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November 22, 2017

Commissioner Roderick Bremby
Department of Social Services
55 Farmington Avenue
Hartford, CT 06105

Re: Illegalities in Implementation of Change in Income Eligibility for Medicare Savings Programs

Dear Commissioner Bremby:

As you know, the General Assembly dramatically reduced the three limited benefit Medicaid programs which comprise the Medicare Savings Programs effective January 1, 2018, with the predominant MSP program, QMB, now having an income limit of just 100% of the federal poverty level and the ALMB program having an income limit of just 135% of the federal poverty level. As you also are aware, this will cause severe harm for thousands of the as many as 88,000 affected low-income seniors and people with disabilities. We hope there is the will in the legislature to repeal this cut to MSP, and we wholeheartedly would look forward to working with allies to support this so as to protect vulnerable seniors and people with disabilities statewide. Nevertheless, we understand that you must proceed as if there will not be such a repeal. **We write because the information just brought to our attention indicates that the process you are following to implement this cut violates federal Medicaid law and requires immediate correction, including by ceasing the mailing of any notices to affected individuals until the proper process is followed and the letters are revised accordingly.**

Attached is a (redacted) letter, dated November 19, posted electronically to an MSP enrollee's MyAccount. The letter says that "your MSP coverage is likely to end or change, effective January 1 2018." While it does not say exactly how the person is affected, it includes a chart and directs the person to "[u]se the chart below to see what level of MSP you may qualify for after January 1." While this is troubling in and of itself, the letter declares that no further correspondence will be sent until your agency sends them "an official notice about your personal MSP eligibility around December 15."

We incorporate herein by reference the letter we sent to you yesterday confirming the process to be followed for the terminations of HUSKY A enrollees, based on a reduction of the income eligibility for that program, also effective January 1, 2018 (copy attached for convenience). The same basic structure is mandated to be applied to the MSP enrollees losing their Medicaid coverage, as follows:

(1) DSS must review each affected individual to ascertain whether it has information demonstrating the person is, or may be, eligible for ongoing MSP eligibility or, if not, for any other full or limited benefit Medicaid coverage category, and, where there is an indication that continued or alternative eligibility is likely but additional information is needed, will make an individualized request for this;

(2) DSS will send everyone else, who *might* have information establishing eligibility under MSP or under a different Medicaid category, a generalized notice inviting them to affirmatively bring this information to the attention of the Department before discontinuance; and

(3) DSS will send a formal termination notice to individuals who are determined not to be eligible for MSP or alternative Medicaid eligibility or who do not respond to either the individualized or the generalized invitations to submit additional information.

A. Governing Federal Law

The above process is mandated by detailed Medicaid regulations, particularly 42 C.F.R. § 435.916(f)(1), which provides that "Prior to making a determination of ineligibility, *the agency must consider **all** bases of eligibility*, consistent with § 435.911 of this part." (emphasis added). CMS had previously elaborated on the duty to investigate other categories of eligibility under 42 C.F.R. § 435.930(b) (providing that the Medicaid agency must "[c]ontinue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible") in informal guidance. But it made it very clear in the promulgation of these new regulations in 2012 that individualized reviews of all alternative means of Medicaid eligibility is required and that requests for information covering **all** potential alternative bases of Medicaid eligibility must be sent out prior to any terminations being implemented:

> Proposed § 435.916(a)(2) sought to codify a longstanding policy, explained in a letter to State Medicaid Directors on April 7, 2000, available at http://www.cms.gov/smdl/downloads/smd040700.pdf, that States must rely on information that is available and that the State considers to be accurate to renew eligibility. However, if available information suggests that a beneficiary is no longer eligible, if information is subject to change is missing, or if the State has information that suggests that available information is inaccurate, ***then a State must seek information from the individual before renewing eligibility.***
> * * *
> We have added a new paragraph to § 435.916(f)(1), to clarify that, in accordance with longstanding policy the agency must consider all bases of eligibility when conducting a renewal of eligibility. To meet this requirement, renewal forms will need to ***include basic screening questions***, similar to those that will need to be on the single streamlined application, to indicate potential eligibility based on disability or other basis other than the applicable MAGI standard.
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> 77 Fed. Reg. 17181 (March 23, 2012)(emphasis added).

