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THE VOICE FOR HEALTH CARE CONSUMERS

September 29, 2017

Submitted online via Medicaid.gov

The Honorable Tom Price Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W. Washington, DC 20201

Re: Comments regarding Utah's Primary Care Network Section 1115 Demonstration Project Amendment Application

Dear Secretary Price:

Families USA appreciates the opportunity to provide comments on Utah's proposed 1115 Primary Care Network waiver, specifically amendment 20.

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.

Many of the proposed changes requested to the waiver in amendment 20 do not meet the requirements for approval under section 1115 of the Social Security Act.[1] Specifically, the waiver must be an experimental, pilot or demonstration project; it must be likely to promote the objectives of the Medicaid program; it must be limited to waivers of requirements of section 1902 of the Social Security Act; and, be limited to the extent necessary for the state to carry out the experimental project. A substantial number of the proposals contained in Utah's request fall short of one or more of those requirements and should not be approved as submitted. Others are incompatible with federal Medicaid law and should likewise be denied.

1. General Comments

Based on the waiver amendment application, the state's vision for the PCN and Adults without Dependent Children program is very unclear, and the lack of detail in amendment 20 only compounds this opacity. Indeed, the proposal does not state a hypothesis, nor evidence or rationale for the proposed changes, and therefore cannot be approved by the Secretary under Section 1115.

The PCN program provides limited benefits for low income adults with families and other vulnerable, low-income populations not otherwise eligible for Medicaid. The adults without

dependent children program (sometimes referred to by the state as the "expansion" population), created by the legislature in 2016 through HB 427, targets 1.) chronically homeless individuals 2.) those needing substance use or mental health treatment 3.) and individuals involved in the criminal justice system who are in need of substance use or mental health treatment.

The state requests imposing lifetime Medicaid eligibility limits on adults without dependent children and PCN adults. That request is in conflict with Medicaid law and in conflict with the requirements and limits of section 1115 and must be denied. Furthermore, the request is even in conflict with Utah legislature's intent behind HB 437, namely to extend health coverage to vulnerable populations, increase access to care and support Utahns with complex medical needs. Rather, the imposition of lifetime limits would end access to coverage and care for vulnerable Utahns with complex medical conditions who are targeted by the waiver.

The request to add a work requirement is likewise in conflict with federal Medicaid law and section 1115, and similarly must be denied.

Despite disagreement with these and other specific elements in amendment 20, overall we support the spirit of the PCN program and HB 437 to extend some form of health coverage to more low-income, vulnerable, Utahns.

2. Comments on specific waiver requests.

Time limits. The request to impose a time limit on Medicaid coverage exceeds the Secretary's authority to approve, serves no demonstration purpose, does not support the objectives of the Medicaid program and must be denied.

Utah proposes a 60-month lifetime limit on the number of months an adult can receive PCN or Medicaid for adults without dependent children. The state asserts, "This limit frames public healthcare coverage for adults as temporary assistance (similar to Temporary Assistance for Needy Families (TANF)), with the expectation that they do everything they can to help themselves before they lose coverage."[2]

The request to impose a time limit on Medicaid coverage would change the Medicaid program in a manner far beyond the Secretary's authority through section 1115 of the Social Security Act and therefore must be denied. Section 1115 of the Social Security Act gives the Secretary authority to approve pilot, experimental or demonstration projects that he or she believes will "assist in promoting the objectives of" the Medicaid program.[3]

The objective of the Medicaid program is to provide federal funding to assist 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-

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care….."[4] "Independence" within the context of the statute is clearly referring to improved physical function that can be achieved through medical services and rehabilitation.

Limiting the months that an individual in any eligibility category can receive benefits fundamentally conflicts with the program's core objective of furnishing medical assistance to low income people and changes the very nature of the program.

Congress has placed income and other limits on individual Medicaid eligibility, but in the over 50 years Medicaid has been in operation, it has never placed a limit on the time that otherwise eligible individuals can receive benefits. Limiting time-on-program would be adding a new eligibility requirement that would fundamentally change the program itself.

