MLRI MASSACHUSETTS LAW REFORM INSTITUTE

June 2, 2023

Mike Levine, Assistant Secretary of MassHealth and Medicaid Director
Executive Office of Health and Human Services

Submitted by email to: masshealthpublicnotice@mass.gov

Re: Comments on Proposed and Emergency Regulations regarding the Medicare Savings Programs at 130 CMR 505.000 and 130 CMR 519.000

Dear Director Levine,

These comments are submitted on behalf of the Massachusetts Law Reform Institute and the 14 following organizations on behalf of our clients and members: MetroWest Legal Services, Central West Justice Center, Massachusetts Association for Mental Health, AccessHealth MA (formerly Community Research Initiative), Greater Boston Legal Services, Community Legal Aid, Disability Policy Consortium, Health Care For All, Health Law Advocates, Massachusetts Senior Action Council, Northeast Justice Center, South Coastal Counties Legal Services, Justice Center of Southeast Massachusetts, LLC and Disability Law Center.

We strongly support the expansion of the three Medicare Savings Programs (MSP). It is an important benefit for low-income elderly and disabled Medicare beneficiaries. However, we cannot support the emergency proposed regulations and urge the agency to withdraw the emergency regulations and amend the proposed regulations as recommended in these comments. The emergency proposed regulations not only fail to fully implement legislation directing the agency to expand MSP, but they also add new limitations on access to MSP that violate state and federal Medicaid regulations, including the Maintenance of Effort (MOE) provisions that are a condition of enhanced federal funding. Further, the regulations are unfair to many low- and moderate-income older adults who will be denied the benefits of a program for which they are eligible.

Background. Legislation in 2019 first required an expansion of the financial eligibility criteria for MSP by disregarding an amount equivalent to 30% of the federal poverty level (FPL) and doubling the asset level. Ch. 41, § 48, Acts of 2019. There are three income levels for individuals to qualify for MSP as Qualified Medicare Beneficiaries (QMB), Specified Low Income Beneficiaries (SLMB) or Qualified Individuals (QI). The MSP income standards technically remain 100% FPL, 120% FPL and 135% FPL, respectively, but with a 30% FPL disregard, the upper income limit is effectively increased to 130%, FPL, 150% FPL and 165% FPL respectively. A state plan amendment made these statutory changes to MSP effective on Jan. 1, 2020. The agency amended the regulations regarding MSP at 130 CMR 519.010 and 519.011 to apply the disregard and raise the income upper limit for QMB, SLMB and QI, but did not amend the regulations at 130 CMR 519.002 for MassHealth Standard which remained at 100% and 120% FPL for QMB Plus and SLMB Plus.[1] See, Eligibility Letter 236, Dec 15, 2019. No changes were made to the

[1] QMB Plus and SLMB Plus are terms used by CMS to identify individuals who qualify either for QMB or SLMB and also for full Medicaid coverage under other eligibility categories. See, CMS Manual on State Payment of Medicare Premiums, Pub. 100-24, Ch. 1, Appendix 1.B (rev 2020).

regulations at 130 CMR 505. However, the agency continued to implement the legislation and extended it to individuals eligible for QMB Plus and SLMB Plus in phases. See, e.g. MTF, MassHealth Presentation, October 2020. pp. 22-23 (MassHealth extended higher MSP income limits to 3500 MassHealth Standard members in Home and Community Based Waivers effective on Jan. 1, 2020).

In 2022, state legislation required increasing the amount of the MSP disregard to 90% FPL. Ch. 126, § 55, Acts of 2022. A new state plan amendment increases the disregard in QMB, SLMB and QI pursuant to that legislation effective Jan. 1, 2023. In advance of the May 12, 2023 emergency regulations, Eligibility Operations Memo 23-04 (February 2023) provided that effective Jan. 1, 2023 the income limits for QMB, SLMB and QI increase to 190%, 210% and 225% FPL, respectively, that the income limit for MSP and Standard increase for QMB Plus to 130% FPL, for SLMB Plus to 150% FPL, for QI to 165%, and that the income limits for MSP and CommonHealth remain at 135% FPL for QI. It says these changes are pursuant to forthcoming regulations which are the emergency proposed rules filed May 12, 2023.

