November 7, 2022

Dear Administrator Brooks-LaSure:

Arnold Ventures welcomes the opportunity to provide responses to the Centers for Medicare and Medicaid Services (CMS) on the "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Process" proposed rule (CMS-2421-P).

Arnold Ventures is a philanthropy dedicated to investing in evidenced-based policy solutions that maximize opportunity and minimize injustice. Our work within the health care sector is driven by a recognition that the system both costs too much and fails to adequately care for the people it seeks to serve. Our work spans a wide array of issues including prescription drug prices, health care prices, complex care, clinical trials, Medicare sustainability, and provider payment incentives.

First, we want to thank the agency for its important work to improve the eligibility and enrollment processes that people must go through in order to obtain health insurance coverage. These processes are particularly challenging for people who are enrolled or seeking coverage through both the Medicare and Medicaid programs, the so-called "dual-eligible" population. These people must navigate two large government programs that do not work well together in order to access the care that they need, resulting in relatively high rates of inpatient stays, emergency department visits, and nursing home stays. On average, total government spending for the dual-eligible population was almost double their non-dual-eligible counterparts.[1] Improving outcomes for people who are dual-eligible is the main focus of our work on Arnold Ventures' Complex Care team today.

Significant investment has been made over decades to improve the way in which we deliver care to the dual-eligible population. One of the most promising mechanisms identified to date is to integrate Medicare and Medicaid through a single at-risk entity. Fully-Integrated Special Needs Plans and Medicare and Medicaid Plans, which were developed as part of a Centers for Medicare and Medicaid Innovation demonstration that is coming to an end, represent the most integrated Medicare-Medicaid models available at scale today. By aligning Medicare and Medicaid coverage through these models, CMS and states can hold these entities accountable for improving outcomes for the dual-eligible population, like helping more people to live and stay in the community and reducing hospitalizations.

The unnecessary loss of Medicaid eligibility is harmful to people, especially dual-eligible individuals. Forty two percent of dual-eligible individuals have five or more chronic conditions, which means they are likely to have regular interactions with the health care system.[2] For the dual-eligible population, a meaningful amount of losses in coverage are estimated to occur because of administrative hurdles, not actual changes in an individual's eligibility for Medicaid.[3] Furthermore, these disruptions in eligibility can cause people to be disenrolled from integrated coverage options, undermining CMS' and states'

[1] MedPAC and MACPAC. Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid. February 2022.
[2] *Ibid*.
[3] Zhanlian Feng, et al. Loss of Medicare-Medicaid Dual-Eligible Status: Frequency, Contributing Factors, and Implications. ASPE. May 2019.

investments in the implementation of these models. We therefore look for opportunities to help people who are eligible for Medicare and Medicaid today to get and stay enrolled in their coverage.

We applaud the effort that CMS has put forward in this proposed rule to improve the eligibility and enrollment processes that people must go through in order to obtain Medicaid coverage when they have Medicare coverage. The following responds to specific proposals outlined in the proposed rule.

A. Facilitating Medicaid Enrollment

1. *Facilitate Enrollment Through Medicare Part D Low-Income Subsidy "Leads" data*
   Background: Today, when a person enrolls in Medicare's Part D low-income subsidy program (LIS) and they are not enrolled in the Medicare Savings Program (MSP), the Social Security Administration sends the application data to the state. This is commonly referred to as "leads" data. Federal statute requires states to use this data to initiate an application for MSP, but many states appear to not be using this data, resulting in many people enrolled in the LIS program but not the MSP program. Thus, CMS proposes to codify in regulation specific strategies that states must utilize to maximize the use of leads data to streamline enrollment into the MSP.

   Additionally, states can place asset requirements on MSP eligibility beyond what is required of LIS enrollment (e.g., cash value of life insurance, dividend and interest income, and the value of non-liquid assets). Given that these pieces of information are not used in the assessment of LIS eligibility, they are often not included in the leads data that is sent to the state—therefore, the state may need additional information from the individual to make their MSP eligibility determination. CMS is proposing to require states to process MSP applications if the individual attests that they comply with the state's specific additional requirements. If appropriate, the state may then assess assets further after the application has been acted upon, but the state would be required to assist individuals in obtaining certain information.

   Recommendation: **We are supportive of CMS' effort clarify how states should be using leads data today. We also support CMS' proposal to use attestation to simplify the eligibility process and assist beneficiaries with obtaining information that is relevant to their eligibility.** CMS estimates that "there are 1.25 million people enrolled in full LIS who are not enrolled in an MSP, despite likely being eligible."[4] Challenging eligibility and enrollment processes contribute to this disparity today. CMS' proposed changes to regulation would support making it easier for people to get and stay enrolled in these programs.

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*
   Background: States have the option to define family size for purposes of accounting for income for MSP eligibility. CMS proposes to set a national definition of family size that is consistent with the current LIS definition. The proposed definition would account for the spouse as well as

[4] Centers for Medicare & Medicaid Services. CMCS Informational Bulletin. "Opportunities to Increase Enrollment in Medicare Savings Programs." November 1, 2021. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib11012021.pdf

relatives, by blood or marriage, who reside in the household and are dependent on the applicant of spouse for at least half of their financial support.

Recommendation: **We are supportive of CMS setting a national standard for family size consistent with the LIS definition.** Eligibility distinctions between the way in which we treat the various parts of the Medicare program, with Part D LIS subsidies different than Part A and B MSP subsidies, are confusing for low-income individuals attempting to enroll in these programs. We are supportive of efforts to align the LIS and MSP standards and create more uniformity on eligibility standards nationwide. CMS' proposal to align and standardize the family size definition are aligned with these broader goals.