It is Congress's clear intent that there should be not be time limits on Medicaid eligibility and the Secretary must give effect to Congress's unambiguous intent.[5] Adding time limits through a waiver request would be far beyond the Secretary's authority, a change that would be in conflict with Congressional intent. Therefore, the Secretary must deny this request.

It has likewise been CMS policy that time limits not be approved. In September 2016, CMS denied Arizona's request to impose a similar time limit in coverage and found that such a policy does "not support the objectives of the program."[6]

Imposing a time limit does not promote the objectives of the Medicaid program and therefore does not meet the requirements of section 115 and must be denied. Section 1115 allows the Secretary to waive requirements of section 1902 of the Medicaid Act "In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of title…..XIX."[7] The request to add a lifetime limit on the time a person can receive coverage through Medicaid not only does not further the program's objectives, but runs in opposition to those objectives. Therefore, it must be denied.

We note the Medicaid program's objectives above. Imposing a lifetime limit on the number of months that someone can receive medical assistance—when individuals' need for medical care is unpredictable throughout one's life—does nothing to promote those objectives. It does not promote the delivery of medical assistance or rehabilitative services. In fact, cutting individuals off from coverage does just the opposite. The proposal would increase the ranks of the uninsured and make it more difficult for those needing medical care to receive that care.

It is predictable that many locked out of Medicaid coverage will become uninsured, because of gaps in employment or, if they have employment, because their do not have health coverage through their work. (See discussion of Utah's UB 437, below.) This predictable outcome is not consistent with Medicaid's objectives.

The request to add a time limit serves no demonstration purpose and therefore does not meet the requirements of section 1115 and must be denied. Section 1115 of the Social Security Act is titled: Demonstration Projects. That is because the waivers are, by statute, supposed to serve a

demonstration or experimental purpose. In its waiver application, under the list of waiver hypotheses that would be tested by this demonstration project, the state does not articulate any demonstration or experimental hypothesis that the time limit is designed to test.

The imposition of an eligibility time limit would, as noted above and discussed further below, predictably increase the ranks of the low-income uninsured. There is no plausible demonstration purpose to implementing a program that would have as its main outcome an increase in the low-income uninsured. Through decades of experience, the effects on low-income people of lacking or losing insurance are well documented and no further study could possibly be needed.

Lacking any articulated or plausible demonstration purpose, the request must be denied.

It is not up to Utah to rewrite Medicaid law. In lieu of articulating any demonstration purpose for time limits, Utah states in its waiver application that its request to limit lifetime months of eligibility is to "frame public healthcare coverage for adults as temporary assistance…." As noted above, that would be a fundamental change in the Medicaid program that would be contrary to Congressional intent. It is not up to Utah to reframe the Medicaid program.

States have significant flexibility in the design of their Medicaid programs, but that flexibility is not unlimited. By accepting federal Medicaid funds, states agree to abide by requirements in Medicaid law. In FY 2016, Utah accepted over $1.5 billion in federal Medicaid funding covering over 70 percent of program costs.[8] As long as Utah accepts federal Medicaid funds, it must abide by the requirements to the Medicaid Act.[9] This includes following federal requirements to extend the program to eligible individuals without regard to their time on the program.

<u>Time limits could have a substantial negative effect on the health of the people the HB 437 program is supposed to help.</u> Locking low-income vulnerable individuals out of health coverage will have a substantial negative consequence on their long term health and ultimately lead to greater costs to the state. Once terminated from the program, enrollees will likely become uninsured and unable to access necessary treatment including substance use treatment, preventative and primary care and mental health treatment. Numerous research studies[10] have shown that uninsured individuals seek care at the emergency room, the most expensive setting, at higher rates than insured individuals and that uncompensated care is overwhelmingly absorbed not only be hospitals but by state and local governments. Likewise, the limit could have the adverse effect of incentivizing enrollees to forego enrolling in coverage and receiving necessary primary care until their health is in dire condition for fear of accruing their 60 months.

