October 31, 2011

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, SW.,
Washington, DC 20201

Regarding: CMS–2349–P

Dear Administrator Berwick:

On behalf of the Consortium for Citizens with Disabilities (CCD) Health, Long Term Services and Supports, and Employment Task Force, we are pleased to submit comments to the Center on Medicare and Medicare Services (CMS) on the Notice of Proposed Rule Making (NPRM) regarding the Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010 (76 CFR 51148 – 76 CFR 51199).

CCD is pleased to see the proposed rules issued to implement the expansion of Medicaid coverage required by the Patient Protection and Affordable Care Act of 2010 (ACA). We also appreciate and support the efforts by CMS to create a single, streamlined application process that ensures eligible individuals receive coverage as quickly as possible. However, we have serious concerns regarding CMS' interpretation of the ACA and its potential impact on people with disabilities and special health care needs. In particular, the interpretation advanced in the NPRM appears to foreclose the ability of some working people with disabilities to retain access to services and supports they need to remain in the workforce. Although a single streamlined application process will make it easy for most applicants and create administrative efficiencies for states, it has the potential to block access to vital services and supports for people with disabilities.

CMS has used the analogy in public forums that we want to get everyone into the house and sort out which room they belong in after they get through the door. The problem is that CMS' interpretation as outlined in the NPRM does not allow people to move from room to room if they end up in the wrong room– that is from one eligibility category to another to ensure the benefits available meet their needs. We are particularly concerned that people with disabilities not eligible for Supplemental Security Income (SSI) will lose

access to Home and Community Based Services (HCBS), Medicaid Buy-In (MBI)[1] and other long-term services and supports as a result of being placed in the new mandatory eligibility category created by the ACA (codified at section 1901(a)(10)(A)(1)(VIII) of the Social Security Act herein after referred to as the "Adult" category) and will become underinsured as a result.

CCD urges CMS to reconsider its fundamental interpretation of some of the basic requirements of the ACA to ensure that people with disabilities, especially working people with disabilities, are not made worse off by the implementation of Medicaid eligibility expansion. Our comments address this basic interpretation point before addressing specific proposed regulatory language.

I. The ACA and Medicaid Expansion

The ACA has dual goals: 1). Provide access to affordable health care coverage to all Americans, especially those who previously were unable to obtain it; and 2). To control the costs of health care by decreasing inflation and changing the cost curve. To help accomplish goal number 1, the ACA created a new mandatory eligibility category for Medicaid coverage – the Adult group. This new category was created to extend Medicaid coverage to previously ineligible childless individuals with household income of up to 133% of the Federal Poverty Level (FPL) regardless of the level of resources possessed by the individual. Because this might represent a significant expansion of the eligible populations in some states, Congress provided states with both an enhanced Federal Medical Assistance Percentage (FMAP) for newly eligible individuals and required states to limit what is included in the benefit package to all individuals in the Adult group by providing a benchmark benefits package (Section 2001 of the ACA). It is the latter accommodation to states that could have disastrous consequences for people with disabilities if the rules are adopted as proposed.

The new Adult group was intended to supplement the current eligibility groups to allow previously uninsured low-income adults who might not be able to afford to purchase insurance (even with premium subsidies) through the new Health Benefit Exchanges established by Part II of the ACA to access to coverage through Medicaid. The expansion group was designed to create a safety net for people who otherwise would not have coverage – not to replace existing categories of eligibility or to subsume other categories and provide eligibility to people who were already eligible through an existing Medicaid eligibility category. The proposed rule turns this on its head – it places everyone who qualifies for the Adult group there, regardless if the person previously qualified through another eligibility category and regardless of whether the Adult group provides the right benefit package. Support that this is not what Congress intended as the purpose of the Adult category can be found in several places in the ACA.

[1]The Medicaid buy-in option is offered in 40 states and offers people with disabilities who are working and earning more than the allowable limits for Medicaid access to health care coverage through Medicaid. This includes important long-term services and supports that may be essential to their retaining employment. These supports and services are not likely to be offered through benchmark plans.

