April 13, 2018

Justin Senior, Secretary
Agency for Health Care Administration
Bureau of Medicaid Policy
Physical Address: 2727 Mahan Drive, MS #20
Tallahassee, Florida 32308
Email: FLMedicaidWaivers@ahca.myflorida.com

RE: § 1115 MMA Waiver Amendment – Retroactive Coverage Elimination (Project Number 11- W - 00206/4)

Dear Secretary Senior:

I respectfully ask that the state hold in abeyance its request to deny Floridians a three-month retroactive coverage grace period for Medicaid application submission, specifically § 1115 MMA Waiver Amendment – Retroactive Coverage Elimination (Project Number 11- W - 00206/4) (the “Amendment”). The requested Amendment not only violates the intent of the federal law, but ignores federal law requiring detailed fiscal impact analysis. Additionally, it is concerning that the state has not demonstrated that this Amendment will strengthen the stated principles of the Medicaid Managed Assistance Program (MMA).

Federal issue #1: Of critical importance to the Safety Net Hospital Alliance of Florida (Safety Nets) is the impact this Amendment will have on tens of thousands of vulnerable Floridians by forcing the denial and delay of their Medicaid covered services. These affected Floridians are primarily disabled adults and our state’s growing population of elderly. The unanimous public outcry in opposition to this proposed Medicaid coverage change reaffirms the original purpose of the retroactive coverage law.

Enacted by Congress in 1972, the stated purpose of the law was to protect: “persons who are eligible for Medicaid but do not apply for assistance until they have received care, either because they did not know about Medicaid eligibility requirements or because the sudden nature of their illness prevented their applying.”

The same need for protection exist today. Florida’s Medicaid eligibility criteria are complicated and not readily understood or accessible to low-income elderly or disabled persons. There are over 40 categories of eligibility thresholds and hundreds of pages of related policies. Many elderly Floridians are unable to navigate the internet or recognize that their dire financial or health circumstances could qualify for Medicaid insurance assistance.
For example, most low-income Florida adults (18-64, those in the coverage gap) do not qualify for Medicaid because the state has not expanded its Medicaid program. So currently, there are extremely low financial eligibility limits and other requirements, which must be met, such as having a disability. Suddenly, some of those healthy adults may qualify because of an unpredictable catastrophic medical event. But as a “healthy adult” they would be ineligible. Purchase of private insurance prior to their illness would be unaffordable, especially for the thousands of Floridians caught in the coverage gap who cannot qualify for premium subsidies on the ACA marketplace.

Similarly, if a senior has a fall and then needs nursing home care, they would only qualify for Medicaid at that point in time. Prior to the fall, their application would be denied as not meeting medical eligibility criteria.

Moreover, once someone learns of the availability of Medicaid, navigating the application process is extremely complex and time-consuming. This responsibility often falls to a family member whose immediate attention is ensuring that their loved one’s medical condition is stabilized before figuring out how to pay for it. It can take a significant amount of time for a patient to complete an application. For instance, it may require submission of five years of bank records, a particularly challenging task for someone who may have Alzheimer’s disease or other cognitive disorders. In the meantime, large medical bills may accrue, exposing families to enormous medical debt and bankruptcy.

**Federal issue #2:** As of this date, the Agency for Health Care Administration (AHCA) has not provided the mandated research methodology detail or comprehensive evaluation of the amendment to the Florida Legislature, the public, or the affected parties. The Safety Nets has made a specific public records request for the individual hospital impact analysis and the Hospital specific data supporting the analysis. This information has not been provided at this time.

In 1981 Congress has specified that:
“states can apply to HHS for a waiver of existing law to test a unique approach to the delivery and financing of services to Medicaid beneficiaries ... contingent upon development of a detailed research methodology and comprehensive evaluation for the demonstration.” H. R. Rep. No. 3982, pt. 2 at 307-08 (1981).

In the absence of this mandated impact analysis, the Safety Nets endeavored to conduct its own analysis. This analysis brought to light 11 significant patient concerns and barriers to efficient implementation. These findings are organized in concert with the three fundamental principles of the Medicaid Managed Assistance Program (MMA) as presented in the State of Florida Waiver Request Public Notice Document informational graphic.

