August 12, 2019

VIA ELECTRONIC SUBMISSION

RE: Request for Information: Reducing Administrative Burden to put Patients over Paperwork (CMS-6082-NC)

The Medicare Rights Center (Medicare Rights) is pleased to submit comments in response to the Request for Information: Reducing Administrative Burden to put Patients over Paperwork (the RFI). Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to nearly three million people with Medicare, family caregivers, and professionals.

The following comments are informed by our experience assisting beneficiaries, their family members, and health care professionals. For additional information, please contact Casey Schwarz, Senior Counsel, Education & Federal Policy at CSchwarz@medicarerights.org or 212-204-6271 or Lindsey Copeland, Federal Policy Director at LCopeland@medicarerights.org or 202-637-0961.

Medicare Rights appreciates the Patients over Paperwork initiative and supports its stated aims. In our response to this RFI, we are particularly focused on Centers for Medicare & Medicaid's (CMS's) specific request for suggestions to ease the burdens placed on 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 as many have relatively low health literacy and often face significant health challenges. This can limit their ability to handle documentation and timely respond to complex income and asset requests or to provide information supporting appeals, requests for waivers, or rate reductions.

In our work providing direct assistance to beneficiaries across the country—on our National Consumer Helpline and though partnered outreach work in New York and other states—we have seen the severe impact on beneficiaries, particularly dual eligibles, from overly complicated procedures. We also see that unnecessarily complex paperwork burdens discourage beneficiaries from even applying for benefits they need, or may lead them to give up because they cannot understand or navigate the complex processes. 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 (SSA) 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 apparent conflicts

between systems. With these considerations in mind, we offer the following suggestions for areas to be addressed by the Patients over Paperwork initiative.

Improved Data exchange among agencies

Determining and maintaining eligibility for programs affecting full and partial 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 and related to eligibility for the Part D Low Income Subsidy (LIS). However, on the state Medicaid side, state programs have not uniformly taken advantage of opportunities to transmit both Part B buy-in files and MMA files daily. CMS has previously proposed to enact regulations that would require states to submit these files daily, and we have supported those proposals. 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. 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.

SSA lags in recognizing changes in Part B payments

State Medicaid programs pay the Part B premiums for Medicare beneficiaries with full Medicaid or Medicare Savings Program 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. Although the beneficiary will eventually receive a refund for the credited months, 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 of a Social Security benefit payment from which both the current month's premium and the (at least) two months of back premiums are deducted, leaving the beneficiary suddenly and potentially unexpectedly without the means to pay rent, purchase food, or otherwise make it through the month. We have heard from tearful beneficiaries, 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.

Streamline and Improve the 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. The QMB benefit is very important in protecting people from catastrophic consequences as a result of a hospitalization or, even worse, encountering barriers to a needed inpatient stay. 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 Social Security. 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, or fail to do so during the circumscribed time frame. 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, Medicare beneficiaries can apply whenever they qualify for a benefit 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. 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.

MIPPA Process for Medicare Savings Programs (MSPs)

The MIPPA process, in which 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 Medicare Savings Program (MSP) eligibility, offers promise for addressing chronic under-enrollment in these important programs. In many states, however, states have not fully utilized the opportunities offered by the MIPPA process. According to a 2016 survey,[1] just five states (AR, IA, NJ, OR, SD) send pre-populated MSP application forms to those identified by SSA, only requiring individuals to provide information that has not already been verified by SSA. Most states, in contrast, 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 into these essential programs is much higher when forms are simple and the amount of information that the individual must supply (for the second time) is limited.

We ask that CMS 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 with states to use pre-populated forms and 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 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 simplification, we would urge 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. Individuals in both programs have low incomes and need financial help to

[1] 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.

access their Medicare benefits. Many barriers, however, stand in the way of full integration of these two programs. 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 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 very significant step in reducing paperwork burdens for beneficiaries. Nine states have done so, including Mississippi, Alabama, Arizona, 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.[2] 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—a costly and burdensome process in itself. 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 adult group 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 their transition into Medicare. 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 low assets generally go hand in hand.[3] Indeed, to have significant assets without generating additional income would require an individual to make perverse choices—keeping assets in cash and foregoing income gains that would likely outstrip the value of the MSP itself. 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.

