FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

September 13, 2019

The Honorable Alex Azar
Secretary Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

Re: Comments on Pending Utah Per Capita Cap 1115 Demonstration

Submitted electronically via *Medicaid.gov*

Dear Secretary Azar:

Families USA appreciates the opportunity to provide comments on Utah's application for Section 1115 Demonstration Waiver, the Per Capita Cap (PCC) Waiver.

Families USA is a national health care advocacy organization that supports policies and programs at the state and federal levels to expand access to high quality, affordable health care, with a particular focus on policies that affect lower-income individuals.

Multiple elements of Utah's proposal are both legally problematic and poor policy choices for the state. We support state decisions to accept federal funds to expand Medicaid coverage; however, to receive those added funds, states must comply with the requirements of the Medicaid program and Medicaid law. Much of Utah's request fails to meet that test. The elements of the waiver request that fail to meet federal requirements are discussed in greater detail below.

Comments on Specific Provisions in the Amendment Request

Context of the analysis

The Supreme Court's decision in National Federation of Independent Business v. Sebelius (NFIB) made the Affordable Care Act's (ACA's) Medicaid expansion an option for states.[1] However, that same decision also made clear that when a state accepts the option to expand Medicaid, the requirements related to the ACA's Medicaid expansion still apply.[2] In writing for the majority, Justice Roberts explicitly stated that the opinion did not rewrite Medicaid law. He made it clear that the opinion was indeed quite narrow, only reversing the requirement that states expand Medicaid. The remainder of the law was unaffected by that decision.[3] Once a state accepts the expansion, all Medicaid laws and regulations apply.

[1] *NFIB –v- Sebelius*, 567 U.S. 519 (2012).
[2] *Ibid*. Noting that the law allows the Secretary to withhold all Medicaid funds from a state if it is not in compliance with Medicaid requirements, including those applying to the expansion.
[3] *Ibid.*

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Upon receipt of Utah's new waiver application, the Centers for Medicare and Medicaid Services (CMS) must apply all Medicaid laws in its review. Under the statutory requirement that Medicaid waivers be reviewed in light of whether they will promote the core objective of Medicaid—provision of medical assistance—many elements in the state's request, including but not limited to the request for a cap on enhanced federal match for less than a full expansion and the request for a cap on enrollment, must be denied.

1. Enhanced match for partial expansion

Utah is requesting an enhanced 90-10 federal match for its partial expansion of Medicaid for adults up to 100 percent of the federal poverty level (FPL). Families USA believes this is bad policy and illegal. To date, CMS has not approved requests to partially expand Medicaid with the enhanced federal match rate. In fact, as indicated in Administrator Verma's August 2019 correspondence with Utah Governor Herbert (https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/per-capita-cap/ut-per-capita-cap-correspondence-ltr-20190816.pdf), CMS already informed the state that it will not grant its request to "cover only a portion of the adult expansion group and still access the enhanced federal funding available under section 1905(y)(1) of the Social Security Act."

This rejection is the correct decision, but not necessarily based on the right reasoning. Federal law clearly stipulates that states are eligible for the 90-10 match rate only if they expand Medicaid up to 133 percent FPL. CMS does not have the authority to approve an enhanced federal match for an expansion that does not extend coverage to 133 percent FPL, as specified in section 1905 of the Social Security Act.[4,5] Additionally, the enhanced match for the Medicaid expansion is codified in section 1905 of the Social Security Act. That section of the Act cannot be waived under section 1115 authority. **This request for partial expansion should be rejected both on its merits as bad policy and because CMS does not have the authority to approve it.**

2. Per capita cap on federal funding

Utah is proposing to set a "per capita cap" that limits the amount of federal funding available to the state depending on the number of enrollees in the waiver. This is a fundamentally different federal

[4] Section 1905(y) of the Social Security Act [42 USC sec. 1396d(y)]. Income calculations in these comments do not include the 5 percent income disregard.

