TENNESSEE JUSTICE CENTER

211 Seventh Ave., N., Ste. 100, Nashville, TN 37203
Phone: (615) 846-4701 Fax: (615) 255-0354
Website: www.tnjustice.org

November 7, 2022

Via Electronic Transmission

The Honorable Xavier Becerra
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

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: CMS-2421-P; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment and Renewal Processes

Dear Secretary Becerra and Administrator Brooks-LaSure,

The Tennessee Justice Center (TJC) is a non-profit law firm serving the Volunteer State that, among other things, helps its clients navigate Medicaid eligibility, enrollment, and renewal processes. TJC also advocates for Medicaid programmatic changes that are likely to result in better health outcomes for Tennessee residents. We are grateful for the opportunity to submit comments on the Centers 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 (2022 Proposed Rule).[1]

TJC supports CMS finalizing the 2022 Proposed Rule and making it effective as soon as possible. Based on our experience, the implementation of many of the provisions of the 2022 Proposed Rule will result in more efficient and less burdensome application, eligibility, enrollment, and renewal processes for state agencies, applicants, and beneficiaries alike. We provide feedback on specific proposals below.

[1] This comment was prepared with the assistance of Maddy Gitomer of the Democracy Forward Foundation.

The 2022 Proposed Rule responds to a crisis in access to Medicaid and CHIP coverage for eligible people, including many Tennesseans. Tennessee residents' struggles navigating the TennCare (Tennessee's Medicaid program) enrollment and renewal processes offer important insight into the value of the 2022 Proposed Rule's streamlining measures. More than 1.7 million residents are enrolled in TennCare. That includes one in eight adults ages 19-64, two in five children, three in five nursing home residents, and one in three people with disabilities.[2] Many of these individuals have faced procedural barriers to obtaining or maintaining TennCare coverage. For example, in 2017 and 2018, Tennessee's flawed renewal system led to 200,000 TennCare enrollees erroneously losing coverage. Most were terminated for procedural reasons, like failing to return the renewal packet, not because they were no longer categorically eligible for the program.[3] In a 2017 audit, "TennCare officials told state auditors they don't know how many enrollees in the health coverage program lost Medicaid coverage due to paperwork snarls and confusion arising from the years-long delay in getting a new eligibility-redetermination system up and running."[4] Further, the audit found that enrollees faced "issues with coverage being terminated without warning, lengthy call center wait times, coverage being temporarily lost when packets are returned by the due date, and other problems." [5]

The state has been lackluster in addressing this crisis in obtaining coverage. Indeed, until 2019, Tennessee—the state that in 2018 saw the largest percentage drop in children covered by Medicaid and CHIP—did not allow beneficiaries to create an online account to renew their eligibility.[6] These types of procedural missteps, inefficiencies, and hurdles resulted in loss of needed health insurance coverage, medical instability, and financial hardship for Tennessee residents.

As we approach the potential unwinding of the Maintenance of Eligibility policy following the end of the federal COVID-19 public health emergency, there is even more urgency to ensure that Medicaid enrollment and renewal processes are efficient and inclusive. This unwinding will test the eligibility, enrollment, and renewal processes as never before.

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[2] *See Medicaid in Tennessee*, KFF (Oct. 2022), *available at* https://files.kff.org/attachment/fact-sheet-medicaid-state-TN.

[3] *See TennCare Enrollment Strategies for 2022,* TENNESSEE JUSTICE CENTER (2022), *available at* https://www.tnjustice.org/wp-content/uploads/2022/01/2022-Applying-for-TennCare-Provider-Best-Practices-Guide.pdf.

[4] *See* Andy Sher, *State auditor: Some TennCare enrollees having problems renewing Medicaid coverage,* CHATTANOOGA TIMES FREE PRESS (Dec. 7, 2017), *available at* https://www.timesfreepress.com/news/2017/dec/07/tenncare-says-addressing-problems-found-audit/.

[5] *Id.*

[6] *See The Return of Churn: State Paperwork Barriers Caused More Than 1.5 Million Low-Income People to Lose Their Medicaid Coverage in 2018,* FAMILIES USA (Apr. 2019)*, available at* https://familiesusa.org/wp-content/uploads/2019/09/Return_of_Churn_Analysis.pdf.

We discuss in greater detail below how certain 2022 Proposed Rule provisions will impact Tennessee residents and how the proposed streamlined processes will improve efficiency in enrollments and renewals, and reduce barriers to eligible people obtaining health insurance coverage.

