

June 5, 2018

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

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

Thank you for the opportunity to comment on the Florida Agency for Health Care Administration's proposed amendment to its 1115 Managed Medical Assistance Waiver. The amendment seeks to eliminate three-month retroactive coverage for non-pregnant Medicaid beneficiaries age 21 and older. The undersigned organizations strongly support Medicaid's retroactive coverage protection, and our comments address the shortcomings of Florida's proposal with specific focus on how the proposal would harm older Floridians who rely on Medicaid-funded long-term services and supports (LTSS). As explained below, Florida'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 Florida'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."<sup>1</sup> 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.<sup>2</sup>

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

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<sup>1</sup> Senate Report No. 92-1230, at 209 (Sept. 26, 1972) (discussing section 255 of H.R. 1).

<sup>2</sup> 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.<sup>3</sup>

Florida's waiver amendment request states that in the 2015-2016 fiscal year, less than 1% of all Florida Medicaid recipients were made retroactively eligible.<sup>4</sup> This seems to imply that the impact of eliminating retroactive eligibility would be small. We disagree. While the majority of Medicaid recipients may not utilize retroactive coverage, the impact would be enormous on each individual who needs retroactive eligibility but would not have access to it.

### 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.

We take particular issue with the state's assertions that removing retroactive coverage "cannot accurately be described as a 'cut'" and that "Most individuals who have services paid for during the retroactive period already qualify for Medicaid and would be enrolled if they had applied."<sup>5</sup> First, eliminating retroactive eligibility is cutting coverage for people who are Medicaid eligible. As noted above and the state itself recognizes, this protection does not apply unless the person was in fact eligible for Medicaid.

Second, expecting every person in any situation to apply for Medicaid as soon as they are eligible is unrealistic. The retroactive coverage protection exists because instantaneous Medicaid applications are unrealistic and, in many cases, impossible. This is particularly true for people needing nursing facility care. Many older adults and their families assume nursing facility care will be covered by Medicare.<sup>6</sup> 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

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<sup>3</sup> 42 U.S.C. § 1396a(a)(34).

<sup>4</sup> Florida Agency for Health Care Administration, Managed Medical Assistance Waiver Amendment Request—Low Income Pool and Retroactive Eligibility, at 15 (April 27, 2018), available at [www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-mma-pa2.pdf](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-mma-pa2.pdf).

<sup>5</sup> *Id.* at 7.

<sup>6</sup> 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](http://www.apnorc.org/PDFs/Long%20Term%20Care/AP_NORC_Long%20Term%20Care%20Perception_FINAL%20REPORT.pdf).

limited to a maximum of 100 days, though often cut off much sooner.<sup>7</sup> 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 is not 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 Florida's proposal were implemented, many low-income Floridians likely would be saddled with unaffordable health care bills. Even more, many Floridians 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.

#### 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. Florida's proposal fails to meet these standards. Without identifying what it is trying to test by eliminating prior quarter coverage, Florida states that the proposal's objective is to "enhance fiscal predictability."<sup>8</sup> But fiscal predictability is not an objective of the Medicaid program.

The application could be read to imply that Florida intends to test whether elimination of retroactive coverage would encourage Floridians 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. Furthermore, 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. Finally, 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*.

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<sup>7</sup> 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](http://www.medpac.gov/docs/defaultsource/data-book/june-2016-data-book-health-care-spending-and-the-medicare-program.pdf).

<sup>8</sup> Florida Agency for Health Care Administration, Managed Medical Assistance Waiver Amendment Request—Low Income Pool and Retroactive Eligibility, at 15 (April 27, 2018), *available at* [www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-mma-pa2.pdf](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-mma-pa2.pdf).

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. Florida stakeholders agree, as evidenced by the summary of public comments the state received all opposing this proposal.<sup>9</sup> A simple benefit cut is not a legitimate foundation for approval of this proposal.<sup>10</sup>

### 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 Florida. Florida’s proposal does not meet the statutory standards for waiver under Section 1115.

Sincerely,

Aging Life Care Association®  
Autistic Self Advocacy Network (ASAN)  
Center for Medicare Advocacy  
Disability Rights Education and Defense Fund (DREDF)  
The Jewish Federations of North America  
Justice in Aging  
National Academy of Elder Law Attorneys  
National Adult Day Services Association (NADSA)  
National Association for Home Care and Hospice  
National Association of Social Workers (NASW)  
NASW Florida Chapter  
National Association of State Long-Term Care Ombudsman Programs (NASOP)  
National Consumer Voice for Quality Long-Term Care  
National Disability Rights Network  
Medicare Rights Center  
Program to Improve Eldercare, Altarum

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<sup>9</sup> *Id.* at 20-23.

<sup>10</sup> *See, e.g.,* *Beno v. Shalala*, 30 F.3d 1057, 1069-71 (9<sup>th</sup> Cir. 1994).