[5] Section 1905 of the Social Security Act defines the increased federal match for adults as applying when a state provides medical assistance to the group covered in 1902(a)(10)(A)(i)(VIII).[5] The statutory language clearly defines the expansion group as a whole, consisting of *all individuals* with incomes below 133 percent of poverty who are under 65, not enrolled in Medicare, and not entitled to Medicaid on any other mandatory coverage basis (emphasis added). The group is defined clearly without permissive language or flexibility. There is no language allowing states to cover some of the defined group and receive the enhanced federal match. The group for which states can receive enhanced funding is clearly defined as a whole; it is not divisible. A state's receipt of enhanced federal funding is predicated on it meeting all of the coverage requirements outlined in section 1902(a)(10)(A)(i)(VIII).

funding arrangement than what the state would receive if it continued with the voter-approved traditional expansion up to 133 percent FPL. This proposal would end the 50-plus year federal guarantee of matching each states' actual Medicaid spending, passing risk and costs onto the state. Utah will be faced with no choice but to cut coverage and benefits for children, seniors, people with disabilities, and working families; cut other funding priorities; or raise taxes.

The bottom line is that changing Medicaid to a capped structure passes costs and risks onto states. It puts state finances and the people who rely on Medicaid and their families at risk. If CMS and the state fail to reach an agreement on the proposed PCC waiver, under current state law the state will move forward with a "fallback plan" that includes expansion up to 133 percent FPL.[6] This fallback plan will extend health care coverage to more low-income Utahans and is a more fiscally responsible option for the state.

3. Cap on enrollment

CMS granted Utah authority to limit enrollment for its "Adult Expansion" and "Targeted Adult" populations in March 2019, as part of its amendment to its "Primary Care Network" 1115 waiver. However, Utah's proposed request for enhanced match makes it clear that the state would be requesting an enrollment cap on a state plan population, an unprecedented and legally non-approvable step. According to the state's new waiver proposal, an enrollment cap would take effect "when projected costs exceed annual state appropriations." In other words, the state has the ability to set an enrollment limit, preventing eligible people from enrolling in Medicaid and keeping them uninsured whenever the state's Medicaid costs exceed the amount of funding appropriated by the executive and legislative branch. The state intends to use 1115 demonstration authority to deny Medicaid eligibility to state plan eligible adults. Preventing Medicaid-eligible people from enrolling in affordable health care coverage is the very opposite of promoting medical assistance.

Administrator Verma also rejected this proposal in her August 2019 correspondence with Utah Governor Herbert. Much like the rational for rejecting partial expansion, Families USA agrees that this proposal should be rejected, but for a different reason. As described in the partial expansion section above, the statute requires that in order to receive an enhanced federal match, a state must cover *all individuals* in subclause (VIII) of section 1902(a)(10)(A)(i).[7] "All" in the context of the statute is not an ambiguous term. The statute does not allow for partial expansion, capped enrollment, or other non-statutory diminutions in the covered population.

It is not within CMS's authority to waive the definition of the expansion population, the group to which the enhanced federal match applies. That definition is codified in section 1905 of the Social Security Act. That section of the Act is not within section 1115 waiver authority. **Therefore, this request for capped enrollment should be rejected both on its merits as bad policy and because CMS does not have the authority to approve it.**

4. Community engagement through a work reporting requirement

[6] https://medicaid.utah.gov/Documents/pdfs/Adult%20Expansion%20Comparison%20Chart_FINAL.pdf
[7] Social Security Act sec. 1905 (y).

Utah received approval from CMS to implement a work reporting requirement for its "Adult Expansion" population in March 2019, as part of its amendment to its "Primary Care Network" 1115 waiver. The state is now requesting to implement the work reporting requirement under its proposed new waiver. Utah requires Medicaid beneficiaries who are subject to the work reporting requirement to: register for work through the state system; complete an evaluation of employment training needs; and complete job training modules. If a beneficiary fails to complete the required reporting activities or fails to qualify for an exemption within a three-month period, it results in a loss in Medicaid eligibility and a loss in coverage for that individual.

As we have outlined in numerous comments, including our comments on the amendment to Utah's 1115 Primary Care Network (PCN) Demonstration Waiver, a work reporting requirement will result in coverage losses and is in conflict with Medicaid's objectives.[8] Approval of a work reporting requirement request would constitute an abuse of Section 1115 demonstration authority.