Agency Action on Returned Mail is Necessary Because as Many as 220,000 Eligible Tennessee Children Lost Coverage Due to Procedural Errors Like Mail Being Sent to an Old Address (§§ 435.919 and 457.344)

TJC strongly supports the 2022 Proposed Rule provisions that require state agencies to take additional steps to locate and contact applicants and beneficiaries in the event of returned mail. Currently, regulations governing Medicaid and CHIP do not require states to take steps to follow-up on mail that is returned as undeliverable, even though a missed mailing leads to a significant number of otherwise eligible individuals losing coverage. We support the portions of the 2022 Proposed Rule that would require states to take reasonable steps to find enrollees' correct addresses by checking available data sources and making multiple attempts at contact through different modes of communication. We also support requirements for acting on mail that is returned with in-state, out-of-state, or no forwarding addresses. In our experience, such efforts will make it more likely that those eligible maintain coverage.

When mail to TennCare applicants or enrollees, such as a notice regarding renewal or a request for more applicant information, is returned to the state without a forwarding address, Tennessee takes no additional steps (other than resending the mail to the address on record) to contact applicants and beneficiaries; it does not attempt to contact individuals by phone, text, or email.[7] As referenced above, in 2018, TennCare disenrolled more children than any other state Medicaid system in the nation.[8] According to state data supplied to TJC in response to a public records request, TennCare terminated coverage for at least 220,000 children between 2016 and 2018 because of alleged problems with paperwork (including potential mailing address issues)—not because the state determined that the children were no longer eligible.[9]

During that period—the most recent time frame for which we have data—more children in Tennessee were denied benefits because of procedural hurdles than for ineligibility. Specifically,

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7 *See State Follow-Up on Returned Mail,* KFF, *available at* https://www.kff.org/other/state-indicator/549892/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

8 *See* Brett Kelman, *At Least 220,000 Tennessee Kids Faced Loss of Health Insurance Due to Lacking Paperwork,* THE TENNESSEAN (July 14, 2019), *available at* https://www.tennessean.com/story/news/investigations/2019/07/14/tenncare-coverkids-medicaid-children-application-insurance-denied/1387769001/.

9 *Id.*

review of a database containing data on 319,000 Tennessee children who went through the TennCare redetermination (renewal) process between 2016 and 2018 showed that only 16,629 (5 percent) were denied because they were determined not to be eligible for benefits.[10] Yet more than 19,500 children were denied benefits because their renewal paperwork was incomplete or late. What's more, 202,091 children (or their families) did not respond to renewal paperwork, which emphasizes the vast shortfalls of a mail-only outreach process. There is the potential for many children to lose needed healthcare in procedural barriers. Lifting these barriers is essential to Medicaid and CHIP meeting their promise of providing healthcare coverage for needy children.

The number of mailing-related problems is likely to significantly increase as a result of stale address information following the likely end of the continuous coverage requirement put in place during the COVID-19 public health emergency. At a time when many enrollees have not verified their TennCare address information in more than two-and-a-half years, the potential for disenrollment based on mailing errors or a failure to return mail is especially high. According to the Kaiser Family Foundation, roughly 1 in 10 Medicaid enrollees moved in-state in 2020.[11] Applying this figure to TennCare's current enrollment of 1.6 million people, approximately 160,000 TennCare enrollees likely changed addresses. Without additional processes in place to contact these individuals, their coverage could be terminated as a result of failing to receive a piece of forwarded mail.

These bureaucratic issues lead to real world harms. Several TJC clients, for example, suffered significant hardship because of eligibility denial based on mailing errors or oversights. In 2019, Mason Lester,[12] a toddler, fell off his family's porch and broke his wrist. His mother, then nine months pregnant, rushed him to a nearby hospital where she discovered that the family was no longer covered by TennCare. Alarmed, Ms. Lester called TennCare and discovered that the family was no longer enrolled because they had failed to respond to a packet of essential paperwork. But the Lesters had not seen either the packet or a termination letter. TennCare had erroneously mailed both the packet and the termination letter to a horse pasture, not to the Lesters. The family reapplied but were denied benefits after the mailed paperwork once again failed to reach their home. The family was left uninsured for most of 2019 to 2022, during which time COVID-19, injuries, and a C-section left them with more than $100,000 worth of medical debt,

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[10] *Id*. (also stating that 65,938 individuals did not have outcomes that were documented in the reviewed database).

