**State 1115 waiver comment period: Framing suggestions for state comments**

As of May 2018, 19 states were pursuing 1115 waivers that would make it harder for people to get or keep Medicaid coverage, and the list of states is growing. One way organizations can voice opposition to state waiver proposals is by submitting public comments during the state comment period.

Submitting state comments can result in the state changing what’s in the final waiver submitted to the Center for Medicare and Medicaid Services (CMS) for federal approval (particularly if a lot of commenters make the same point). Even if the comments aren’t incorporated into the waiver, they lay a foundation for future waiver changes and even court challenges.

Families USA has developed guidelines to help organizations frame t state-level comments on Section 1115 waivers. They address requested program changes that would make it harder for consumers to get or keep Medicaid coverage and that have appeared in recent state waiver requests.

The focus of these framing points for comments is on state-level comment drafting. Organizations should file federal comments as well. Those should have a heavier focus on the limits of CMS’s approval authority under federal Medicaid law. See Families USA’s 1115 [federal waiver comments](http://familiesusa.org/initiatives/waiver-resource-center/families-usa-comments-medicaid-1115-waivers-and-1332-innovation) for ideas on content.

**Guidelines for Framing State-level 1115 Waiver Comments**

**How to use these guidelines**

Each state waiver request is different. However, the broad outlines of the changes states are asking for in restrictive 1115 waivers are very similar.

Please note that these framing guidelines are general and focus on common themes we are seeing across state waiver requests. However, each state waiver request is different. Whenever possible, you should use state- specific data or discuss state- specific situations to support your points.

Each section below presents framing guidelines for specific waiver requests or parts of your comments. Most likely, only a few will apply to any given waiver request.

* Introduction and context for your comments (applies to all waiver comments)
* Work requirements
* Time limits
* Drug testing as a condition of eligibility
* Lock-outs associated with prompt paperwork filing requirements
* Premiums and cost sharing
* Lock-outs generally (i.e., with work requirements, failure to meet paperwork requirements, failure to pay premiums)
* Partial expansion
* Making dental benefits conditional
* Eliminating Early, Periodic Screening Diagnostic and Treatment (EPSDT)
* Eliminating non-emergency transportation
* Eliminating retroactive coverage
* Asset tests

**Introduction and context for your comments**

**Introduction**

Your comments should include an introductory paragraph that connects your organization’s work and interests to the state’s Medicaid program.

Be sure to thank the state for the opportunity to submit comments.

**Context**

Provide some detail on the importance of Medicaid to the state and state residents, particularly for the population being targeted by the waiver (typically adults). Mention Medicaid’s positive impact on the state’s health care providers and the state economy.

***Drafting Suggestion****:* Throughout your comments, whenever possible, point out how the proposal runs counter to or undermines positive initiatives that the governor, the legislature, or key legislators have embraced, such as improving the state residents’ overall health status, revitalizing rural communities, or promoting childhood health.

**Framing recommendations for specific waiver provisions**

**Work requirements**

***Background:*** Several states have asked to apply work or community engagement requirements in Medicaid, similar to those in the Temporary Assistance for Needy Families (TANF) program. Failure to meet those requirements would result in disenrollment and lock-out. As of May 2018, CMS had approved these programs in four states: Kentucky, Indiana, New Hampshire and Arkansas. Requests from several other states were pending approval.

***Drafting Suggestion:*** At the outset of this section, note your organization’s support for programs that truly help get people back to work. Note that Medicaid is one of those programs. Threatening people with loss of health insurance, and cutting people off health insurance, will not promote work. The work requirement and associated paperwork will cause Medicaid enrollees across the board—those who are working, not working, or unable to work—to lose coverage.

**Medicaid helps people work; the state’s proposal to take Medicaid health coverage away from people will make it harder for them to work.** Cutting people off health insurance will not increase their employment opportunities. However, there is data showing that providing people with health insurance through Medicaid will help them get and keep employment.

