May 22, 2018

The Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

**Re: AHCCCS's Proposed Amendment Section 1115 Waiver to Eliminate Retroactive Coverage**

Thank you for the opportunity to comment on Arizona Health Care Cost Containment System's (AHCCCS) proposed amendment to the AHCCCS 1115 Demonstration. The amendment seeks to eliminate three-month retroactive coverage for all Medicaid beneficiaries. The undersigned organizations strongly support Medicaid's retroactive coverage protection, and our comments address the shortcomings of AHCCCS's proposal with specific focus on how the proposal would harm older Arizonans who rely on Medicaid-funded long-term services and supports (LTSS). As explained below, AHCCCS's proposal does not meet the requirements for approval of an 1115 waiver as it does not test a proposition nor promote the objectives of federal Medicaid law. Consequently, CMS must deny AHCCCS's request.

Without Retroactive Coverage, Unavoidable Delays Will Deprive Low-Income Persons of Needed Coverage.

When the retroactive coverage guarantee was established in 1972, the Senate Finance Committee noted that the provision would "protect[] persons who are eligible for [M]edicaid but do not apply for assistance until after they have received care, either because they did not know about the [M]edicaid eligibility requirements or because the sudden nature of their illness prevented their applying."[1] This statement is just as true now as it was 45 years ago, and Congress has continued to support such coverage by rejecting recent legislative efforts to eliminate this protection.[2]

In many instances, a person in need of health care cannot be expected to apply for Medicaid coverage at the exact moment they become eligible. They may be hospitalized after an accident or unforeseen medical emergency. They may also be unfamiliar with Medicaid, or unsure about when their declining financial resources might fall within the Medicaid eligibility threshold. However, under the proposal, a person could be hit by an uninsured driver on the evening of April 29 and be liable for thousands of dollars of hospital expenses due to the "failure" to file a Medicaid application within 36 hours, when April becomes May. The three-month retroactivity window is a rational and humane response to these concerns. We note and emphasize that

[1] Senate Report No. 92-1230, at 209 (Sept. 26, 1972) (discussing section 255 of H.R. 1).
[2] *See* H.R. 1628, 115th Cong. § 114(b) (2017); H.R. 180, 115th Cong. § 1 (2017); H.R. 5626, 114th Cong. § 1 (2016); S. Amdt. 270 to S. Amdt. 267, 115th Cong., Tit. I of Better Care Reconciliation Act of 2017, § 127(a) (2017), in 163 Cong. Rec. S4196, S4205 (July 25, 2017).

retroactive eligibility is only available to persons who meet Medicaid eligibility standards for the month[s] in question.[3]

Retroactive Coverage Is Vital for Persons Needing Nursing Facility Care or Other LTSS.

We have extensive experience with persons who need nursing facility care or other LTSS. The need for these services may arise unexpectedly and when the person needing care and their families are already experiencing the stress of dealing with either a sudden or a prolonged illness. In some instances, families provide the bulk of needed services at home up until family caregivers are physically, emotionally, and financially exhausted. Alternatively, persons may be discharged directly to a nursing facility from a hospital after an emergency, such as a stroke or fall. In either situation, the transition to a nursing facility can be a confusing, overwhelming process for both the nursing facility resident and their family.

Many older adults and their families assume nursing facility care will be covered by Medicare.[4] They do not realize that Medicare coverage of skilled nursing facilities is restricted to follow-up of hospital admissions of more than three days, and limited to a maximum of 100 days, though often cut off much sooner.[5] Furthermore, many people are not familiar with Medicaid, nor do they know whether the resident meets eligibility requirements. Even if the need for Medicaid coverage is clearly understood, submitting an application may not be a simple process. Medicaid eligibility rules are complex, and the resident's finances may not be well organized. It can take a significant amount of time for a resident and/or family to put an application together. For instance, an application may require submission of five years of bank records. This is not an easy task, particularly for a nursing facility resident who may well have Alzheimer's disease or another dementia.

Thus, if AHCCCS's proposal were implemented, many low-income Arizonans likely would be saddled with unaffordable health care bills. Similarly, many Arizonans would not receive care in the first place. A nursing facility or other provider will require assurance that payment will be made. Absent retroactive coverage, facilities might very well deny care. Delaying nursing facility admission and other LTSS would endanger fragile elders and persons with disabilities, and in many cases would lead to bloated hospital stays, since the hospital would be unable to find an alternative placement at time of discharge.