1. **In 130 CMR §§ 519.010 and 519.011, the emergency proposed regulations increase the income limits for MSP but also add an unlawful new condition on eligibility for individuals who apply or renew using the full Medicaid application.**

The emergency proposed regulations amend the regulations governing the QMB, SLMB and QI programs to raise the income standards as required by the 2022 state legislation and the state plan, but they add a new criterion for eligibility, namely that the QMB benefit will be available to individuals who "are applying for only MSP benefits and not full Medicaid" (130 CMR 519.010 (A)(2)) and the SLMB and QI benefit will be available to people who "(c) are applying only for MSP benefits." 130 CMR 519.011(A)(1(c) and (B)(1)(c)). The new more restrictive eligibility criterion should be removed.

This language alone is far from clear about what it means. Neither the new regulation nor EOM 23-04 explicitly state that anyone using the SACA-2 application or renewal form is applying for full Medicaid, and therefore will not satisfy the new criterion requiring that they be applying only for MSP benefits and not full Medicaid. However, the MassHealth Eligibility Director has told us that is what the agency means, at least with respect to application of the 2023 income standards raising MSP to 190%, 210% and 225% FPL. Further, in practice the agency continues to apply the 2020 income standards in 2023 to those who took the SACA-2 "pathway."[2] MassHealth is not applying the 2023 MSP income standards to individuals who apply or renew using the SACA-2 form. Instead, the agency is still using the 2020 income standards for people who apply or renew using the SACA-2. However, MassHealth is using the 2023 MSP income standards for people who, after Jan. 1, 2023, apply for MSP using the MassHealth Buy In (MHBI)

[2] The new eligibility criterion requiring that someone must be "applying only for MSP" in order to qualify under 519.010 or 519.011 appears to preclude anyone who applies or renews using the SACA-2 from obtaining MSP-only. The emergency proposed regulations don't make the distinction that MassHealth appears to be making in practice between people who are over or under 165% FPL. The only other regulations authorizing MSP are those at 519.002 and 519.012 but they apply to people MassHealth has determined eligible for MassHealth Standard or CommonHealth not to those eligible for MSP-only.

application. MassHealth also automatically upgraded people in SLMB and QI to QMB if they had initially applied using the MHBI, but not if they had initially applied using the SACA-2.

These were not the eligibility procedures in effect on Jan. 1, 2020; at that time, both people who applied or renewed using the SACA-2 and those who used the MHBI were determined eligible based on the same Jan. 1, 2020 standards. MTF, MassHealth Presentation, Jan. 2020 p 26 (Phase 1 effective Jan. 1, 2020 for those eligible for MSP only using MHBI or SACA-2).

This new eligibility criterion for MSP, whether it precludes any determination of MSP-only for applicants using the SACA-2 form regardless of income as it states, or only applies to individuals with income over 165% FPL as it is being applied, is unlawful and should be removed.

a. The emergency proposed regulations are implementing new more restrictive eligibility rules and procedures that unfairly burden individuals eligible for MSP under the 2023 standards.

Prior to EOM 23-04 and the emergency regulations, it has always been possible to apply for MSP using the SACA-2 application or renewal form. Nothing in the SACA-2 application itself or the accompanying Member Guide gives an applicant any warning that the agency applies lower income standards for MSP for people using the SACA-2 than if they were to use a different form. On the contrary, Step 6 of the SACA-2 application concerns Health Insurance Information and explicitly asks if any of the people with Medicare coverage want help paying for Medicare Part B premiums. While the SACA-2 instructions advise older adults caring for children under 19 to apply using the ACA-3 form which has more generous financial eligibility rules, it has no such advice regarding the MHBI application form. The Member Guide describes the Medicare Savings Programs in Section 6 on MassHealth coverage types; it gives no clue that any different financial standards apply if a different form than the SACA-2 is used to apply.

In 2023, many people will be applying or renewing using the SACA-2 forms and, for that reason alone, will receive determinations that erroneously apply the 2020 standards. For many years, the only way to obtain QMB was to apply using the SACA-2 application; the MHBI form was used exclusively for the Buy-In programs (SLMB and QI) not for QMB. Another reason for Medicare beneficiaries to apply using the SACA-2 was because it is the only application form available to adults 65 and older (other than those caring for children under 19) that identifies itself as an application for the Health Safety Net which is a valuable supplement to MSP. In fact, the whole purpose of common applications forms like the SACA-2 and ACA-3 is to enable applicants to apply for benefits administered by MassHealth or the Health Connector without having to know the separate rules that apply to different programs and to select an application form specific to that program. For all the many people who are now in the SACA-2 "pathway," the agency must send out the SACA-2 renewal form. The SACA-2 renewal form has already been sent to Medicare beneficiaries who turned 65 and have been "protected" from losing full MassHealth until now, as well as those with income over 150% FPL only eligible for partial HSN until MSP was increased on January 1, 2023. The renewal notice itself as well as the message from the MassHealth Redetermination Outreach Campaign advise MassHealth beneficiaries to return the renewal form MassHealth sends them in order to receive the best benefits for which they qualify. Yet under EOM 23-04 and the emergency regulation, individuals eligible for MSP under the 2023 standards will not get the MSP benefits for which they are eligible by returning the SACA-2 renewal form that the agency sends them.

