JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

April 17, 2023

Identifying and Reducing Burdens in Administrative Processes
Administrative Conference of the United States
1120 20th Street NW, Suite 706 South
Washington, DC 20036

Submitted via email to info@acus.gov

Re: Request for Comments on Identifying and Reducing Burdens in Administrative Processes; Request for Comments, 88 FR 9851 (February 15, 2023), Docket No. 2023-03181

Thank you for the opportunity to provide feedback on identifying and reducing burdens in administrative processes.

Justice in Aging is a national organization that uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. Since 1972, we've focused our efforts primarily on those who have been marginalized and excluded from justice such as women, people of color, LGBTQ+ individuals, and people with limited English proficiency. Justice in Aging is the opportunity to live with dignity, regardless of financial circumstances—free from the worry, harm, and injustice caused by lack of health care, food, or a safe place to sleep. By using the law to strengthen the social safety net, and remove the barriers low-income seniors face in trying to access the services they need, we work to ensure the future we all envision for our loved ones and ourselves.

We offer the following feedback on the questions in the request for comments:

1. What has been your experience interacting with an agency regarding a benefit or service that you are applying for or renewing, for example unemployment insurance or student loan assistance? Was any portion of the process especially easy or particularly difficult? Do you have specific suggestions for reducing burdens?

SSI and Social Security

For SSI and Social Security benefits, the application process can be daunting for older adults and individuals with disabilities, particularly individuals who face additional barriers such as having limited income or resources, being homeless, being formerly incarcerated, or having limited English proficiency. For those seeking disability-based benefits, SSA's disability determination process is complex, paperwork-intensive, and often challenging to navigate.

With such a large and complex system, changes both large and small matter in reducing burdens. This could take the form of doing outreach to individuals who are potentially eligible for SSI, providing more assistance to individuals facing barriers in applications and renewals, simplifying verification requirements, and increasing partnerships with state, local and nonprofit entities who are assisting individuals through these processes. For example,

individuals who qualify for a Social Security retirement benefit that is less than the SSI benefit amount are not automatically screened for SSI eligibility when they apply for the retirement benefit; providing automatic screening in this situation would ensure that the individuals who qualify for SSI can receive it, without having to affirmatively ask SSA to apply for SSI.

This could also take the form of removing policies that increase the burden of applying for benefits, such as by allowing individuals whose SSI disability benefits were suspended due to incarceration to reinstate those benefits after their release regardless of the length of the incarceration. Currently, SSI disability benefits can only be reinstated if the person is released and requests reinstatement within 12 months, which means that an individual released after 12 months must submit a new application and go through the complex, challenging disability determination process anew in order to receive SSI disability benefits. For individuals working to rebuild their life, and who may have few or no supports to rely on, application burdens can be particularly devastating.

Medicare and Medicaid

The Medicare and Medicaid enrollment processes can be similarly daunting. While older adults may be generally aware of Medicare eligibility at age 65, the fact that enrollment is not automatic can be confusing. And most people do not realize that there are programs to help low-income individuals with their Medicare premiums and cost-sharing. In fact, many more people are eligible for the Medicare Savings Programs and the Part D Low-Income Subsidy (LIS) than are enrolled. Because SSA receives and processes Medicare applications and enrollment, it is in the best position to screen and enroll people in LIS when they first become Medicare eligible, without those individuals needing to independently apply. And because SSA sends data to the state Medicaid programs about LIS enrollees, this more proactive approach to getting people enrolled in LIS would also help many of them get enrolled in Medicare Savings Programs as well.

