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Comment on Proposed Streamlining Medicaid Eligibility Rule

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Overview

The proposed rule is unlawful, illogical, and extraordinarily harmful. It unilaterally coerces states to artificially maximize Medicaid enrollment by prohibiting critical program integrity and eligibility verification processes at the expense of state flexibility, taxpayers, and the truly needy who rely on the sustainability of Medicaid.

The Medicaid program is already plagued with program integrity issues. More than one in five dollars is spent improperly.[1] Rather than address the eligibility errors driving these improper payments, the proposed rule would double down and direct that all states must implement more of the lax procedures that have led to skyrocketing error rates.

The proposed rule would ban states from conducting more frequent eligibility reviews, disregard mail showing an address change, eliminate in-person interviews, create unnecessary "reconsideration periods," bar states from asking follow-up questions on resources and citizenship, eliminate requirements to seek other supports, and prohibit meaningful enforcement of statutory state options. The rule introduces alarming new concepts, erodes Medicaid's state-federal partnership, and imposes significant costs on state and federal taxpayers when states have a record-high number of ineligible enrollees.

Worse yet, the proposed rule is unlawful. It exceeds the scope of statutorily delegated power, asserting without evidence that weakening program integrity is necessary for the "proper administration" of the program. It is arbitrary and capricious, illogical, based on unreasoned decision-making, and lacks the rational connection between the facts found and the choices made that is required to promulgate all regulations.

The proposed rule would also plainly violate the Constitution, commandeering states' regulatory authority and coercing them into eliminating core program integrity tools and accepting other unforeseen conditions they never agreed to under threat of potentially losing all Medicaid funding. It makes clear that officials at the Centers for Medicare & Medicaid Services (CMS) are primarily concerned with maximizing enrollment, regardless of its impact on program integrity and whether enrollees are eligible.

CMS's goal of "increasing enrollment and retention" in the Medicaid program is based upon an unsupported and erroneous assumption that eligible individuals face major "barriers" in applying for, enrolling in, and maintaining coverage through Medicaid and the Children's Health Insurance Program (CHIP).

> ***Numerous state and federal audits have revealed millions of ineligible and potentially ineligible enrollees on the program, even before the federal government prohibited states from removing ineligible enrollees during the public health emergency.***

This is the foundation upon which the proposed rule is built. But it is totally unmoored from reality. A record-high 97 million people are enrolled in Medicaid today, nearly three times as many people as just two decades ago.[2-3] Numerous state and federal audits have revealed millions of ineligible and potentially ineligible enrollees on the program, even before the federal government prohibited states from removing ineligible enrollees during the public health emergency.[4-5] These results are simply incompatible with the program CMS describes as having the kind of barriers that would even remotely begin to justify the unlawful proposed rule.

It is not "retention rates" or "coverage barriers" that continue to dominate state budgets and warp America's largest welfare program. Instead, it is fraud, improper payments, and coverage of ineligible individuals that continue to rob the truly needy and taxpayers. Those are the issues that urgently confront Medicaid today.

Enrolling more ineligible people is not the solution to those problems. It is the problem. CMS should withdraw the proposed rule and refocus its efforts on providing states with more tools to ensure resources meant for the truly needy are not diverted to ineligible enrollees.

Medicaid is already plagued with program integrity problems

The Medicaid program has a long history of program integrity issues. More than one in five dollars spent on Medicaid is improper, with virtually all those improper payments resulting from eligibility errors, administrative oversights, and outright fraud.[6] Indeed, eligibility errors make up more than 80 percent of improper payments, meaning countless individuals are receiving Medicaid benefits for which they are not eligible.[7] CHIP has even more extensive problems, with improper payments making up nearly one in three dollars spent.[8]

State and federal audits have revealed significant problems in ensuring that only those eligible for these programs are enrolled.[9] In California, for example, auditors found more than 4.3 million Medicaid enrollees who were ineligible or potentially ineligible for the program.[10-12] In New York, federal auditors found more than one million ineligible and potentially ineligible enrollees on the program.[13-15] Audits in other states have revealed similar levels of eligibility errors.[16-22]

Improper enrollment largely results from the failure of states to properly verify income, citizenship, residence, incarceration status, and even whether people are still alive. These failures are driven, in large part, by existing federal regulations and administrative guidance. Some individuals have multiple enrollments in the same state or even across states. State and federal audits have identified tens of thousands of individuals enrolled multiple times in the same state.[23-34] In some cases, individuals had as many as seven different open Medicaid cases.[35] Audits have also revealed hundreds of thousands of individuals enrolled in Medicaid in multiple states simultaneously.[36-39]

A federal review of 47 states with available data found individuals enrolled in multiple states' Medicaid programs in every single reviewed state.[40] States then paid managed care companies multiple times for these same individuals, costing taxpayers millions of dollars.[41]

In many cases, this duplicate enrollment may result from identity fraud. In Arkansas, auditors discovered more than 20,000 enrollees with high-risk identities, including individuals with stolen or fraudulent Social Security numbers linked to multiple people.[42] A similar audit in New Jersey identified more than 18,000 enrollees with fake or duplicate Social Security numbers.[43]

States' reliance on self-attestation for various eligibility factors leaves ample opportunity for errors and fraud, as applicants may submit false information and enrollees may fail to update key information, such as large income changes. For example, all states accept self-attestation for household composition, 45 states accept self-attestation of residency, and at least 15 states accept self-attestation of income to some degree.[44] Unfortunately, this information may not be verified for months, if at all, once accepted.

