



National Association of State Head Injury Administrators

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Administrator Donald M. Berwick
Center for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Regarding: CMS-2349-P

Dear Administrator Berwick:

The National Association of State Head Injury Administrators (NSAHIA) has reviewed the Notice of Proposed Rule Making (NPRM) regarding the Medicaid Program; Eligibility Changes Under the Affordable Care Act (ACA) of 2010 (76 CFR 51148 – 76 CFR 51199), and is submitting the following comments with regard to the new Adult category created by the ACA to expand Medicaid coverage to non-disabled adults previously ineligible and uninsured. NASHIA is concerned that the proposed eligibility criteria for this new expanded category will have a negative impact on adults with disabilities, both in terms of the new eligibility requirements and the benefits that may be offered through benchmark plans. At the same time there appears to be conflicting language with regard to whether eligibility requirements as specified apply to adults with disabilities who may be receiving Medicaid benefits through a HCBS waiver program and/or Medicaid Buy-In Program.

Congress included a list of categories of individuals who are exempt from the MAGI (modified adjusted gross income) eligibility determination in section 2002(a) of the ACA. The relevant language added a section at the end of 42 USC 1396a(e)(14)(D) stating that the MAGI methodology SHALL NOT be applied to: “Individuals who qualify for medical assistance under the State plan or under any waiver of the State plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3).” (emphasis added) (§2002(a) of the ACA; 42 USC 1396a(e)(14)(D)(i)(III)).

The rules as proposed would require everyone applying (or whose eligibility was being redetermined) for insurance affordability programs, regardless of whether the person was already receiving State plan or waiver services on the basis of being blind or disabled, to be put through the MAGI income calculation. We believe this is in conflict with the above language. In addition, the proposed rules limiting the exception to those people receiving SSI seems in direct conflict with the clause “without regard to whether the individual is eligible for supplemental security income benefits under title XVI on the basis of being blind or disabled.”

A similar exemption from application of the MAGI financial calculation was included in the statute for people requiring long-term services and supports. Specifically, the ACA says “[MAGI] shall not apply to any determinations of eligibility of individuals for purposes of medical assistance for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, home or community-based services furnished under a waiver or State plan amendment under section 1915 or a waiver under section 1115, and services described in section 1917(c)(1)(C)(ii).” (§2002(a) of the ACA; 42 USC 1396a(e)(14)(D)(iv)). The interpretation presented in the proposed rule is inconsistent with this statutory exemption.

Under the proposed interpretation, a person currently receiving HCBS services through a section 1915 waiver would be examined for eligibility at their redetermination using the MAGI calculation, even if he/she qualify for medical assistance under the State plan or under a waiver on the basis of being blind or disabled” and also are applying for “medical assistance for...home and community-based services under a waiver or State plan amendment under section 1915 or waiver under section 1115...”

If the person’s MAGI turns out to be less than 133% of FPL, the person would be placed in the new Adult category and lose access to the 1915 waiver services. The same would be true of a working individual with a disability eligible for Medicaid through a Medicaid Buy-In (MBI) option established under 42 USC 1396(a)(10)(ii)(II). The HCBS and other services included in the service package specifically to support a working individual with a disability would no longer be available if the person were placed in the Adult category, as the interpretation contained in the proposed rule would require.

Because of these inconsistencies with the provisions of the ACA, the proposed rules have the potential to restrict access to critical benefits that allow people with disabilities to live and work independently in the community. By performing the MAGI calculation on everyone applying or reapplying for Medicaid eligibility and requiring States to enroll all people who qualify for it in the Adult category, the proposed rules appear to deny people found eligible for the new Adult category any route to access long-term services and supports through waivers and other benefit packages states have created to provide those critical services.

Since 1991, States have developed specific HCBS waivers for individuals with brain injury, similar to waivers provided to individuals with other disabilities, in order for individuals to live in the community in lieu of institutional care. And, since 1997, 40 States have extended Medicaid coverage, including long-term supports and services, to working people with disabilities whose earnings are too high for them to qualify for Medicaid under existing rules, in accordance with Section 4733 of the Balanced Budget Act of 1997.

NASHIA urges CMS to reconsider its interpretation of some of the basic requirements of the ACA to ensure that people with disabilities, especially working people with disabilities, are not harmed by the implementation of Medicaid eligibility expansion in an attempt to expand health care coverage to adults who were previously unable to obtain it. We urge CMS to reconsider its interpretation that eligibility be determined using the MAGI financial calculation for everyone applying for medical assistance. In addition, screening questions should be included in the application for coverage to determine whether the person has a disability, needs long-term services and supports, and belongs to a category that is exempt from mandatory benchmark coverage.

While we appreciate CMS’ efforts through the proposed rules to simplify income standards for eligibility for the Medicaid program, we have grave concerns that these efforts will negatively impact adults with disabilities.



Susan L. Vaughn
Director of Public Policy