[11] Bradley Corallo & Jennifer Tolbert, *How Many Medicaid Enrollees Moved in 2020 and What Are the Implications for Unwinding the Public Health Emergency*?, KAISER FAMILY FOUNDATION (Mar. 17, 2022), *available at* https://www.kff.org/medicaid/issue-brief/how-many-medicaid-enrollees-moved-in-2020-and-what-are-the-implications-for-unwinding-the-public-health-emergency/.

[12] Parents consented to use of names in news reports.

lowered their credit, and destroyed their plans to buy their first home.[13] The 2022 Proposed Rule's requirement that the state agency take two additional steps to contact or locate the Lester family would have meant that TennCare would have texted, email, or called the Lesters—and checked their address in the USPS National Change of Address Database—making it significantly more likely that the family would never have lost the TennCare coverage for which they were eligible, and would have avoided the ensuing emotional and financial hardship.

Similarly, the Sewell[14] family, in Chattanooga, had a five-year-old son who had finished three years of chemotherapy and a teenage son who had been diagnosed with ADHD. However, the family, like many others in Tennessee, had lost their children's TennCare coverage because of late, incomplete, or unreturned eligibility forms—a process that is difficult to complete adequately and timely even when not caring for a young child undergoing cancer treatments. As a result, the family was responsible for medical bills totaling $900 per month and had to extend their home mortgage—adding decades of debt to a modest home that was nearly paid off.[15]

In addition, TJC has seen that clients who are institutionalized also experience issues timely receiving notices and mailings from TennCare. TJC's clients who are in nursing homes, hospitals, and other settings outside of their own homes for long periods of time also often have difficulty receiving timely written notice.

While we fully support the 2022 Proposed Rule's changes in this regard, it could be made even more effective and efficient. For example, as proposed, Section 457.344(f)(5) instructs states to follow out-of-state procedures when the new address is outside of the geographic area for separate CHIPs that are not statewide. We recommend changing the 2022 Proposed Rule so that if the new address is outside of the separate CHIP program region, but still within the State, these requirements still apply. In such cases, we recommend sending a combined notice, as set forth in Sections 435.1200(h) and 457.350(g).

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[13] Brett Kelman, *They Lost Medicaid When Paperwork Was Sent to an Empty Field, Signaling the Mess to Come*, NATIONAL PUBLIC RADIO (Aug. 2, 2022), *available at* https://www.npr.org/sections/health-shots/2022-08/02/1114857641/lost-medicaid-paperwork.

[14] Parents consented to use of names in news reports.

[15] *See* Brett Kelman, *At Least 220,000 Tennessee Kids Faced Loss of Health Insurance Due to Lacking Paperwork,* THE TENNESSEAN (July 14, 2019), *available at* https://www.tennessean.com/story/news/investigations/2019/07/14/tenncare-coverkids-medicaid-children-application-insurance-denied/1387769001/.

Changes to Enrollment Rules are Necessary Because in Tennessee, More Individuals are Disenrolled for Procedural Reasons Than Loss of Eligibility (§§ 435.916, 435.919, and 457.344)

The vast majority of individuals who are disenrolled in Tennessee are terminated not because they are determined to be ineligible, but because they fail to respond to informational requests or for other non-merits-based reasons. As set forth above, a loss of coverage for otherwise eligible individuals may result in bad health outcomes, catastrophic medical debt, and damaged credit.

TJC supports the 2022 Proposed Rule changes that would help reduce coverage losses for procedural reasons. Specifically, we support the proposed requirement that agencies may not take adverse action if an enrollee does not respond to a request for information to verify a change reported by either the individual or a trusted third party that would qualify the enrollees for more favorable coverage. Medicaid enrollees often have job-related, family-related, or other time demands that may make responses to informational requests challenging. A default rule in which individuals maintain coverage when there is no reason to believe the individual is ineligible will help prevent terminations when the individual is otherwise eligible.

In addition, TJC supports proposals to send enrollees pre-populated renewal forms, allow enrollees at least 30 days to respond, and allow a 90-day reconsideration period. TJC clients have benefited from pre-populated renewal forms. Prior to TennCare's use of pre-populated renewal forms, during the renewal process, many clients had difficulty quickly locating pieces of information requested by the agency because of unstable housing, volatile family dynamics, or lack of access to electronic records. However, TennCare already had on file much of that information. These process changes have already been shown to be both feasible and effective at reducing churn on and off Medicaid for MAGI groups. The same changes should be applied to non-MAGI groups.