Another enrollment that is particularly cumbersome and difficult for older adults to navigate is enrollment in "conditional" Medicare Part A, a process that is frequently required for individuals applying for the Medicaid Qualified Medicare Beneficiary (QMB) benefit who are not eligible for premium-free Part A. Currently most applicants begin by going to their local Medicaid office to apply for benefits and are told that, before they can file a QMB application, they must first make an appointment to apply in person at the Social Security Office and, after they have been to Social Security, they should return to the Medicaid office with evidence of the conditional Medicare enrollment. Not surprisingly many of these individuals never complete the process and, even if they do, their application for the QMB benefit may be significantly delayed. A much better practice would be for SSA to coordinate with state Medicaid offices so that the individual could file the conditional Medicare application electronically while at the Medicaid office with the assistance of the Medicaid eligibility worker. The Medicaid worker could verify the individual's identity and assist with an electronic signature. This would eliminate the need for a trip to SSA and allow the Medicaid program to

proceed immediately with the QMB application during the initial visit, reducing administrative burden for both agencies and speeding the start of the QMB enrollment process.

An additional burden to enrollment is inadequate language access. The Medicare Part B and LIS applications can only be submitted in English and Spanish. And we hear from advocates that SSA field offices incorrectly tell people with limited English proficiency that they do not provide interpreters. Improving language access at enrollment would be a critical first step to reducing burden.

A step to reduce burden that has worked well in the Medicare program has been the use by CMS of specific colored paper for important notices about the Low-Income Subsidy program (LIS or "Extra Help"). For example, a notice of auto-enrollment in a Medicare Prescription Drug Plan is sent on yellow paper. A notice to individuals who need to choose a new plan or face an increase in premiums is sent on tan paper. This simple technique has made it easier for the agency and for advocates and assisters to understand which notice a caller is referring to when asking a question. It also facilitates consumer education about important papers to expect in the mail and, at least partially, addresses the issue that many advocates encounter of beneficiaries just putting notices in a pile or throwing them out because they don't know where to begin.

General suggestions

Rules that increase program complexity cause a strain in the system for both agencies and individuals seeking assistance. Rules that increase burden and complexity can deter individuals who qualify from applying for benefits, such as the restrictions in the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) that restricted immigrant access to TANF, SSI, Medicaid, and SNAP. The confusion surrounding immigrant eligibility after PRWORA ended up deterring even immigrants who remained eligible from applying for these benefits. Removing these burdensome restrictions would reduce the burden on immigrants applying for these benefits.

Across program areas, cross-enrollment should be increased. For example, SSI has programmatic linkages to Medicaid and SNAP that help ensure that SSI recipients also receive these other benefits. More can be done to improve these existing linkages, and to create new linkages. For example, Congress could expand and align eligibility for the Medicare Savings Programs and the Part D LIS. Building cross-enrollment into the rules is the least burdensome way to ensure that people receive benefits to which they are entitled.

There are additional opportunities to streamline enrollment processes across programs. Benefit enrollment forms should be simplified as much as possible. While a universal application for benefits can be helpful, the burden is only reduced if that application is clear and concise and if applicants are not required to provide the same information again to complete enrollment. Another issue is that once information is submitted to an agency, it is difficult or impossible to verify that it was in fact associated with the enrollee's file. SSA and state Medicaid agencies still

primarily use fax, mail, or in-person delivery to receive documents. Yet documents routinely get lost or otherwise do not end up in the file or with the appropriate staff person. Often, applicants and their advocates have to make multiple calls and resubmit documents. Expanding online filing and ability to review records would make the application process easier and faster.

Use of prepopulated forms and only requesting information that is not already available to agencies are important to ease burdens on individuals. Allowing additional reasonable opportunities for self-attestation also can smooth enrollments and redeterminations.

Proving the value of assets, particularly non-monetary property, creates serious burdens on low-income individuals. The complexity of gathering documentation leads many to give up, even though in most cases the value of the assets is small. Eliminating asset tests, which usually requires legislation, greatly simplifies program administration.

Individuals with limited English proficiency face particular challenges in applying for or getting information about needed benefits. Although agencies offer interpreter services free of charge, accessing those services can be difficult. One simple challenge is getting through phone trees, which are becoming increasingly complex. It would be very helpful if every agency were to use the same prompt for Spanish (e.g., all agencies use "press 2") and also use a single universal prompt (e.g., "press 3") across agencies for access to interpreters for other languages beyond Spanish. Uniformity would make it easier to educate the public on how to access language services regardless of the agency they are calling. Within an agency, attaching an individual's interpreter needs to their file (and if possible to their phone number) would also facilitate interpreter access for repeat callers.