According to the Medicaid Eligibility Policy Director, there is a new unwritten procedure whereby applicants and beneficiaries who used the SACA-2 forms can call and revoke their full Medicaid application and be redetermined on an MSP only pathway. However, according to most people who have attempted to do this, they are required by the MEC to submit an MHBI, and, if now eligible for QMB, the effective date is the first of the following month as if the MHBI were an initial application. Whereas, had they been on the MHBI pathway, in March 2023 MassHealth automatically upgraded eligible individuals with only SLMB or QI benefits to QMB retroactively to Jan 1, 2023.

This procedure is burdensome, and unreasonable as well as unlawful. We have all seen during the last three years of the COVID-19 pandemic how attempts to implement new policies based on training and outreach simply do not work well. Agencies are required to implement programs based on regulations in order to assure consistent and lawful administration, avoid both bias and "worker error," and make it possible to hold the agency accountable for following the regulations through the fair hearing process. None of this is possible with the procedure envisioned by the agency. It is moving in exactly the wrong direction.

> **b. People who meet the eligibility criteria for QMB, SLMB or QI must be determined eligible for those programs whether they apply or renew using the full Medicaid form (SACA-2) or the MSP (MHBI) form.**

Nothing in the state statute or state plan amendment increasing the MSP income limits permits the MassHealth agency to deny MSP to people who qualify for it because they failed to use a form (the MHBI) with less information than the full Medicaid form (SACA-2). The full Medicaid form captures all the information required to make a determination about whether an individual is eligible for MSP, and the agency must provide MSP to individuals who are eligible for it. The Medicare Savings Programs are mandatory categorically eligible Medicaid programs. 42 CFR §§ 435.123 (QMB), 435.124 (SLMB), and 435.125 (QI).

This basic principle of the Medicaid program is set out in state regulations, including the regulations introducing MassHealth coverage types at 130 CMR § 519.001(C). This regulation provides that individuals will be considered for all available coverage types unless they elect to use an application, like the MHBI, that does not capture sufficient information to make a determination for all available coverage types:

> (C) Determining Eligibility. The MassHealth agency determines eligibility for the most comprehensive coverage available to the applicant, although the applicant has the right to choose to have eligibility determined only for MSP for Qualified Medicare Beneficiaries (QMB) or MSP for Specified Low Income Medicare Beneficiaries and Qualifying Individuals coverage. If no choice is made by the applicant, the MassHealth agency determines eligibility for all available coverage types.

The federal Medicaid regulations that apply to applications and eligibility determinations make it clear that state Medicaid agencies must consider all bases of Medicaid eligibility at the time of application as well as at renewal. 42 CFR 435.911(C)(2), and 435.916(f)(1). This is explicitly stated in the CMS Manual on State Payment of Medicare Premiums, Pub. 100-24, Ch. 1 Sec. 1.4 (rev 2020)

> If the state finds the Medicaid beneficiary is no longer eligible for the eligibility category under which the individual is receiving coverage, the state must consider whether the beneficiary may

be eligible under another eligibility category covered by the state. See 42 CFR § 435.916(f)(1). The state must continue to furnish Medicaid until an individual is determined ineligible. See 42 CFR § 435.930(b).

Specifically in the context of the current unwinding, CMS has once again reminded states of their obligation to consider all bases of eligibility including MSP:

> SHO# 22-001 RE: Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency p. 9 (March 3, 2022):
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> > In Medicaid, states must determine eligibility on all bases prior to making a determination of eligibility as required at § 435.916(f)(1), including the Medicare Savings Programs.

c. The regulations are implementing a new more restrictive eligibility procedure than the procedures in effect on Jan. 1, 2020 in violation of federal maintenance of effort requirements.