State Retention of Records Will Help Medicaid Beneficiaries Maintain Coverage (§ 431.17)

The 2022 Proposed Rule requires state Medicaid agencies to retain records for at least three years after an applicant or enrollee's case is no longer active. TennCare and other state Medicaid agencies should be required to maintain individual case records for a minimum of 10 years after a case is no longer active to better ensure coverage continuity for those who move or become eligible again. The same policy arguments for 12-month continuity of coverage regardless of changes in a families' income also justify the maintenance of records. Maintenance of records would help eligible people maintain coverage following out-of-state moves or financial changes in eligibility, prevent coverage disruptions for those with volatile incomes, reduce Medicaid administrative costs, and ensure that children and others can receive appropriate preventive care, primary care, and treatment for health issues more seamlessly.

Currently, under state public record law, TennCare already maintains certain enrollee records for at least 10 years. For example, TennCare maintains Applicant/Enrollee, Service requests, Eligibility applications, and Preadmission Evaluation Correspondence, as well as Long Term Services and Support Member Files, for at least 10 years.[16] Further, it would not be a significant burden to retain this additional information, in part because the administrative costs associated with storage of large amounts of data have declined and computer security measures have improved dramatically.

Changes to Citizenship Verification Will Help U.S-Born Children with Non-Citizen Parents Obtain Health Insurance Coverage (§ 435.407)

TJC supports proposed Section 435.407, which would allow two additional data sources—state vital statistics systems and data from the Department of Homeland Security (DHS)— to be used as freestanding proof of citizenship (in addition to data from the Social Security Administration). Currently, a two-step process is required to check an applicant's citizenship when data is unavailable from the Social Security Administration, which includes verifying an applicant's citizenship, and then verifying their identity. This two-step process is burdensome and time-consuming. Allowing the utilization of data sources from state vital statistics systems or DHS would help ease not only administrative burden on the agency, but also the burden on applicants.

In particular, this 2022 Proposed Rule change would ease the burden on parents and caretakers of newborns, including those who are undocumented. Studies have shown that citizen children with at least one non-citizen parent are two-and-a-half times more likely to be uninsured than citizen children with citizen parents.[17] Relying on state vital record statistics would remove obstacles facing caretakers of newborns born in the United States, who would otherwise be required to navigate the current two-step process, which, as noted, can be time-consuming and confusing.

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[16] *See* Tenn. Dept. of State, *RDA No. 2977: Long Term Services and Support Member Files*, RECORDS DISPOSITION AUTHORIZATION, *available at* https://rmd-rda.tnsos.net/node/34404 (effective Oct. 30, 2018) ; Tenn. Dept. of State, *RDA No. 2046: Applicant/Enrollee, Service Requests, Eligibility Applications and Preadmission Evaluation Correspondence*, RECORDS DISPOSITION AUTHORIZATION, *available at* https://rmd-rda.tnsos.net/node/35587 (effective Nov. 11, 2019)..

[17] *Health Coverage of Immigrants*, KAISER FAMILY FOUNDATION (Apr. 6, 2022), *available at* https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/.

Changes to Medicaid Family Size Definitions Will Help Tennessee Residents Living in Inter-Generational Homes Afford Medicare (§ 435.601)

The proposed Section 435.601, which TJC supports, would establish a new requirement for how state Medicaid programs define family size for determining Medicare Savings Program (MSP) eligibility. The 2022 Proposed Rule change to the definition would better align MSP and Low Income Subsidy (LIS) methodologies, which would increase MSP enrollment. Under the 2022 Proposed Rule, the definition of family size would be expanded to include not just the spouse, but all relatives, by blood or marriage, who reside in the household and who are dependent on the spouse or applicant for least half of their financial support.

TJC has a number of clients who live in inter-generational homes or who live with grandchildren, dependent adult children, or other relatives, and who would become eligible for MSP enrollment under the expanded definition. This would allow those Tennessee residents, who have limited income and savings, to obtain assistance paying their Medicare costs.

Eliminating Requirements to Apply for Other Benefit Programs Will Create Efficiency and Allow Individuals Access to the Benefits to Which They are Entitled (§ 435.608)

TJC supports CMS's proposal to remove the provision within Section 435.608 that requires applicants and enrollees to apply for other benefit programs to receive Medicaid. The provision is outdated, based on other legislative efforts, and, as CMS points out, has no underlying statutory mandate.[18] Take, for example, the timing of Social Security applications. Most adults can apply for Social Security benefits at age 62; however, delaying this application five or 10 years can significantly increase the amount of benefits received. Applicants for Medicaid should not have to forgo their complete Social Security benefits in order to access Medicaid.

