June 15, 2013

Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

[Submitted Electronically]

Re: CMS 2392-P “Medicaid Program; Mechanized Claims Processing and Information Retrieval Systems (90/10)”

Dear Mr. Slavitt:

The American Health Care Association (AHCA) and the National Center for Assisted Living (NCAL) appreciate the opportunity to comment on the proposed rule, CMS 2392-P “Medicaid Program; Mechanized Claims Processing and Information Retrieval Systems (90/10)” (73 Federal Register 20455, April 16, 2015) (hereinafter referred to as the “Proposed Rule”). In our comments, we highlight some existing challenges in the eligibility determination process for the aged, blind, and disabled (ABD) populations and offer suggestions CMS might consider to achieve a truly streamlined and seamless approach to Medicaid eligibility determinations for all populations eligible for the program.

AHCA/NCAL represents nearly 13,000 non-profit and for-profit providers dedicated to continuous improvement in the delivery of professional and compassionate care for our nation’s citizens who are frail, elderly, or have developmental disabilities (DD) who live in nursing centers, assisted living residences, post-acute care centers, and homes for persons with DD.

Overview

AHCA/NCAL lauds any effort aimed at improving state eligibility and enrollment systems. However, eligibility systems that enroll the ABD populations have received considerably less attention than other categorical eligibility groups’ eligibility systems and processes.

AHCA/NCAL urges CMS to provide clearer guidance to states on how eligibility for modified adjusted gross income (MAGI) exempt populations should be included in
system upgrades made possible by the enhanced funding in this proposed rule. This would help to streamline the eligibility process and address current state capacity problems associated with determining eligibility for ABD populations as well as persons who are Medicare-Medicaid eligible.

**Existing Medicaid ABD Eligibility Challenges**

According to the Congressional Budget Office (CBO), out of a total Medicaid enrollment of about 66 million people in 2015, approximately 5 million are aged and 9 million are blind and/or have some form of disability, with these numbers expected to increase in the coming years. Although these numbers suggest the proportion of Medicaid ABD enrollees is small compared to other Medicaid populations, ABD-related expenditures reflect the high health care needs of this population. The average federal spending on benefits in 2015 is expected to be $10,080 per older adult enrollee and $13,230 per enrollee with a disability. Non-ABD expenditures were less than half ABD costs during this same time period.

In order to qualify for Medicaid, potential enrollees must meet qualifications that can differ in a variety of ways from state to state. This means that potentially eligible individuals must fit into one of the many eligibility categories allowed in federal statute, as well as meet the income and asset criteria for these pathways defined by states. And, in order to access long term services and supports (LTSS), such as nursing center and home and community based services, individuals must also meet level of care criteria established by the state in order to qualify for Medicaid enrollment.

Other key state decisions that affect eligibility for ABD populations include:

- **Whether or not to have a “medically needy” program**, allowing certain individuals with high healthcare costs to spend down to a financial eligibility level set by the state; and

- **Methods of treating assets**. For example, approximately eight states have dropped asset tests for Medicare Savings Programs (MSP) beneficiaries to ease the eligibility for assistance with drug benefits since the enactment of the Medicare drug benefit. However, most states continue to apply an asset test to nearly all who are potentially eligible through ABD pathways. The Deficit Reduction Act of 2005 (DRA) notably expanded the scope of state asset verification requirements, however little research is available on the impact of these changes.

Some of the determinations that affect Medicaid eligibility are made outside of the state Medicaid agency. For example, in most states judgments about whether individuals meet definitions of disability that involve measures of income, functional status, and sometimes the ability to work are the responsibility of the Social Security Administration (SSA), which in turn delegates some of this work to state disability determination units that are separate from Medicaid program administration. In addition, many ABD enrollees qualify for Medicaid because they are eligible for the federal Supplemental Security Income (SSI) cash assistance program administered by the SSA. In all but 11 states, individuals receiving SSI automatically qualify for Medicaid (though some states
still conduct their own eligibility determinations for this population). Many states have noted the operational challenges with coordinating collection of financial and functional information for purposes of ABD eligibility determination as well as ongoing challenges with SSA data exchange. Additional special programs, waivers, and other pathways to eligibility further complicate eligibility processes for older adults and persons with disabilities, as detailed in a June 2011 Congressional Research Service Report.

While states have made significant progress and improvements to eligibility and enrollment systems as a result of changes required and funding made available through the Affordable Care Act (ACA), such simplifications have not been expanded to all persons seeking Medicaid. The requirements for extensive financial and functional assessments for the ABD population, as well as the involvement of multiple agencies, have confounded attempts to address ABD eligibility. These challenges include long lags between application and final decisions about eligibility, especially for determinations of disability and level of care, as well as lapses in services when beneficiaries must re-certify eligibility.

In addition, managed care can create an additional layer of administrative complexity for both states and providers related to eligibility determinations specific to nursing center care.

Streamlining of Medicaid Eligibility Processes

As stated earlier in this comment letter, AHCA/NCAL supports the efforts taking place at the federal and state levels to improve, simplify, and streamline the Medicaid eligibility determination and enrollment process. We remain concerned, however, that while these are much needed improvements, ultimately Medicaid eligibility systems will continue to be siloed in the years to come because so much of the focus regarding systems improvements related to eligibility determinations for MAGI populations, not the MAGI-exempt populations.

We recognize CMS’ hard work with ACA implementation. However, AHCA/NCAL strongly urges CMS to work with the states to also modernize ABD eligibility systems to help ensure that all Medicaid eligible individuals are able to easily enroll and re-enroll in the program, and do so in a timely manner. In finalizing the Proposed Rule, CMS should consider the following comments:

- How electronic systems can integrate information on assets, annuities, and functional status measures. In many states financial eligibility and functional eligibility are maintained in separate systems. We urge CMS to provide guidance on how such information could be better integrated to streamline eligibility and recertification;

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1 In 32 states and the District of Columbia, the application for SSI and Medicaid are the same, while 7 states require a separate Medicaid application but use the SSI eligibility criteria to determine Medicaid eligibility.
• **The potential benefits of using the MAGI methodology to simplify ABD applications.** We recognize that CMS has pointed out that Section 1902(r)(2) and Section 1115 demonstration waivers could be used for such an endeavor. However both avenues are complex. We urge CMS to identify more straight forward paths to using MAGI methodology to simplify ABD application; and

• **Options for simplifying enrollment for some portions of the ABD population before others, including the most efficient sequencing of change so that actions build upon each other.** Specifically, we suggest screening people for potential eligibility for MAGI-exempt eligibility groups first. We suggest this because ABD eligibility determination typically consumes more time because of assets tests and functional eligibility assessment or level of care determination. In addition, sharing best practices learned in states that have already worked to streamline eligibility for the ABD populations with those that have begun to undertake this work, or are considering doing so, would help to avoid implementation challenges as states expand eligibility and enrollment system improvements to this population.

• **Consider all elements necessary for system functionality.** The Medicaid program covers populations with varying health care needs, who quality for the program through a variety of different pathways, and receive care via delivery systems that continue to evolve. AHCA urges CMS to consider eligibility and enrollment in light of the various populations that will be impacted by these systems. For example, as CMS and states continue to work to modernize these systems, all necessary elements that could impact enrollees’ ability to access care, including the need for these systems to be able to send information to or be accessed by appropriate parties, which can include providers and managed care plans, should be considered.

We thank you for consideration of our comments, and we would be pleased to answer any questions you may have.

Sincerely,

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Senior Vice President, Finance Policy & Legal Affairs  
American Health Care Association

cc: Victoria Wachino  
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