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[3] 42 U.S.C. § 1396a(a)(34).

[4] *See, e.g.*, T. Thompson et al., Associated Press-NORC Ctr. or Public Affairs Research, *Long Term Care: Perceptions, Experiences, and Attitudes Among Americans 40 or Older* 7 (2013) (survey shows Americans "overestimate the long-term care services that Medicare will cover"), *available at* www.apnorc.org/PDFs/Long%20Term%20Care/AP_NORC_Long%20Term%20Care%20Perception_FINAL%20REPORT.pdf.

[5] 42 C.F.R. §§ 409.30(a), 409.31(b), 409.32, 409.61(b). In 2016, the average length of stay under Medicare was only 27.6 days. Medicare Payment Advisory Commission (MedPAC), A Data Book: Health Care Spending and the Medicare Program 112, Chart 8-4 (June 2016), *available at* www.medpac.gov/docs/defaultsource/data-book/june-2016-data-book-health-care-spending-and-the-medicare-program.pdf.

The Proposed Waiver Would Not Test Any Acceptable Premise, and Would Not Assist in Promoting the Medicaid Program's Objectives.

Section 1115 requires an "experimental, pilot, or demonstration project … [that] is likely to assist in promoting the objectives" of the Medicaid program. AHCCCS's proposal fails to meet these standards. Without identifying what it is trying to test by eliminating prior quarter coverage, AHCCCS states that the proposal would promote the objectives of Medicaid by "(1) encouraging members to obtain and continuously maintain health coverage, even when healthy; (2) encouraging members to apply for Medicaid without delays to promote continuity of eligibility and enrollment for improved health status; and (3) containing Medicaid costs."[6]

The application could be read to imply that AHCCCS intends to test whether elimination of retroactive coverage would encourage Arizonans to maintain coverage and apply for Medicaid as soon as they are eligible, but such a test would be contrary to the Medicaid program's objective to protect low-income persons who otherwise cannot afford needed health care. First, private insurance coverage is out of reach financially for persons who meet Medicaid financial eligibility standards. Crucially, retroactive coverage only applies in months *when the person cannot afford to pay for health care or commercial health insurance*. Second, as discussed above, even if a person is able to start preparing an application for Medicaid as soon as they are eligible, the process may take weeks or months. Thus, without retroactive coverage, even those who apply for Medicaid as soon as possible are likely to experience gaps in coverage. The only "benefit" to the state of this proposal is a reduction in Medicaid expenditures, but that reduction is accomplished by denying health care coverage to persons who desperately need it. Waivers should be used to improve coverage, not to leave Medicaid-eligible persons without coverage. A simple benefit cut is not a legitimate foundation for approval of this proposal.[7]

[6] Arizona Health Care Cost Containment System, Arizona Section 1115 Waiver Amendment Request: Proposal to Waive Prior Quarter Coverage, at 3 (April 6, 2018). We note that, as indicated in the appendices to this request, an earlier draft waiver request stated that a purpose of this proposal is "[t]o better align Medicaid policies with commercial health insurance coverage."[6] This rationale makes little sense, given the substantial differences between Medicaid and commercial insurance. The principal difference is the fact that commercial insurance relies on premium payments, while Medicaid coverage is based upon a determination that a person has limited financial resources and thus cannot afford private coverage. Retroactive coverage is not allowed in commercial insurance because the program's financing relies on premium payments in advance, before a person knows the medical services that he or she may require in any particular month. The same is not true in Medicaid, which does not require premiums from its low-income beneficiaries. *Id.* at 32, 37.

[7] *See, e.g.*, Beno v. Shalala, 30 F.3d 1057, 1069-71 (9th Cir. 1994).

Conclusion

Thank you for consideration of our comments. We urge CMS to reject this amendment given the harm to Medicaid beneficiaries and the lack of meaningful rationale provided by AHCCCS. AHCCCS's proposal does not meet the statutory standards for waiver under Section 1115.

Sincerely,

Aging Life Care Association
Center for Medicare Advocacy
Community Catalyst
Disability Rights Education & Defense Fund
The Jewish Federations of North America
Justice in Aging
Medicare Rights Center
National Academy of Elder Law Attorneys
National Adult Day Services Association (NADSA)
National Association of Area Agencies on Aging (n4a)
National Association for Home Care and Hospice
National Association of Long-Term Care Ombudsman Programs
National Association of Social Workers (NASW)
National Consumer Voice for Quality Long-Term Care
Program to Improve Eldercare, Altarum