November 4, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS–2421–P
7500 Security Boulevard
Mail Stop C4-26-05
Baltimore, MD 21244-1850

Re: Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes

Dear Administrator Brooks-LaSure:

The National PACE Association (NPA) is a national organization representing 148 operating Programs of All-Inclusive Care for the Elderly (PACE) organizations in 32 states. PACE organizations (POs) serve among the most vulnerable of Medicare and Medicaid populations– medically complex older adults over age 55 who are state certified as requiring a nursing home level of care. The objective of PACE is to safely maintain the independence of older adults and people with disabilities in their homes and communities for as long as possible. POs currently serve over 62,000 patients, known as participants, nationwide.

On behalf of our membership, NPA appreciates the opportunity to respond to the Centers for Medicare and Medicaid Services' (CMS) proposed rule "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Process." Given that 99 percent of individuals enrolled into PACE are eligible for Medicaid, NPA commends the Biden Administration's efforts to streamline the Medicaid eligibility and enrollment process. NPA offers the following comments for consideration to ensure that the proposed changes improve the enrollment process for Medicaid beneficiaries – including PACE participants.

Allowing Medically Needy Individuals to Deduct Prospective Medical Expenses

NPA supports CMS' proposal to allow noninstitutionalized medically needy individuals to deduct prospective medical expenses similar to how institutionalized individuals can deduct their anticipated medical and remedial care expenses from their income. Given that PACE participants meet nursing home level of care but, with PACE services can stay in their homes and communities, we applaud the effort to remove the inherent bias in only permitting projection of the cost of care for institutionalized individuals.

In the proposed rule, CMS specifically outlines services in an individual's care plan pursuant to a few home and community-based services (HCBS). While CMS notes that the list of

services is not meant to be comprehensive, NPA respectfully requests that CMS specifically include PACE in the list of programs for which an individual would be allowed to deduct prospective medical expenses in order to determine their financial eligibility for Medicaid.

PACE providers are reimbursed through a capitated, per member per month payment methodology. This amount is constant and predictable and therefore could be used to "project" expenses in the spenddown process. Including PACE in the list will provide clarity to states as they implement this provision. Without this specificity, we could see states being unclear as to whether or not the provision applies to PACE as a provider of HCBS services. We note that this clarification is consistent with both POs role as direct care providers and the recent precedent recognizing PACE as an HCBS provider under the enhanced Federal Medical Assistance Percentage (FMAP) for HCBS providers enacted in the American Rescue Plan Act of 2021.

Aligning Non-MAGI Enrollment and Renewal Requirements with MAGI Policies

PACE participants often face lengthy delays in the Medicaid eligibility determination process. Therefore, NPA is supportive of the various provisions aiming to expedite enrollment and improve retention. Given that PACE participants are medically complex and at least 55 years old, NPA applauds CMS' efforts to extend some of the flexibilities afforded to the modified adjusted gross income (MAGI) individuals to the non-MAGI individuals. The failure to streamline eligibility rules for non-MAGI groups has resulted in higher rates of procedural denials, even though older adults and people with disabilities are more likely to have stable incomes. NPA believes streamlining some of these policies and procedures will help the non-MAGI population enroll and access Medicaid more efficiently.

Timely Determination and Redetermination of Eligibility

NPA supports the proposed changes to improve timely eligibility determination and redetermination. The changes would help ensure that applicants and enrollees have adequate time to furnish all requested information and that states complete initial determinations and redeterminations of eligibility within a reasonable timeframe at application, at regular renewals, and following changes in circumstances. NPA believes that a reconsideration period of 30 days for new applicants and 90 days for redeterminations will accelerate the processes. In addition, not requiring a new, full application when an applicant responds within 30 days of a denial notice due to a request for additional information could save PACE organizations and PACE participants time and resources.

Automatically Enroll Certain SSI Recipients into the Qualified Medicare Beneficiaries Group

NPA supports CMS' proposal to streamline enrollment in the Medicare Savings Programs (MSPs), through which Medicaid provides coverage of Medicare premiums and/or cost-sharing for lower income Medicare beneficiaries. NPA strongly agrees that the MSPs are essential to the health and economic well-being of those enrolled, promoting access to care and helping free up individuals limited income for food, housing, and other of life's necessities.

This provision of the proposed rule is important to POs as it relates to partial-dual participants. PO Medicare payments are paid monthly based on an interim per capita rate per participant. Under that methodology, separate rates are established for Part A and Part B. The PO receives payments based on each participant's entitlement to Medicare Part A and Part B. Therefore, if the participant was entitled to Part A benefits, but was not enrolled under Part B, the PO receives only the monthly capitation rate established for Part A. The same is true for those participants enrolled in Part B but not entitled to Part A, they would only receive that amount established for Part B.

Because states view a partial-benefit dual individual as a "dually" eligible individual, the state Medicaid payment to the organization is approximately half of what the organization would have received if the participant was a Medicaid-only individual. This reduced Medicaid amount coupled with a partial Medicare payment places an incredible financial burden on the PO.

This financial burden comes as result of the PACE benefit package being required to include for all participants, regardless of source of payment, all Medicare covered services, all Medicaid covered services as specified in the State's approved Medicaid plan, and any other services determined necessary by the participants Interdisciplinary Team (IDT) to meet the participant's needs and which improve or maintain the participant's overall health status. POs are also at full -financial risk for the services provided to their participants.

NPA recognizes that Medicaid enrollment and subsequent Medicare eligibility determinations happen long before a participant enrolls into PACE, however, if and when, correct determinations are not made in the first instance, in many cases the PO ultimately bare the financial burden unnecessarily.

NPA believes this proposal, if finalized, will help ensure that POs are being fairly compensated for the care and services being provided to its participants.

Changes in Circumstances, Timeframes and Protections

NPA supports the proposed changes to current regulations on changes in circumstances. In particular, NPA supports the proposed requirement that agencies may not take adverse action if an enrollee doesn't respond to a request for information to verify a change reported by either the individual or a reliable third party that would qualify the enrollee for more favorable coverage.

For a variety of reasons, enrollees may not always receive the request for additional information or be able to gather the appropriate documents in a timely manner. Defaulting to keep someone enrolled, especially when there is no evidence of ineligibility, is most beneficial for continuity of coverage and this must be preserved in the case of any adverse actions. Additionally, NPA supports giving states flexibility to either act on reliable third-party information that may result in an increase in the amount of coverage or assistance a beneficiary is entitled to, or to contact the beneficiary to determine whether the information received is accurate.

NPA thanks you in advance for considering our comments. Should you need additional information or for dialogue, please contact Liz Parry, Senior Director, State Policy, at lizp@npaonline.org or (703) 535-1521.

Sincerely,

R. Peter Fitzgerald
Executive Vice President, Policy and Strategy