2. What has been your experience trying to use a government benefit or service that you are receiving? For example, how easy or difficult is it to use your food stamps, Medicaid health insurance, or Medicare health insurance? Do you have specific suggestions for reducing burdens in programs with which you have interacted?

Social Security and SSI

SSI's complex income and resource rules can be difficult for beneficiaries to understand and follow, which then leads to terminations, reductions, and overpayments. When such a problem occurs, the individual must then figure out how to navigate the complex appeal and overpayment waiver processes. One idea for reducing burdens is to eliminate the income rule that penalizes individuals for receiving help with food or shelter, which would reduce the reporting burden on individuals. Updating the overpayment waiver rules to make them less punitive and easier to use would also help to reduce burdens in that area.

The SSA administrative rule[1] permitting a $10/month repayment plan for overpayments if an individual is enrolled in the Part D Low Income Subsidy is one example of an administrative

[1] SSA POMS GN 02210.030(C).

procedure that could be streamlined. Currently SSA does not automatically apply this provision and a beneficiary must request it. Further, overpayment notices do not mention its availability and there is no protocol for SSA staff to routinely alert beneficiaries to the option. Since SSA administers the Low-Income Subsidy, the agency can easily identify who would benefit from this provision and could automatically apply it to them. At the very least, overpayment notices should highlight the option and SSA staff should alert affected individuals to its availability.

Medicare and Medicaid

With the proliferation of Medicare Advantage plans, narrow provider networks, prior authorization requirements and other restrictions can make it difficult for older adults to get care. For example, when prior authorization is required, it can delay care, especially if the initial request is denied. Analyses show that when MA plan denials of prior authorization are appealed, 82% are overturned.[2] Ensuring that prior authorization procedures are not over-used or mis-used should be a high priority

Accessing providers of covered services is another concern. Individuals who are in Qualified Medicare Beneficiary (QMB) program report frequent difficulties in finding Medicare providers, particularly specialists, who are willing to accept them as patients. As QMB participants, they are protected from payment of all Medicare deductibles and co-insurance for Part A and Part B services and their state Medicaid program takes on that responsibility. However, under current law, states have the option to pay the lesser of the Medicare approved amount or the Medicaid amount. As a practical matter, this "lesser of" policy results in most providers receiving no reimbursement of Medicare co-insurance. The result is that many Medicare providers refuse to see QMB patients. Modifying the lesser of policy would require statutory change.

Another provider access issue faces Medicaid enrollees it the impact of low provider payment rates on the number of providers willing to enroll in Medicaid. One area where this issue frequently arises in the Medicaid dental benefit where enrollees in many states report serious difficulties in finding any Medicaid provider or face unacceptably long wait times to get appointments. Both state Medicaid agency action and federal oversight of network availability are needed to address this issue.

Medicare-eligible individuals returning to the community after incarceration face many barriers to using their benefits, one of which is the current definition of being "in custody" used by the Medicare program. In 42 C.F.R 411.4(b), CMS broadly defines individuals in custody of penal authorities as "individuals who are under arrest, incarcerated, imprisoned, escaped from confinement, under supervised release, on medical furlough, required to reside in mental health facilities, required to reside in halfway houses, required to live under home detention, or confined completely or partially in any way under a penal statute or rule." The regulation assumes that

[2] KFF, Over 35 Million Prior Authorization Requests Were Submitted to Medicare Advantage Plans in 2021 (Feb. 2023).

correctional authorities have responsibility to cover, and will cover, medical expenses during all these circumstances, an assumption that is simply incorrect. Under this Medicare definition, a significant portion of Medicare-eligible individuals returning to the community find that their Medicare benefits in "suspension" and they cannot access any Medicare benefits to which they would otherwise be entitled. This causes serious gaps in access to urgently needed health care at a time when they most need a smooth transition.[3] Advocates have reported instances of individuals needing to postpone cancer treatment or scheduled surgery once they learned that, though enrolled in Medicare, the program had kept them in suspended status and would not pay for their treatment. Using this outdated and unrealistic definition frustrates other CMS efforts to improve health care for the justice-involved population.[4]

3. Have you experienced any unintended consequences from agencies' burden-reduction efforts? For example, have an agency's attempts to reduce one burden created others, either for members of the public or for agency officials?