* In a [comprehensive assessment](https://ccf.georgetown.edu/2017/01/10/the-return-on-investment-of-medicaid-expansion-supporting-work-and-health-in-rural-ohio/) of Ohio’s Medicaid expansion program, 52.1 percent of expansion enrollees said that Medicaid coverage made it easier for them to get and keep employment.
* In surveys of unemployed Medicaid expansion enrollees in Ohio and Michigan, the majority (74.8 percent in Ohio and 55 percent in Michigan) said that [having Medicaid coverage made it easier for them to look for work](https://www.clasp.org/sites/default/files/publications/2017/04/The-Evidence-Builds-Access-to-Medicaid-Helps-People-Work.pdf).

**Cutting state residents off Medicaid will hurt families’ financial security.** Like all insurance, Medicaid helps protect state residents from medical costs and debt. That helps improve enrollees’ financial security. Arguments that a work requirement linked to coverage disenrollment will help improve individuals’ economic security do not hold up. Medicaid coverage in and of itself improves individuals’ financial security. Taking Medicaid away will hurt families’ financial security.

* [Two studies](http://familiesusa.org/blog/2016/09/medicaid-expansion-improves-people%E2%80%99s-financial-stability) of the impact of Medicaid expansion on financial health found that Medicaid expansion is associated with a significant reduction in unpaid medical bills, a decline in credit card debt, and a decline in debts sent to collections.
* Medicaid expansion is [associated with](https://ccf.georgetown.edu/2017/08/02/medicaid-expansion-reduced-unpaid-medical-debt-improved-financial-well-being-for-families/) reduced medical debt and improved finances among enrollees.
* [Ohio’s assessment](https://ccf.georgetown.edu/2017/01/10/the-return-on-investment-of-medicaid-expansion-supporting-work-and-health-in-rural-ohio/) of Medicaid expansion enrollees found that Medicaid coverage helped enrollees’ finances: 22.9 percent of expansion enrollees said their financial situation improved. Medicaid also made it easier for enrollees to afford other life essentials: 58.6 percent said Medicaid coverage made it easier for them to purchase food; 48.1 percent said it made it easier for them to pay rent or a mortgage; and 44.8 percent of enrollees with medical debt said that with Medicaid expansion, they saw that debt end.
* When Oregon extended Medicaid coverage to previously uninsured low-income adults in 2008 (before the Medicaid expansion), the individuals gaining coverage [reported](http://www.nejm.org/doi/full/10.1056/NEJMp1108222) improved financial security. Greater financial security and stability [reduces individuals’ risk of homelessness](https://www.nhchc.org/2013/05/oregon-study-shows-obtaining-medicaid-improves-financial-security/) and is a foundation for moving out of poverty.

**Paperwork/work documentation requirements will make it harder for all enrollees to keep Medicaid.** The state is requiring paperwork from a broad swath of adults on Medicaid. Enrollees who are already working will need to document hours worked at regular intervals. Those who are exempt from the work requirement will need to prove that they are exempt. Those who are not currently working will need to document hours in community service, job training, or hours spent applying for jobs. All stand to lose coverage if they don’t keep up with the paperwork requirement.

When states [add paperwork](https://www.nytimes.com/2018/01/18/upshot/medicaid-enrollment-obstacles-kentucky-work-requirement.html) requirements to Medicaid, enrollment falls. That will happen with the state’s proposed work requirement as well, and enrollment will fall across the board—including for working adults, people with medical conditions who cannot work but do not qualify for SSI disability, and family caregivers.

**The added administrative costs to taxpayers are unnecessary, and likely ineffective as well.** The added paperwork and tracking will [increase program administrative costs](https://ccf.georgetown.edu/2018/01/23/weaponizing-medicaid-paperwork/) to taxpayers, in addition to causing enrollees across the board to lose health coverage. This is also an unnecessary taxpayer expense, because most adults in Medicaid are already working. **[***Drafting Suggestion:* Insert percentage of adults in Medicaid in the state who are working or who are in a working family, available [here](https://www.kff.org/medicaid/state-indicator/distribution-by-employment-status-4/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D)**];** most who do not work have [a major work impediment](https://www.kff.org/medicaid/state-indicator/distribution-by-employment-status-4/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D), such as poor health, a disability, or caregiving responsibilities.