3. *Automatically Enroll Certain SSI Recipients Into the Qualified Medicare Beneficiaries Group*
Background: The majority of states have set their eligibility rules such that when an individual is determined eligible for Social Security Income (SSI) they are also eligible for the full range of Medicaid benefits, technically this eligibility group is referred to as "Qualified Medicare Beneficiary" (QMB). However, many of these states fail to enroll this group into Medicaid coverage because of procedural and technical barriers. CMS is proposing to require these states to automatically enroll people into Medicaid when they become SSI eligible.

   There are 14 states that use a different policy for QMB eligibility for people who are enrolled in SSI—these states are referred to as "group payer states". CMS is encouraging, but *not* requiring, these states to enroll SSI recipients in at least Part A without requiring an individual to first file a "conditional" Part A enrollment with the Social Security Administration.

   Recommendation: **We are supportive of CMS' proposal to streamline the eligibility process into Medicaid for those already determined eligible for SSI where applicable. We encourage CMS to extend these requirements to at least Part A in group payer states.** The process for getting an eligibility determination and enrolling in a program is far too cumbersome. We are supportive of efforts by CMS and the states to automatically enroll people in programs when there is the prerequisite data collection that indicates people are indeed eligible. Evidence from the health care sector and beyond show that automatic enrollment into a program increases the likelihood that people stay enrolled.

5. *Facilitate Enrollment by Allowing Medically Needy Individuals to Deduct Prospective Medical Expenses (435.831)*
Background: One pathway in which people can get Medicaid coverage is referred to as the "Medically Needy" pathway. Under current rules for this eligibility category, people who live in the community cannot count their costs on medical care towards their Medicaid eligibility until the costs have been incurred, even in states that permit people to project their medical expenses for purposes of their Medicaid eligibility determination. Conversely, individuals residing in an institutional setting, like a nursing home, are able to project their costs and can be deemed Medicaid eligible. CMS is proposing to allow individuals who reside in the community to project costs for medical expenses so long as they are consistently high and predictable, similar

to those in an institutional setting, and gain eligibility through the Medically Needy pathway where this is permitted by a state.

Recommendation: **We are supportive of CMS' proposed change to allow people living in the community to count medical expenditures towards gaining eligibility through the Medically Needy eligibility pathway.** CMS' current eligibility rules for the Medically Needy pathway can create an institutional bias. If the only way to obtain assistance in paying for life-saving care is by entering an institution then that may influence a family's decision. Evidence shows that once people move into a nursing home it is very hard to get them back out of one of these facilities.[5] One of our goals is to address the institutional bias within Medicaid today, identifying policy solutions that help to keep people in the community when it is consistent with their wishes and clinically appropriate. This proposal would assist with meeting this broader goal, we therefore are supportive of CMS' proposed change.

B. Promoting Enrollment and Retention of Eligible Individuals

Background: CMS is proposing a wide range of improvements to the enrollment, renewal, and redetermination processes. These changes include:

- Limiting routine renewals to once every 12 months,
- Prohibiting in-person interviews,
- Requiring use of pre-populated forms,
- Allowing more time for individuals to respond to requests, including at least 30 days for response and a 90-day reconsideration period,
- Simplifying the process for reporting changes in circumstances, and
- Amending the current requirements around returned mail in order to limit unnecessary terminations in coverage due to an address change.

Recommendation: **We are supportive of the efforts CMS outlines to streamline the eligibility and enrollment process for beneficiaries.** In general, we need to make it easier for people to get and stay enrolled when they are eligible for coverage. CMS' proposed changes taken in combination have the power to significantly simplify the process for people across the country.

C. Other considerations

There are two other issues pertinent to the implementation of this rule that we encourage CMS to contemplate, related to the timeline and cost of these proposed changes.

Implementation Timeline and State Support

While we are supportive of many of CMS' proposals outlined in this rule, we also recognize that it will be the states that must implement these changes. Depending on when the rule goes into effect, these changes could be layered on top of the unwinding of the public health emergency at which time states will have to reprocess millions of individuals that are enrolled in the Medicaid program today. While we do believe states can and should employ many of the

[5] Timo W. Hakkarainen, et. al. Outcomes of Patients Discharged to Skilled Nursing Facilities After Acute Care Hospitalization. February 2016.

strategies outlined in this proposed rule in redeterminations associated with the unwinding of the public health emergency, we also recognize that there may not be adequate time or capacity to implement significant changes at this time. We encourage CMS to consider this reality when determining the most appropriate timeline for the rule to go into effect. We also encourage CMS to contemplate providing states with additional technical assistance and educational resources to assist them with effectively implementing the new requirements.

Federal and State Spending

The changes proposed in this rule are not about making people who were otherwise ineligible for coverage eligible. Instead, the changes referenced above would largely serve to ease the administrative processes that people must go through to get and maintain their Medicaid and Medicare coverage. CMS estimates that this will lead to higher enrollment rates among eligible individuals, which comes at a cost the state and federal government. These costs are justifiable given they represent a more efficient delivery of benefits. However, we believe that increases in government spending should be offset to the greatest extent possible. Therefore, we encourage CMS to monitor the costs associated with these proposed changes if they are finalized and contemplate program integrity measures within the Medicaid program—like addressing inappropriate uses of provider taxes by states to draw down additional federal dollars—to offset the cost of these important program improvements.

We appreciate the Administration's commitment to improving the enrollment and eligibility processes, especially for people who are dually eligible for Medicare and Medicaid. We also appreciate the opportunity to provide responses to this proposed rule. Please contact Mark Miller at mmiller@arnoldventures.org or Arielle Mir at amir@arnoldventures.org with any questions.

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