If CMS moves forward with this proposal, they should provide technical assistance to address these AVS data quality and timeliness concerns.

CMS should also provide clarification on how reasonable compatibility would interact with resource assessments and 90-day asset transfers to community spouses. It is unclear how reasonable compatibility would apply in these circumstances.

7. Verification of Citizenship and Identity

In this rule, CMS proposes to no longer require separate verification of identify when citizenship is verified through a match with a state's vital statistics records or the SAVE Program, similar to the current process for verification of citizenship with the SSA. NAMD supports ending this requirement to streamline Medicaid enrollment.

CMS also proposes to require that states utilize data matches with their state vital statistics agencies if such a match is available and would be effective. State Medicaid Agencies report limitations to the use of state vital statistics records, as they only apply to individuals who were born in-state. In many states, accessing vital statistics would require a manual process or file transfer and would only help verify citizenship in a very small number of cases, so this would not be a cost-effective strategy. Although CMS clarifies that the rule would not necessarily require states to establish a match with their state vital statistics agency, if such a match is not available and effective, this provision should be a state option and not a requirement.

B. Promoting Enrollment and Retention of Eligible Individuals

1. Aligning Non-MAGI Enrollment and Renewal Requirements with MAGI Policies

In this rule, CMS proposes a number of changes to align policy for MAGI and non-MAGI applications and renewals. Although some states report having already aligned procedures between the MAGI and non-MAGI eligibility groups, other states report that implementing these changes would require significant systems changes and a multi-year implementation timeline. States also request clarification on how certain MAGI policies would interact with unique eligibility rules and processes for Medicaid-funded long-term services and supports.

In this rule, CMS proposes to require states to send a pre-populated renewal form to non-MAGI members. States report that they would need significant resources, lead time, and technical assistance to implement this policy. This provision would be especially hard to implement in states that still use legacy systems to administer non-MAGI cases; these states would need at least three years to conform with this provision. States with integrated eligibility systems also report concerns, as the same form would be used for programs like the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) that use different income counting methodologies.

CMS proposes to establish a 90-day reconsideration period for members who are enrolled on a non-MAGI basis. States request clarification on if this reconsideration period would apply to HCBS, which have waitlists in many states, or only to state plan benefits. If this provision does apply to HCBS, there would be clear conflicts with eligibility rules for relevant waivers. For example, if a member has a 30-day break in HCBS services in some states, the member is transferred to a different eligibility group;

the 90-day reconsideration period would conflict with this policy. This would be especially challenging for states that maintain waitlists for their HCBS waivers.

CMS also proposes to end the state option to require in-person interviews during the application and renewal processes for non-MAGI members. Although states generally did not have concerns about this change, many states flagged that new applicants often find interviews helpful, given the complex eligibility rules associated with the non-MAGI pathway. CMS should clarify that states may still encourage interviews. States also flagged potential unintended consequences if eligibility workers bias applicants away from interviews, as interviews can be time-intensive and tedious but also help ensure that applications are accurate.

2. Acting on Changes in Circumstances: Timeframes and Protections

In this rule, CMS proposes a set of steps states must take when acting on changes in circumstances. Although NAMD agrees with CMS' intent to clarify processes for members, these changes would require a significant amount of time and state resources to implement. CMS should provide states with at least three years to implement these changes. States who administer their non-MAGI cases through legacy systems report the most acute implementation challenges.

The proposed rule would establish timeframes for members to respond to requests for information associated with changes in circumstances. States note that while these longer timeframes could be helpful for members, they would also misalign response timeframes for SNAP and TANF in states with integrated eligibility systems, which could lead to member confusion and a higher rate of procedural denials. This provision would also create different response timelines for members applying on the basis of a disability, which would lead to operational difficulties processing changes in circumstances for households with "mixed" eligibility groups (i.e., households where some members are eligible on the basis of disability and some members eligible on other bases). CMS should provide technical assistance on these issues.