**Work requirements in Medicaid are being litigated; a work requirement may need to be rescinded.** The work requirement approved in Kentucky’s Medicaid waiver is currently the [subject of litigation](https://www.kff.org/medicaid/issue-brief/a-guide-to-the-lawsuit-challenging-cmss-approval-of-the-kentucky-health-medicaid-waiver/), as being outside of CMS’s authority to approve by waiver. It is irresponsible and a waste of taxpayer dollars for the state to pursue a work requirement, and build up the bureaucracy required to administer the program, when its legality is in question and the state may end up having to defend a law suit.

**Volunteer referrals to work programs put people back to work without taking their health care away.** As part of its Medicaid expansion, Montana incorporated a ***voluntary*** referral to a state job counseling program with no disenrollment penalty. With the combined Medicaid expansion/job referral program, the state has [seen employment gains](https://mthcf.org/wp-content/uploads/2018/04/BBER-MT-Medicaid-Expansion-Report_4.11.18.pdf) among the Medicaid expansion population that are above the US average for that income group, and above the gains for higher income groups in the state.

**Time limits on Medicaid coverage**

***Background:*** Several states have asked to limit lifetime Medicaid eligibility for adults age 19 to 65. As of May 2018, CMS had rejected one request (Kansas). Other requests were still pending.

## **Most individuals cut from Medicaid will become uninsured.** By definition, Medicaid enrollees are low-income. Most, including those who are working, do not have any access to another source of health coverage. Employer coverage is often not offered to low-wage workers or, if offered, [it is unaffordable to them](https://www.liebertpub.com/doi/10.1089/pop.2017.0191) and effectively not available. Health coverage for part-time workers is [typically not offered](https://www.ebri.org/pdf/notespdf/EBRI_Notes_05_May-14_PrtTime.pdf) by employers. The proposal to time-limit Medicaid eligibility will increase the number of uninsured state residents. **[*Drafting suggestion*: Discuss percentage of private firms offering health insurance in your state, available** [**here**](https://www.kff.org/other/state-indicator/percent-of-firms-offering-coverage/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D)**; also, note the percentage of Medicaid enrollees working part time, available** [**here**](https://www.kff.org/medicaid/state-indicator/distribution-by-employment-status-4/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D)**.]**

## **Cutting people off Medicaid, which a time limit will do, will make it harder for low-income people to work.** Medicaid helps people work. Most of those losing Medicaid coverage will become uninsured, and unable to access health care that can make it possible for them to get or stay healthy, so that they can work. (See Work Requirements section, above.)

**There is no limit to the time period individuals may need Medicaid coverage.** There are 70 million Americans on Medicaid. Medicaid is a not a small, time-limited program—it is a foundational pillar of the American health care system. There is no limit to the number of times, or duration of time, that individuals may get sick, fall on hard financial times, and need Medicaid insurance.

**Cutting people off Medicaid, which time limits will do, will not help them move out of poverty—in fact, the opposite will happen.** Medicaid coverage in and of itself helps people improve their financial security, a key step for individuals who are trying to move out of poverty. (See Work Requirements section.)

**A time limit would increase hospital uncompensated care costs, and health care costs for everyone in the state**. Those losing Medicaid coverage will still get sick and eventually seek health care—but without insurance, they will not be able to pay for the care they receive. That will increase uncompensated care costs for hospitals and other health care providers. Those costs would be passed on to [**state and local governments**](https://kaiserfamilyfoundation.files.wordpress.com/2013/07/8457-the-cost-of-not-expanding-medicaid4.pdf) and insured patients, increasing health care costs for all state residents.

**Time limits violate federal Medicaid law.** Time limits are inconsistent with federal Medicaid law and are outside of CMS’s waiver authority. If CMS approves the state’s request, litigation will likely follow. The program may be held invalid. Any money the state has spent on implementation will have been wasted. Pursuing this is a known and irresponsible risk of taxpayer money.

**Required drug testing**

***Background:*** Wisconsin has asked CMS for approval to require adults to submit to drug testing and, if they test positive, to enroll in treatment as a condition of Medicaid eligibility. As of mid-May 2018, this request had not been approved; no other states have submitted similar requests.