Thousands of Medicaid beneficiaries are projected to lose coverage due to the state's proposed work reporting requirements. Although the state does not provide a direct estimate of coverage losses, they do provide an estimate of the number (49,000-63,000 individuals) and percentage (70 percent) of the adult expansion population who will be exempt from the requirement. They also estimate the percentage (75-80 percent) of non-exempt beneficiaries who will comply with the requirement. Based on these estimates, we have determined that between 4,200 and 6,750 Medicaid beneficiaries will neither comply with, nor be exempt from the requirements and will consequently lose coverage.

Contrary to explicit federal regulations, this drop in enrollment is not reflected in the state's budget projections on pages 49 and 50 of its application. Rather, these budget projections indicate that Medicaid enrollment (i.e. eligible member months) will remain the same with or without the waiver, which directly conflicts with the state's estimated decrease in enrollment due to the work reporting requirement. The state notes that, "budget neutrality is calculated at a per-member level and there are no calculated savings that result from reduced enrollment." While per member per month (PMPM) costs may remain the same with or without the waiver, the reduced enrollment would result in fewer eligible member months and lower annual total expenditures with the waiver compared to without the waiver.

In Arkansas, the only state to this point to have disenrolled beneficiaries for failure to comply with its Medicaid work reporting requirement, more than 18,000 people lost coverage in only a few months. Arkansas' Medicaid work reporting requirement waiver was then suspended by U.S. Federal Judge James Boasberg as a violation of the federal statutory requirement that Medicaid waivers promote the core objectives of the Medicaid program.

Additionally, a work reporting requirement is contrary to Medicaid law. The relevant statutory provisions for this analysis are Section 1115 of the Social Security Act and section 1901 of the Act.

[8] See Families USA's August 4, 2018 comments on Utah's amendment to its 1115 Primary Care Network (PCN) Demonstration Waiver online at https://familiesusa.org/sites/default/files/documents/Families_USA_comments_Utahs_Waiver_amendment_August_2018_cfp.pdf

Section 1115, "Demonstration Projects," outlines the Secretary's authority to grant demonstration waivers. Section 1115 gives the Secretary the authority to "waive compliance with any of the requirements of section […] 1902" of the Social Security Act for any experimental, pilot, or demonstration project which, in the judgment of the Secretary, "is likely to assist in promoting the objectives of title […] XIX."[9]

Section 1901, "Appropriations," states the purpose of federal Medicaid funding, i.e., the program's objectives referred to in section 1115. It states that federal Medicaid dollars are for the purpose of enabling states "to furnish (1) medical assistance on behalf of [statutorily eligible individuals], and (2) rehabilitation and other services to help such [individuals] attain or retain capability for independence or self-care…."[10] In the context of the statute, it is absolutely clear that "independence or self-care" refers to federal funding enabling states to provide care that can help individuals attain or retain physical independence.

While HHS has updated its Medicaid.gov website to redefine the objectives of the Medicaid program, that has no legal import. Statutory language has precedence over any website language, no matter how official the website.

- A work reporting requirement is unrelated to Medicaid's objectives as defined in statute. The language in the statute is clear. Federal Medicaid dollars are to be used to *furnish* medical, rehabilitation, and long-term services. Requiring work or community service as a condition of program participation is not in any way related to the *state furnishing* medical services or to the *state furnishing* rehabilitative or other services—indeed it achieves the opposite goal by withdrawing medical and rehabilitative services from otherwise eligible low-income people if they do not meet the work reporting requirement. It is therefore outside of CMS's authority to approve under section 1115 authority.

  In his recent ruling to vacate the approval of Arkansas' waiver amendment to work reporting requirement, Judge Boasberg affirmed that a work reporting requirement is unrelated to Medicaid's objectives. Boasberg ruled that, "the Secretary's approval of the Arkansas Works Amendments is arbitrary and capricious because it did not address – despite receiving substantial comments on the matter—whether and how the project would implicate the "core" objective of Medicaid: the provision of medical coverage to the needy."[11]

- Adding a work reporting requirement is beyond the Secretary's authority to "waive" requirements in section 1902. Section 1115 gives HHS the authority to waive requirements in Section 1902. It does not allow states to add new program requirements that are not mentioned in 1902 and that are unrelated to the program's statutory purpose of furnishing medical or rehabilitative services. Section 1902 does not mention engaging in work or community service. States do not have the authority to add new requirements unrelated to the program's objective of *furnishing* medical care.