Allowing Medically Needy Enrollees to Deduct Prospective Expenses Would Help Tennessee Residents Avoid Medical Debt (§ 435.831)

TJC supports the 2022 Proposed Rule change that would give states the option to allow additional groups of individuals with catastrophic medical costs to be eligible in the medically needy category based on prospective medical costs. Extending coverage in the medically needy category for prospective constant and predictable expenses, such as prescriptions and home and community-based services, would be immensely helpful for beneficiaries. Typically, coverage begins either at the date of application, or the date on which all eligibility criteria are met—

[18] *See* Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes, 87 Fed. Reg. 54760, 54803 (Sept. 7, 2022).

whichever is later. And, for individuals in the medically needy category, medical debt must accumulate before an individual is eligible. If states like Tennessee were to be subject to this provision, individuals with predictable, substantial medical expenses could receive coverage upon the application date, if the prospective costs at that point establish the medically needy status, rather than waiting to accrue ruinous medical debt. More than 65 percent of all bankruptcies in the United States were tied to medical issues.[19] Additionally, budgeting can be administratively complex and time-consuming, and if future medical debt could be reliably anticipated for purposes of extending coverage, it would reduce the burden on the applicant. Thus, TJC supports legislative action or, to the extent possible, CMS action, to go one step further to *require* all states to extend this option to medically needy individuals.

Use of Pre-Populated Forms and Prohibitions on In-Person Interviews Will Reduce Burdens on Applicants and Beneficiaries, Including Those with Disabilities (§§ 435.907 and 435.916)

The Affordable Care Act and its implementing regulations simplified eligibility determinations and renewals for individuals whose financial eligibility is determined through MAGI (Modified Adjusted Gross Income) rules. But eligibility determinations and renewals for non-MAGI groups, such as the aged, blind, or disabled are often done in a manner that creates unnecessary burdens on applicants and enrollees. The failure to simplify eligibility rules for non-MAGI groups has resulted in higher rates of procedural denials. This is the case even though seniors and the disabled are more likely to have stable incomes and thereby retain eligibility. Simplifying the eligibility rules for non-MAGI groups is imperative because non-MAGI groups, including the aged, blind, and disabled, are more likely to lack transportation and have health-related barriers to responding to requests for documents. We also support the proposed requirement that individuals in non-MAGI categories be able to apply through all avenues currently set forth in Section 435.907(a).

In addition, TJC supports changes to rules that would permit agencies to review eligibility no more often than once every 12 months. This change will reduce the number of enrollees that are removed from and reinstated with coverage multiple times a year. The Kaiser Family Foundation estimated this churn was as high as approximately 10.3 percent of enrollees.[20] Other studies have placed the rate at 25 percent. The churn creates unnecessary administrative costs for

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[19] *See* Lorie Konish, *This is the Real Reason Most Americans File for Bankruptcy,* CNBC (Feb. 11, 2019), *available at* https://www.cnbc.com/2019/02/11/this-is-the-real-reason-most-americans-file-for-bankruptcy.html.

[20] *See* Bradley Corallo et al., *Medicaid Enrollment Churn and Implications for Continuous Coverage Policies*, KAISER FAMILY FOUNDATION (Dec. 14, 2021), *available at* https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/.

the agency, increases medical debt for enrollees due to lack of coverage, and makes it less likely individuals will seek care if they are sick.[21] Some estimates have placed this added administrative cost between $400 to $600 per person.[22] Using these estimates as applied to the current total TennCare enrollee number of 1,700,000 individuals, the state agency would save $68,000,000 in administrative costs through continuity of care.

TJC also encourages CMS to eliminate interview *requirements* all together. The application process for TennCare includes no interview requirement, which we believe has been a significant factor in securing and maintaining TennCare coverage for individuals with disabilities in particular. We draw this conclusion based on our experience with interview requirements in other public benefit programs. For example, unlike in the TennCare enrollment process, the Tennessee Supplemental Nutrition Assistance Program (SNAP) program, which combats hunger in our communities by providing much-needed food benefits to families, requires interviews to access services.