As discussed above, the new eligibility criteria applied in Jan 2023 and now set out in the emergency regulations represent more restrictive eligibility standards and procedures than the standards and procedures in effect on Jan. 1, 2020 for the MSP program. This is a violation of the maintenance of effort (MOE) provision of §6008 of the FFCRA as amended by the Consolidated Appropriations Act of 2022. The MOE is a condition for the state's ability to receive enhanced federal matching funds through December 2023. As summarized by CMS in its Jan 27, 2023 Letter to State Health Officials (SHO 23-002):

> **Maintenance of Effort Condition through December 31, 2023**
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> Under section 6008(b)(1) of the FFCRA, states may not claim the temporary FMAP increase for a quarter if, during that quarter, they impose eligibility standards, methodologies, or procedures that are more restrictive than those in effect on January 1, 2020. Section 5131 [of the CAA of 2022] did not change this condition, and states must continue to meet it for any quarter in which they claim the temporary FMAP increase, through December 31, 2023. See previous guidance in Section IV.F. in the COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies for additional guidance on this condition.

2. The regulation at 130 CMR § 519.002 addressing MSP for individuals who also qualify for MassHealth Standard should reflect the 2023 income standards not those from 2020.

The regulations at 130 CMR § 519.002(A)(4) (a) should increase the income standards for payment of Part B premiums to 210% FPL not 165% FPL, and the regulations at § 519.002(A)(4) (b) should increase the income standards for payment of other Medicare costs to 190% FPL not to 130% FPL. The higher figures are the ones required in 2023.

When 130 CMR §§ 519.010 and 519.011 were amended in 2020 to reflect the higher MSP income and asset standards, section 130 CMR § 519.002 regarding MassHealth Standard and MSP (QMB Plus and SLMB Plus) was unchanged; it only authorized payment of Part B premiums for those with income up to 120% FPL, and payment for additional cost-sharing for those with income of 100% FPL or less. See,

Eligibility Letter 236, Dec 15, 2019. The emergency proposed regulations belatedly increase the income standards for QMB Plus and SLMB Plus to 150% FPL and 130% FPL pursuant to the 2020 standards, but those are no longer the current standards for those programs. State legislation and the state plan have increased the income standards for QMB Plus to 190% FPL, and for SLMB Plus to 210% FPL and those are the income limits that should be in the 2023 regulations.

The 2023 income standards for QI are now 225% FPL and they are not currently applicable to people enrolled in MassHealth Standard, but the reasons for that limitation do not apply to QMB or SLMB. The federal statute limits QI, which is entirely federally funded, to individuals who are not otherwise eligible for a state plan benefit like MassHealth Standard. MassHealth would need authority from CMS through the MassHealth 1115 Demonstration to provide QI benefits to MassHealth Standard members with income at the 2023 QI levels (210-225% FPL), and it does not currently have such authority. However, no waiver is required to provide QMB Plus and SLMB Plus to individuals who qualify for MassHealth Standard under § 519.002 with income and assets under the standards for QMB and SLMB. Individuals who qualify for both Standard and QMB or SLMB, should receive QMB Plus or SLMB Plus. This issue is discussed further below in reference to the regulations at 130 CMR § 505.000.

There is one special case for individuals who qualify for MassHealth Standard as medically needy after submitting expenses to offset a deductible pursuant to 130 CMR § 520.028 that should be processed differently. These individuals may have indicated on the SACA-2 application that they do not want help paying for Part B premiums because they intend to use their Medicare expenses to offset a deductible and qualify for MassHealth Standard based on a spenddown. Any applicant who checked "No" to help paying for Medicare Part B premiums on the application, should have that choice honored. If applicants did not make that election when completing the SACA-2, they should still be able to make it later. The notice of decision should inform people denied MassHealth Standard based on excess income of the option to decline MSP if they prefer to use unreimbursed Medicare costs to meet a deductible. It would also be important for the agency to provide better information about MSP and deductibles on the SACA-2 application, in the Senior Guide, and in its training materials. However, this special case does not justify denying MSP to everyone applying or renewing with the SACA-2. Most people with excess income who are denied MassHealth Standard do not qualify through a spenddown. It also does not justify denying MSP to individuals with income over 165% FPL who qualify for MassHealth Standard without a deductible such as those who qualified for Home and Community Based Services or PACE because their income is below the special income level which is significantly higher than 165% FPL.

3. **The regulation at 130 CMR § 519.012 adding a provision for MSP for individuals on CommonHealth is better addressed in reference to § 505.007.**

The regulations at 519.012 for working disabled adults aged 65 and older to obtain CommonHealth have generally just cross-referenced to the regulations in 505.004 that apply to those 65 and over, but oddly have never cross-referenced to 505.004(L) regarding payment of Part B premiums for those with income of 135% FPL or less. However, because people 65 and over are required to use the SACA-2 application, they have supplied their asset information just like the seniors who qualified for Standard under 519.002, and therefore disabled Seniors on CommonHealth should be eligible to qualify for MSP up to 225% FPL if they separately qualify for MSP and CommonHealth. See, our further comments on this in reference to the emergency proposed regulations at 505.007.