In Louisiana, for example, auditors found tens of thousands of ineligible individuals who were allowed to enroll in the program because the state did not verify self-attested information on household size, composition, or certain types of income.[45] New Jersey auditors identified thousands of enrollees with unreported six-figure incomes, including some earning as much as $4.2 million per year.[46] In Minnesota, at least 15 percent of enrollees misreported their incomes to the Medicaid agency, with the average enrollee having nearly $21,000 in underreported income.[47] Several of these cases included individuals who self-attested to no income but had income far above the eligibility limits.[48]

Accepting self-attested information has also led states to spend millions of taxpayer dollars on individuals who had moved out of state or who may never have lived in the state in the first place. Missouri and Minnesota auditors identified thousands of Medicaid enrollees with out-of-state addresses.[49-50] In Arkansas, nearly 43,000 out-of-state enrollees were discovered in the program, including nearly 7,000 enrollees with no record of ever living in the state.[51]

States have also discovered individuals enrolled in Medicaid while in state or federal prison, even though federal law generally prohibits states from using Medicaid funds to pay for inmates' medical care. Auditors in Arkansas, Louisiana, Missouri, and Ohio discovered that the Medicaid program paid managed care companies millions of dollars to cover incarcerated individuals who are unable to utilize Medicaid services, many of whom were not expected to be released for five or more years. [52-55]

Even more shocking, recent state and federal audits have uncovered hundreds of millions of dollars in Medicaid funding spent on deceased individuals, some of whom had died as long ago as 1981.[56-76]

As a result of these major program integrity issues, the amount of waste, fraud, and abuse within the Medicaid program has skyrocketed in recent years. Federal Medicaid spending has grown by more than $200 billion since 2013, with rising improper payments making up more than 40 percent of that growth.[77] The proposed rule would make these issues even worse.

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"Streamlining" enrollment will erode program integrity to maximize enrollment

CMS states that the proposed rule aims to "streamline" eligibility processes.[78] But the requirements of the proposed rule itself make clear that CMS is not seeking to "reduc[e] administrative burden on States" as it claims, but rather is seeking to artificially maximize enrollment, regardless of the impact on program integrity.

Throughout the proposed rule, CMS states its desire to "improve access" and "improve retention" for the Medicaid program.[79] CMS claims the proposed rule attempts to "remove barriers" to enrollment and fix "challenges in enrolling applicants" into Medicaid.[80] According to CMS, the rule is designed to "make it easier for individuals to enroll in and retain coverage" through Medicaid.[81] CMS expects the proposed rule will result in "increasing enrollment and retention" in Medicaid.[82]

Throughout the proposed rule, CMS asserts that eligible individuals face major "barriers" in applying for, enrolling in, and maintaining coverage through Medicaid, which it states makes the proposed rule necessary.[83] But CMS offers little or no evidence to support these claims.

For example, CMS repeatedly states that the proposed rule is necessary to "mitigate churn," citing an issue brief published by the Assistant Secretary for Planning and Evaluation's Office of Health Policy that discusses policy options for reducing "churn."[84]

But "churn" occurs when enrollees leave the program and later return, regardless of the reason for their exit. As the issue brief explains, many enrollees experience changes in circumstances—such as large changes in income—that **make them ineligible** for the program.[85] Still, CMS considers this "churning" because they may later become eligible if their circumstances change again.[86] The issue brief cites that a portion of individuals "changed coverage within one year" in explaining churn.[87]

CMS also cites self-reported survey data on insurance status from the Census Bureau's American Community Survey as justification, asserting that the survey data proves that the number of eligible uninsured individuals has risen in recent years.[88] This self-reported survey data, however, has long undercounted Medicaid enrollment, with nearly one in four Medicaid enrollees misreporting their status.[89] The survey tables that CMS relies upon undercounts total Medicaid enrollment by more than 10 million people in 2019, according to CMS's enrollment reports.[90-93]

Numerous state and federal audits and enrollment reports have debunked these unsupported claims of large-scale barriers for eligible enrollees. Before the COVID-19 public health emergency, auditors identified millions of individuals enrolled in Medicaid despite being ineligible or potentially ineligible for the program.[94-104] Medicaid enrollment has also reached an all-time high, with an estimated 97 million individuals on the program by October 2022.[105] These facts suggest that the problems plaguing the Medicaid program are the direct opposite of what CMS proposes to address in this rule.

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The proposed rule would ban states from conducting more frequent eligibility reviews

The proposed rule would eliminate a key state option that at least 10 states currently use: more frequent eligibility redeterminations.[106] Medicaid rules require that states review enrollees' cases through a redetermination process at least once yearly.[107] These periodic redeterminations make perfect sense: Individuals' situations often change, and states have good reason to ensure those receiving taxpayer-funded benefits remain eligible.

