FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

June 28, 2019

Utah Department of Health
Medicaid and Health Financing
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Jennifer Meyer-Smart

Dear Ms. Meyer-Smart:

Families USA appreciates the opportunity to provide comments on Utah's application for a new Per Capita Cap Section 1115 Demonstration 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). To date, CMS has not approved requests to partially expand Medicaid with the enhanced federal match rate. 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]

Massachusetts and Arkansas have made similar requests to CMS for enhanced federal match for a partial Medicaid expansion. CMS has not approved these requests. Utah would be the first state to receive approval from CMS to partially expand Medicaid with the enhanced federal match. If approved, the legality of CMS's approval would almost certainly be challenged.

If CMS does not approve Utah's request for the enhanced match, the state would continue to receive its current match rate of 68 percent for the expansion population, creating a major additional fiscal liability for Utah separate from the prosed cap on federal funding. Importantly, Utah is covering fewer people at a much higher cost to the state by partially expanding Medicaid, and is leaving millions of dollars in federal funding on the table.

Congress defines the enhanced federal match as only applying when a state expanded coverage to all individuals in the groups defined in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

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.

[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] Social Security Act sec. 1905(y).

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).

The requirement to cover all individuals up to 133 percent of poverty in order to receive an enhanced federal match is not affected by the Supreme Court's decision in NFIB.

The Supreme Court decision in *NFIB v. Sebelius* made expanding Medicaid an option for states.[6] It did not, however, change the requirement that states that take up the option to expand coverage extend that coverage to *all individuals* with incomes below 133 percent of poverty in order to receive an enhanced federal match.

There is no question that in passing the Affordable Care Act, Congress intended all states to extend Medicaid eligibility to all otherwise eligible adults with incomes below 133 percent of poverty.

NFIB held that Congress unconstitutionally coerced states when it enacted provisions requiring states to expand Medicaid eligibility to low income adults or risk losing all of their existing federal Medicaid funding. A majority of the Court held that the problem was "*fully remedied*" by prohibiting the Secretary from using her authority to terminate existing funding of a state that did not implement the expansion. Id. at 2606-07 (emphasis added). The Court explicitly found: "The Medicaid provisions of the Affordable Care Act … require States to expand their Medicaid programs by 2014 to cover all individuals under the age of 65 with incomes below 133% of the federal poverty line," (emphasis in original), and "Nothing in our opinion precludes Congress from … requiring that states accepting such funds comply with the conditions on their use."[7]

In his opinion, Justice Roberts stated that the ruling did not affect the Secretary's ability to withdraw funds "if a State that has chosen to participate in the expansion fails to comply with the requirements of that Act. This is not to say, as the joint dissent suggests, that we are rewriting the Medicaid expansion."[8] The defining condition for receiving such enhanced funding is expanding coverage up to 133 percent of poverty.

There is nothing in NFIB to authorize approval of partial expansion at the enhanced federal match.

Section 1115 waiver authority does not extend to section 1905 of the Social Security Act.

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.

In setting out the payment parameters for increased medical assistance for newly eligible individuals, section 1905 of the Act does reference section 1902 to describe the enrollees eligible for enhanced federal payments. However, merely because section 1905(y) cross-references a section in the statute

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[6] *NFIB –v- Sebelius*, 567 U.S. 519 (2012).
[7] *Ibid.*
[8] *Ibid.*

that can be waived under section 1115 authority, that does not give CMS the authority to waive section 1905(y).

As discussed above, the group eligible for enhanced federal payments is:

> "all individuals……who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A or title VIII, or enrolled for benefits under part B of title XVIII, and are not described in a previous subclause of this clause, and whose income (as determined under subsection e(14)) does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5) applicable to a family of the size involved…."[9]

It is absolutely clear from the language in the statute that the enhanced payments apply to coverage of "*all individuals*" with incomes not exceeding 133 percent of poverty who meet the other coverage related characteristics enumerated. Income is a defining characteristic of the group eligible for enhanced funding.

CMS does not have the authority to waive section 1905 and is not authorized to make enhanced payments for coverage of less than all individuals with incomes below 133 percent of poverty.[10]

In its December 10, 2012 clarifying guidance, CMS correctly stated that the law does not allow for phased-in or partial expansions at the enhanced matching rate.[11]

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 based on the number of enrollees in the waiver. This is a fundamentally different federal funding arrangement than what the state would receive if it continued with the voter-approved traditional expansion up to 133 percent FPL.

Under a traditional Medicaid expansion, the state would receive the enhanced 90 percent federal medical assistance percentage (FMAP) regardless of enrollment levels or per-enrollee cost. In other words, for every one dollar the state spends on Medicaid, the federal government contributes nine dollars, no matter how many people enroll or how much the state spends per enrollee. This arrangement provides the state and taxpayers a level of financial security to ensure that, as Medicaid spending fluctuates from year to year, the state and its taxpayers are not made solely responsible for covering any increased costs.