4. **The regulations at 130 CMR § 505.002 should specify the applicable income limits for MSP under the 1115 Demonstration instead of cross-referencing to §§ 519.010 or 519.011.**

The emergency proposed regulations at 505.002 (O) provide that MassHealth pays for Medicare costs for certain people who qualify for MassHealth without an asset test "in accordance with 130 CMR §§ 519.010 and 519.011." This cross-reference is confusing. Pursuant to the 1115 Demonstration, MassHealth has authority to pay for Medicare costs for people on MassHealth Standard without an asset test, but it is in accordance with the Demonstration, not with the MSP state plan benefit set out in 130 CMR §§ 519.010 and 519.011. While the MSP state plan benefit has higher income limits than the current 1115 Demonstration provision, it also has an asset test which people who qualified under § 505.002 are not required to meet. We suggest that the regulations remove the cross-references to Section 519 in 505.002(O). Instead, § 505.002(O)(a) should specify the applicable upper income limit for payment of Part B premiums, and in (b) and (c), it should specify the upper income limit for payment of Part A premiums and other cost-sharing. Under the current demonstration those amounts are not yet set at the 2023 income standard but are 165% FPL for payment of Part B premiums and 133% FPL for other Medicare costs. A further amendment to 130 CMR § 505.002(O) is also needed for several additional groups of individuals on MassHealth Standard who may qualify for payment of Part B premiums under the demonstration. The additions include those Medicare beneficiaries with income over 133% FPL but at or below 165% FPL who are disabled but eligible for Standard based on pregnancy, breast or cervical cancer treatment, or receipt of EAEDC in a rest home rather than on the basis of disability.

5. **The regulations at § 505.007 should be revised to clarify that people on MassHealth Standard or CommonHealth under §§ 505.002 or 505.004 who separately qualify for MSP under §§ 519.010 or 519.011 are eligible to receive both.**

The regulations at § 505.002 provide for payment of MSP for full duals without an asset test pursuant to the 1115 demonstration which currently only authorizes MSP without an asset test for income limits up to 165% FPL for Standard and 135% FPL for CommonHealth. However, this should not preclude full duals in Standard or CommonHealth pursuant to §§ 505.002 and 505.004 from separately establishing eligibility for QMB or SLMB and, in the case of CommonHealth, which is not a state plan benefit, for QI as well if they can satisfy all of the eligibility criteria for §§ 519.010 and 519.011 including the asset test. The cross reference in § 505.007 to §§ 505,002(O) and 505.004 (L) imply those two regulations define the only circumstances in which Medicare Part B premiums can be paid for MassHealth Standard and CommonHealth members. But CMS guidance is clear that if people qualify for full Medicaid and MSP they should receive both:

> Individuals eligible as a QMB may also meet the separate requirements for another Medicaid eligibility group. In such cases, the individual is eligible for both groups, and therefore eligible for coverage of Medicare cost-sharing and any other state plan services available under the non-QMB group.
>
> CMS, Medicaid and CHIP Program Implementation Guide: Qualified Medicare Beneficiaries (undated)

Section 505.007(B) should not be deleted. Instead, this section should say that people qualifying for Standard or CommonHealth under §§ 505.002 and 505.004 who do not automatically qualify for

payment of Medicare costs under (L) or (O) may qualify for QMB or SLMB in addition to Standard or CommonHealth if they separately establish that they qualify under §§ 519.010 or 519.011. The regulations should also describe whatever procedure the agency elects to use to obtain asset information for people who qualified under §§ 505.002 and 505.004.

Thank you for the opportunity to make these comments. Should the agency have any questions or require any additional information regarding these comments, please contact Vicky Pulos at vpulos@mlri.org, 617-357-0700 Ext 318.

Submitted on behalf of the following organizations:

Massachusetts Law Reform Institute

MetroWest Legal Services

Central West Justice Center

Massachusetts Association for Mental Health

AccessHealth MA (formerly Community Research Initiative)

Medicare Advocacy Project, Greater Boston Legal Services

Community Legal Aid

Disability Policy Consortium

Health Care For All

Health Law Advocates

Massachusetts Senior Action Council

Northeast Justice Center

South Coastal Counties Legal Services

Justice Center of Southeast Massachusetts, LLC

Disability Law Center