The same research that CMS favorably cites related to Medicaid "churn" concludes that most low-income households have "significant income changes"—defined as an income change of more than 25 percent—within a year.[108] Nearly five million Americans move from one state to another every year, with individuals in poverty among those most likely to move.[109] Marriages and deaths occur, jobs change, income fluctuates, and life's happenings occur outside of an annual schedule.

But the proposed rule would take the current minimum requirement—that states conduct redeterminations at least once per year—and make it the maximum.[110] The Obama administration unilaterally made similar changes for one group of enrollees—individuals whose income is determined based on modified adjusted gross income (MAGI)—without statutory authority in 2012, which went into effect in 2014.[111]

The proposed rule would expand those unlawful changes to the remainder of the Medicaid population. Rather than eliminating state options for more frequent eligibility reviews for some enrollment categories, CMS should permit states to perform more frequent redeterminations for all eligibility groups.

The proposed rule would disregard mail showing an address change

One way state Medicaid agencies are alerted to changes in circumstance that may affect a person's Medicaid eligibility is through mail that was returned to the agency for an incorrect address. **The proposed rule requires states to ignore returned mail that could signal a change in circumstances.** CMS asserts, without evidence, that "returned mail with an in-state forwarding address is not an indication of a change affecting eligibility."[112] This claim is not only unfounded but nonsensical.

First, information need not definitively prove a change in circumstance to be considered relevant for further review. Federal regulations require states to promptly redetermine eligibility when they receive information indicating a change in circumstances that "may affect eligibility" [emphasis added].[113] The determination of whether the change in circumstances ultimately did or did not affect eligibility is made during the renewal and redetermination process. Receiving information that indicates a change in circumstance—such as returned mail—serves as a trigger for necessary further review.

Second, in-state moves can indicate a change in circumstances that may affect eligibility. Individuals move primarily for three reasons: family, employment, and housing.[114] These factors can often indicate changes in Medicaid eligibility. Changes in household composition, employment, and income are frequent reasons for changes in address, each of which is a significant factor in whether someone would remain eligible for Medicaid.

Forcing states to ignore in-state changes of address that could indicate one of these common changes in life circumstances will weaken program integrity. Rather than prohibiting states from utilizing this information, CMS should require states to follow up on returned mail that signals an address change.

The proposed rule would eliminate in-person interviews

Federal law allows states to conduct in-person interviews as part of the Medicaid eligibility determination process. **The proposed rule would eliminate in-person interviews from Medicaid entirely, even as a state option.** Medicaid and other welfare programs have long used in-person interviews as a critical tool to help verify applicants' identities, household situations, income, and more. The proposed rule's elimination of this option is especially problematic when rampant identity theft is rising.

The number of complaints reported to the Federal Trade Commission by victims whose identities were stolen for government benefits has increased nearly 3,000 percent since 2019.[115] State audits have revealed tens of thousands of enrollees with high-risk identities, including individuals with fake and stolen Social Security numbers committing identity theft.[116-117]

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A man in Michigan, for example, was recently charged with 10 felonies after having submitted nearly 3,000 fraudulent Medicaid applications based on stolen identities, costing taxpayers $11 million.[118] In-person interviews are one tool states have to curb this kind of fraud based on identity theft, but the proposed rule would eliminate this state option.

Rather than eliminating this option, CMS should encourage more states to utilize this tool and allow or even require states to use it for other eligibility groups.

The proposed rule would create unnecessary "reconsideration" periods

In many ways, the proposed rule demonstrates its purpose is to drive higher enrollment, despite claims that it is designed to improve administrative efficiency or strengthen program integrity. Nowhere is this clearer than the proposed rule's creation of "reconsideration" periods. **The reconsideration proposal would force states to keep case processing open and use outdated data to make eligibility determinations.**

Deadlines are a reality in any part of life and applying for welfare benefits should be no different. But the proposed rule would force states to accept very late information from applicants—up to 90 days

after they are determined ineligible based on available data.[119] States would then have to accept the outdated data from the original application as current, widening the door to waste, fraud, and abuse.

Ironically, the proposed rule also proposes stricter timeliness standards for states to complete eligibility determinations.[120] This duplicitousness sends the clear message from CMS that they expect "procedural" timeliness and standards to quickly give away benefits but do not want to hold the recipients of those benefits to the same standards and deadlines. Under current rules, someone who is ineligible is allowed to resubmit an application at any time, so this change is unnecessary to protect potential recipients from errors or delays.

The proposed rule bars states from asking follow-up questions on resources and citizenship

The proposed rule would eliminate an essential program integrity tool by requiring states to accept certain electronic information without allowing any follow-up requests for information. This proposed change primarily affects two critical parts of the eligibility process: assessing available resources and verifying citizenship. Under current rules, states may follow up with applicants and recipients to request verification of certain information they have received via an application or from a data system. The proposed rule would ban those verifications regarding available income resources.

Worse yet, particularly with the current border security issues, **the proposed rule weakens the ability of states to verify the citizenship status of applicants.** Under current regulations, individuals whose citizenship is verified based on certain data sources must also establish their identities.[121]

However, the proposed rule would allow just one data source to be considered "stand-alone evidence of citizenship," prohibiting states from further identity verification efforts.[122] These programs would further weaken program integrity, and CMS should instead increase efforts to verify identity, citizenship, and resources.