This requirement has resulted in barriers for our clients. For example, a Nashville mom who TJC worked with had difficulty accessing SNAP as a result of the interview requirement. After our client sent in a SNAP application for her family, a phone interview was scheduled, and she set aside time in order to be available for the call. However, she did not receive a call during her scheduled interview time. Instead, she waited by her phone for half a day in case a state official might call her to conduct the interview. She also tried calling the agency office multiple times to clarify when the interview would take place. When she finally was able to speak with someone, the agency representative told her to just wait and that she may get a call at any time that week. She did not receive a call that week, but ten days later our client received a written notice stating that she missed her interview. As a result, she was not able to obtain SNAP benefits at that time. It was only after she worked with TJC that she was able to gain SNAP benefits—for which she had been eligible the whole time. This delay in services was the result of procedural failures, not a substantive determination that our client did not qualify for SNAP. Our client had provided all the necessary verifications and information within her application. The interview requirement was not necessary to determine her eligibility, but she and her child went without benefits for a month as a result of this requirement. TJC is pleased that our clients do not face this same obstacle with respect to TennCare enrollment and supports the 2022 Proposed Rule's prohibition on an in-person interview requirement.

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[21] *See* Sarah Sugar et al., *Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before After the COVID-19 Pandemic*, ASPE (Apr. 12, 2021), *available at* https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf.

[22] *See* Katherine Swartz et al., *Reducing Medicaid Churning: Extending Eligibility For Twelve Months Or To End Of Calendar Year Is Most Effective*, 34 HEALTH AFFAIRS 1180, 1187 (2015), *available at* https://doi.org/10.1377/hlthaff.2014.1204.

TJC also recommends the following additions to the 2022 Proposed Rule to make clearer that, when someone appeals a denial/termination for failure to submit requested information:

- the state is required to accept their appeal as required by 42 U.S.C. § 1396a(a)(3);
- the state is required to inform the individual about their ability to obtain reinstatement by submitting the missing information within 90 days of termination consistent with the State's obligation to provide information, 42 C.F.R. §§ 431.206, 435.905, and 435.908, and to assist with the eligibility process, 42 C.F.R. § 435.908;
- the state can only dismiss the appeal as moot after the person's coverage has begun and there is no dispute about type of coverage, cost-sharing, coverage date; and
- the state must start a new 90 day reconsideration period if the state again denies coverage again for procedural reasons, like not turning in information, with appropriate notice.

Changes to Application and Renewal Timelines Would Help Tennessee Residents Facing Unexpected Delays or Burdens in Obtaining Records and Information (§§ 435.907, 435.912, and 457.340)

TJC generally supports the proposed changes to Sections 435.907 and 435.912, as well as to CHIP at Section 457.340. The changes would help to ensure that (1) both applicants and enrollees have enough time to provide all requested information and (2) states finish initial eligibility determinations and redeterminations within a reasonable timeframe at application, at regular intervals, and after a change in circumstances.

TJC frequently has clients who have extended delays in navigating the enrollment or renewal process. Because of unstable housing, volatile family dynamics, or lack of access to electronic records, many clients encounter burdens in obtaining income, resource, health records, and other information quickly. Providing more time for requested information would prevent otherwise eligible individuals from not receiving coverage just based on their ability to quickly get paperwork together.

For example, one family underwent redetermination at a time when a tree had fallen on their house, and they were temporarily living in a motel. One of the children in the family has significant medical needs. Unfortunately, because they were living in the motel, they missed the redetermination notices. They realized they had missed the notices after going to their doctor and having issues with their TennCare coverage. After calling the agency, the family realized how much paperwork was needed, and how difficult it would be to get that information to the agency

by the required deadline as a result of their emergency situation. Only after connecting with our organization was the family able to secure an extension to the deadline.

In another example, a family of a mom and her two young children underwent redetermination while living in a rental property at which their mailbox was destroyed. The post office would not deliver the family's mail because of the broken mailbox, even though the family had set up a temporary mailbox close to their door. The family contacted their landlord to fix the mailbox multiple times, but the landlord was unresponsive. As a result, the family did not receive notices from TennCare. When the family failed to respond to the requests by TennCare, they lost TennCare coverage. Shortly after, the mom lost her job, and the family was houseless for some time. They were unable to regain coverage due to the instability of their housing.

We support the proposal to provide most applicants at least 15 days from the date a request is sent to respond with additional information and at least 30 days for individuals with disabilities. We recommend the use of calendar days to assure timely determinations, because this approach appears consistent with how most states calculate deadlines and is easier to administer. The proposed changes advance the underlying purposes of the rule: to prevent denials of coverage without an accurate determination of ineligibility while minimizing extensions of coverage beyond an enrollee's eligibility.