***Drafting Suggestion:*** Preface comments noting that it is critical that the state effectively address the opioid epidemic. However, conditioning receipt of health insurance on drug testing and treatment is not an effective way to address the problem.

If there is a drug overdose report or county map for your state, use that to reference areas that would be most heavily affected by this policy as part of your comments. See this example DEA report for [Pennsylvania](https://www.dea.gov/docs/DEA-PHL-DIR-034-17%20Analysis%20of%20Overdose%20Deaths%20in%20Pennsylvania%202016.pdf).

**Drug testing will be difficult and costly to implement**. **[This section needs to be specific to your state.] Note any deficiencies in the state’s drug testing infrastructure that would need to be addressed, such as:**

* Are there enough test sites?
* Are they easily accessible by public transportation?
* Are they available in rural and urban areas?
* Do they have hours that can accommodate people who can only come in the evening or weekends?
* What is the staffing capacity of those test sites? What’s the plan for increasing capacity if needed?
* Will there be transportation or childcare support so child caregivers can comply?
* What is the estimated cost to taxpayers? (If there is a fiscal cost analysis for the program, note that.)

**The cost of drug testing far outweighs the benefits.** [Experience](https://thinkprogress.org/states-spend-millions-to-drug-test-the-poor-turn-up-few-positive-results-81f826a4afb7/) from states that include drug testing in TANF shows that program costs are high, and few individuals test positive. **[If your state uses drug testing in TANF, add program experience here, if it supports your position.]**

**Connecting people with health insurance is a better way to address the problem.** Requiring drug testing [delays Medicaid coverage for individuals who need access to substance use treatment.](http://familiesusa.org/blog/2017/12/drug-testing-medicaid-illegal-and-hurts-people-who-need-help-most) It also makes it less likely that individuals needing treatment will enroll in the first place—many may be wary of disclosing drug use as part of an application for public benefits for fear of retribution; others may find the process humiliating and invasive. Neither outcome helps address the opioid epidemic.

Making it easy for people to enroll in health coverage so that they can access treatment, and [medical and mental health care](http://www.slate.com/articles/health_and_science/medical_examiner/2017/06/bcra_would_remove_mental_health_care_coverage_a_critical_piece_of_solving.html) they may need to address any underlying conditions that spurred their substance use, [is critical to addressing](https://www.cbpp.org/blog/medicaid-expansion-essential-to-address-opioid-epidemic) the state’s opioid crisis.

**Delaying treatment can have other public health costs.** Intravenous drug use can lead to the spread of conditions like [HIV](https://www.cdc.gov/hiv/risk/idu.html) and [Hepatitis C](https://www.cdc.gov/hepatitis/hcv/pdfs/factsheet-pwid.pdf). Delayed substance use treatment can contribute to the spread of such diseases. It is critical to connect people who need treatment with health coverage as quickly and easily as possible. Requiring drug testing in order to receive Medicaid coverage stands in the way of that.

**Required drug testing will suppress Medicaid enrollment across the board.** Required drug testing is an obstacle to enrollment for all potential enrollees, regardless of their substance use status. The drug testing process is humiliating, invasive, time-consuming, and inconvenient. [Any time Medicaid programs add enrollment requirements, participation drops.](file:///C%3A%5CUsers%5CMahan%5CBox%20Sync%5CG%20Drive%5CHealth%20Policy%5CMedicaid%5Cmedicaid%20waivers%20and%20%20interactive%5Ccampaign%20around%201115%5Ctemplate%20comments%5Cent-obstacles-kentucky-work-requirement.html) This requirement will predictably mean fewer people sign up for Medicaid, increasing the state’s uninsured population.

**Required drug testing violates federal Medicaid law.** Drug testing is inconsistent with federal Medicaid law and outside of CMS’s waiver authority. If CMS approves the state’s request, litigation will follow. The program may be held invalid. Any money the state has spent on implementation will have been wasted. This is a known and irresponsible risk of taxpayer funds.

**Required drug screening may violate the Americans with Disabilities Act (ADA).**The ADA states that individuals shall not be denied health services or services provided in connection with drug rehabilitation on the basis of current illegal use of drugs if the individual is otherwise entitled to such services. A drug testing program will mire the state in lawsuits.