The proposed rule eliminates requirements to seek other supports

One basic tenet of welfare programs like Medicaid is that individuals seek other supports that may be available. It is part of the social contract: America is willing to help those who are genuinely in need, but taxpayer-funded benefits should not be the first resort for those with other resources available to them. Medicaid has enshrined this basic principle in regulation, requiring that potential recipients and applicants seek out possible access to other resources like pensions, annuities, retirements, or disability benefits as a condition of eligibility.[123] **The proposed rule would eliminate the requirements to seek other supports entirely.**[124]

In addition to undermining the fundamental principle that welfare applicants seek out other available resources before turning to taxpayers, this proposed change further illustrates CMS's primary goal is to artificially enroll as many people into Medicaid as possible.

The proposed rule prohibits meaningful enforcement of statutory state options

The proposed rule has no statutory basis for its voluminous list of regulatory changes. Even worse, the proposed rule undermines statutory state options to achieve the desired political ends. In particular, **the proposed rule would end key program integrity provisions in CHIP**.

First, the proposed rule would ban states from having temporary lockout periods in CHIP for nonpayment of premiums, even after lengthy grace periods.[125] As CMS knows, eligibility for CHIP is significantly higher than for the Medicaid program, with eligibility limits reaching as high as four times the federal poverty line.[126] That is the equivalent of $111,000 in annual income for a family of four.[127]

Although most states charge premiums to these higher-income enrollees, these premiums are capped at nominal amounts.[128] States also provide a grace period for payment of these premiums, with a 60-day grace period most common, although it can last as long as 12 months in some states.[129] The temporary lockout period ends when the enrollee pays the premium or after a short fixed period, whichever comes first.[130] Enrollees who fail to pay those premiums may return to the program after the lockout period ends, regardless of whether past-due premiums are paid or not.[131] Congress expressly provided states with the authority to charge these nominal premiums, subject to statutory limits.[132]

Unable to eliminate this statutory option, the proposed rule seeks to gut its enforcement by prohibiting states from imposing temporary lockout periods for enrollees who refuse to pay those nominal premiums after a lengthy grace period.[133]

Likewise, the proposed rule would prohibit states from protecting the program from crowd-out issues, where individuals with affordable employer-sponsored coverage move to taxpayer-funded CHIP coverage.[134] These protections were created to ensure that individuals with affordable private insurance do not simply cancel that coverage to get taxpayer-funded coverage. Federal law actually requires states to ensure that CHIP "does not substitute" for private coverage.[135]

Even with these anti-crowd-out provisions in place, research on recent CHIP expansions finds that crowd-out of private coverage accounts for nearly two-thirds of new enrollees.[136] The proposed rule would eliminate these protections, allowing individuals to drop private coverage and immediately enroll in CHIP, despite federal law mandating that states ensure such crowd-out does not occur.[137]

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The proposed rule introduces alarming new concepts

In addition to eliminating numerous state options for protecting program integrity, the proposed rule introduces alarming new concepts that will lead to future expansions of waste, fraud, and abuse. Throughout the proposed rule, CMS bemoans what it refers to as "terminations for procedural reasons."[138] CMS appears to assert that, ultimately, no one should be disenrolled from Medicaid based on process.

While this may be consistent with CMS's desire to artificially maximize enrollment regardless of its impact on program integrity, it is inconsistent with the clear intent of Medicaid's authorizing statutes, not to mention proper administration of the program. All welfare programs have "procedural steps" involved—such as providing accurate information on key eligibility factors, verifying necessary information, notifying appropriate agencies of changes in circumstances, and more—which must be followed to receive benefits. Procedural steps exist in all interactions with the government, whether applying for benefits, filing taxes, obtaining a license, or any other interaction.

CMS's position that states should not terminate benefits for individuals who refuse to follow appropriate, basic procedural steps—even if such individuals are ineligible for the program—is exceptionally alarming and a warning sign for future weakening of program integrity measures.

The proposed rule is unnecessary and erodes Medicaid's state-federal partnership

Medicaid is a state and federal partnership, with states funding a large portion of the program and directly administering it. Medicaid is already states' largest budgetary line-item and consumes nearly one in three dollars in states' budgets.[139] CMS estimates that states will bear roughly 40 percent of the proposed rule's cost in its regulatory impact analysis, adding tens of billions of dollars in new costs for taxpayers.[140] But the proposed rule undermines this partnership by further eroding longstanding state options for processes and procedures.

States already have the option to operate their Medicaid programs with many similar processes and procedures described in the proposed rule. CMS acknowledges that many of the changes proposed are already allowed by state option in regulation or already done in practice.[141] As CMS acknowledges, "almost all States adopt at least one of the optional processes for renewals of non-MAGI beneficiaries."[142] CMS also acknowledges that 40 states already use the 12-month renewal option for non-MAGI groups.[143]

This begs the question: Why is CMS proposing to unilaterally and unlawfully mandate that states adopt these options? The states that choose not to exercise these various practices and procedures know they are available. These states have simply decided to operate the program without them. CMS asserts that the widespread use of these options supports its decision to impose new mandates, but in reality, it does the opposite. If states have voluntarily adopted such provisions, new mandates to adopt them are unnecessary. The Medicaid program is already overflowing with federal mandates. The proposed rule would strip states of even more flexibility, eroding the balance in the program's state and federal partnership.

