

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

September 11, 2020

The Honorable Alex Azar
Secretary, U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Submitted electronically via [Medicaid.gov](https://www.Medicaid.gov)

Re: Opposition to Florida's Request to Extend its Wavier of Retroactive Eligibility

Justice in Aging appreciates the opportunity to comment on the Florida Agency for Health Care Administration's (AHCA) proposal to extend its Managed Medical Assistance (MMA) demonstration waiver project under section 1115 of the Social Security Act. Our comments focus on our opposition to the proposed extension of the waiver of the federal protection that provides up to three months of retroactive Medicaid coverage for MMA program enrollees.

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older Floridians and older adults nationwide. We use 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, particularly populations that have been marginalized and excluded from justice such as women, people of color, LGBTQ individuals, and people with limited English proficiency. We have decades of experience with Medicaid and working with advocates who represent low-income older adults. Justice in Aging conducts trainings and engages in advocacy regarding Medicare and Medicaid, provides technical assistance to attorneys in Florida and across the country on how to address problems that arise under these programs, and advocates for strong consumer protections at both the state and federal level.

We have cited research demonstrating the harms of these proposals and we respectfully request that the Centers for Medicare & Medicaid Services (CMS) review each of the sources cited and made available to the agency through active hyperlinks. We further request that the full text of each of the sources cited, along with the full text of our comments, be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act.

[Waiving Retroactive Eligibility Deprives Low-Income Floridians of Coverage](#)

The state's elimination of Medicaid's three-month retroactive coverage protection harms the health and financial well-being of Floridians who are in fact eligible for Medicaid. This cut also harms providers and the state by increasing the uncompensated care burden, an impossible burden for individuals, hospitals, and the state to bear amid a public health crisis.

Retroactive coverage is a long-standing safeguard built into the Medicaid program. When Congress established the retroactive coverage guarantee in 1972, the Senate Finance

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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.

A person in need of health care cannot be expected to make an instantaneous application for Medicaid coverage.² 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. The three-month retroactivity window is a rational and humane response to these concerns, and ensures that people who are facing unexpected or unaffordable health care can get their bills paid, both before they are aware of the need and their eligibility and while their Medicaid application is being prepared.³ We emphasize that retroactive eligibility is only available to persons who meet Medicaid eligibility standards for the months in question.

The impossibility of instantaneous Medicaid applications is always the case for individuals who become eligible for Medicaid based on needing nursing facility care or other long-term services and supports (LTSS). These applications are complex and cannot be completed until after both the functional and financial eligibility criteria are met and documented. It can take weeks, or even months, for an individual and their loved ones to consider how their care will be paid for, and additional weeks or months to prepare a Medicaid application and be approved because the application requires gathering bank records and other information about assets that may not be readily available. For example, in Iowa, the average application for a nursing home resident takes 71 days to assemble, file and be approved.⁴

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, individuals 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. This is especially true for older adults with dementia, a common reason people need nursing facility care.

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

² Justice in Aging, Medicaid Retroactive Coverage: What’s at Stake for Older Adults When States Eliminate this Protection? (Sept. 2019), <https://www.justiceinaging.org/wp-content/uploads/2019/09/Medicaid-Retroactive-Coverage-Issue-Brief.pdf?eType=EmailBlastContent&eld=a7bb9cdd-1ce1-4012-b154-7981533a4875>.

³ Kaiser Family Foundation, Medicaid Retroactive Coverage Waivers: Implications for Beneficiaries, Providers, and States (Nov. 2017), www.kff.org/medicaid/issue-brief/medicaid-retroactive-coverage-waivers-implications-for-beneficiaries-providers-and-states/.

⁴ Harris Meyer, Medicaid Non-Emergency Medical Transportation: Overview and Key Issues in Medicaid Expansion Waivers, *Modern Healthcare* (Feb. 9, 2019), www.modernhealthcare.com/article/20190209/NEWS/190209936/new-medicaid-barrier-waivers-ending-retrospective-eligibility-shift-costs-to-providers-patients.