Redeterminations

Redeterminations, both in Medicaid and in Medicare Savings Programs, are 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.

Advocates report several problems with current practice in some states. At least for MSPs, some states conduct redeterminations all at once each year, regardless of when an individual first became eligible. This means that someone who is a new QMB, for example, could receive a redetermination letter within just a couple of months of eligibility. Not surprisingly, many beneficiaries believe the letters are erroneous and fail to respond, thus losing their eligibility almost immediately. Other states conduct redeterminations every six months. Poor older adults have relatively steady income and redeterminations more frequent than annually are unnecessary. Also, it is important that states make the redetermination process as passive as possible and rely on available resources to determine income so that the burden on

[2] Available at www.health.ny.gov/forms/doh-4328.pdf.
[3] 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/.

beneficiaries is limited. State practice varies greatly in this area. We ask that CMS work with states to develop more uniformity and rationality, reduce beneficiary burden in redeterminations, and limit redeterminations to once annually.

Another redetermination issue has been computer problems in state systems, often happening when systems changes are introduced. Recent examples include Rhode Island[4] and Georgia.[5] 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.

We also 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 Medicare Savings Programs, 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.[6] 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 and that CMS oversee prompt and transparent resolutions. We appreciate the assistance that CMS provided in these two situations, but it was ad-hoc and we believe that there need to be better systems to ensure that CMS is involved from the onset.

Change in Overpayment Recovery Rate for LIS-eligible beneficiaries

Many low income Medicare beneficiaries experience overpayment situations with their SSA benefits. Currently the SSA POMS GN 02210.030(C) provides relief for Medicare beneficiaries who qualify for the full Part D low-income subsidy. If these beneficiaries request 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.

For a beneficiary, the paperwork issues related to this valuable and needed benefit are many. Individuals must ask for the LIS-based relief and must assert their LIS status, even though SSA knows every beneficiary's LIS status. Beneficiaries do not read the POMS, yet the POMS is the only place where the availability of this relief is spelled out. The overpayment notice sent by SSA nowhere mentions the availability of LIS-related relief. SSA Form 634, "Request for Change in Overpayment Recovery Rate" 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.

---

[4] See, e.g., Katherine Gregg, Rhode Island Recommits to VendorBehind 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/.

[5] 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/.

[6] See *supra* note 4.

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 all 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 and is told of this relief in the original letter informing the beneficiary of the overpayment.

Improve Coverage Coordination for DME

Separately from eligibility and enrollment for dual eligible individuals, many dual beneficiaries encounter issues accessing durable medical equipment, particularly expensive DME, in situations where the coverage criteria is different for Medicare and Medicaid. For example, wheelchairs are covered under the Medicare benefit only when needed for use in the home, but may be covered under Medicaid for individuals who need to use an assistive device in the community. In some states, the Medicaid agency will not accept or process a request for prior authorization until the Medicare claim has been paid or denied. But because the DME will not be paid for by Medicare, the supplier will not provide the chair until Medicaid has processed the prior authorization. The Medicare claim will not be generated until after the chair is delivered. Even if the supplier will deliver, the timing of the Medicare claim and the Medicaid prior authorization requirements may still come into conflict, jeopardizing Medicaid payment.

We appreciate that CMS has sought to address this issue by encouraging states to refer to lists of items rarely or never covered by Medicare and to treat these items (for example, lift chairs) separately or differently. Unfortunately, however, this does not fully solve the problem, especially in situations where the item in question is coverable by both programs, but the coverage criteria are different. Instead, we urge CMS to work with the States to establish procedures by which Medicaid will issue pre-delivery prior authorizations even where Medicare is the primary payer.

Thank you for the opportunity to provide comment.

Sincerely,

Fred Riccardi

Fred Riccardi
President
Medicare Rights Center