Agency automation efforts can lead to unintended consequences that reduce the usability for individuals seeking assistance, sometimes due to the experience of these individuals not being fully considered in the development of the automation. Having community members and partners involved the planning process can help to catch some of these issues before the automation is rolled out.

In making decisions on automation, if there is a conflict between reducing the burden on the person seeking assistance and reducing the burden on the agency, efforts should be made to prioritize reducing the burden on the person seeking assistance.

4. Are you aware of specific, temporary burden reductions instituted during the COVID-19 pandemic that you believe should be made permanent? This can include (and please specify, if possible) burden-reduction efforts that agencies can implement under current statutes as well as those that would require statutory changes.

Social Security and SSI

The Social Security Administration instituted a number of temporary burden reductions during the pandemic, including deferring processing adverse actions for a period of time, allowing

[3] In contrast, the Medicaid program allows Medicaid coverage for individuals "on parole, probation, or released to the community pending trial; living in a halfway house where individuals can exercise personal freedom; voluntarily living in a public institution; or on home confinement." Vikki Wachino, State Health Official Letter Re: To Facilitate successful re-entry for individuals transitioning from incarceration to their communities (CMS, SHO #16-007, April 28, 2016), available at www.medicaid.gov/sites/default/fles/Federal-Policy-Guidance/ Downloads/sho16007.pdf.

[4] See, e.g., HHS Approves California's Medicaid and Children's Health Insurance Plan (CHIP) Demonstration Authority to Support Care for Justice-Involved People | CMS and the newly effective Medicare Special Enrollment Period for Formerly Incarcerated Individuals, 42 C.F.R. § 407.23(d).

pandemic-related issues to be good cause for late filing of an appeal, and allowing the use of electronic signatures. SSA should consider which of these burden reductions should be made permanent. For example, providing an electronic signature option can help update SSA processes to better reflect how community members are increasingly using technology.

Unexpected crises will occur again in the future, and SSA should use the lessons learned from the pandemic to plan for temporary flexibilities to help individuals harmed during periods of delay. For example, the average wait time for an initial disability determination has steadily increased throughout the pandemic from four months to over seven months currently.[5] These processing delays cause personal hardship for individuals in need, and they also have other spillover effects. For example, if someone's disability benefits ended because they worked and had earnings, they can ask SSA to start their benefits again without having to complete a new application, and get provisional (temporary) benefits for up to six months while SSA decides if they can receive disability benefits again ongoing. That six-month provisional benefit period makes more sense when the average wait time for an initial disability determination is four months, but does not make sense when the average is over seven months as it is now. Until these delay issues are resolved and to plan for other similar situations in the future, the disability program rules should be updated to allow for increasing the provisional benefit period.

Medicare and Medicaid

Both CMS and states instituted numerous waivers and flexibilities during the pandemic that eased burdens for people with Medicare and Medicaid. For example, CMS waived the three-day hospital stay requirement for Medicare coverage of skilled nursing facility stays. This waiver eliminated a barrier that causes confusion, unnecessarily long hospital stays, and worse outcomes by allowing for smoother and faster transitions between hospitals and nursing facilities.

State Medicaid programs implemented waivers that eased home- and community-based services (HCBS) eligibility, enrollment and service delivery. For example, many states allowed virtual evaluations and level of care assessments and extended the time before reassessments; allowed electronic signatures; and authorized telehealth for many services. While it is critical to not *replace* in-person assessments and services with electronic methods, continuing these flexibilities, can help facilitate faster access to critical services and avoid disruptions due to delays in paper work.