The state has not demonstrated that the amendment will further the MMA principles. To the contrary, the state’s § 1115 Waiver Amendment request will:
1. Not improve access to care.
3. Not enhance fiscal predictability and financial management

Therefore, state’s retroactive coverage denial Amendment request should be placed in abeyance until a thorough analysis of the Amendment’s impact on the Purpose, Goals and Objectives of Florida’s § 1115 MMA Waiver is completed and provided to the legislature, the public, and affected providers. The
proposal contravenes the objectives of the Medicaid Act and fails to meet federal § 1115 demonstration amendment criteria.

1. **NOT IMPROVE ACCESS TO CARE**

   a. **Discourages physicians and other providers from accepting Medicaid Patients** – Denying coverage to eligible Medicaid patients will impact access to primary care and specialty physicians and ancillary provider in the early stages of diagnosis as well as post-acute hospital care who will stop taking potential Medicaid patients or refer them to Hospitals prematurely and/or back to hospital care.

   Many of our hospitals already have only a small pool of post-acute providers which will accept patients in a Medicaid pending status. This pool will undoubtedly shrink by a significant factor if this proposal is finalized. One of our Hospitals, at a public policy meeting with two area post-acute providers, said that they would be less likely to “gamble” on these patients in the future. A reduction in post-acute providers will cause hospital acute care to backup. This will in turn lead to higher overall costs in the healthcare continuum by not placing patients in the correct lower cost setting of care where they could receive the most appropriate treatment. In short, this proposal runs counter to every part of the state’s MMA waiver goals and objectives.

   b. **Targets elderly in poverty or disabled.** The proposal to deny retroactive coverage for non-pregnant adults but retains the coverage for children and pregnant women. This arbitrary line recognizes the significant negative financial impact of such a process and policy change will have on children and pregnant adults while ignoring the impacts on Elderly, disabled and poor adults. Just a short stay in a hospital from a catastrophic event will cause this vulnerable group financial hardship and will ultimately increase uncompensated care to hospitals.

   c. **Affects dual eligible’s who qualify for the SLMB and QI-1 Programs.** Low-income Medicare beneficiaries in Florida with incomes between 101 and 135 percent of the federal poverty level can qualify for the Specified Low-Income Medicare Beneficiary (SLMB) or Qualified Individual-1 (QI-1) Medicare Savings Programs (MSPs). These programs pay Medicare Part B monthly premiums. (The standard monthly Part B premium for 2018 is $134). Beneficiaries can also qualify for three months retroactive coverage. The federal government pays 100 percent of the cost for QI-1 eligibles and the regular state match percent applies to SLMBs. Lack of awareness of these programs and burdensome enrollment processes have delayed many eligible Floridians from timely accessing these benefits. Eliminating retroactive coverage means taking away up to $402 from each low-income Medicare beneficiary who qualifies for SLMB or QI-1 but did not apply concurrent with the month of their initial Medicare enrollment. Notably, the Medicare enrollment process is separate from the process for enrolling in these MSPs. There is nothing in Florida’s proposal, which carves out these groups. In fact, they are carved in through the state’s broad designation of “non-pregnant adults” as the targeted population. (Public Notice Document, p.6) Yet, the state’s rationale for this proposal, “to enhance fiscal predictability” makes absolutely no sense for this group of beneficiaries. For QI-1s, there is no state costs- they are borne entirely by the federal government. For SLMBs, the costs of retroactive eligibility for this group are predictable. They are a flat premium of no more than $402 for three months of eligibility.
d. **Affects nursing home patients, and those hit by catastrophic illnesses or medical crises like cancer, a stroke or a car accident** - Despite their poverty, they cannot qualify for regular Medicaid until their health seriously deteriorates. Floridians needing nursing home care already face extraordinary difficulties finding a provider that will accept Medicaid and they will undoubtedly face even more obstacles if RME is eliminated. The RME proposal would take away safety net coverage at precisely the time when it is needed the most by this extremely vulnerable group of Floridians. It protects not only Medicaid beneficiaries from being saddled with medical bills that they cannot afford but also hospitals from having to absorb 100 percent of the cost of caring for these patients. One of the most common examples of this is a dual eligible beneficiary that is unaware they have exhausted their Medicare benefits until after they have had a traumatic health event. Once it is realized that the patient needs to apply for Medicaid coverage, they may already have accrued hefty medical expenses.