**Lock-outs for renewal paperwork/Missing change of circumstance reporting requirements**

***Background:*** States have asked for coverage lock-outs for failure to promptly renew Medicaid eligibility (often in conjunction with requiring renewal more frequently), or failure to report changes in circumstances, whether material to Medicaid eligibility or not, within a set number of days. CMS has approved this request.

**Medicaid is the only type of health insurance that requires annual documentation for redetermination of eligibility.** This process can result in many people briefly losing coverage, and then coming back on Medicaid once they resolve documentation or mailing address issues affecting the renewal process. This is often called “churn.” Percentages of people churning on and off Medicaid at renewal generally range from 25 percent to as high as 50 percent. **[If you have state numbers on renewal drop-off in Medicaid, add here.]** In contrast, **Medicare, employer sponsored insurance, and marketplace coverage all renew automatically.**

**Lock-outs tied to failure to renew eligibility will result in huge coverage losses.** A lock-out at renewal will mean that a large percentage of Medicaid-eligible individuals will be shut out of coverage. This will dramatically increase the number of uninsured state residents—just as such a policy would if it were applied to employer or Medicare coverage.

**A lock-out policy for failure to complete renewal paperwork fails to recognize the multiple challenges facing low-income residents.** Low-income Medicaid enrollees can face multiple challenges to completing the sometimes-lengthy redetermination processes, including difficulty receiving mail, lack of a fixed address, and chronic or intermittent homelessness. Medicaid is likely to be all the more important during a time in which someone has difficulty completing redetermination paperwork—for example, during an episode of acute illness.

**Lock-outs will interfere with treatment for people with mental illness or needing substance use treatment.** [Continuity of care is particularly important](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3424831/) in treating people with substance use disorders or mental illness. These are also individuals who may have greater difficulty complying with paperwork time lines. Locking people out of coverage will undercut state efforts to provide comprehensive addiction and mental health treatment.

**Disenrollment (and lock-out) for failure to report changes in circumstances is, at its core, a policy to cut people off coverage.** Locking state residents out of Medicaid coverage for failure to report a change in circumstances promptly is nothing short of paperwork harassment. It is a policy that has the sole purpose of cutting people from coverage. **[If there are any reports estimating the number of state Medicaid enrollees who could be affected, include that.]**

**Premiums with lock-outs**

***Background:*** Several states have asked to apply premiums to Medicaid enrollees (income level of affected enrollees varies by state) and disenroll and lock individuals out of coverage for failure to pay. Several states have been approved to add premiums, including with coverage lock-outs.

**Premiums in Medicaid cause people to drop coverage, which will increase the number of uninsured in the state.** Numerous studies have found that premium payments in Medicaid [reduce enrollment](http://www.healthlaw.org/about/staff/david-machledt/all-publications/Medicaid-Premiums-Cost-Sharing#.WqcdLSVG0W4http://www.healthlaw.org/about/staff/david-machledt/all-publications/Medicaid-Premiums-Cost-Sharing), [increase disenrollment](http://www.pnhp.org/news/2016/march/medicaid-and-chip-premiums-increase-disenrollment), and increase the number of uninsured in a state. The same will happen in this state.

**The administrative costs to taxpayers outweigh any benefit to the state.** There is an administrative cost to collecting premiums, tracking payments, sending notices, and administering any disenrollment penalties. Staffing and running premiums collections can be costly—greater than any [amounts](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/print/) collected. This is not a prudent use of taxpayer money.

**Declines in Medicaid coverage resulting from premiums would increase pressure on the state’s safety-net providers**. The increase in uninsured that would predictably result if the state imposed the premiums requested would hurt state safety-net providers. States’ implementation of Medicaid premiums has been [associated with](https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/print/) an increased in uninsured patients, and increases in emergency department use by the uninsured. Those predictable outcomes would strain the state’s health care system.

**Lock-outs generally**

***Background:*** States are asking to apply lock-outs for a variety of reasons: failure to renew on time; failure to report a change in circumstances, whether material to coverage or not; failure to pay premiums; failure to meet a work requirement; and failure to pass a drug test or enter drug treatment. The generic comments listed below deal with lock-outs. They can be tailored to whatever provision(s) your state is attaching lock-outs to. As of mid-March 2018, CMS had approved lock-outs for failure to pay premiums, meet the conditions of a work requirement program, and promptly renew or submit status changes.