Requiring Enrollment in the QMB Program for SSI Beneficiaries Would Help More Than 450,000 People (§ 435.909)

Proposed Section 435.909 requires states to automatically enroll almost all Supplemental Security Income (SSI) beneficiaries into the Qualified Medicare Beneficiary program (QMB), in order to increase participation in the QMB category and advance administrative efficiency. Currently, though all individuals eligible for SSI meet the income and resource eligibility limits for QMB, some eligible individuals are not enrolled into the QMB program because of procedural and technical barriers, such as a requirement to file a separate application with a state Medicaid agency for QMB benefits. According to the regulatory impact analysis for the 2022 Proposed Rule, automatic enrollment would increase QMB enrollment by an estimated 470,000 more people (full-year equivalents) in 2023 and by 980,000 more by 2027, who would all gain access to critical financial assistance with Medicare premiums and cost-sharing and protections against balance billing. We support these proposed changes.

Proposed Requirements to Enroll Individuals Receiving LIS Benefits in a MSP Would Allow More Tennessee Residents to Access Cost-Sharing Benefits (§ 435.911)

As the preamble to the 2022 Proposed Rule makes clear, federal law—specifically the Medicare Improvements and Patients and Providers Act of 2008—requires the Social Security

Administration (SSA) to transmit eligibility data ("leads data") collected from LIS applications to state Medicaid agencies. It also requires that such transmissions constitute an initiated MSP application, and it further requires state Medicaid agencies to receive and treat such data as if they were a MSP application. But as discussed in the 2022 Proposed Rule, not all states are in full compliance, with over a million individuals enrolled in full LIS benefits who are not enrolled in a MSP.

Proposed Section 435.911 would formally codify these requirements by making clear that states (1) must accept LIS leads data, (2) treat receipt of leads data as a Medicaid MSP application, (3) promptly determine MSP eligibility without requiring another application, (4) request additional information only when needed to determine MSP eligibility, (5) not request other information that is already included in LIS leads data, (6) accept information verified by SSA without further verification, and (7) collect any additional information that is required to establish citizenship and immigration status. In addition, the state must notify individuals that they may be eligible for MSP benefits if more information is needed, if the SSA LIS data is insufficient to support a determination of MSP eligibility, and to provide individuals at least 30 days to provide such information. According to the 2022 Proposed Rule's regulatory impact analysis, these amendments would result in 240,000 more individuals enrolled in MSPs in 2023 and an estimated 520,000 more by 2027, who would newly gain access to MSP benefits, including payments for Medicare cost-sharing and/or premiums. TJC supports the 2022 Proposed Rule changes.

This change would benefit Tennessee residents. For example, TJC worked with an individual with disabilities who successfully completed an LIS application and was told that her Medicare premiums should be covered going forward. After this notification, however, she continued to be required to pay for her Medicare costs. Our client took it upon herself to try and understand the problem and ask for help to fix it. She contacted multiple agencies and each time would be redirected to a different agency. The representatives at TennCare did not understand our client's question or issue. The agency – the administrators and individuals who were experienced on these issues—did not understand the LIS aspect of the process. After many months of trying to solve the problem on her own, our client ended up paying for premiums that amounted to $6,049—premiums that should have been covered. Even after our client fought to get an administrative hearing on the issue, the agency's attorney admitted to not being familiar with the LIS process. Only with counsel was our client finally able to get her MSP approved and backdated.

Applying the CMS "Reasonable Compatibility Policy" to Financial Resource Verification Will Reduce the Burden on Tennessee Beneficiaries (§ 435.952)

We support the 2022 Proposed Rule provisions that change 42 C.F.R. § 435.952(b) and (c) to clarify that CMS's "reasonable compatibility policy" applies to financial resource verification for non-MAGI eligibility groups—particularly in the context of asset verification systems (AVS).

Reasonable compatibility avoids burdensome, unnecessary requests for verification by comparing the applicant or enrollee's attestation to available electronic sources and analyzing whether any difference in those sources affects eligibility. The current reasonable compatibility requirements were issued before states had used AVS to check the financial resources of seniors and people with disabilities. As a result, some states do not apply reasonable compatibility rules to resources identified via AVS. The 2022 Proposed Rule, if finalized, would ensure that individuals would not be subjected to burdensome informational requests in instances where state Medicaid plans like TennCare, through AVS, already possesses reliable information concerning their financial eligibility.