State Medicaid Agencies also report that the proposed requirement to notify members when a reported change does not impact a member's eligibility would be operationally challenging. This provision would be administratively burdensome without providing a clear benefit to members; states also note the ongoing paper and envelope shortages, which would limit their ability to send this type of notice. NAMD is also concerned that an increased volume of notices that do not require a response may actually decrease the likelihood that members open important notices. This may lead to an increase in procedural denials. Given these challenges, these notices should be at state option.

3. Timely Determination and Redetermination of Eligibility

In the rule, CMS proposes to establish minimum timeframes for members to respond to requests for additional information that occur at application or renewal. CMS also

proposes a maximum timeframe for states to complete redeterminations at regular renewals, when they receive information indicating a change in circumstances, and for anticipated changes in circumstances. States report that these changes would require extensive systems changes and staff training, so CMS would need to provide significant resources, lead time, and technical assistance.

Like the changes in circumstances provisions, this proposal would be especially challenging to implement in states with integrated eligibility systems. States report that having different timeframes to return requested information for Medicaid, SNAP, and TANF may increase member and provider confusion. Similarly, establishing different timelines for members seeking coverage on the basis of disability vs. through other eligibility pathways would also be confusing.

In the rule, CMS proposes creating a 30-day reconsideration period at application. Some states report that this would be difficult to implement and impact caseload and fiscal forecasting. Conversely, other states note that they have already implemented longer reconsideration periods (up to 60 days) and would like to preserve these longer timeframes; one state reports that their longer reconsideration period is especially important for applicants seeking long-term care coverage, as it can take several weeks to obtain required documentation (e.g., current market value of property). Given these differing perspectives, CMS should give states flexibility to set the length of this reconsideration period.

States also have divergent opinions on if the effective date of coverage for this new 30-day reconsideration period should be determined in accordance with the application date or if the return of additional information should constitute a new application with a new effective date of coverage. Using the application date may be administratively simpler to implement, but an application date could be several months old by the time all needed information is returned. Providing retroactive coverage to the date of the application would also be challenging and could disincentivize the timely return of information.

In the rule, CMS proposes requiring states to provide current members with at least 30 days to return requested information at renewals or changes in circumstances. States highlight serious operational concerns with this provision. For states that send notices 60 days before the end of the eligibility period, this 30-day minimum timeframe may result in many renewals being completed after the end of the eligibility period. Although CMS proposes additional time for states to complete renewals if required information is not returned by at least 25 days before the end of the renewal period, this would mean many individuals would receive an additional two months of Medicaid eligibility. This represents a significant fiscal impact to states; this impact would be especially acute in managed care states who would continue making capitation payments on these members.

NAMD supports CMS' proposal to provide states with an additional month to process renewals and anticipated changes tin circumstances if a member does not return requested information at least 25 days before the end of the eligibility period or date of change. This would help ensure that Medicaid Agencies have adequate time to complete eligibility determinations and are not unfairly penalized for "late" determinations.

Additionally, if CMS moves forward with these provisions, it should provide states with additional information on how these new timelines would be captured in CMS' quarterly reports on application processing timelines. CMS should be sure to distinguish untimely determinations past 45 days vs. determinations that extended past 45 days due to individuals being given additional time to respond to requests for information.

4. Agency Action on Returned Mail

In this rule, CMS proposes establishing a set of actions State Medicaid Agencies would be required to take when they receive returned mail. NAMD has serious concerns about CMS' proposal, which would lead to intense administrative burden on states and potential unintended consequences for members. Preparing for the post-PHE unwinding has highlighted the importance of ensuring accurate member contact information, but NAMD would encourage CMS to work directly with states to develop returned mail policies that are operationally feasible and would accomplish CMS' policy goals. CMS should, however, give states the option to accept updated addresses from managed care organizations, the United States Postal Service (USPS), and the National Change of Address (NCOA) database without having to first contact members. These strategies, currently being widely utilized under PHE-related waiver authority, are proving effective and should be made permanent.