[9] Social Security Act, section 1115 [42 U.S.C. 1315].
[10] Social Security Act Sec. 1901. [42 U.S.C. 1396].
[11] https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv1900-58, page 26.

- A mere nexus between an activity and health is not a sufficient basis for the Secretary to use 1115 authority to make Medicaid eligibility conditional upon participation in that activity. In its request, Utah's rationale for adding a work reporting requirement to Medicaid is that "many studies have concluded that employed individuals have better physical and mental health, and are more financially stable than unemployed individuals."[12] While that may be true, the mere connection between an activity and health status is not a basis to make Medicaid eligibility conditional upon an individual's participation in that activity. There are numerous activities that have been shown to improve physical and mental health: diet[13]; exercise[14]; marital status[15]; social engagement[16]; to list only a few of the nearly endless activities that can impact individual health.

  It is gross regulatory overreach and a misuse of federal and state funds to add extra-statutory conditions on Medicaid eligibility that are not within the program's objectives simply because one or more of those activities have been shown to be related to individual health.

  Medicaid is a program to furnish medical assistance: it is a health *insurance* program. Health insurance protects people from financial loss associated with medical costs. That is not synonymous with health. That distinction holds true for Medicaid, Medicare, employer sponsored coverage, and any health insurance program. Following a path of adding reporting requirements to Medicaid simply because they arguably promote health is far beyond the program's objectives and could turn the program into a virtual a la carte menu of extra-statutory requirements approved at any administration's whim. It sets up a dynamic that could lead to near unending government micromanagement of the lives of Medicaid enrollees.

  Judge Boasberg affirmed that promoting health is not a freestanding objective of Medicaid in his ruling to vacate the approval of Kentucky's work reporting requirement waiver. In his decision, Boasberg notes that, were health to be considered a freestanding objective of Medicaid, "nothing would prevent the Secretary from conditioning coverage on a special diet or certain exercise regime."[17] He also notes that, "Even if health were such an objective, approving Kentucky HEALTH on this basis would still be arbitrary and capricious. The Secretary, most significantly, did not weigh

[12] Utah's Per Capita Cap Section 1115 Demonstration Waiver Application, page 8.
[13] See the U.S. Dietary Guidelines, Office of Disease Prevention and Health Promotion, Department of Health and Human Services, for an overview of the near endless number of studies looking at the relationship between diet and health, at https://health.gov/dietaryguidelines/2015/guidelines/introduction/nutrition-and-health-are-closelyrelated/.
[14] See the U.S. Physical Activity Guidelines, Office of Disease Prevention and Health Promotion, Department of Health and Human Services, for an overview of the near endless number of studies looking at the relationship between physical activity and health, at https://health.gov/paguidelines/
[15] For a summary of the copious data on this topic, see the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, The Effects of Marriage on Health: A Synthesis of Recent Research Evidence. Research Brief, 7/01/2007 online at https://aspe.hhs.gov/report/effects-marriagehealth-synthesis-recent-research-evidence-research-brief.
[16] For a summary of the data on the connection between social relationships and health see Debora Umberson, et al., "Social Relationships and Health: A Flashpoint for Health Policy," Journal of Health and Social Behavior, 2010; 51 (Suppl): S55-S66, online at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3150158/.
[17] https://www.courtlistener.com/recap/gov.uscourts.dcd.192935/gov.uscourts.dcd.192935.132.0_2.pdf, page 27.

health gains against coverage losses in justifying the approval."[18] If approved, the same could be said for Utah's waiver to add a work reporting requirement, given that it would similarly result in a loss of coverage.