Based on the attached electronic notice, it appears the department is out of compliance with these governing regulations in several material respects: (1) no *ex parte* review of all other potential Medicaid eligibility categories for all affected individuals has been conducted prior to sending out this letter, (2) no individualized mailings are being sent to individuals whose *ex parte* reviews indicated possible but not certain alternative Medicaid eligibility, (3) the one generalized letter it intends to send out, and has already sent out electronically, fails to identify several alternative bases of Medicaid eligibility which could well allow the person to stay on Medicaid or the evidence recipients of the letter should put forward to try to establish such eligibility (or how to submit it), and (4) even for the one of two alternative bases for Medicaid eligibility mentioned, MedConnect, the notice erroneously tells them

that they can stay on Medicaid only if they affirmatively "apply for MED-Connect on line at www.connect.ct.gov."

B. <u>Alternative Bases of Medicaid Eligibility Not Considered</u>

Per the above regulations, prior to taking any action toward individuals believed to no longer qualify for Medicaid under a particular Medicaid category, including MSP, a Medicaid agency must affirmatively review each file to determine whether a person might be eligible for Medicaid under some other category. At a minimum, for individuals who currently qualify for MSP based on being elderly or disabled, the alternative eligibility categories could include:

- Continuing eligibility under MSP because of having income from earnings or rental income which is subject to substantial disregards
- Qualifying for HUSKY C through spenddown
- Qualifying for HUSKY C through a Medicaid waiver
- Qualifying for MEDConnect because of having income from earnings and being disabled (including if over 65)
- Qualifying for HUSKY A because of being a caretaker relative of a minor child
- Qualifying for HUSKY A as pregnant
- Breast or Cervical Cancer
- Tuberculosis
- Family Planning group

The Department has to affirmatively review its files to see if perhaps the individual has earned income or rental income and make sure the applicable disregards are being applied to this income, such that they might still qualify for MSP under the reduced income guidelines. The department also has to check all files to see if the person might meet any other Medicaid eligibility categories, such having earned income AND being disabled and thus qualifying for MEDConnect, living with a minor child and thus qualifying for HUSKY A, etc. And it must check claims files to see if perhaps the individual has been treated for tuberculosis, is pregnant or has breast or cervical cancer, any of which can be the basis for alternative full or partial benefit Medicaid eligibility.

There is no evidence that the Department did any of this before sending out its electronic letter, needlessly alarming some individuals whose review of their records would have established ongoing eligibility for MSP or perhaps coverage under HUSKY A as a pregnant individual or as a caretaker relative of a minor child.

C. <u>No Intention to Inform All Affected Individuals of the Opportunity to Submit New Information Establishing Eligibility under All Other Medicaid Coverage Categories</u>

There are cases whereby the Department, after reviewing all of its files and claims data, will not be able to tell if the person is eligible for an alternative Medicaid category or categories. In these cases, if it identifies some evidence of such eligibility but needs additional data, it must affirmatively request this from the individual before taking any action to terminate the individual. An example would be a person over 65 whose file shows earnings from employment which still make the person ineligible for MSP after the application of the appropriate disregards, but who might qualify for MEDConnect **if** they also are disabled. The Department must inquire if they in fact believe they are disabled. Another

example would be someone whose claims record indicates diagnosis of breast cancer, to ascertain where the diagnosis was obtained.

For those whose file reviews indicate no such alternative eligibility being likely, the Department, per 42 C.F.R. § 431.916(f)(1), still must identify in writing all other alternative basis of Medicaid, including those set forth above, and affirmatively ask for evidence indicating such eligibility and tell them how to submit it. This would include asking them if they have any income from a job or any rental income. It would include asking them, for example, if they are the caretaker relative of a minor child, are pregnant, have a diagnosis of breast cancer, cervical cancer or tuberculosis, have high unpaid medical bills which could instantly satisfy a HUSKY C spenddown, or are both working and disabled.