CONCLUSION

We endorse the 2022 Proposed Rule with the additions noted above. As evidence of the value of the proposed changes, we have included numerous citations to supporting research, including direct links to the research. We direct CMS to each of the materials we have cited and made available through active links, and we request that the full text of each of the studies and articles cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act.

Thank you for the opportunity to comment on this important issue. If you have further questions, please contact Brant Harrell at the Tennessee Justice Center at (615) 846-4701.

Sincerely,

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BRANT HARRELL
Tennessee Justice Center, Inc.
Legal Director

DOCUMENTS CONTAINED IN TJC COMMENT APPENDIX

1. *Medicaid in Tennessee*, KFF (Oct. 2022), *available at* https://files.kff.org/attachment/fact-sheet-medicaid-state-TN.

2. *TennCare Enrollment Strategies for 2022,* TENNESSEE JUSTICE CENTER (2022), *available at* https://www.tnjustice.org/wp-content/uploads/2022/01/2022-Applying-for-TennCare-Provider-Best-Practices-Guide.pdf.

3. Andy Sher, *State auditor: Some TennCare enrollees having problems renewing Medicaid coverage,* CHATTANOOGA TIMES FREE PRESS (Dec. 7, 2017), *available at* https://www.timesfreepress.com/news/2017/dec/07/tenncare-says-addressing-problems-found-audit/.

4. *The Return of Churn: State Paperwork Barriers Caused More Than 1.5 Million Low-Income People to Lose Their Medicaid Coverage in 2018,* FAMILIES USA (Apr. 2019), *available at* https://familiesusa.org/wp-content/uploads/2019/09/Return_of_Churn_Analysis.pdf.

5. *State Follow-Up on Returned Mail,* KFF, *available at* https://www.kff.org/other/state-indicator/549892/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

6. Brett Kelman, *At Least 220,000 Tennessee Kids Faced Loss of Health Insurance Due to Lacking Paperwork,* THE TENNESSEAN (July 14, 2019), *available at* https://www.tennessean.com/story/news/investigations/2019/07/14/tenncare-coverkids-medicaid-children-application-insurance-denied/1387769001/.

7. Bradley Corallo & Jennifer Tolbert, *How Many Medicaid Enrollees Moved in 2020 and What Are the Implications for Unwinding the Public Health Emergency*?, KAISER FAMILY FOUNDATION (Mar. 17, 2022), *available at* https://www.kff.org/medicaid/issue-brief/how-many-medicaid-enrollees-moved-in-2020-and-what-are-the-implications-for-unwinding-the-public-health-emergency/.

8. Brett Kelman, *They Lost Medicaid When Paperwork Was Sent to an Empty Field, Signaling the Mess to Come*, NATIONAL PUBLIC RADIO (Aug. 2, 2022), *available at* https://www.npr.org/sections/health-shots/2022-08/02/1114857641/lost-medicaid-paperwork.

9. Tenn. Dept. of State, *RDA No. 2977: Long Term Services and Support Member Files*, RECORDS DISPOSITION AUTHORIZATION, *available at* https://rmd-rda.tnsos.net/node/34404 (effective Oct. 30, 2018).

10. Tenn. Dept. of State, *RDA No. 2046: Applicant/Enrollee, Service Requests, Eligibility Applications and Preadmission Evaluation Correspondence*, RECORDS DISPOSITION AUTHORIZATION, *available at* https://rmd-rda.tnsos.net/node/35587 (effective Nov. 11, 2019).

11. *Health Coverage of Immigrants*, KAISER FAMILY FOUNDATION (Apr. 6, 2022), *available at* https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/.

12. Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes, 87 Fed. Reg. 54760, 54803 (Sept. 7, 2022).

13. Lorie Konish, *This is the Real Reason Most Americans File for Bankruptcy,* CNBC (Feb. 11, 2019), *available at* https://www.cnbc.com/2019/02/11/this-is-the-real-reason-most-americans-file-for-bankruptcy.html.

14. Bradley Corallo et al., *Medicaid Enrollment Churn and Implications for Continuous Coverage Policies*, KAISER FAMILY FOUNDATION (Dec. 14, 2021), *available at* https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/.

15. Sarah Sugar et al., *Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before After the COVID-19 Pandemic*, ASPE (Apr. 12, 2021), *available at* https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf.

16. Katherine Swartz et al., *Reducing Medicaid Churning: Extending Eligibility For Twelve Months Or To End Of Calendar Year Is Most Effective*, 34 HEALTH AFFAIRS 1180, 1187 (2015), *available at* https://doi.org/10.1377/hlthaff.2014.1204.