The proposed rule's asserted focus on "administrative efficiency" is questionable and inconsistent

Much of the justification and framework for the proposed rule is that it will significantly improve "administrative efficiency" for state Medicaid programs. **But this promise of increased administrative efficiency is untrue and undermined throughout the proposed rule by inconsistent policy proposals.**

First, the proposal will result in millions of additional enrollees, which will add administrative burden. Even CMS's estimates—which likely understate the impact of the proposed rule—project that the proposal would increase enrollment by three million people.[144] Higher enrollment will bring massive new administrative costs to states, as administrative costs in welfare programs are primarily driven by caseloads.[145] In fiscal year 2021, nearly 90 percent of the variance in states' administrative costs could be explained by enrollment levels.[146-152] Promised savings from less work per case are virtually always far outweighed by the workload to manage more cases.

Second, the proposed rule includes a massive new state mandate to handhold every recipient who is ineligible upon application or redetermination.[153] The proposed rule would turn Medicaid agencies into insurance brokerage firms, forcing state workers to help with new applications every time someone is determined ineligible for Medicaid or CHIP. This will incentivize state workers to award Medicaid coverage when it's questionable, simply to avoid the paperwork of making them ineligible and then helping determine potential eligibility for other programs or the exchange. Without question, it adds a significant administrative burden to states, directly countering the false claims from CMS that this rule is to achieve administrative efficiencies.

Third, the rule requires using third-party data without verification, but only when it makes someone eligible for a benefit. In two locations in this rule, CMS proposed provisions allowing states to achieve "administrative efficiency" by using third-party data to evaluate eligibility.[154] But this data only helps reduce administrative burden if the data shows that someone is eligible for a benefit or a higher benefit level.[155] If the same data set shows the person is ineligible or "may result in an adverse action," states must do additional verification of the information's accuracy.[156]

Similarly, the proposed rule would utilize "leads data" transmitted to state Medicaid agencies to qualify individuals for the costly Medicare Savings Program (MSP) if the data shows they are eligible.[157] If that same data shows that the individual is ineligible, the proposed rule would require additional follow-up and information.[158]

These dramatic inconsistencies show that the real goal of the rule is solely to increase enrollment, not to decrease administrative effort. If the burden on state workers were the primary concern, third-party data would be accepted as verified when it also shows someone to be ineligible.

Fourth, the proposed rule requires state agencies to chase returned mail. Returned mail is an obvious reason to seek clarification or take adverse action on a case. If someone no longer lives at the address, there is a change in circumstances that may affect eligibility. CMS prohibits using returned mail as a trigger for additional review, and the proposed rule also requires states to "conduct a series of data checks and outreach attempts to locate the beneficiary and verify their address."[159] This proposed change is designed to keep people on Medicaid after they ghost caseworkers and refuse to respond to any attempts to contact them.

States would rightly move to close cases when people disappear, but CMS is trying to add new administrative burdens to keep them from taking action to close these cases, even when it's appropriate. CMS wants states to "make at least two attempts with at least three business days between the first and last attempt."[160]

CMS is also proposing to ban states from terminating coverage when someone does not respond, proposing that states "may not terminate the beneficiary's coverage if the State does not receive a response to its requests that the individual confirm their correct, current address."[161] This is the opposite of reducing administrative burden. It is adding burden and removing program integrity.

The proposed rule's attempt at "modernizing records" may be an attempt to cook the books on improper payments

The proposed rule's attempt at "modernizing records" is an additional concern. These provisions would change recordkeeping practices for eligibility casefiles.[162] While a certain amount of modernizing is expected and understandable, CMS appears to be blaming massive payment error rates on basic recordkeeping issues. But state and federal audits make clear that core program integrity problems exist in the program. Indeed, the number one source of eligibility errors in both Medicaid and CHIP is not misplaced paperwork but the fact that the agency never correctly verified eligibility.[163]

This is a red flag that the true goal of the "modernizing records" change may be to reduce the payment error rate through paperwork shuffling instead of minimizing the number of ineligible enrollees on the program through proper administration.

CMS cites the egregious case of ineligible enrollees on Medicaid in California, where 4.3 million ineligible or potentially ineligible individuals were given Medicaid.[164-167] But this was not a case simply of missing records that a different record retention schedule would remedy. The Office of the Inspector General (OIG) found nearly 1.2 million enrollees were definitively ineligible, in addition to the millions of potentially ineligible enrollees.[168] Similar results have been found in Colorado, Kentucky, Ohio, New York, and beyond.[169-177] Any proposal to update retention timelines of case records should ensure that records are maintained long enough that the OIG or other oversight entities can ensure that eligibility can be reviewed and verified.