2. **NOT IMPROVE PROGRAM PERFORMANCE**

a. **Disrupts primary care coordination and disease management by discouraging physicians and other providers from accepting Medicaid Patients** - Denying coverage to eligible Medicaid patients will impact access to primary care and specialty physicians and ancillary provider in the early stages of diagnosis as well as post-acute hospital care who will stop taking potential Medicaid patients or refer them to Hospitals prematurely and/or back to hospital care.

b. **Limits initial eligibility to the month of application. This change will arbitrarily and unfairly expose some people to significantly more medical debt depending on when in the month they can apply.** - Currently patients can qualify for Medicaid coverage going back three months prior to the month of application. In addition, whatever day of the month their initial application is filed, they will be eligible for all days in that month. Thus, patients can get three months of retroactive Medicaid, *plus* up to 30 days of "back" coverage for the days in the month prior to the specific date of application. There are many variables to the timing of the filing of an application, often beyond the control of the patient. However, under this proposal, those applying at the beginning of the month will have significantly less coverage days than those applying at the end of the month. For example, an unconscious patient ending up in the emergency room from an auto accident may not have the capacity to file a Medicaid application at the beginning of a medical crisis when care is initially provided. If that patient files an application on the 1st of the month, they will have no "back" coverage days. But if that same patient filed instead on the 31st day of the month they will get 30 days of "back" coverage. Retroactive Medicaid even out this unfairness by giving everyone coverage up to three additional months. Eliminating this coverage creates substantial hardships for patients and their families, potentially exposing them to more unpaid medical bills. It also creates more burdens for hospital personnel administering the application process and trying to help families avoid medical debt.

c. **Wastes time by requiring chasing of information** - The length of time it takes to submit an application can greatly exceed 30 days. Patients that typically exceed 30 days to complete the application include: very sick and injured trauma and emergency room admits, elderly, high acuity, and disaster related patients.
d. **Shortens the time available to complete and submit an application** – Hospitals faced with the prospects of eligible Medicaid patients losing benefits will submit partial Medicaid applications to the Department of Children and Families (DCF) upon uninsured patients’ admittance to a hospital. With insufficient time to complete an application many of the applicants will end in denial. DCF will undoubtedly experience a dramatic increase in applications many of which will be denied.

3. **NOT ENHANCE FISCAL PREDICTABILITY AND FINANCIAL MANAGEMENT**

a. **Lacks the § 1115 Waiver requirement for detailed research methodology and comprehensive evaluation of the proposal.**

   In 1981 Congress has specified that:
   
   “[s]tates can apply to HHS for a waiver of existing law to test a unique approach to the delivery and financing of services to Medicaid beneficiaries ... **contingent upon development of a detailed research methodology and comprehensive evaluation for the demonstration.**”  
   

   At this time ACHA has not provided this critical analysis and documentation to the legislature, the public or the affected parties prior to the comment period.

b. **Challenged in Kentucky court** - The waiver of retroactive coverage in Kentucky is currently being challenged in federal court in the case of *Stewart v. Azur*, Case No. 1:18 cv-152, (U.S.D.C. D.C.)  
   
   The plaintiffs contend the Secretary does not have legal authority to waive retroactive Medicaid and such action is arbitrary and capricious. Until the issue is settled in the courts, Florida will face similar legal exposure if this waiver Amendment is implemented. The inevitable related state litigation costs arising from defending such a suit, would be much better used to covering health costs for low income aged and disabled Floridians.

c. **Underestimates $98.4 million cost for the denied coverage** – ACHA reduced Medicaid appropriation for FY 2018-19 by $98.4 million based on a FY 2015-16 analysis of retroactive eligibility claims and is estimated to affect 39,000 non-pregnant adults. Concerns on the accuracy of these estimate include:

   i. The data and methodology supporting this analysis has not yet been provided.

   ii. In a letter to Secretary Tom Price from Justine Senior, Secretary, AHCA, stated that the elimination of 3 months of retroactive eligibility to all beneficiaries would reduce benefits by $500m. (attached)

   iii. Four small states Iowa, Arkansas, New Hampshire, and Indiana are the only 4 states that have currently eliminated 3 months of retroactive eligibility. A Kaiser Foundation release reported that Iowa, an expansion state with a population of only 3.1 million, had more than 40,000 Medicaid beneficiaries impacted by the elimination of retroactive eligibility.