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II. Proposed Rule Includes People Who Should Be Exempt in MAGI Calculation

First, the inclusion of exemptions from using the Modified Adjustment Gross Income (MAGI) calculation to determine eligibility for specified groups is evidence that it was not intended that individuals already eligible under a pre-ACA eligibility category be placed in the new Adult group. Congress included a list of categories of individuals who are exempted from having the MAGI eligibility determination being performed on them in section 2002(a) of the ACA. For people with disabilities, the relevant language added a section at the end of 42 USC 1396a(e)(14)(D). The language states 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 preceding language is quite clear. The Department of Health and Human Services is prohibited from using the MAGI income calculation to determine eligibility for Medicaid for any person with a disability – regardless of whether or not the person receives SSI. The rules as proposed would require everyone applying (or whose eligibility was being redetermined) for insurance affordability programs, regardless of whether the person were already receiving State plan or waiver services on the basis of being blind or disabled, to be put through the MAGI income calculation. The interpretation in the proposed rules appears to very clearly violate the prohibition on using the MAGI financial criteria for this group established by this exceptions clause. 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.**" The proposed interpretation renders this clause meaningless and Congress does not include language in statutes unless it has meaning. (§2002(a) of the ACA; 42 USC 1396a(e)(14(D)(i)(III))

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.

The rule as proposed could lead to some particularly strange results. For example, under the proposed interpretation, a person currently receiving HCBS services through a section

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1915 waiver would be examined for eligibility at their redetermination using the MAGI calculation, although they clearly seem to "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…" It is unclear how someone who was already eligible and receiving services on the basis of being blind or disabled and for HCBS is somehow not captured by the exemptions listed in 42 USC 1396a(e)(14)(D)(i)(III) or 42 USC 1396a(e)(14)(D)(iv). The proposed rule therefore appears to make part or all of the language in 1396a(e)(14)(D) superfluous or meaningless. If a person currently receiving waiver services is not a person intended by Congress as being included in the exemption, it is hard to figure out who would be. As such, we strongly disagree with CMS' interpretation of this provision of the ACA.

Continuing with the example from the previous paragraph, 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.

Congress did not intend this result. States have made significant progress in supporting individuals with disabilities to live and work in their communities and maximize their independence by creating waivers and other service packages that provide the services people with disabilities need to obtain and maintain independence. In part these efforts have been required by the Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999), but Congress and recent Administrations have also provided significant support to states in these efforts through the New Freedom Initiative and the Money Follows the Person (MFP) demonstration project. The ACA reiterated that commitment by extending and providing additional funding for MFP, establishing the Community First Choice program (see Subtitle E of Section II of the ACA), and the Balancing Incentives Payments Program (Section 10202 of the ACA). Any interpretation of the Medicaid expansion that would hinder those state efforts is clearly at odds with Congress' support of community integration of people with disabilities and Congressional intent in creating the Adult category.

III. The Proposed Rule Requires People Who Are Exempt to Be Enrolled in Benchmark Coverage

Second, in order to assist states in expanding their Medicaid coverage, the ACA requires states to offer only a benchmark or benchmark equivalent benefit package to those eligible for the new Adult category (Section 2001 of the ACA). When Congress created the flexibility for states to offer a benchmark benefit package in the Deficit Reduction Act of 2005, it excluded certain individuals from mandatory inclusion in the benchmark plan because its benefits would be too limited to meet the needs of those individuals

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(section 1937 of the Social Security Act). Congress reiterated that the exemptions from mandatory enrollment in a benchmark plan created by §1937 of the Social Security Act applied to the new Adult category in §2001 of the ACA.

Section 1937 of the Social Security Act prohibits states from requiring a blind or disabled individual to enroll in benchmark coverage (section 1937(a)(2)(B)(ii) and 42 CFR §440.315(b)). The same section also exempts people who are medically frail or have special health care needs as defined by the Secretary of Health and Human Services from being required to participate in a benchmark benefit plan (section 1937(a)(2)(B)(vi). In April 2010, the Secretary issued final regulations that required states to include the following in their definition of medically frail for the purposes of exemption from the benchmark, "…must include at least those individuals described in §438.50(d)(3), children with serious emotional disturbances, *individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and/or mental disabilities that significantly impair their ability to perform one or more activities of daily living.*" (42 CFR §440.315(f) *emphasis added*). It is hard to see how someone currently enrolled in Medicaid with a disability and receiving HCBS through a 1915 waiver or a MBI option would not qualify under one or both of these exemptions. **States would then be faced with a catch 22** – the proposed rule would require the state to place the individual in the Adult category but other existing rules regarding benchmark coverage would prohibit them from providing an exempted individual with benchmark coverage (as is required by the statute for the Adult category).

States can elect to provide all of the services included in the State plan to people enrolled in benchmark coverage. However, even if every state chose to do so (which we find doubtful), it would not solve the problem identified here. States can only include those services included in §1905(a) of the Social Security Act in their benchmark plans, as states may only require full-benefit eligible individuals to be enrolled in the benchmark plans (§1937(a)(2)(c)(i) of the Social Security Act). Because of this provision, states would not be eligible for federal financial participation for the additional services if they elected to extend waiver services to people eligible for medical assistance through the Adult category.