> *In California, **4.3 million ineligible** or potentially ineligible individuals were given Medicaid.*

The proposed rule attempts to justify the rule to address "inequity" created by an unlawful Obama-era regulation

CMS repeatedly asserts that the rule is necessary to create "equity across enrolled populations."[178]

Under a regulation issued by the Obama administration, the renewal and enrollment procedures for individuals whose eligibility is determined by MAGI differ from those used for non-MAGI eligibility groups.[179] CMS attempts to justify the proposed rule as a way to bring equity between the MAGI and non-MAGI eligibility groups.

But if any inequity exists, it is solely because an Obama-era regulation unilaterally and unlawfully applied similar changes for the MAGI eligibility groups. That regulation had no statutory basis. As it does here, CMS attempted to justify the changes simply by asserting that "very few" states determined eligibility more frequently than once per year, and it was therefore making the change "consistent with this state trend."[180]

CMS created the inequity with its unlawful rule change for MAGI eligibility groups and now absurdly asserts that the similarly unlawful proposed rule is necessary to address the inequity created by that earlier rule.

The only "equity" the proposed rule will achieve is to further undermine program integrity within the rest of the program. Rather than weakening program integrity for the remainder of the program, CMS should reverse the Obama-era regulations that prohibited states from conducting more frequent eligibility reviews of MAGI eligibility groups.

The proposed rule expands eligibility processes that have led to skyrocketing improper payments

Many provisions in the proposed rule mirror regulations adopted by the Obama administration for individuals whose eligibility is determined based on MAGI.[181] Those provisions, while having no statutory basis, were implemented in 2014 and have led to massive increases in eligibility errors. Between 2013 and 2021, the amount of improper federal Medicaid and CHIP payments caused by eligibility errors increased roughly tenfold, reaching more than $80 billion by 2021.[182]

The distribution of these errors varies heavily by eligibility category. Medicaid and CHIP enrollees whose eligibility is determined based on MAGI—and whose cases are already subject to similar regulations as those contained in the proposed rule—have more than 22 percent eligibility error rates.[183] Those enrollees whose eligibility is not determined based on MAGI—and whose cases would become subject to the regulations contained in the proposed rule—have eligibility error rates of less than 13 percent.[184]

This means that the error rate for eligibility groups already subject to the provisions outlined in the proposed rule is roughly 75 percent higher than the error rate for groups not currently subject to those provisions. [185] Rather than expand these provisions to all Medicaid enrollees, causing improper payments to skyrocket even further, CMS should roll back the unlawful Obama-era regulations and allow states to perform more frequent eligibility reviews.[186]

The proposed rule would impose significant new costs on state and federal taxpayers

The proposed rule carries significant costs for state and federal taxpayers. According to CMS's regulatory impact analysis, the proposed rule would add $100 billion in new costs over the next five years.[187] Over the typical 10-year budget window used by the Congressional Budget Office and the Office of Management and Budget, those costs increase to roughly $225 billion over a decade.[188]

State taxpayers are expected to cover 40 percent of those new costs, or roughly $90 billion over a decade.[189] Medicaid is already states' single largest budgetary line item, reaching a record-high $745 billion in 2021 and crowding out funding for other core priorities such as education, public safety, and infrastructure.[190-191]

Even worse, the proposed rule would represent a massive cost shift from federal taxpayers to the states. CMS estimates that the proposed rule would shift individuals from private health insurance on the exchange to Medicaid.[192] This would "save" nearly $40 billion in federal premium tax credits over a decade, but only by shifting more costs to state taxpayers.[193]

CMS's regulatory impact analysis also likely understates the proposed rule's total cost. CMS offers little to no evidence to justify its various assumptions in the analysis. Worse yet, CMS's track record of estimating the effect of other policy proposals is questionable, having consistently underestimated the cost of past proposals such as Medicaid expansion.[194] If the proposed rule increases eligibility error rates for non-MAGI eligibility groups to match those of the MAGI groups, the rule would increase taxpayer spending by $25 billion per year on improper payments alone.[195]

Whether CMS's projected costs are accurate, the sheer size and scope of the proposed rule make clear that its provisions should not be advanced by regulation. A regulation of this magnitude warrants congressional review and approval. Several provisions of the proposed rule were included in the initial "Build Back Better" proposal, which were rejected by Congress and removed from the bill's final version, which was retitled the "Inflation Reduction Act."[196-197]

Having failed to get these provisions through Congress, the Biden administration is now attempting to impose them on states through this unilateral and unlawful proposed rule.

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The proposed rule is unlawful

CMS lacks a legal basis for the proposed rule. First, CMS exceeded the scope of its powers under the Social Security Act in advancing the proposed rule, violating the Administrative Procedure Act (APA).[198] Second, the proposed rule is arbitrary and capricious as a matter of law, violating the APA.[199] Third, CMS's attempts to justify the proposed rule as necessary to resolve an inequity created by a previous unlawful regulation are invalid.