Prior to the pandemic, Medicaid eligibility redeterminations often improperly ended coverage for older adults who remained eligible. These improper terminations result both from computer system errors and from the paperwork burden that requires older adults to verify both income and assets. As the Medicaid continuous eligibility requirements come to an end, states should

[5] USAFacts, Wait times to receive Social Security disability benefit decisions reach new high (Published January 12, 2023, updated March 03, 2023)

be working to permanently implement policies and processes that reduce burdens, such as using existing data sources to verify income, allowing self-attestation for asset verification, and minimizing the frequency of redeterminations.

5. Are there existing legal impediments that have slowed or stopped efforts to identify or reduce burdens? If so, please describe examples, especially those that you believe would have the greatest burden-reduction impact.

Older adults have to navigate multiple agencies to access benefits. It is a burden in and of itself to understand where to go for what. For example, SSA processes Medicare enrollment, premiums, and Part D Low-Income Subsidy (LIS) applications, whereas CMS oversees Medicare benefits, Medicare Advantage and Part D plan enrollment, and appeals. Eliminating the gaps and silos between SSA and CMS could reduce these navigation burdens for individuals. For example, improving data collection and sharing between SSA, CMS, and states (for people dually enrolled in Medicaid) could ease paperwork burdens, eliminate enrollment lags, and help ensure people with limited income get enrolled in LIS and Medicare Savings Programs.

Data collection provides important background information to understand administrative burdens and how to reduce them in an effective and equitable way. This includes race and ethnicity data, as well as language access data. This data in conjunction with other agency data may help to identify areas where individuals seeking assistance experience increased burdens.

6. What has been your experience regarding collaborations between agencies and other public- and private-sector organizations when trying to reduce burdens. Please describe whether these collaborations were successful and describe any factors (e.g., statutory, organizational, other) that either enhanced or impeded the collaboration.

SSI and Social Security

Collaborations between SSA and public and nonprofit entities can be very helpful in increasing access to SSA benefits for those who qualify, and especially for those who face additional barriers that make it challenging for them to complete the application and appeal process. This includes collaborations with community agencies that are helping underserved individuals to apply for SSI and Social Security benefits. Where these collaborations have existed, SSA's involvement was instrumental to the success of the collaboration in providing training to partners, points of contact to resolve issues, and regular meetings that helped to ensure communication and to increase the effectiveness of the collaboration. Increasing collaborations would help to reduce burdens for the individuals served as part of the collaboration, and would also help with identifying administrative burdens that could be reduced or eliminated in order to reduce burdens for everyone seeking assistance.

Medicare and Medicaid

Similar collaborations between state Medicaid offices, regional Medicare offices and community-based organizations could help people navigate complex Medicare and Medicaid applications, coverage issues and appeals. Medicare SHIP counselors are a good example of a successful federally-funded program. Expanding these programs, especially to partner with organizations that serve limited English proficient and other marginalized communities would help ensure culturally appropriate support for older adults navigating Medicare and Medicaid.

7. What role can private-sector groups play in helping to reduce burdens, and how can government agencies encourage such actions? For example, how might regulations on access and sharing of personal financial data be structured to encourage private-sector groups to provide tools to reduce burdens that members of the public experience when they apply for, engage with, or participate in federal programs?

CMS has encouraged Medicare Advantage plans to help their members with Medicaid redeterminations and there has been some success with those efforts. There may be more data exchange that would be helpful with that process.

We have seen with Medicaid redeterminations during the unwinding of the public health emergency that pharmacies and other private players have been helpful with posting notices reminding individuals to update their addresses and watch their mail. Many Medicare and Medicaid enrollees visit their pharmacies often and have a trusting relationship with them. It would be worth exploring additional ways to partner with pharmacies.

Thank you for the opportunity to provide these comments. If there are questions concerning this submission, please contact Trinh Phan at TPhan@justiceinaging.org and Natalie Kean at nkean@justiceinaging.org.

Respectfully submitted,

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