FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

August 4, 2018

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

Dear Secretary Azar:

Families USA appreciates the opportunity to provide comments on Utah's amendment to its 1115 Primary Care Network (PCN) 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 quality, affordable health care, with a particular focus on policies that affect lower-income individuals.

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, which are discussed in greater detail below, must be denied.

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 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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It does not matter that Utah's waiver would expand Medicaid coverage to a new state population. In reviewing Utah's request, the Secretary must apply all Medicaid laws to that request. In doing so, he must conclude that many elements in the state's request, including but not limited to the request for an enhanced federal match for less than a full expansion and the request to cap enrollment, must be denied.

1. Demonstration eligibility: "Partial expansion."

Utah is requesting to expand Medicaid coverage to currently non-eligible adults 19 through 64 with household incomes up to 95 percent of poverty and obtain the enhanced federal match established under the Affordable Care Act for that newly eligible population.[4]

The Secretary does not have the authority to approve an enhanced federal match for an expansion that does not extend coverage to 133 percent of poverty, as specified in section 1905 of the Social Security Act.[5] This request must be denied.

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).[6] 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).

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.[7] 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.

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[4] The poverty calculation does not include the 5 percent income disregard that is part of the Medicaid's modified adjusted gross income (MAGI) calculations which would in effect increase the state's requested income eligibility limit to 100 percent of poverty.

[5] 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.

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

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

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."[8]

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."[9] The defining condition for receiving such enhanced funding is expanding coverage up to 133 percent of poverty.

There is nothing in *NFIB* to authorize the Secretary to approve partial expansion at the enhanced federal match.

The Secretary's 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 that can be waived under 1115 authority, that does not give the Secretary 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…."[10]

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

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

related characteristics enumerated. Income is a defining characteristic of the group eligible for enhanced funding.

The Secretary 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.

It does not matter that Utah is requesting to expand Medicaid coverage. The Secretary must apply all applicable laws when analyzing waiver requests.

Utah's request would extend Medicaid eligibility to a population currently not covered by the state's Medicaid program. In that regard, it would meet the core objective of the Medicaid program, i.e., furnishing medical assistance to low income individuals. Therefore, it satisfies one prong of the analyses that the Secretary must go through when evaluating an 1115 waiver request, i.e., the request would further Medicaid's objectives. However, the Secretary's analysis cannot end there. The Secretary must also consider whether the waiver request falls within a section of the statute that the Secretary has the authority to waive. Section 1905 does not.[11] Therefore, this request must be denied as being outside of the Secretary's authority.

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.[12] States have the option to extend adult coverage and cap that coverage at less than 133 percent of poverty at the regular matching level. If Utah wishes to do that, it can do so.

2. Enrollment limits.

Utah is asking to impose enrollment limits for the demonstration group, limiting enrollment to stay within the state's appropriated budget. The state estimates capping enrollment between 70,000 and 90,000 enrollees, although based on the request, there is no guarantee as to the number in the future since it would depend on future appropriations. However, the number of enrollees projected is immaterial to the analysis of whether this request can be approved. The analysis of this request must 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).[13] "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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[11] 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.

[12] 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.

[13] 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 match.

It is not within the Secretary'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 the Secretary's waiver authority. As with the state's request for a partial expansion at an enhanced federal match, the Secretary must similarly deny the state's request to cap enrollment and still receive the enhanced federal match.

3. Community engagement through a work requirement

Utah is asking to implement a work requirement as part of this demonstration. Individuals who are among those in the demonstration population to whom the requirement applies will lose Medicaid eligibility if they do not comply with the proposed work requirement activities. Enrollment will be reinstated only once they either complete the required activities or demonstrate that they fall within one of the demonstration's work requirement exemptions.

As we have outlined in numerous comments, most recently our comments on Ohio's work requirement request, a work requirement is in conflict with Medicaid's objectives.[14] Approval of a work requirement request would be an abuse of the Secretary's Section 1115 demonstration authority, and therefore the request must be denied.

Granting a work 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." [15]

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…."[16] In the context of the statute, it is absolutely clear that "independence or self-care"

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[14] See Families USA's June 14, 2018 comments on Ohio's 1115 waiver request to add work requirements to its Medicaid program, online at http://familiesusa.org/sites/default/files/documents/comments/Families_USA_Ohio_work_requirements_comments_June_14_2018.pdf.

[15] Social Security Act, section 1115 [42 U.S.C. 1315].

[16] Social Security Act Sec. 1901. **[**42 U.S.C. 1396**].**

refers to federal funding enabling states to provide care that can help individuals attain or retain physical independence.

While HHS has recently 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 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 mandate. It is therefore outside of the Secretary's authority to approve under 1115 authority.

- Adding a work requirement is beyond the Secretary's authority to "waive" requirements in section 1902. Section 1115 gives the Secretary authority to waive requirements in Section 1902. It does not grant the Secretary the authority 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. The Secretary does 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 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."[17] 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[18]; exercise[19]; marital status[20]; social engagement,[21] to list only a few

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[17] Utah waiver application page 5.

[18] 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-closely-related/.

[19] 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/

[20] 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-marriage-health-synthesis-recent-research-evidence-research-brief.

[21] 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/.

of the near endless activities that can impact individual health.

It is gross regulatory overreach and a misuse of federal funds for this, or any subsequent administration, to go down the path of adding any extra-statutory conditions on Medicaid eligibility that are not with 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 requirements to Medicaid simply because they arguably promote health is far beyond the program's objectives and could turn the program into a Christmas tree 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.

- 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 requirements. While a laudable public policy goal, improved financial stability for low-income people is not an objective of the Medicaid program. Indeed, even 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.[22]

- Evidence from other programs indicates a work 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.[23] In fact, individuals with the most significant barriers to employment often do not find work.[24] There is no reason to believe that results in Medicaid will be any different. There is no data supporting the theory that taking health insurance away from low-income people will improve their health, finances, or employment prospects.

4. Waiving EPSDT for 19 and 20 year olds.

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[22] 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-health-insurance-good-for-your-financial-health.html#.V2fhz_krLct.

[23] 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

[24] *Ibid.*

Utah is asking to waive coverage of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit for 19 and 20 year olds. Utah does not offer any justification for or support this request in any way.

There is a real health benefit to extending EPSDT to age 21. 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 other 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 healthy teeth—and related health concerns like nutrition and other chronic disease management-- up to this point in their lives. The state of a person's mouth 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 other parts of this waiver request.

We urge the Secretary to reject this request. At the least, he should require that the state submit a coherent, data supported rationale for this request, showing how granting the request will further the objectives of the Medicaid program. That rationale should be part of a resubmitted request that includes public notice and comment. 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.

Respectfully submitted,

Dee Mahan

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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 on http://www.ada.org/en/scienceresearch/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; UnitedHealthcare, Medical Dental Integration Study, 2013, available at www.uhc.com/content/dam/uhcdotcom/en/Private%20 Label%20Administrators/100-12683%20Bridge2Health_Study_ Dental_Final.pdf; Nasseh, Vujicic and Glick, "The Relationship between Periodontal Interventions and Healthcare Costs and Utilization," Health Economics, January 22, 2016;

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