THE DISABILITY COALITION
A Coalition of Persons with Disabilities, Family Members, and Advocates

P.O. Box 8251, Santa Fe, New Mexico 87504-8251
Telephone: (505) 983-9637

October 25, 2018

Brent Earnest, Secretary
New Mexico Human Services Department
PO Box 2348
Santa Fe, NM 87504-2348

Submitted by email to : madrules@state.nm.us

Re: HSR vol. 41, #27

Secretary Earnest:

The Disability Coalition offers the following comments on the Human Services Department's proposed revisions to the Medicaid regulations implementing changes in the Centennial Care waiver renewal ("Centennial Care 2.0").

Effective date – This Register proposes changes to numerous sections of the Medicaid regulations. In each case, the department proposes to make the revised regulation effective on January 1, 2019 (the date Centennial Care 2.0 begins) or upon federal approval by the Centers for Medicare and Medicaid Services (CMS). Presumably the intent is to make the changes effective on the later of those two dates, to account for the possibility that CMS may not approve the change by January 1, 2019. If CMS approval is received before that date, as expected, we assume the changes will not go into effect until the waiver renewal period begins. The language of these provisions throughout the regulations should be clarified.

8.200.400.14 and related sections of numerous regulations listed in the Register – Retroactive eligibility

We reiterate our prior objections to the department's proposal to shorten and then eliminate the period of retroactive eligibility for many Medicaid enrollees and to institute delayed eligibility for adult expansion enrollees who would be subject to premiums in Centennial Care 2.0.

a) The change is not permitted under federal law, which requires Medicaid to cover bills for health care services received in the three months before the month in which a person applies for Medicaid. This is required not only by §1902 of the Social Security Act, 42 USC

§1396a, but also by §1905, 42 USC §1396d(a); the latter section cannot be waived under §1115, which authorizes waiver only of provisions of §1902.

Beyond their legality, elimination of retroactive eligibility will impose significant financial costs on low-income New Mexicans and burden providers with unpaid medical bills. HSD has argued that retroactive coverage will no longer be necessary once the department is able to make "real-time" eligibility determinations – i.e., a prompt determination immediately upon application. But this position makes no sense, since the retroactivity period covers the time *before* the application; the speed with which the application is acted on is irrelevant. Although this point has been made repeatedly throughout the process of developing the Centennial Care waiver renewal, HSD inexplicably has continued to insist that real-time eligibility determinations somehow justify the proposed elimination of retroactive coverage, without further explanation of any possible relevance.

HSD further contends that retroactive coverage is unnecessary because hospitals and federally qualified health centers (FQHCs) are authorized to process presumptive eligibility for individuals they serve so that retroactive coverage will be unnecessary. However, the department acknowledges that not all hospitals have taken on this role; in addition, there are many other types of providers and not all are authorized to make presumptive eligibility determinations. Even where a provider is permitted to process presumptive eligibility, the patient's condition may make it impossible, thus delaying Medicaid enrollment.

Even with the expanded options for presumptive eligibility put in place by the Affordable Care Act, many people will incur burdensome medical bills before applying for Medicaid. This is particularly likely to occur because many people don't even realize they're eligible for Medicaid until *after* they incur medical expenses (sometimes quite large ones), a situation exacerbated by HSD's reluctance to engage in meaningful outreach activities to promote enrollment by eligible New Mexicans. Retention of retroactive eligibility is essential to protect both individuals and providers by ensuring that expenses incurred before formal application are covered. Such coverage is available only if the person would have been eligible for Medicaid during that time, so Medicaid payment is appropriate. Any possible disadvantage to the program is far outweighed by the harm to individuals and providers if retroactive coverage is not provided.

The problematic nature of the proposed elimination of retroactive eligibility is further demonstrated by the department's intended premiums for some Medicaid recipients. As set forth in the proposed regulatory changes, eligibility for individuals subject to premiums would not begin until the month *after* the premium was paid. In those circumstances, presumptive eligibility or real-time eligibility determinations would provide no protection whatsoever.