State Medicaid Agencies highlight a number of implementation challenges with CMS' returned mail proposals. The proposed rule would require states to send notices to two addresses, but many states report that their systems do not have the functionality to hold (or send mail to) two addresses. In some states, implementing this provision would be impossible using existing IT systems. In other states, eligibility workers could manually enter a secondary address into the member's case notes, but this would significantly increase the risk of data input errors that lead to notices going to wrong addresses. To conduct outreach through two modalities, some states report they would need to procure a Customer Relationship Management (CRM) system, which would require years and significant state funds to implement. States also report ongoing paper and envelope shortages; given this reality, CMS should minimize the amount of paper notices states are required to send.

Many states report they would need to bring on additional staff to implement the proposed returned mail policies; in many states this would require new legislative and budget authority. NAMD is also concerned that the proposed policies do not account for

the differing mail systems across states. For example, many states report that they do not receive returned mail if there is a forwarding address: the mail is simply forwarded without notice to the state. In these cases, CMS' proposed framework does not make sense, as the state would never receive returned mail with a forwarding address.

NAMD is also concerned that the proposed rule, as written, would lead to delays in processing updated contact information. States report that forwarding addresses and updated contact information from the NCOA database are almost always accurate; one state reports that they have never had a member report that the updated address is incorrect. States report that they also often receive address changes that at are least six months old, meaning that there is a very low risk that the member incorrectly updated their address and did not realize their error in the intervening six months. In these cases, giving the member 30 days to respond would significantly delay the state's ability to update the address and not meaningfully increase the accuracy of the Medicaid Agency's contact information.

The proposed changes would also lead to complications in states with integrated eligibility systems and/or county-based eligibility systems. The proposed framework, which has different rules for in-state and out-of-state forwarding addresses, does not seem to account for county-based eligibility systems where cases are transferred between local agencies when members move. States also highlight the misalignment this rule would cause between Medicaid and SNAP policy, as SNAP does not consider a new address as proof of move. In states with integrated eligibility systems, this could lead to conflicting policies.

Due to these operational challenges, NAMD strongly encourages CMS to not finalize the proposed returned mail policies. Instead, CMS should work directly with states to gain an understanding of the operational realities and develop state-specific strategies that meet local need.

NAMD does, however, strongly encourage CMS to adopt some of the flexibilities proposed in the rule at state option. States report that being able to accept updated contact information from the USPS, the NCOA, managed care plans, State Human Services Agencies, and other data sources would be helpful. However, this should be done at state option, as the quality of data and the feasibility of accepting updated addresses varies between states and data sources. CMS should also give states the option to update contact information without having to first contact the member, so long as the updated contact information comes from a trusted source like the NCOA or a managed care organization. As discussed above, states report that these addresses are almost always accurate, and having to verify updated contact information with members is administratively burdensome.

5. Transitions between Medicaid, CHIP and BHP Agencies

In this rule, CMS proposes changes to streamline transitions between Medicaid, CHIP, and Basic Health Plans (BHPs). This would require states with separate CHIPs to develop agreements and processes to accept determinations of Medicaid eligibility from CHIP and complete determinations of eligibility for CHIP. States report that their policies are generally already aligned with this proposal.

6. Optional Group for Reasonable Classification of Individuals Under 21 Who Meet Criteria for Another Optional Group

In this rule, CMS proposes to allow states to provide coverage to all individuals under age 21, 20, 19, or 18, or to a reasonable classification of such individuals, who meet the requirements of any clause of section 1902(a)(10)(A)(ii) of the Act. NAMD does not have comments on this proposal.

C. Eliminating Barriers to Access in Medicaid

1. Remove Optional Limitation on the Number of Reasonable Opportunity Periods

NAMD does not have concerns about CMS' proposal to remove the optional limitation on the number of reasonable opportunity periods (ROPs). As discussed in the rule, no states are currently electing the option to limit ROPs.