IV. The Proposed Rules are Inconsistent with the ACA

CCD does not believe that the interpretation of the ACA proposed in this NPRM are consistent with its statutory requirements. People with disabilities and/or people in need of long-term services and supports, whether currently receiving medical assistance services (especially HCBS through waivers or MBI) or applying for the first time, regardless of whether the individual is SSI eligible, should not be evaluated for eligibility based on the MAGI financial calculation. The exemptions from the MAGI contained in §2002(a) clearly prohibit including these individuals and the proposed rule appears to make the exemptions completely meaningless. If the eligibility of everyone on application or redetermination is evaluated based on the MAGI calculation, it becomes impossible for the exemptions to come into play. This is not what Congress intended. Congress mindfully included these exemptions to avoid the kind of absurd results the

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proposed regulations might create. In addition, states would be required to place individuals who are also exempted from mandatory enrollment in a benchmark plan into the Adult category, which requires states to offer benchmark coverage. This is also clearly not what Congress intended.

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.** Taken to its logical conclusion, the proposed rules would result in people with disabilities, people who are medically frail, and people with special health care needs no longer being able to get the services and supports they need in the community and instead being forced to enter institutions to receive care. This would reverse progress made toward community integration, would result in increased costs for both the Federal government and the states, and would not be consistent with the Supreme Court's ruling in Olmstead v. L.C., 527 U.S. 581 (1999) or the Sense of the Senate as expressed in the ACA that "…long term services and supports should be made available in the community in addition to in institutions." (Title II, Subtitle E of the ACA).

RECOMMENDATION: We urge CMS to reconsider its interpretation that eligibility be determined using the MAGI financial calculation for everyone applying for medical assistance. **At the very least, anyone already eligible for Medicaid as of December 31, 2013 on the basis of disability <u>("without regard to whether the individual is eligible for supplemental security income benefits under title XVI on the basis of being blind or disabled</u>) or needing long-term services and supports (whether in an institution or in the community) should be exempted from the MAGI calculation.** Screening questions should be included in the application everyone applying for coverage completes 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. Consistent with CMS's analogy, the final rule must permit such individuals to move from room to room based on their individual circumstances once they enter the front door of the house.

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Comments Regarding Specific Provisions:

Subpart G: General Financial Eligibility Requirements and Options

As stated in the general comments above, CCD has serious concerns regarding the way these provisions are interpreted in the proposed rules. As previously analyzed, we do not believe it was Congress' intent that any person with a disability that could be eligible in any mandatory or optional category for coverage in a state prior to passage of the ACA be evaluated for eligibility based on the MAGI financial methodology. The preamble to the proposed regulations states on page 51159, "This exception applies only to those individuals for whom the determination of eligibility is made on the basis of being blind or disabled. Individuals who are blind or who have disabilities can also be covered under the new mandatory eligibility group for adults."

The provisions in the ACA do not support this interpretation. We believe this is akin to saying a person is not eligible on the basis of disability because we have decided not to evaluate them on the basis of disability. This is circular logic and will lead to absurd results if retained in the final rule. The language in the ACA states 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…" CMS' interpretation effectively eliminates this exception unless an individual is receiving SSI and does not live in a 209(b) state. We do not believe this was Congress' intent. The inclusion by Congress of people qualifying for medical assistance under any waiver of the state plan is particularly helpful to understand why the proposed interpretation is flawed. CMS proposes to evaluate new applicants and current beneficiaries using the MAGI financial methodology if not covered by an exception even if the person was previously eligible based on a category that would be encompassed by that exception.

To fully evaluate the absurd results that could follow from this interpretation, it might be best to look at an example. Take a person who is eligible for waiver services, including HCBS, on the basis of being blind or disabled on December 31, 2013. This individual would seem to be exempt from evaluation under the MAGI based on two exceptions: qualifying on the basis of being blind or disabled and on the basis of needing long-term services and supports. Based on the NPRM, this person would still be evaluated at their next redetermination using the MAGI methodology because the agency is evaluating their eligibility based on the Adult category. This argument is tautological and makes the exceptions meaningless. Surely Congress meant to exempt a person who is already eligible on the basis of disability and the need for long-term services and supports from being evaluated under the MAGI methodology but CMS only need say they are not evaluating them on that basis to side step the exemption.