Yet, the attached electronic notice indicates that no further correspondence will be sent to the individual until the termination notices are sent out on December 15th . Unless all MSP individuals threatened with termination are first asked whether they might qualify under any of these alternative Medicaid eligibility categories, the Department will inevitably terminate from the MSP programs some individuals who in fact are still eligible for Medicaid. To avoid this and comply with § 435.916(f)(1), the department must first ask them about their status under all of these alternative categories, and ask them to provide evidence of this. If such evidence is received, by phone or in writing, the person must be kept on the MSP program until the submitted evidence is fully reviewed and adjudicated. In the case of individuals who are working and qualify for Medicare on the basis of being **over** 65, they must be asked if, besides having a job, they also believe they are disabled. If they so state, termination from MSP cannot occur until the question of disability, and hence eligibility for MedConnect, is adjudicated. *See Crawley v. Ahmed,* 2009 WL 1384147 (E.D. Mich. 2009).

Of course, since the department cannot know in advance who among the 88,000 or so affected individuals would be eligible for Medicaid under one of these alternative eligibility categories, it must provide this opportunity to **all** affected MSP enrollees, before any termination notices are sent out.

D. <u>Issuance of Appropriate Advance Termination Notices</u>

Individuals who, after *ex parte* review, and the provision of an opportunity to submit new information and the review of anything submitted, are nevertheless determined to be ineligible for Medicaid under any category must receive a detailed advance termination notice pursuant to 42 U.S.C. § 1396a(a)(8); 42 C.F.R. § 431.200, et seq. Benefits must continue if someone requests a hearing before the discontinuance effective date. But other information is warranted to be included in the final termination notices as well.

It is our understanding that the HUSKY A termination notices will provide information about potential access to non-Medicaid coverage through a subsidized Qualified Health Plan on the exchange. Subsidies on the exchange are not available to MSP enrollees, since their status as Medicare enrollees disqualifies them. However, there are **other** non-Medicaid options which could minimize some of the harm from the MSP cuts, of which they should be informed, if briefly.

This would include, at least, (1) purchasing a Medigap plan, (2) creating a pooled trust which would allow a significant portion of their income to be disregarded such that they might still qualify under the lower MSP eligibility rules, and (3) applying for the Medicare Part D low income subsidy if

under 150% of the federal poverty level.[1] Your letter appropriately informs individuals of some of these potential options and the availability of help through the CHOICES program, but it is not complete and some options are excluded. For the final termination notices, more complete information is needed.

E. Suggested Dedicated Phone Line

Based on the agency's data, the wait times at the DSS ConneCT call center have grown significantly in recent months. The center is not equipped to address an influx of tens of thousands of new MSP callers frightened by the notices they are about to receive. Accordingly, we urge the Department to create a dedicated telephone line with a separate queue for all MSP terminations related to the change in the income guidelines, with that number prominently provided on all information solicitation or termination notices, and with sufficient staff so that average waits are far below the current average wait times for the call center.

Conclusion

As it comes to light that this budget cut severely cuts a critical Medicaid program which ensures access to essential health care for vulnerable elderly and disabled individuals throughout the state, we hope and expect that there will be a movement to attempt to repair the damage. In the meantime, as you implement the MSP cut as passed, we urge you to adopt all of the suggestions in this letter and the letter of yesterday, so that, in compliance with federal law, no individuals are cut off without an individualized review by your agency of all possible alternative bases for Medicaid eligibility, including a reasonable opportunity, for those not apparently eligible under any Medicaid category, to affirmatively submit any new information which might establish that eligibility. **At a minimum, the letters scheduled to be mailed out next week have to be pulled until they are revised to fully comply with 42 C.F.R. § 435.916(f)(1), as elaborated on in the Federal Register at the time of its promulgation.**

We also would welcome the opportunity to have input on the revised form notices which the Department will be sending out to the affected individuals, compliant with the governing regulations. This may allow the Department to avoid legal jeopardy, as it successfully did when it and AHCT shared with us drafts of notices at the time of the last mass termination of HUSKY A enrollees.

[1] For current MSP enrollees, LIS eligibility will automatically continue until 1/1/19. After that, their current LIS eligibility, tied to their MSP eligibility, will end, and they will have to affirmatively apply for LIS, for which they will be eligible if under 150% of the poverty level.

Thank you for your attention to this matter of great importance to the individuals we mutually serve.

Respectfully yours,

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Encs.

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