Finally, the proposed rule would violate states' constitutional rights by commandeering them and coercing them into eliminating strong program integrity protections and accepting new unforeseen regulatory measures they never agreed to, violating the Tenth Amendment, the Spending Clause, and the APA.[200-202]

The proposed rule exceeds the scope of statutorily delegated power

CMS points to no statutory authority to make most of the sweeping changes mandated in the proposed rule.[203] Several provisions in the proposed rule were only promulgated after Congress considered and expressly rejected them.[204-205] Having failed to get its policy goals through Congress, CMS has proposed sweeping regulatory changes to the Medicaid program, relying upon a single provision of law that authorizes the U.S. Department of Health & Human Services (HHS) Secretary to make changes "necessary for the proper administration of the program."[206]

But mandating states abandon essential program integrity requirements cannot promote the "proper administration" of state Medicaid programs. Data provided by CMS illustrates that proposed changes are associated with higher improper payments among the groups where such changes have already been implemented.[207] Forcing states to adopt these policies for all enrollees—prohibiting them from running the kind of routine eligibility checks many currently run—would ensure that more ineligible individuals are allowed to remain on the Medicaid rolls. This would result in the opposite of "proper administration of the program."

CMS has exceeded the scope of its statutorily delegated power in seeking to impose new regulations that would undermine the "proper administration" of the Medicaid program. As such, the proposed rule violates the APA and must be withdrawn.

The proposed rule is arbitrary and capricious

CMS claims that unilaterally imposing new eligibility and enrollment regulations on states will "promote the proper and efficient administration" of the program.[208] This assertion is illogical, as the proposed rule would create new administrative burdens on states, which in many cases would complicate and lengthen the process, eliminate important tools to protect program integrity, and invariably lead to more ineligible individuals obtaining and retaining Medicaid benefits.

These sweeping regulatory changes represent more than executive-branch overreach. They are illogical, based on unreasoned decision-making, and lack the "rational connection between the facts found and the choices made" that is required by federal law.[209-211]

The proposed rule makes it clear that CMS has been politically strong-armed to deliver a proposed rule to the Biden White House that aligns with the political goals outlined in Executive Order 14009 and Executive Order 14070, aimed at aggressively expanding Medicaid by weakening program integrity measures states have traditionally employed.[212-213]

Having failed to achieve its policy objectives through Congress, the Biden administration has turned to executive fiat to hamstring states' abilities to enforce current threshold limits and identify or remove individuals who are not entitled to Medicaid benefits under the law. Worse yet, it attempts to use regulation to undermine statutory options that Congress specifically granted states for program administration.

In the end, CMS did not develop the proposed rule based on a demonstrated need for program change or a statutory change enacted by Congress and signed by the president, which is what Congress envisioned when it granted the HHS Secretary the authority to specify "methods of administration" that are "necessary for the proper administration" of the program. The proposed rule is arbitrary and capricious and must be set aside.

> ***The proposed rule makes it clear that CMS has been politically strong-armed to deliver a proposed rule to the Biden White House that aligns with the political goals outlined in Executive Order 14009 and Executive Order 14070.***

The proposed rule cannot be justified by prior unlawful regulations

CMS attempts to justify the proposed rule as necessary to resolve an inequity between specific eligibility categories.[214] Under current regulations, individuals enrolled in Medicaid under MAGI eligibility groups may have their eligibility redetermined no more than once per year.[215] States must also follow other special procedural steps, such as sending pre-populated renewal forms, as part of the redetermination process.[216] Individuals enrolled in Medicaid under non-MAGI eligibility groups are not subject to these provisions.[217] The proposed rule would mandate states adopt these MAGI enrollment processes for the remainder of the Medicaid program.[218]

CMS asserts that these new mandates are necessary to create equity across enrollment groups. But its attempt to justify the proposed rule to resolve an inequity created by a previous unlawful regulation is invalid.

CMS's initial regulations on enrollment procedures for MAGI eligibility groups had no statutory basis, were arbitrary and capricious, and cannot be used to justify the current proposed rule. In adopting the initial regulations, CMS cited no statutory authority for the changes to enrollment processes or eligibility determination regulations.[219] With no statutory basis available, CMS noted only the "state trend" that "very few states" had more frequent eligibility reviews as its basis for prohibiting those periodic eligibility checks.[220]

CMS cannot now use an inequity between eligibility groups created by an unlawful regulation as the legal justification for the proposed rule. Doing so would grant agencies and bureaucrats the unchecked ability to unilaterally create unlimited power for themselves, adopting one unlawful regulation to create the authority to adopt another unlawful regulation. If CMS wishes to address the inequities caused by its unlawful regulation affecting enrollment processes for the MAGI eligibility group, it must roll back that regulation, not double down on it with the proposed rule.