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The reason that this is a particularly salient example is that if this person is found eligible for the new Adult category, they will lose their access to the waiver and HCBS services they were previously receiving. Under the proposed rule, the state could not evaluate the individual for eligibility in other eligibility categories once a person was found eligible for the new Adult category. Coverage in this category is mandatory and waivers and MBI programs are optional and mandatory eligibility will trump optional eligibility. Ironically, this interpretation has the potential to place people with disabilities with income over 133% of the federal poverty level and people with disabilities who are Medicare eligible in a better position to access long-term care services through Medicaid than an individual with income under 133%. States will be required to evaluate a person who is found ineligible for the new Adult category due to income or Medicare eligibility (for example) for eligibility for Medicaid under all categories, including optional ones that provide HCBS. This is certainly not what Congress intended.
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At the very least, we urge CMS to change their interpretation so that a person is considered to be applying on the basis of disability or the need for long-term care services when a person's eligibility is being redetermined and was previously receiving Medicaid on the basis of disability or the need for long-term care services.

RECOMMENDATION: We urge CMS to reconsider its interpretation that eligibility be determined using the MAGI financial calculation for everyone applying for medical assistance. **At the very least, anyone already eligible for Medicaid as of December 31, 2013 on the basis of disability (<u>"without regard to whether the individual is eligible for supplemental security income benefits under title XVI on the basis of being blind or disabled</u>) or needing long-term services and supports (whether in an institution or in the community) should be exempted from the MAGI calculation.** Screening questions should be included in the application everyone applying for coverage completes to determine whether the person has a disability, needs long-term services and supports, or qualifies under any other category that is exempt from the MAGI financial calculation method and mandatory benchmark coverage.

Subpart J: Eligibility in the States and the District of Columbia Applications

§435.907 Application

CCD understands the rational for creating a single streamlined application for all insurance programs. It is simple for most applicants to use and understand and easy for states to administer. For people with disabilities and those who need long-term services and supports, however, this application could result in them ending up in an eligibility category that does not meet their needs (and that Congress intended them to be excluded from). It is our understanding that under these proposed rules everyone applying for benefits will use the same application and have the MAGI methodology applied to them. If an individual applying might be eligible for coverage on a basis other than MAGI, the proposed rule permits states to use *either* the single, streamlined application and supplemental forms to collect additional information needed to determine eligibility on such other basis *or* an alternative application approved by the Secretary.

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CCD has several concerns regarding the way this section is designed. First, these proposed regulations do not require states to ask any screening questions to determine whether an applicant might be eligible on a basis other than MAGI. Although it is our understanding that CMS intends to follow up with additional guidance (possibly outside the formal notice and comment rule making context) that would include suggested questions and examples of supplemental forms, it is not clear that this additional guidance will require states to ask these additional questions and complete additional screening. We strongly support requiring states to ask additional screening questions prior to running the MAGI calculation to make sure that people do not end up in an eligibility category from which they ought to be exempt.

Second, as previously discussed, the proposed rules require states to put everyone through the MAGI financial calculation. A person who might be identified by a screening question as needing long-term services and supports or being eligible for medical assistance on the basis of having a disability would have their eligibility under the MAGI evaluated at the time of the initial application. If the applicant meets the criteria for eligibility under the Adult category, they would be placed there regardless of how they answer the screening question. In essence, it appears that for anyone who would be eligible under the Adult category, a screening question would be futile. Even if a person responded positively to a screening question to identify disability or long-term services and supports needs, the person would be placed in the Adult category.

Further, there is no requirement in the regulations for states to explain the possible advantages to being found eligible for another category (and conversely the potential limits to the coverage in the Adult group) to applicants. Nor are states required to explain that an additional application might entitle a person to additional benefits. There is no explanation in the proposed rules regarding how a state would determine when the supplemental form or alternative application should be provided to an applicant. As explained previously, if the screening question is in the streamlined application and the streamlined application gets processed prior to completion of the supplemental form (or alternative application) and a person is found eligible for the Adult group, the person will be unable to access any other eligibility category regardless of whether they might be eligible and regardless of whether the service package better meets their needs.

RECOMMENDATION: States should be required to ask a question or set of questions to determine whether a person is exempt from their eligibility being determined based on the MAGI financial calculation. States should be required to determine whether the person is exempt prior to processing the streamlined application so that eligibility is not established for the Adult group if the person is potentially eligible based on a non-MAGI category that has a service package that better meets their needs. CMS should also require a State agency to determine an individual's eligibility on a basis other than MAGI prior to running a MAGI calculation for any person who asserts their eligibility on an alternate basis. CMS should also consider:

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- Requiring the State agency or other entity taking the application to make sure the individual is enrolled in the best eligibility category they qualify for (even if this a non-MAGI category and even if this an optional category when they might qualify for a mandatory one); and
- Establishing some enforcement or review mechanism to monitor states' policies and practices to ensure that people with disabilities, people who need long-term services and supports, and the medically frail are placed in the eligibility category most beneficial to them with the service package that best meets their needs.