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[9] Social Security Act 1902 (a)(10)(A)(i)(VIII) [42 USC sec. 1396(a)(10)(A)(i)(VIII)].

[10] Social Security Act section 1115, "Demonstration Projects," gives the Secretary the authority to waive requirements in section 1902 of the Medicaid act in order to approve requests that would promote Medicaid's objectives.

[11] CMS, Frequently Asked Questions on Exchanges, Market Reforms and Medicaid (December 10, 2012) https://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf.

However, with a per capita cap, the state is at significantly greater financial risk. The state receives the 90 percent FMAP for Medicaid spending below the limit set by the cap. If spending exceeds the per capita cap, the state would become increasingly responsible for covering the additional costs. If the state's proposal for receipt of non-enhanced match for expenses above the cap is accepted, the state share of costs above the cap would triple to about 32 percent and federal funding would drop to the current FMAP of about 68 percent of costs. In that event, the state would have to generate additional revenue to cover the increased costs of Medicaid or find ways to reduce spending by cutting services or provider payment rates. If CMS demands a full cap on federal funding, the state's liability will be 100% for per capita expenses above the cap level.

According to the state's proposal, the per capita cap on enhanced federal funding will be established in advance for the first year of the waiver and will then increase at a rate of 4.2 percent[12] each year for the five-year waiver period. As the state acknowledges, this proposed trend rate is not likely to keep pace with the current cost projections of the Medicaid program. The state's waiver application projects that, without the per capita cap waiver, the cost per enrollee will increase at an annual rate of about 5.3 percent.[13] The annual increase in cost is projected to outpace the per capita cap, which translates to a compounding cut in federal funding. Each year of the waiver, it will be increasingly likely that the state will exceed the per capita cap and forfeit its enhanced match.

Although the state's waiver application clearly proposes a trend rate for the per capita cap, it remains unclear where exactly the cap will be set. The state's application is internally inconsistent in its proposals for what amount of spending will receive enhanced match. According to the waiver application, "expenditures in excess of the total per capita cap but within budget neutrality will receive the State's traditional FMAP." It is unclear whether the "per capita cap" in this sentence refers to the "Per Capita PMPMs" for the enrollment groups in the tables on pages 38-43 of the application, or to the "PMPM Costs" in the in the "Demonstration With Waiver Budget Projection" table on page 48 of the application. It is also unclear if "budget neutrality" in the above sentence refers to the "Demonstration Without Waiver Budget Projection" table on page 47 or the "Demonstration With Waiver Budget Projection" table on page 48, which references the 4.2% trend rate.

Depending on the answers to the above ambiguities regarding where the state is proposing to set the per capita cap, the estimated shortfall in federal funding, when compared to 90 percent FMAP with a 5.3 percent trend rate, ranges from $29 million to as high as $121 million over the five-year waiver period. In other words, the per capita cap funding arrangement is projected to cut between $29 million and $121 million in federal funding for the state over five years, which the state will either have to cover or pass to safety net providers in uncompensated care.

Of course, any per capita cap level the state proposes is subject to negotiation with, and approval from CMS. Because the enhanced federal funding for partial Medicaid expansion has never been approved in

[12] This 4.2 percent trend rate is based on the Medical Consumer Price Index (CPI-M), for more information on on why this is a flawed trend rate, visit https://familiesusa.org/blog/2017/05/capita-caps-medicaid-would-result-devastating-funding-cuts

[13] The trend rate is lower than 5.3 percent for certain discrete populations and benefits under the state's current funding mechanism.

any state, it is questionable whether CMS will approve any funding arrangement that includes a 90 percent FMAP and a partial expansion. Approval of such an arrangement specific to Utah would invite a legal challenge from states such as Arkansas and Massachusetts that have previously requested enhanced federal match for a partial expansion.

If CMS and the state fail to reach an agreement on the proposed per capita cap, under current state law the state will move forward with a "fallback plan" that includes expansion up to 133 percent FPL.[14] This fallback plan will extend health care coverage to more low-income Utahns and is a more fiscally responsible option for the state. By expanding Medicaid coverage up to 133 percent FPL, the state will receive the 90 percent FMAP, which will bring more federal funding into the state. The state should embrace this fallback plan and honor the will of its voters who passed a ballot initiative to fully expand Medicaid.

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.