- The connection of an activity to greater financial stability is also not a sufficient basis for the Secretary to use 1115 authority to add that activity as a requirement for Medicaid eligibility. Utah cites the connection between work and improved financial stability as support for Medicaid work reporting requirements. While a laudable public policy goal, improved financial stability for low-income people is not an objective of the Medicaid program. Indeed, even if it were, there is data showing that expanding Medicaid coverage per se improves the financial health of those gaining coverage by protecting them against out-of-pocket medical costs.[19]

  Judge Boasberg also noted in his ruling to vacate the approval of Kentucky's work reporting requirement that financial stability is not an objective of Medicaid. He states, "financial self-sufficiency is not an independent objective of the [Social Security] Act and, as such, cannot undergird the Secretary's finding under § 1115 that the project promotes the Act's goals."[20]

- Evidence from other programs indicates a work reporting requirement in Medicaid will not result in sustained increased employment. Evidence from work requirements in other social services programs indicates that they do not result in sustained employment and that any employment increases faded over time.[21] In fact, individuals with the most significant barriers to employment often do not find work.[22]

  There is reason to believe that results in Medicaid will be no different. No data supports the theory that taking health insurance away from low-income people will improve their health, finances, or employment prospects. In fact, a recently published study in the New England Journal of Medicine measured the effect of Arkansas' work reporting requirement on insurance coverage and employment in the state. The study concluded that implementation of the work reporting requirements was associated with significant losses in health insurance coverage and had no significant effect on employment.[23]

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[18] *Idem*, page 28.
[19] See: Kenneth Brevoot, et al., "Medicaid and Financial Health," the National Bureau of Economic Research Working Paper 24002, Issued November 2017, online at http://www.nber.org/papers/w24002.pdf; Luojia Hu, et al, "The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Wellbeing," the National Bureau of Economic Research Working Paper 22170, Issued April 2016 and revised August 2017, online at http://nber.org/papers/w22170; Nicole Dussault, et al., "Is Health Insurance Good for Your Financial Health?" Liberty Street Economics, June 6, 2016 online at http://libertystreeteconomics.newyorkfed.org/2016/06/is-healthinsurance-good-for-your-financial-health.html#.V2fhz_krLct.
[20] https://www.courtlistener.com/recap/gov.uscourts.dcd.192935/gov.uscourts.dcd.192935.132.0_2.pdf, page 29.
[21] LaDonna Pavette, *Work Requirement Don't Cut Poverty, Evidence Shows* (Washington, DC: Center of Budget and Policy Priorities, June 2016) online at https://www.cbpp.org/sites/default/files/atoms/files/6-6-16pov3.pdf
[22] *Ibid.*
[23] https://www.nejm.org/doi/full/10.1056/NEJMsr1901772

5. Lockouts for "intentional program violation"

The state's new waiver proposal includes a six month "lock out" or temporary disenrollment for beneficiaries who commit a "program violation." The state's definition of "program violation" includes failure to provide documentation to the state of changes in income within 10 days, a requirement that is extraordinarily difficult for households of any income level to meet and that will predictably lead to high levels of disenrollment. If the state imposes an enrollment cap while a beneficiary is suspended for an intentional program violation (IPV), the beneficiary is not allowed to re-enroll in Medicaid until an open enrollment period begins.

Over the five-year waiver period, an estimated 2,500 beneficiaries are projected to lose coverage due to IPV. Although the state provides an estimate of annual coverage loss in the body of its waiver proposal, this drop in enrollment is not reflected in the state's budget projections on pages 49 and 50 of its application. Rather, the state's budget projections indicate that Medicaid enrollment will remain the same with or without the waiver. The state notes that, "budget neutrality is calculated at a per-member level and there are no calculated savings that result from reduced enrollment." While per member per month (PMPM) costs may remain the same with or without the waiver, the reduced enrollment would result in fewer eligible member months and lower annual total expenditures with the waiver compared to without the waiver.

In addition to resulting in coverage losses, the proposed lockouts for IPV are extra-statutory and administratively burdensome. The state notes in its application that the Utah Attorney General's office already has a process for determining and prosecuting severe IPVs that could constitute Medicaid fraud. Medicaid eligibility is not a tool for enforcing program fraud issues, and most of the violations described under the IPV narrative do not constitute fraud.

6. Waiver of hospital presumptive eligibility

The state's new waiver proposes to eliminate hospitals' ability to make presumptive Medicaid eligibility determinations for the adult expansion population.[24] Currently, under federal law hospital staff can make a preliminary eligibility determination for uninsured patients that need care. After a patient is deemed "presumptively eligible," the state performs the full eligibility process to determine if they can continue to receive Medicaid benefits. Presumptive eligibility helps patients get health care as soon as they arrive at the hospital and ensures that doctors and hospitals are reimbursed for that care. By waiving presumptive eligibility, the state would create additional barriers for uninsured patients who receive care at hospitals.

