

September 5, 2017

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

Re: Iowa’s Proposed Amendment of Section 1115 Waiver to Eliminate Retroactive Coverage

Dear Administrator Verma,

Thank you for the opportunity to comment on Iowa’s proposed amendment to the Iowa Wellness Plan 1115 Demonstration. The amendment seeks to eliminate three-month retroactive coverage for all Medicaid beneficiaries. These comments address the shortcomings of Iowa’s proposal with specific focus on how the proposal would harm older persons and persons with disabilities who rely on Medicaid-funded long-term services and supports (LTSS). As explained below, Iowa’s proposal does not test a proposition nor promote the objectives of federal Medicaid law. Consequently, CMS must deny Iowa’s request.

Iowa Wrongly Bases Its Request on an Illogical Comparison to Commercial Insurance.

According to Iowa’s application, “[t]he State’s rationale for this amendment request is founded on the fact that the commercial market does not allow for retroactive health coverage.”¹ The State claims that “[e]liminating Medicaid retroactivity encourages individuals to obtain and maintain health insurance coverage, even when healthy,” and that “by more closely aligning Iowa Medicaid policy with policy in the commercial insurance market, members will be better prepared if they are eventually able to transition to commercial health insurance.”²

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.

We disagree strongly with Iowa’s suggestion that low-income Iowans could purchase private insurance for months for which retroactive Medicaid coverage would not be available. Importantly, retroactive coverage is available under federal law only for months in which a

¹ State of Iowa, Dep’t of Human Services, Section 1115 Demonstration Amendment, at 3 (June 27, 2017).

² *Id.*

person meets financial eligibility standards.³ Given such a person's limited financial resources, he or she is not able to pay for health care or for private insurance, and needs the coverage that only Medicaid can provide.

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.”⁴ 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 instantaneous applications for Medicaid coverage. She may be hospitalized after an accident or unforeseen medical emergency. She may also be unfamiliar with Medicaid, or unsure about when her declining financial resources might fall within the Medicaid eligibility threshold. The three-month retroactivity window is a rational and humane response to these concerns. We note and emphasize again that retroactive eligibility is only available to persons who meet Medicaid eligibility standards for the month[s] in question.

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. In many instances, families provide the bulk of needed services 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.

The transition to a nursing facility is a confusing, overwhelming process for both the nursing facility resident and his or her family. They may or may not be familiar with Medicaid, or 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 can be 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 have Alzheimer's disease or another dementia.

Thus, if Iowa's proposal were implemented, many low-income Iowans likely would be saddled with unaffordable health care bills. Similarly, many Iowans 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 deny care. Holding off 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.

³ 42 U.S.C. § 1396a(a)(34).

⁴ Senate Report No. 92-1230, at 209 (Sept. 26, 1972) (discussing section 255 of H.R. 1).

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. Iowa’s proposal fails to meet these standards. Iowa does not identify a specific proposition to be tested. A reader can infer a test of whether elimination of retroactive coverage would increase use of private insurance, but such a test would be contrary to the Medicaid program’s objectives. As discussed above, private insurance coverage is out of reach financially for persons who meet Medicaid financial eligibility standards. Waivers should be used to improve coverage, not to divert Medicaid-eligible persons into private coverage — or, more likely, no coverage. If CMS were to approve Iowa’s proposal, CMS’s action would be arbitrary and capricious.⁵

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 the state of Iowa. Iowa’s proposal does not meet the statutory standards for waiver under Section 1115.

Sincerely,

Aging Life Care Association®
Altarum Institute Center for Elder Care and Advanced Illness
American Federation of State, County and Municipal Employees (AFSCME)
Community Catalyst
Disability Rights Education and Defense Fund
The Jewish Federations of North America
Justice in Aging
National Association of Social Workers (NASW)
NASW–Iowa Chapter
National Academy of Elder Law Attorneys
National Consumer Voice for Quality Long-Term Care
National Council on Aging
National Disability Rights Network
Special Needs Alliance

CC:

Adele Sink
Acting Regional Director/Executive Officer
Region 7
Office of the Regional Director
The Centers for Medicare & Medicaid Services
601 East 12th Street, Room S1801
Kansas City, MO 64106

⁵ See, e.g., *Beno v. Shalala*, 30 F.3d 1057, 1069-71 (9th Cir. 1994).