**Lock-outs are punitive policies with the main goal of cutting people off Medicaid.** Lock-outs are designed to punish people when they are already facing hardship, making it even more difficult for them to get back on their feet.

**Lock-outs will create disruptions in care, leading to poor health outcomes and increased costs for state residents.** The vast majority of Medicaid enrollees locked out of coverage will become uninsured, with those below 100 percent of the poverty level particularly at risk, because they do not have access to marketplace coverage. Multiple studies have found that [regular and ongoing access to health care reduces preventable hospitalizations](https://jamanetwork.com/journals/jama/article-abstract/389289?redirect=true) for people with chronic diseases such as [diabetes](http://care.diabetesjournals.org/content/35/7/1566) and heart disease. The direct, foreseeable consequence of this policy will be worse health for the state’s lowest-income residents.

**Lock-outs will increase hospital uncompensated care costs, increasing costs for state and local governments and ultimately state taxpayers. Those locked out of coverage will, for the most part, be uninsured. However, they will still get sick and need care. The result will be an increase in state hospitals’ uncompensated care costs.** That will raise costs for the state and local governments, in addition to straining hospital budgets. [State and local governments are the second-largest funding source for uncompensated care](https://www.kff.org/report-section/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination-sources-of-funding-for-uncompensated-care/), making up 40 percent of all subsidies for hospital uncompensated care.

**Partial Expansion**

***Background and advocacy note:*** Partial expansion—expanding Medicaid coverage to 100% of poverty rather than the 138% mandated by law—may be something advocates in many non-expansion states see as a way to get their states to approve coverage. However, as of mid-May 2018, CMS had [not approved](http://familiesusa.org/product/what-cms-did-and-didnt-approve-arkansas-waiver-both-tell-us-lot) state requests to reduce expansion coverage to 100% of poverty while retaining the enhanced federal match for Medicaid expansion.

The arguments below respond to state requests for partial expansion. They focus on the fact that asking for a partial—rather than a full—expansion could be a political dead end.

**Partial expansion has not been approved in other states; it is unlikely that it would be approved here.** CMS [failed to approve](http://familiesusa.org/product/what-cms-did-and-didnt-approve-arkansas-waiver-both-tell-us-lot) Arkansas’s request to move from a full to a partial Medicaid expansion. There is no reason to believe that another state’s request would have a different outcome.

**If the state is serious about helping its low-income residents, it should ask for full expansion.** The partial expansion request shows that the state fully understands that there are many low-income residents who need (but currently lack) affordable health coverage through Medicaid. States that want to enroll expansion adults in the marketplace can do so via a premium assistance program and retain an enhanced match arrangement. The state also knows that a partial expansion request is likely not to be approved. If the state is serious about helping low-income residents—rather than trying merely to score political points with a phony request—it should ask for a full expansion.

**A full expansion will be good for the state economy.** A full Medicaid expansion will mean health coverage for many uninsured state residents, increasing their health and financial security—and therefore will also create a stronger health system, and a stronger state economy. The added federal funding that will come into the state with a full expansion will create more jobs and economic growth. **[Here you can insert available state data on numbers helped, economic impact/jobs created, support for working families, support for rural health systems, etc.].**

**Making dental benefits conditional**

***Background:*** Some states are asking for permission to make enrollees’ dental coverage conditional on premium payments, participation in health education classes, or other enrollee activities. Dental care should be a standard part of coverage, not conditional on enrollees’ meeting other requirements. CMS has approved such programs in Kentucky and Indiana.

**Dental coverage improves Medicaid enrollees’ overall health *and* employability.** Cutting dental coverage is penny-wise and pound-foolish, and runs counter to the state’s efforts to increase employment among Medicaid enrollees.