Because Utah has already waived retroactive eligibility for Medicaid, uninsured patients who visit the hospital will be responsible for the entire cost of their care, even if they could have been determined eligible during their visit or retroactively after receiving care. A waiver of both retroactive and presumptive eligibility eliminates a vital pathway for hospitals to be reimbursed after caring for low-income, uninsured patients and for uninsured patients to avoid crippling financial liabilities.

[24] The state already does not allow presumptive eligibility for its targeted adult population.

In effect, a waiver of presumptive eligibility is another way for the state to cut Medicaid costs. Beneficiaries who are determined eligible for Medicaid while receiving care in a hospital are more likely to have an above average per member per month cost, since a claim will be generated as soon as the beneficiary is determined eligible for Medicaid.

7. Waiver of Early and Periodic Screening, Diagnostic, and Treatment benefits

CMS granted Utah authority to cut Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits for adults ages 19 and 20 in its expansion population and targeted adult population in March 2019, as part of the amendment to the state's "Primary Care Network" 1115 waiver. The state proposes to continue this authority under the new waiver. EPSDT covers items such as vision and hearing screening and treatment (e.g., glasses or hearing aids), basic dental, medical, mental health, and developmental services for children and young adults. Congress designed Medicaid with the EPSDT requirement because low-income children and young adults have a distinct need for comprehensive care in order to lead healthy lives.

Extending EPSDT to age 21 is critical. The brain does not develop fully until children reach about age 25.[25] As a result, young adults benefit from frequent screenings and access to comprehensive treatment as their medical needs, particular mental health needs, continue to change. Furthermore, EPSDT is cost effective. EPSDT provides sweeping benefits for all Medicaid enrollees under age 21, but it is not a high-cost service. Removing the EPSDT benefit for 19- and 20-year-olds would not produce large savings, and would make it more difficult for these young adults to receive the care they need.

One important piece of EPSDT that would also be eliminated for 19 and 20 year olds is dental care. Utah recognizes the importance of dental care in its previously approved waiver request to provide dental coverage to people in SUD treatment. It makes no sense to simultaneously eliminate dental care for young adults, ending the investment the state has made in oral health for this population. The condition of a person's mouth and teeth impacts his or her ability to get a job as well as the person's overall health[26], and Utah's attempt to roll back oral health care runs counter to the state's goals laid out in its previous waiver request.

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[25] Massachusetts Institute of Technology, Young Adult Development Project, online at http://hrweb.mit.edu/worklife/youngadult/brain.html.

[26] Utah notes in its SUD waiver that its evaluation of a HRSA grant found dental care to make a difference in employment.
Also see ADA Health Policy Institute, Oral Health and Well-Being in the United States, 2016, available online at https://www.ada.org/en/science-research/health-policy-institute/oral-health-and-well-being;
M.K. Jeffcoat, et al "Impact of Periodontal Therapy on General Health: Evidence from Insurance Data for Five Systemic Conditions." American Journal of Preventive Medicine 47(2)(2014):166–74;
A. Marano, et al, "Appropriate Periodontal Therapy Associated with Lower Medical Utilization and Costs." Bloomfield, CT: Cigna, 2013; United Healthcare, Medical Dental Integration Study, 2013;
Nasseh, Vujicic and Glick, "The Relationship between Periodontal Interventions and Healthcare Costs and Utilization," Health Economics, January 22, 2016;

Conclusion

For the reasons outlined in this letter, CMS should reject this new proposed Medicaid section 1115 demonstration waiver. Approval and implementation of this waiver request will increase the state's share of Medicaid costs and will result in thousands losing coverage and even more losing access to valuable benefits. Many of the specific provisions of the state's proposed waiver are simply not approvable under section 1115 authority. **Therefore, our recommendation is that CMS should reject this waiver request**.

Thank you for your consideration of these comments. If you have any questions, please feel free to contact us. If you have any questions, please contact Joe Weissfeld at JWeissfeld@familiesusa.org or 202-628-3030.

Respectfully submitted,

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