Via Electronic Submission

November 7, 2022

Administrator Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Re: Agency/Docket Number CMS-2421-P, proposed rule considering changes to simplify the processes for eligible individuals to enroll and retain eligibility in Medicaid

Dear Ms. Brooks-LaSure,

The Home Care Association of America ("HCAOA") respectfully submits these comments to the Centers for Medicare and Medicaid Services ("CMS") in response to the above-referenced proposed rulemaking published in the Federal Register on September 7, 2022 at 87 FR 54760.

HCAOA is the home care industry's leading trade association. We currently represent over 4,200 companies that employ nearly two million caregivers (home care aides) across the country. HCAOA member companies primarily provide supportive services in people's private homes, including Medicaid HCBS, VA services, and Medicare Advantage Supplemental Services. Home care agencies also provide in-home care, which is family-funded (also called private pay). Our caregivers assist with a variety of non-medical activities of daily living, such as bathing, dressing, eating, and many other services necessary for seniors and the disabled to live independently at home.

The purpose of these comments is to assist CMS in forming and implementing a final rule that simplifies the processes for eligible Americans to enroll and retain eligibility in Medicaid while considering the growing importance of HCBS within our nation's health care continuum. HCAOA believes in a client first approach and strives for a future where a diverse set of Medicaid enrollees receive more affordable, suitable, and equitable care.

Allow Medically Needy Individuals To Deduct Prospective Medical Expenses From Their Income For Eligibility Purposes

The Medically Needy Income Level and the "Spenddown"

The current medically needy income eligibility regulation (42 CFR 435.831) permits institutionalized individuals (those in a nursing home or other long-term care setting) to deduct their anticipated medical and remedial care expenses from their income. HCAOA agrees with

CMS's proposal to amend this regulation to allow noninstitutionalized individuals, including those receiving home and community-based services, to do the same for purposes of medically needy eligibility determinations. Implementing this proposal would eliminate the institutional bias inherent in only permitting projection of the cost of care for institutionalized individuals. This bias has long served to prohibit Americans from aging in their preferred location: their homes.

Section 1902(a)(10)(C) of the Social Security Act (the "Act") provides States the option to extend Medicaid eligibility to "medically needy" individuals[1]. The medically needy are individuals who have incomes too high to qualify in a categorically needy group described in section 1902(a)(10)(A) of the Act, but who have specific and often costly health needs. Currently, States establish a separate income standard to determine the income eligibility of medically needy individuals (referred to as the "medically needy income level," or "MNIL"). [2] A State's determination of a prospective medically needy individual's income eligibility includes the deduction of the uncovered medical and remedial expenses incurred by the individual, the individual's family members, or the individual's financially responsible relatives, from the individual's countable income.[3] This process of deducting incurred medical and remedial expenses from an individual's countable income is commonly referred to as the "spenddown."

The Need to Project Noninstitutional Expenses

In a 1994 rulemaking, based on the authority granted to the Secretary to create rules necessary to effectively operate Medicaid[4], and under section 1902(a)(17) of the Act to prescribe the extent to which costs of medical care may be deducted from income, CMS established[5] that States have the option to "include medical institutional expenses (other than expenses in acute care facilities) projected to the end of the budget period at the Medicaid reimbursement rate" in calculations[6]. Importantly, the 1994 rulemaking also confirmed that certain States are authorized to implement the authority established in the rule relating to the projection of medical institutional expenses.

"Projecting" expenses means that a State includes in incurred medical expenses those costs that it anticipates an individual will incur during a budget period, which can make eligibility effective on the first day of an individual's budget period, if the anticipated expenses equal or exceed the individual's spenddown. In promulgating the above mentioned 1994 regulation, CMS reasoned that institutional services are, by their nature, constant and predictable, which supported a simplified approach for States to determine that an institutionalized individual will meet their spenddown amount each budget period. As required by regulations in § 435.831(i)(2), States must

[1] See also 42 CFR part 435, subpart D
[2] Section 1902(a)(10)(C)(i)(III) of the Act and corresponding regulations at § 435.811(a)
[3] Section 1903(f)(2) of the Act and corresponding regulations at § 435.831(d)
[4] Sections 1102 and 1902(a)(4) of the Act
[5] § 435.831(g)(1)
[6] https://www.govinfo.gov/content/pkg/FR-1994-01-12/html/94-547.htm

reconcile the projected amounts with the actual amounts incurred at the end of the budget period in order to confirm that the individual's incurred expenses were at least equal to the individual's spenddown.

However, **only permitting projection of the cost of care for institutionalized individuals creates an inherent institutional bias**. Noninstitutional services, such as HCBS, are similarly constant and predictable, allowing States to accurately project them for individuals who are required to meet a spenddown to become income-eligible. Permitting projection of HCBS would dramatically reduce much of the complexity that both State agencies and individuals seeking HCBS coverage currently experience. Perhaps more importantly, it would have the effect of reducing the institutional bias that has plagued our industry for years.

Allowing projection of HCBS expenses would reduce administrative costs associated with disenrolling and reenrolling individuals, as well as lead to better outcomes for individuals who would no longer cycle on and off Medicaid and experience disruptions to their continuity of care.

HCAOA also supports the amendment of § 435.831(g) to permit States to project certain additional services that the State can determine with reasonable certainty will be constant and predictable. The projection of expenses for noninstitutional services can easily be narrowly tailored and limited to those that are reasonably certain to be received by the individual, since only the amounts for which the individual is ultimately liable can be used to reduce income. To avoid erroneous grants of spenddown-related eligibility, States could be mandated to reconcile actual noninstitutional services received with those projected at the end of budget periods.

Including in the regulatory language examples of specific types of expenses that CMS believes could be projected would provide additional flexibility and clarity for States in identifying additional costs that meet the criteria of being constant and predictable. HCAOA believes that allowing the projection of medical or remedial expenses for the HCBS that are included in a plan of care for an individual receiving a section 1915(i), 1915(j), or 1915(k) benefit or participating in a section 1915(c) HCBS waiver would be wise. States could reasonably calculate, and deduct, the anticipated cost, based on the Medicaid reimbursement rate, of the services in an individual's plan of care. Doing so would also have the effect of eliminating the institutional bias created by the current regulation's allowance for the projection of only institutional expenses.

Projection of institutional expenses is often a straightforward calculation involving only one provider that charges a fixed and easily identifiable rate. By contrast, for those HCBS beneficiaries who need a spenddown to qualify for coverage, it may take time before a State develops a reasonable degree of certainty regarding the predictable costs the individual incurs each month. For HCBS beneficiaries whose use of services in their plan of care varies greatly over the course of multiple budget periods, a State may be unable to reasonably predict the individual's service costs in a forthcoming budget period. Therefore, CMS should expressly permit States to

project the expenses of certain HCBS where a determination that such services are constant and predictable can be made.

HCAOA appreciates that CMS has prioritized increased engagement with its partners and the communities it serves throughout the policy development and implementation process. HCAOA wishes to increase its engagement with CMS and believes we can provide meaningful feedback on a number of different issues currently facing Medicaid enrollees across the country.

Thank you for your consideration of our submission. Please know that our association is always here to assist CMS in any way possible. Feel free to contact me at vicki@hcaoa.org or our Vice President of Government Relations, Eric Reinarman, at eric@hcaoa.org, with any questions you may have.

Sincerely,

Vicki Hoak, CEO
Home Care Association of America