The interaction between the enrollment cap and the proposed per capita cap is important. Assuming the enrollment cap is not triggered earlier, it would become much more likely to be triggered after the state hits the per capita cap on enhanced federal funding and Utah's taxpayers assumes an increased share of Medicaid costs. After exceeding the per capita cap, state-source spending would increase and so would the likelihood of exceeding state budget appropriations.

The analysis of this request's approvability must also follow the same logic as the analysis of Utah's request for a partial expansion at the enhanced federal match, above. We will not repeat that analysis in its entirety here. In summary, 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).[15] "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.

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[14] https://medicaid.utah.gov/Documents/pdfs/Adult%20Expansion%20Comparison%20Chart_FINAL.pdf

[15] Social Security Act sec. 1905 (y).

The statute defines the expansion group as a mandatory group in its entirety. While the Supreme Court's decision in NFIB made a state's take-up of the expansion optional, as outlined above, the decision did not affect any other application of the statute to this group. Once a state decides takes up the option to expand Medicaid at the enhanced federal matching level, it must follow all of the requirements in the statute in order to receive that enhanced federal match. More broadly, the absence of enrollment caps for statutory Medicaid populations is a legal pillar of the Medicaid program and its role in health care for low income people. The prohibition on enrollment caps cannot be waived consistent with the statutory directive to promote Medicaid objectives in section 1115 demonstrations.

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, the request should not be submitted to CMS.

4. Community engagement through a work reporting requirement

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.[16] Approval of a work reporting requirement request would constitute an abuse of Section 1115 demonstration authority.

A work reporting requirement will result in coverage losses.

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.

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[16] 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

Contrary to explicit federal regulations this drop in enrollment is not reflected in the state's budget projections on pages 47 and 48 of its application. Rather, these budget projections indicate that Medicaid enrollment 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.

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.

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.

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."[17]

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…."[18] 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.

- <u>A work reporting requirement is unrelated to Medicaid's objectives as defined in statute. The language in the statute is clear.</u> 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

[17] Social Security Act, section 1115 [42 U.S.C. 1315].
[18] Social Security Act Sec. 1901. [42 U.S.C. 1396].

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."[19]

- 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.

- 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."[20] 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[21]; exercise[22]; marital status[23]; social engagement[24]; 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.

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[19] https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv1900-58, page 26.
[20] Utah's Per Capita Cap Section 1115 Demonstration Waiver Application, page 8.
[21] 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/.
[22] 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/
[23] 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.
[24] 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/.

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."[25] 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 health gains against coverage losses in justifying the approval."[26] 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.

- <u>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.</u> 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.[27]

  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."[28]

- <u>Evidence from other programs indicates a work reporting requirement in Medicaid will not result in sustained increased employment.</u> Evidence from work requirements in other social services

[25] https://www.courtlistener.com/recap/gov.uscourts.dcd.192935/gov.uscourts.dcd.192935.132.0_2.pdf, page 27.
[26] *Idem*, page 28.
[27] 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.
[28] https://www.courtlistener.com/recap/gov.uscourts.dcd.192935/gov.uscourts.dcd.192935.132.0_2.pdf, page 29.

programs indicates that they do not result in sustained employment and that any employment increases faded over time.[29] In fact, individuals with the most significant barriers to employment often do not find work.[30]

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.[31]

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 47 and 48 of its application. Rather, the state's budget projections indicate that Medicaid enrollment will remain the same with or 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.

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[29] 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

[30] *Ibid.*

[31] https://www.nejm.org/doi/full/10.1056/NEJMsr1901772

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.[32] 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 liabiliities.

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. The brain does not develop fully until children reach about age 25. As a result, young adults benefit from frequent screenings and access to comprehensive treatment as their medical needs, particularly mental health needs, continue to evolve.

There is a real health benefit to extending EPSDT to age 21. The brain does not develop fully until children reach about age 25.[33] 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

[32] The state already does not allow presumptive eligibility for its targeted adult population.
[33] Massachusetts Institute of Technology, Young Adult Development Project, online at http://hrweb.mit.edu/worklife/youngadult/brain.html.

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[34], and Utah's attempt to roll back oral health care runs counter to the state's goals laid out in its previous waiver request.

The state provides no justification for waiving EPSDT benefits.

Conclusion

For the reasons outlined in this letter, it is not in the state's best interest to move forward with this request for a 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 the state should not submit its request to CMS.

The state's application lacks a coherent, data supported rationale for its proposal, showing how approval of the proposal will further the objectives of the Medicaid program. It lacks meaningful projections of enrollment losses from the proposal's major provisions. The legally required 1115 notice and comment period is not meaningful if states do not articulate how their requests are related to Medicaid's objectives and if the process does not afford full public comment on that rationale.

Thank you for your consideration of these comments. If you have any questions, please feel free to contact us.

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[34] 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;

Respectfully submitted,

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