In addition, many older adults and their families assume nursing facility care will be covered by Medicare.⁵ 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.⁶

Without the three-month retroactive coverage protection, low-income Floridians who need nursing home care are at risk of being denied entry. According to AHCA, over 70% of retroactive payments prior to this waiver being implemented were for services provided through institutions such as hospitals, nursing homes and hospices.⁷ A nursing facility or other provider requires assurance that payment will be made. Absent retroactive coverage, facilities might very well deny care. Delaying nursing facility admission endangers older adults and people with disabilities with fragile health, and in many cases leads to bloated hospital stays, since the hospital would be unable to find an alternative placement at time of discharge.

This protection is equally critical for low-income older adults living at home. In Florida, an older adult under age 65 cannot become eligible for Medicaid until they experience a medical emergency or their prolonged illness reaches a point where they have become disabled. The point that triggers Medicaid eligibility is impossible to predict and a person who needs health care in these situations cannot be expected to apply for Medicaid coverage at the exact moment they become eligible: they may be hospitalized for COVID-19 or after an accident; they may be struggling to cope with the shock of a diagnosis or sudden decline in functional ability; they may also be unfamiliar with Medicaid, or unsure about when their declining financial resources might fall within the Medicaid eligibility threshold. Right now, people who are becoming eligible for the first time after losing a job are simultaneously dealing with unprecedented financial and health issues, childcare obligations, and multiple other pressing needs. The impossibility of an immediate Medicaid application has never been more apparent.

This is exactly what happened to George after he moved to Florida to be closer to his daughter.⁸ In late January 2020, George suffered a heart attack and was rushed to the hospital. He filed a Medicaid application in February, but could not get coverage for the \$62,000 hospital bill for

⁵ 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.

⁶ 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.

⁷ Fla. Agency for Health Care Administration, *Florida Medicaid Retroactive Eligibility Legislative Report* (Jan. 10, 2020), www.ahca.myflorida.com/Medicaid/recent_presentations/2020/Retroactive_Eligibility_Report_20200110.pdf.

⁸ <https://www.floridahealthstories.org/george>

charges incurred just a few days earlier in January. Now George is faced with the stress of managing medical debt while trying to recover.

Finally, AHCA has not considered the effect the COVID-19 pandemic is having on Floridians' need and ability to apply for Medicaid as soon as they are eligible. The pandemic is most harshly impacting the communities who are also most likely to need retroactive Medicaid coverage—that is people of color who have limited income and wealth, are more likely to be uninsured and more likely to have medical debt, and who are most at risk of contracting and becoming seriously ill from COVID-19 due to poorer health and other effects of systemic racism.⁹ This includes older adults and people with disabilities who may need LTSS weeks or months before a complicated Medicaid application can be filed.

AHCA's Extension Request Exceeds its Authority

AHCA is seeking to extend the waiver of retroactive eligibility three years beyond the temporary extension period ending June 30, 2021 authorized by the state legislature. Thus, AHCA's waiver request to extend this cut through June 30, 2024, is without legislative authority and CMS should not approve it.

Moreover, the state has failed to evaluate the effect of eliminating retroactive eligibility on low-income Floridians or providers, as required by the state legislature and federal demonstration waiver authority. When deciding to temporarily extend the waiver through June 2021 instead of making the cut permanent, the legislature once again directed AHCA to submit a report on the impact by March 2021. Clearly, the legislature did not want to authorize a longer term or permanent rollback of this protection without understanding its impact. In addition, CMS cannot approve this extension because it does not meet the agency's evaluation requirements for the retroactive coverage waiver.¹⁰ The extension application does not include any findings on retroactive coverage, stating that AHCA will conduct evaluation of this aspect of the waiver in the future.¹¹ A plan to evaluate is not the same as an evaluation. Without an evaluation, CMS does not have the information it needs to determine whether the demonstration promotes the objectives of the Medicaid program. Therefore, an extension is at the very least premature, especially given that the current waiver is not set to expire until 2022.