8.299.400 – Family planning

HSD proposes to impose a maximum age of 50 for eligibility in this category and to make individuals with other insurance coverage ineligible, regardless of whether that insurance covers family planning services. In the Centennial Care 2.0 waiver application submitted to

CMS, the department said that there would be "certain exceptions" to these restrictions, "including those individuals under age 65 who have only Medicare coverage that does not include family planning." (Emphasis added.) We expressed concern at that time about the imprecision of HSD's position but believed that this phraseology indicated that the department would recognize that others whose insurance coverage did not cover these services also should have access to Medicaid family planning. This unfortunately proved not to be the case. We again urge that this provision be revised so that only those whose health insurance adequately covers these services are excluded from the program.

We note again that the age limit proposed by HSD is inappropriate. Women over 50 can and do get pregnant; men remain fertile long past that age. While we recognize the concerns about the administrative burden associated with enrolling large numbers of people into this category even though it does not meet their needs and they may not even want it, we continue to believe that the department should address these concerns through improved communication rather than arbitrary limits on access to the services.

8.290.600.12 and elsewhere – Ongoing nursing facility level of care (NFLOC) determinations

We continue to support the proposal to provide for ongoing NFLOC determinations for individuals whose condition is unlikely to improve. Full annual reviews are burdensome for the individual and impose an unnecessary administrative burden on the Medicaid program, so streamlining the process makes sense.

However, we have the following concerns with the proposed criteria for an ongoing NFLOC determination:

- Such a determination would not be permitted unless the person has had a NFLOC determination for the past three years. In many cases, that kind of track record may be needed as the basis for a determination that the individual's condition is unlikely to improve. However, where it is clear from that condition that this level of care will continue, there is no reason to delay that determination for three years. For example, it is completely reasonable to determine that a person with quadriplegia will continue to meet NFLOC criteria without waiting three years to confirm that fact.[1] Similarly, the condition of someone with a progressive degenerative disease such as amyotrophic lateral sclerosis will only get worse, not better, and there is no justification for a three-year wait to prove it.
- The other provisions in the proposed regulation are process requirements for approval by the managed care organization's medical director and documentation from the individual's primary care provider, rather than substantive criteria to use in determining the appropriateness of an ongoing NFLOC determination.
- Rather than laying out criteria in the rule, the proposed language says that they can be found "in the New Mexico medicaid nursing facility level of care criteria and instructions document". The criteria should be set forth in the regulations themselves and not in a

[1] In its waiver renewal application to the Centers for Medicare and Medicaid Services, HSD specifically cited quadriplegia as a condition that would justify a continuing NFLOC.

side document that is not subject to the same requirements for notice and promulgation as rules. We also note that a search of the HSD website turns up no such document. Burying the relevant criteria in a document that is not readily available to the public or interested parties is inappropriate and inadequate.

In addition, the department now proposes to allow ongoing NFLOC determinations only for persons receiving Community Benefit services and not for those who receive facility-based care. We are not aware that this distinction was disclosed at any time during the process of developing the Centennial Care 2.0 waiver, nor has there been any explanation as to why ongoing level of care determinations should not be available to individuals receiving Medicaid long-term services and supports in institutional settings. We encourage the department to make this option available to persons receiving Medicaid institutional care as well as those served in the community.

We note that we have been hampered in commenting on the provisions in this and certain other sections of the proposed regulatory changes due to HSD's failure to properly post them on the Registers/Rule Changes section of the department's website until only two days before the due date for comments.[2] This left inadequate time for careful review and consultation before submitting comments. We again urge the department to make these provisions the subject of a new rulemaking with adequate notice, or to reopen the comment period in this Register.

Thank you for your consideration of these comments.

Sincerely,

Ellen Pinnes

Ellen Pinnes
for The Disability Coalition

[2] This includes 8.281.600 and 8.290.400 as well as 8.290.600.