2. Remove or Limit Requirement to Apply for Other Benefits

In this rule, CMS proposes to end the requirement that applicants and members apply for all benefits to which they may be entitled**.** In general, NAMD is supportive of this proposal. States report that this requirement creates administrative burden on Medicaid members and state staff, and that applicants generally do not receive additional income that changes their eligibility. States also report that this requirement can lead to delays in processing applications. Removing this requirement would streamline enrollment and renewal for Medicaid members and State Medicaid Agencies.

That being said, some states highlight operational concerns with removing the requirement to apply for Social Security Disability Insurance (SSDI). Some states report that they use the Social Security Administration's disability determination for certain Medicaid eligibility pathways; if the requirement to apply for SSDI were removed, states would need to grow their eligibility teams notably beyond current capacity to conduct determinations directly. These states note that removing the SSDI application requirement could also impact an individual being appropriately enrolled in Medicare benefits and potentially shift costs to Medicaid programs. CMS should consider allowing states to continue requiring applications to SSDI.

In the rule, CMS also discusses several alternative policies, including only requiring that members apply for benefits that would count as income under the relevant financial methodology or exempting SSI members from the requirement to apply for other benefits. NAMD would encourage CMS to remove the requirement altogether instead of

implementing one of these alternatives; states report these alternatives would be administratively burdensome.

D. Recordkeeping

In this rule, CMS proposes to establish recordkeeping standards for applicant and member case records. These standards propose a 3-year retention period and a requirement that all case information be stored in an electronic format. Some states report already being in alignment with this proposal, but for other states, implementing these recordkeeping standards would require significant time and resources. States report particular challenges transitioning their non-MAGI legacy systems, which still use some paper records, to the required all-digital format. States report similar concerns about eligibility offices in smaller, more rural regions of their states that do not have modernized recordkeeping systems. NAMD also anticipates that implementing this rule would be significantly more challenging in states with integrated eligibility systems (where the Medicaid Agency does not directly hire eligibility staff) or county-based eligibility systems.

If CMS does move forward with this proposal, states should be given a multi-year implementation timeline, as conforming with this rule may require new procurements and close work with partner agencies. CMS should also allow flexibility in how states preserve records electronically; some of the underlying processes may be manual in nature and not automatically stored in the eligibility system.

In the rule, CMS also proposes that states be required to make records available to CMS or other appropriate parties within 30 days of a record request. CMS should establish a process for states to request an extension. In states with county-based eligibility systems or integrated eligibility systems, delays in responding to records requests may be outside the control of the Medicaid Agency, and extensions would be appropriate in these cases.

E. Streamlining Enrollment and Promoting Retention and Beneficiary Protections in CHIP

In this rule, CMS proposes to extend the proposed Medicaid enrollment and retention policies to CHIP. NAMD supports alignment between Medicaid and CHIP but has the same concerns around CMS' proposed mail policies as described above. States would also face the same challenges with the proposed recordkeeping requirements.

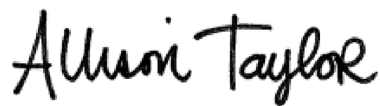
F. Eliminating Access Barriers in CHIP

In the rule, CMS proposes to prohibit premium lock-out periods, waiting periods, and annual and lifetime benefit limits in CHIP. States utilizing these flexibilities report that these policies are sometimes used to ensure that states do not meet their CHIP spending caps; if CMS moves forward with these provisions, states should be granted

fiscal resources to account for increased spending. NAMD also notes that these policies are often enacted by state legislatures in order to create more commercial-like coverage. Ending these options may lead to legislative complexities.

We appreciate CMS's consideration of state perspectives on these important issues. NAMD and our members look forward to continued collaboration with our federal partners to ensure eligibility and enrollment policies are both effective and administratively streamlined.

Sincerely,



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