⁹ See, e.g., Jacqueline Wiltshire et al., Medical Debt and Related Financial Consequences Among Older African American and White Adults, *AM. JOURNAL OF PUBLIC HEALTH* (2016), available at www.ncbi.nlm.nih.gov/pmc/articles/PMC4880274/ (concluding that "African Americans incur substantial medical debt compared with Whites, and more than 40% of this is mediated by health status, income, and insurance disparities").

¹⁰ 42 CFR 431.412(c)(vi); see also Medicaid.gov, 1115 Application Process, www.medicaid.gov/medicaid/section-1115-demonstrations/1115-application-process/index.html (1115 waiver extension applications must include: "An evaluation report of the demonstration, including evaluation activities and findings to date, plans for evaluation activities during the extension period, and if changes are requested, identification of research hypotheses related to the changes and an evaluation design for addressing the proposed revisions.")

¹¹ Fla. Agency for Health Care Administration, Managed Medical Assistance Waiver Extension Request, at 30-31 (July 29, 2020), <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/fl-mma-pa4.pdf>

The Waiver 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. Medicaid’s primary objective is to furnish medical assistance to low-income persons.¹² The waiver of retroactive coverage does not promote that objective. In fact, it actually reduces coverage for thousands of low-income Floridians, especially older adults.

In its waiver extension request, AHCA continues to cite “fiscal predictability for the State.” However, cutting costs is a misconception when it comes to retroactive coverage. In reality, eliminating retroactive coverage increases spending elsewhere, including for older adults who forego preventative care and routine services and are more likely to require emergency or institutional care in the future. Moreover, not providing retroactive coverage leads to unsurmountable debt for individual Floridians and increases uncompensated care burden on providers. In addition, reducing Medicaid expenditures is antithetical to the purpose of the Medicaid program, which is to furnish assistance to low-income persons who otherwise cannot afford needed health care. Even if waiving retroactive coverage may save the state some amount of money, this “goal” does not legitimize a Section 1115 demonstration project because that reduction in spending is accomplished by denying health care coverage to people who desperately need it.

AHCA also states that eliminating retroactive coverage “encourages Medicaid recipients to obtain and maintain health coverage, even when healthy, or to obtain health coverage as soon as possible after becoming eligible (if eligibility depends on a finding of disability or a certain diagnosis).”¹³ However, this does not accurately reflect access to Medicaid in Florida. First, individuals like George cannot obtain health coverage when they are healthy because Florida has not expanded Medicaid. And many older adults who become sick would not be eligible no matter how little income they have. Additionally, 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, retroactive coverage is not a well-known benefit because it is unique to Medicaid and is precisely available to people who are not already enrolled. Thus, AHCA’s implication that Floridians who have a disability or diagnosis making them eligible for Medicaid were purposely delaying their application because they were aware of retroactive coverage is not a plausible rationale for utilizing this benefit.

Conclusion

Justice in Aging opposes Florida’s proposal to extend its waiver of retroactive coverage. We urge CMS to reject this amendment given the harm to Medicaid beneficiaries and the lack of meaningful rationale provided by Florida. Waivers should be used to improve coverage, not to leave Medicaid-eligible individuals without coverage. Florida’s proposal does not meet the statutory standards for waiver under Section 1115.

¹² See 42 U.S.C. § 1396-1; *Stewart v. Azar*, 366 F. Supp. 3d 125, 131 (D.D.C. 2019); *Gresham v. Azar*, 363 F. Supp. 3d 165, 169 (D.D.C. 2019); *Stewart v. Azar*, 313 F. Supp. 3d 237, 243 (D.D.C. 2018).

¹³ MMA Extension Request at 7.

Thank you for the opportunity to comment. If any questions arise concerning this submission, please contact Natalie Kean, Senior Staff Attorney, at nkean@justiceinaging.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Jennifer Goldberg". The signature is fluid and cursive, with a long horizontal stroke at the end.

Jennifer Goldberg
Deputy Director