**Untreated dental disease can have a negative impact on overall health**. Difficulty eating, sleeping, and chronic pain all have significant [health implications beyond oral health](https://www.nidcr.nih.gov/research/data-statistics/surgeon-general). Poor oral health is also linked to complications for people with diabetes and heart and lung disease, and to poor birth outcomes. And untreated dental disease is more than [twice as common](https://www.kff.org/medicaid/issue-brief/access-to-dental-care-in-medicaid-spotlight-on-nonelderly-adults/) among lower-income adults as among adults with higher incomes. For lower-income state residents, dental coverage can help improve overall health, and ultimately lower Medicaid costs.

**Access to dental services can improve employment prospects*.*** Twenty-nine percent of low-income adults—nearly twice the rate of those with higher incomes—report that the state of their mouth [negatively affects their ability to interview for a job](http://www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/Documents/hck1ocv.%40www.surgeon.fullrpt.pdf). By helping people improve their oral health and appearance, dental coverage can help promote enrollees’ employment opportunities. Reducing their access to dental care can make it harder for them to get a job.

**Eliminating EPSDT for 19-20 year olds**

***Background:*** Early, Periodic Screening Diagnostic and Treatment (EPSDT) for 19-20 year olds is a required benefit for Medicaid expansions. As of mid-March 2018, two states had pending requests to waive EPSDT for 19-20 year olds.

**Medicaid—and the EPSDT benefit—help low-income children do better long-term.** Children’s health is [strongly linked](https://www.urban.org/sites/default/files/publication/49116/2000178-How-are-Income-and-Wealth-Linked-to-Health-and-Longevity.pdf) to family income: children in poorer families tend to have more health problems. Medicaid’s added EPSDT services—including hearing, vision, dental, and behavioral health services—address health care needs so that children from low-income families can have a better chance at succeeding. Children covered by Medicaid [do better](http://www.nber.org/papers/w20178) than their uninsured counterparts later in life, in part because of the EPSDT benefit.

**Extending EPSDT to age 21 gives young adults needed support as they enter the workforce.** Young adults from low-income families are more likely than other young adults to be unemployed, and face greater employment challenges. EPSDT’s added services—from mental health support to vision and dental care—can support these young adults so that they will be better able to succeed.

**Eliminating non-emergency medical transportation**

***Background:*** Non-emergency medical transportation**(**NEMT) is a required benefit for Medicaid expansions. States are asking to waive this. These requests have been granted in several states.

**Eliminating NEMT will make it harder for Medicaid enrollees to get appropriate care at the appropriate time.** For Medicaid enrollees, lack of transportation is a [major barrier](http://www.annemergmed.com/article/S0196-0644%2812%2900125-4/abstract) to timely access to care. [Many do not have cars](http://web1.ctaa.org/webmodules/webarticles/articlefiles/Medical_Transportation_Assurance_Report.pdf) and, particularly in rural areas, do not have access to public transportation. NEMT helps lower-income state residents get the health care they need *before* it becomes a more expensive emergency.

**NEMT is cost effective: Reliable NEMT is correlated with fewer emergency visits.** [Studies have consistently shown](http://onlinepubs.trb.org/Onlinepubs/tcrp/tcrp_webdoc_29.pdf) that providing Medicaid enrollees with transportation to non-emergency care results in fewer missed appointments, shorter hospital stays, and fewer emergency room visits. Alternatively, poor access to transportation is related to lower use of preventive and primary care and [increased use of emergency department](http://web1.ctaa.org/webmodules/webarticles/articlefiles/NEMTpaper.pdf) services. Eliminating NEMT will mean less healthy state residents, increased emergency department use, and higher costs to the state. That is a bad deal for state residents.

**NEMT can help the state better address some serious health care needs.** The majority of NEMT services are used for [regularly scheduled, non-emergency medical trips](http://web1.ctaa.org/webmodules/webarticles/articlefiles/NEMTreportfinal.pdf) for behavioral health services, substance abuse treatment, and dialysis treatment. Without NEMT, patients with these conditions could miss appointments, making treatment less effective. Chronically ill patients could end up sicker and hospitalized or institutionalized, leading to more expensive care or, in the case of missed dialysis, death. [A report](http://www.apta.com/mc/legislative/previous/2015/program/agendas/Documents/NEMT%20-%20A%20Vital%20Lifeline%20for%20a%20Healthy%20Community.pdf) issued by the National Conference of State Legislatures called NEMT “a vital lifeline for a healthy community.” The state should not cut off that lifeline.