The proposed rule would violate the Constitution

The proposed rule would violate states' constitutional rights by commandeering them and coercing them into eliminating strong program integrity protections, violating the Tenth Amendment, the Spending Clause, and the APA.[221-223]

Under the APA, courts are required to hold unlawful and set aside any agency rule "contrary to constitutional right."[224-225] The Tenth Amendment provides that powers not delegated to the federal government are reserved to the states or the people. [226-227] In addition, under the Spending Clause, if a state does decide to participate in a federal program, they must do so "voluntarily and knowingly," fully "cognizant of the consequences of their participation."[228-229]

Federal courts have clarified that the Tenth Amendment protects states from "impermissible compulsion" or "commandeering" by the federal government.[230-231] Meanwhile, the Medicaid program—a program involving the exercise of federal power grounded in the Spending Clause—is considered "much in the nature of a contract" between states and the federal government.[232] Thus, the legitimacy of major changes to the program requires that states "voluntarily and knowingly accept[] the terms of the contract."[233] The federal government may not "surpris[e] participating states with post-acceptance or retroactive conditions."[234-235]

This is particularly true when those changes are accompanied by "threats to terminate" other significant funding, which serves as a "means of pressuring the states to accept policy changes."[236] When the "financial inducement" offered by the federal government is "so coercive as to pass the point at which pressure turns into compulsion," that inducement is unconstitutional.[237]

The proposed rule would rewrite the rules for Medicaid eligibility verification and review to weaken program integrity measures embedded in the law and in the "intricate statutory and administrative regimes" that states have developed "over the course of many decades to implement their objectives" under the Medicaid program.[238] When agreeing to the state and federal partnership underlying the Medicaid program, states could not have anticipated that the federal government reserved the right to "transform it so dramatically" by executive fiat.[239]

If states refuse to implement these new mandates, CMS may attempt to "withhold payments to the states, in whole or in part," for non-compliance with federal requirements.[240-241] CMS could seek to withhold a large share, or even all, of states' Medicaid funding for such refusal. The Medicaid program is the single largest line item in states' budgets, representing nearly 30 percent of states' budgets on average.[242] Federal matching funds account for almost two-thirds of that Medicaid spending, with Medicaid now representing the majority of all federal funding received by states.[243]

The potential threat to withhold this funding is "so coercive as to pass the point at which pressure turns into compulsion."[244] As the Supreme Court concluded, this type of threat is "much more than a relatively mild encouragement" but rather is "a gun to the head."[245] Such a budgetary loss would be so coercive as to leave states "with no real option but to acquiesce" to CMS's demands.[246]

The proposed rule invariably violates the Tenth Amendment rights of states not wishing to weaken program integrity measures currently in place, commandeers them into adopting policies that the Biden administration failed to pass through Congress, and coerces them into implementing those new mandates with the threat of losing some or all Medicaid funding.

Moreover, the proposed rule is a clear violation of the Spending Clause which under the *Pennhurst* Clear Notice Rule guards states that choose to participate in a federal program such as Medicaid against federal bait-and-switch tactics such as the one CMS is seeking to impose through this rule.[247] These actions violate the U.S. Constitution and the APA and must be withdrawn.

The proposed rule was submitted at a time that states have a record-high number of ineligible enrollees

The proposed rule was submitted at a time when Medicaid enrollment—particularly enrollment of ineligible individuals—has reached record highs.[248] By October 2022, Medicaid enrollment had reached an estimated 97 million, with the program on track to reach 100 million enrollees by early 2023.[249] But much of the enrollment growth has been caused by keeping ineligible individuals on the program.

As part of the Families First Coronavirus Response Act, states are prohibited from removing ineligible enrollees in exchange for a small bump in federal funding.[250] These Medicaid handcuffs have driven most new enrollment growth. According to state-level data, more than 90 percent of enrollment growth since February 2020 was caused by the Medicaid handcuffs.[251]

Overall, an estimated 21 million ineligible individuals remained on the program in October 2022, with those numbers growing by the day.[252] Although President Biden declared "the pandemic is over" on national television, the official public health emergency that keeps these handcuffs in place was renewed yet again.[253-254]

The millions of ineligible enrollees on Medicaid are costing state and federal taxpayers billions of dollars every month.[255] Unfortunately, the proposed rule will make it more difficult for states to remove these ineligible enrollees if and when the Medicaid handcuffs are ever unlocked, whether by ending the public health emergency, eliminating the handcuffs in federal law, or states opting out of the increased funding.

> ***By October 2022, Medicaid enrollment had reached an estimated 97 million, with the program on track to reach 100 million enrollees by early 2023.***

Conclusion

CMS should immediately withdraw the proposed rule. The Medicaid program is already plagued with program integrity issues and the proposed rule would further mandate the use of lax procedures that have led to skyrocketing error rates.

The proposed rule would ban states from conducting more frequent eligibility reviews, disregard mail showing an address change, eliminate in-person interviews, create unnecessary "reconsideration periods," bar states from asking follow-up questions on resources and citizenship, eliminate requirements to seek other supports, and prohibit meaningful enforcement of statutory state options. The rule introduces alarming new concepts, erodes Medicaid's state-federal partnership, and imposes significant costs on state and federal taxpayers when states have a record-high number of ineligible enrollees.

The proposed rule exceeds the scope of statutorily delegated power, is arbitrary and capricious, and would plainly violate the Constitution by commandeering states and coercing them into eliminating core program integrity tools under threat of potentially losing all Medicaid funding.

The proposed rule makes clear that CMS is primarily concerned with artificially maximizing enrollment, regardless of its impact on program integrity and whether enrollees are eligible. CMS should withdraw the proposed rule and refocus its efforts on providing states with more tools to ensure resources meant for the truly needy are not diverted to ineligible enrollees.

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