§435.908 Assistance with application and redetermination

CCD is pleased to see the requirement that assistance with the application and redermination process be accessible to people with disabilities. We believe it would be helpful for HHS to provide additional guidance to states in order to ensure that it is accessible to people with a wide range of disabilities – for example, ensuring that written materials are understandable by people with intellectual disabilities and that electronic assistance is §508 compliant and compatible with screen readers for people with vision impairments. CCD would be happy to provide additional recommendations regarding the development of such guidance should CMS adopt this recommendation.

§435.911 Determination of eligibility

CCD is pleased that the proposed regulations require a quick decision regarding a person's eligibility for Medicaid and other insurance affordability programs and for coverage to be furnished to eligible individuals without "undue delay." People entitled to coverage through Medicaid and the other insurance affordability programs should not have to wait unnecessarily for their coverage to begin. However, as stated earlier, we fundamentally disagree with the interpretation contained in this section. Congress included exemptions from the MAGI financial methodology for specified in Section 2002(a) of the ACA. The statute explicitly says that someone eligible on the specified bases (e.g. on the basis of other aid or assistance, on the basis of being over age 65, on the basis of being blind or disabled, or on the basis of being medically frail) should not be evaluated for eligibility based on the MAGI calculation. The regulations as written are not consistent with these statutory provisions (See previous section entitled **Proposed Rule Includes People Who Should Be Exempt in MAGI Calculation).** This proposed language takes the opposite approach – it first puts everyone, including exempt individuals, through the MAGI calculation and only if the individual is found ineligible for the adult category does it require the State agency to determine whether they are eligible on any other basis.

RECOMMENDATION: We urge CMS to reconsider its interpretation that eligibility be determined using the MAGI financial calculation for everyone applying for medical assistance. At the very least, anyone already eligible for Medicaid as of December 31, 2013 on the basis of disability or needing long-term services and supports (whether in an institution or in the community) should be exempted from the MAGI calculation. Screening questions should be asked prior to someone filling out the streamlined

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application for coverage to determine whether the person has a disability, needs long-term services and supports, or belongs to any other category that is exempt from both the MAGI calculation and mandatory benchmark coverage

§435.916 Periodic redeterminations of Medicaid eligibility

Although not explicitly stated in the proposed rule, it is our understanding that everyone eligible for Medicaid as of 12/31/2013 will have their continuing eligibility for medical assistance determined based on the MAGI financial method on their next redetermination unless they qualify for an exemption as defined in proposed §435.603(i). This means that a person receiving services only available to a person with a disability (for example under a Medicaid Buy-In program or disability specific section 1915 waiver) and **therefore already found by the state to "qualify for medical assistance under the State plan or under any waiver of the State plan on the basis of being blind or disabled" prior to the implementation of the new regulations**, will be assumed to no longer qualify on that basis. If the person did still qualify on the basis, they should be exempt from application of the MAGI financial criteria as required by Congress (§2002(a) of the ACA; 42 USC 1396a(e)(14(D)(i)(III)). In the case of a person eligible for services under a waiver that includes HCBS, this would seem to be inconsistent with not only that exemption but also the provision stating that the MAGI financial methodology 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.." (§2002(a) of the ACA; 42 USC 1396a(e)(14(D)(iv)).

RECOMMENDATION: We reiterate that we believe this interpretation is not consistent with Congressional intent regarding the populations who should be exempt from the MAGI calculation. We urge CMS to reconsider this interpretation in light of the statutory language and to require state to use traditional Medicaid financial methodologies and eligibility determinations for anyone who was eligible for medical assistance on the basis of disability or the need for long-term care prior to January 1, 2014 in the final rule. The bottom line is that the final regulation should ensure that no one currently eligible be moved to a different eligibility category after January 1,2014 that potentially will not provide the services and supports the person needs. States have created a variety of optional categories and waivers (including for people who receive State Supplementary Payments and MBI programs for not only people with disabilities but also for those who have medically improved) to meet the complex technological, pharmaceutical, durable medical equipment, personal care, and other needs of people with disabilities, who are medically frail, or have chronic health conditions. The final regulation should ensure that access to those optional categories and service packages is preserved.

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On behalf of the CCD Health, Long Term Services and Supports and Employment Task Forces, we appreciate the opportunity to provide comments on these important regulations. If you have questions please contact the CCD Health Task Force Co-Chairs listed below.

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