**NEMT saves money**. Research from the Federal Transit Administration shows that NEMT services directly [save states money](http://www.trb.org/Publications/Blurbs/156625.aspx) for some medical conditions, reducing the total cost of treating those conditions. Even when NEMT does not produce immediate savings, it is cost-effective in the long run because it decreases future health care costs and improves quality of life.

**Spending on NEMT has a high rate of return.** [A study](http://tmi.cob.fsu.edu/roi_final_report_0308.pdf) conducted by Florida State University concluded that if only 1 percent of NEMT trips prevented a hospital stay, [**the return on investment to the state would be 1,108 percent**](http://www.transportconnect.org.au/resources/PDF/ROI_Florida.pdf)**.** In other words, the state would save an estimated $11.08 for each $1 invested in non-emergency transportation. [A study](http://www.arkleg.state.ar.us/assembly/2015/Meeting%20Attachments/836/I14099/TSG%20Volume%20II%20Recommendations.pdf) commissioned by the state of Arkansas echoed these findings, reporting to the legislature that NEMT is “a very cost effective benefit” and recommended the state not eliminate the benefit. **[Add any studies related to NEMT cost benefit in your state.]**

**Eliminating retroactive coverage**

***Background:*** States are asking to waive Medicaid’s three-month retroactive coverage provision. As of mid-March 2018, this request had been granted in Indiana and Iowa. Some states were limiting this request to adults in Medicaid; other states were asking to waive retroactive coverage for everyone in Medicaid.

**Medicaid is the only type of health insurance that requires annual documentation for redetermination of eligibility.** This process can result in many people briefly losing Medicaid coverage until they resolve documentation or mailing address issues connected to the renewal process. This is often called “churn.” Percentages of people churning on and off Medicaid at renewal generally range from 25 percent to as high as 50 percent. Retroactive coverage helps to fill these gaps in coverage.

**Retroactive coverage helps Medicaid enrollees move out of poverty.** The state contends that one of its key objectives is helping low-income Medicaid enrollees move out of poverty. Retroactive Medicaid coverage can help that happen. It keeps low-income, Medicaid-eligible individuals from incurring crippling medical debt that can make it impossible for them to get ahead. **[This assumes that the state waiver request includes language about encouraging financial independence for Medicaid enrollees, which most waiver requests do.]**

**Retroactive coverage reduces uncompensated care, and that helps the state’s health system.** Eliminating retroactive coverage would result in an approximately [five percent loss](http://www.commonwealthfund.org/~/media/files/publications/fund-report/2017/jun/dobson_ahca_impact_safety_net_hosps_v2.pdf) in Medicaid revenue for safety-net hospitals. Those hospitals—which are often teaching hospitals, major trauma centers, and major area employers—depend heavily on Medicaid revenue. This proposal is a direct hit to critical hospitals in the state, and would hurt the health system for all state residents.

**Reinstating asset tests**

***Background:*** The Affordable Care Act removed eligibility asset tests for all Medicaid enrollees except for seniors and people qualifying through SSI, who also have Medicare. This was replaced with simplified eligibility based on modified adjusted gross income (MAGI). Some states are asking to reapply asset tests. None of these requests had been approved as of mid-May 2018.

**Reinstating asset tests will not save the state money**. Experience from states that removed Medicaid asset tests before the federal requirement to move to MAGI eligibility [found](https://kaiserfamilyfoundation.files.wordpress.com/2001/04/2239-eliminating-the-medicaid-asset-test.pdf) that eliminating asset tests lowered administrative costs and made it easier for people to enroll in Medicaid. The only reason to add a costly-to-administer asset test is to make it harder for state residents to enroll in Medicaid coverage.

**Reinstating asset tests violates federal Medicaid law.** Asset tests are inconsistent with federal Medicaid law and are outside of CMS’s waiver authority. If CMS approves the state’s request, litigation will follow, and the program may be held invalid. Any money the state has spent on implementation will have been wasted. Pursuing this request is a known and irresponsible risk of taxpayer money.