   iv. A number of Safety Nets hospitals have examined their most recent retroactive claims and believe that the 39,000 estimates are dramatically underestimated. Safety Nets has made a public records request on data supporting the 39,000 estimates to validate our concern.
Thank you for the opportunity to provide these comments. The Safety Net Alliance is a Florida not-for-profit corporation whose fourteen members include Florida's largest and most prominent public, teaching, children's and regional perinatal care hospital systems. Despite representing just 10 percent of Florida's hospitals, our members collectively manage one-third of all Florida hospital patient days while absorbing 40 percent of the state's hospital charity care costs and 30 percent of all Medicaid days. This small group of hospitals is recognized for their unique shared mission to provide accessible high-quality specialty care to all Floridians, regardless of their ability to pay.

Sincerely,

James Zingale, Ph.D

Attachment: Letter to Secretary Price
The Honorable Tom Price, M.D.
U.S. Department of Health & Human Services
200 Independence Avenue, S. W.
Washington, DC 20201

Dear Secretary Price:

Thank you for your willingness to hear from Florida on what we need from the U.S. Department of Health & Human Services (HHS) to best care for the most vulnerable people in our state. I appreciate that you and Administrator Verma are empowering states with flexibility to manage our own Medicaid programs based on the needs of the citizens in each state. Our relationship with the previous administration was marred not only by heavy-handed federal regulations and bureaucracy, but by political strong-arming that threatened the very services Floridians already pay federal taxes to receive.

In this letter, I am outlining what Florida needs from the federal government in order to provide higher quality services to our Medicaid population. Below, I have outlined the flexibility we are requesting from HHS to better serve low-income individuals in our state. By granting us these important improvements, you are putting Florida in the position to provide the best services, while making the most efficient use of the taxpayer dollars that fund health care.

Health care decisions made here at the local level will always be more useful and successful than decisions made by the federal government in Washington. Florida can deliver better care in a far more efficient manner. Together, we can put Florida in the position to provide the best Medicaid services – without removing anyone from our current Medicaid program. To accomplish this, we request HHS's support of five key improvements, which include the following:

- A block grant of federal funds as a replacement for Florida’s various supplemental payment programs;
- Flexibility to set eligibility criteria and eliminate retroactive eligibility;
- HHS’s support to strengthen the relationship between Medicaid beneficiaries and primary care providers;
- HHS’s support to eliminate federal requirements that lead to duplicative work at the state and federal level for Medicaid Managed Care rates; and
- HHS to remove the federal administrative burdens placed on the state by the “Access Rule.”
CUTTING FEDERAL RED TAPE ON FLORIDA’S MEDICAID PROGRAM

Florida has a number of specific requests it seeks to add to its current 1115 waiver. These include:

- **Florida requests a block grant of federal funds as a replacement for Florida’s various supplemental payment programs.** Florida requests a block grant of federal funds as a replacement for its various supplemental payment programs along with annual savings it achieves through its current 1115 waiver. Florida receives significantly less than other states with respect to its current supplemental payment and Low Income Pool programs. Nationally, these supplemental payment programs have built-in inequities that no longer make sense as Florida has grown to become the third most populous state in the nation. Moreover, Florida has consistently saved its taxpayers (and federal taxpayers) money over the course of this decade by focusing on efficiencies to our program while ensuring high-quality outcomes. According to the budget neutrality calculations that apply to Florida’s current 1115 waiver, Florida saves taxpayers almost $4 billion per year, and has saved taxpayers nearly $20 billion over the last five years. Florida’s savings are borne out by the fact that it earns quality scores and consumer satisfaction results that more often than not meet or exceed national averages, and yet it spends considerably less per person on its Medicaid program than the national average. In fact, most of Florida’s quality scores are at or above the national average, and consumer satisfaction with Florida’s Medicaid health plans is actually significantly higher than in Florida’s commercial health plans. The federal government should reward states like Florida that generate significant savings and that spend less per capita than the national average with maximum flexibility to meet the health care needs of the state.

- **Florida requests flexibility regarding retroactive eligibility.** Unlike most other states, Florida has kept its program focused on the most vulnerable persons in its state, including children in low-income families, frail elders, disabled persons, and pregnant women. This focus has already saved the state and federal government billions during this decade. Nevertheless, additional flexibilities hold the potential to save billions more, without changing the program’s focus on the most vulnerable and without compromising quality. Specifically, federal rules currently require Florida to provide retroactive eligibility to persons who enroll in the program, sometimes making people eligible for several months prior to the actual date the state found them to be eligible. Florida has to pay the claims during this retroactive period on a fee-for-service basis, and thus pays for uncoordinated and potentially inappropriate utilization of medical services. Florida is therefore requesting that it be allowed to modify retroactive eligibility via a waiver of 42 U.S.C. §1396a(a)(34). Florida estimates that this waiver will save over $500 million per year without compromising quality of care in any way.

- **Florida requests HHS’ support to strengthen the relationship between Medicaid beneficiaries and primary care providers.** Through numerous studies, we know that the best place for Medicaid beneficiaries to receive the highest level of care is through a coordinated relationship with a primary provider. Sporadic visits to the emergency room – especially for non-emergency needs – lead to fragmented care that ultimately
jeopardizes a patient’s ability to get the best level of care possible, especially for those patients who suffer from chronic conditions like diabetes and asthma. Florida’s initiatives will improve quality and outcomes by discouraging uncoordinated and inappropriate ER visits, and encouraging the creation of strong relationships between true primary care patients and providers.

- **Florida requests HHS eliminate federal requirements that lead to duplicative work at the state level for certified Medicaid rates.** Currently, Florida uses an experienced and qualified actuarial firm to spearhead its health plan rate-setting process. These actuaries certify the state’s health plan capitation rates after a rigorous, detailed, and open rate-setting process. Under CMS’s new managed care rule, CMS then forces the state to submit its rates to CMS actuaries for review and approval. This unnecessary duplication often takes months. CMS should limit its review to whether or not Florida’s rates have been developed and certified by qualified actuaries, and nothing more. Florida will seek a waiver of the provisions of the newly enacted Medicaid managed care rule, along with the statutory provisions that purportedly justify it, to allow the state full discretion to set its managed care rates.

Florida will also seek a waiver from the Medicaid managed care rule to give the state full authority to set its own network adequacy requirements. Florida follows Medicare Advantage Organization network adequacy requirements in its system. Because Medicare has an older and sicker population than Medicaid, these network adequacy requirements suffice. Moreover, network adequacy is generally nothing more than a process measure. If Medicaid enrollees show high levels of satisfaction with their health plans, the health plans achieve high quality scores, and the program overall shows low rates of avoidable hospitalizations and avoidable ER use, then the program provides appropriate access. The current network adequacy rules simply make for an additional, labor-intensive reporting requirement.

- **Florida requests that HHS remove the federal administrative burdens placed on the state by the “Access Rule.”** The state requests that CMS waive its recently enacted “Access Rule” for Florida, along with the statutory provision(s) that purportedly justify it. The Access Rule creates massive state and federal administrative burdens and threatens direct federal interference with every state’s appropriations and budget processes. While almost all of Florida’s Medicaid enrollees receive their services via health plans under contract with the state, Florida does have a few remaining fee-for-service populations. Because of these tiny populations, the federal government compels Florida to comply with the “Access Rule,” including its onerous and pointless reporting requirements and its demand for certain proofs from the state prior to enacting fee-for-service rate reductions.

Florida looks forward to working with you and your team on implementing these flexibilities. These measures will allow us to deliver quality health care at an affordable cost which could save an estimated $830 million taxpayer dollars. But, even more important than savings, with your help to remove the burdensome and even duplicative federal requirements put in place by the previous administration, we can improve services for the neediest in our state, while not cutting a single Medicaid recipient from our program. Access and quality of care will always be best determined, and managed, at the local level.
Current federal rules and regulations enacted under the Obama Administration create and focus on burdensome administrative processes that grow government and require layers of bureaucracy. The federal rules and regulations, however, do little or nothing with respect to focusing on access, quality or outcomes for the vulnerable populations Florida serves. Granting Florida -- and potentially other states -- these flexibilities will allow the state to focus on consistent access and quality improvement. I am confident that we can make these Medicaid improvements together and further roll back the big-government constraints of Obamacare in Florida.

Thank you for your time and consideration.

Sincerely,

Justin M. Senior
Secretary