<u>Coverage time limits will not assist the adults without dependent children program secure job-based employment</u>**.** Populations seeking treatment for mental illness, substance use disorders and those recently involved with the justice system will need ongoing support and medical care. Mental illness and substance use disorders are by definition chronic conditions. They will not be cured after 60 months. These individuals often face significant barriers to employment

and job based coverage (in spite of the state's assertion that a time limit will promote access to employer sponsored health care).[11] For those who are able to secure employment, most Medicaid and Medicaid-eligible enrollees work in industries- like retail, home health care and food service—that do not offer employer sponsored insurance (or if they do, it is unaffordable). Just 12 percent of workers earning the lowest 10 percent of wages had employer-provided health insurance in 2016.[12] The odds are high that even after 60 months of Medicaid coverage and a work search requirement, this population will still struggle to maintain employment that offers robust health coverage with mental health and substance use disorder benefits.

Work requirement. Utah requests to add a work requirement as a condition for Medicaid eligibility; work requirements are not part of the Medicaid program and outside of the Secretary's authority to approve through an 1115 waiver, therefore the request must be denied.

The proposal would require PCN participants and eventually adults without dependent children to participate in online job search or job training as a condition of Medicaid eligibility. Additionally, the state requests to link eligibility time limits to hours worked, suspending the "time clock" accruing months on program towards lifetime eligibility limits if an enrollee is working at least 30 hours per week.[13]

A work requirement would be a radical change to the Medicaid program; approving such a change through an 1115 waiver would be an abuse of the Secretary's authority. As we have written in our 1115 comments for Wisconsin's Badgercare Reform waiver request, Kentucky's Kentucky Health modified waiver request, and Arkansas's Arkansas Works waiver request, work requirements are outside of the Secretary's authority. The fact that work requirements have no place in Medicaid law was recently noted by the Congressional Budget Office in September, 2017, in a report in which they stated: "Under current law, states may not condition the receipt of Medicaid on any criteria related to a person's employment status."[14]

Linking Medicaid eligibility to work—whether requiring hours worked or a job search or job training—is adding a wholly new aspect to Medicaid eligibility, one that would fundamentally change the program. Such a radical change to the program must be made through the legislative process, not through waivers. Indeed, Congress has recently failed to pass such a change despite recently taking up such a provision in the American Health Care Act and the Better Care Reconciliation Act. The work requirement on the TANF and SNAP programs were all enacted through Congressional legislation. The Secretary must give effect to Congress's unambiguous intent.[15]

Like time limits, adding a work related eligibility requirement to the Medicaid program is beyond the Secretary's authority, a change that would be in conflict with Congressional intent, and therefore, the Secretary must deny this request.

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A work requirement is inconsistent with Medicaid objectives, and therefore not appropriate for approval under an 1115 waiver. As discussed in detail above, Medicaid's objectives are to provide medical and rehabilitative services to eligible individuals. A work search requirement is far afield from those objectives and is therefore inappropriate for approval through an 1115 waiver. The Secretary must deny the request.

***Work requirements (and eligibility time limits linked to work status) seek to solve a problem that doesn't exist and there is no evidence time limits promote work*.** Most people on Medicaid who can work, do so, and for people who face major obstacles to employment, harsh requirements such as limiting their eligibility for coverage will not help overcome them – indeed they are likely to have the opposite effect.[16]

Eight in 10 non-disabled adults with Medicaid coverage live in working families, and nearly 60 percent are working themselves. Two thirds of Medicaid enrollees that work do so forty hours per week or longer.

From a practical standpoint, work requirements applied to health coverage get it exactly backwards: this policy will work against the goal of ensuring Medicaid enrollees are fully employed. Data from Ohio's Medicaid expansion found that providing access to Medicaid helps people maintain employment and seek employment. More than half of Medicaid expansion enrollees report that their health coverage has made it easier to continue working, and three quarters of unemployed Medicaid expansion enrollees looking for work reported that health coverage has made it easier to seek employment.[17] The majority of adult Medicaid expansion enrollees are employed, and an individual needs to be healthy in order to obtain and maintain employment. A work requirement can prevent an individual from getting the health care they need to be able to work.

Furthermore, this requirement will punish people who cannot find jobs because they live in an economically depressed area, particularly those in struggling rural economies or areas with high rates of unemployment.[18]

Time limits and work requirements would add complexity and administrative cost: Tracking time limits, work and exemptions will add significant complexity and cost to the states administrative process, which will also raise federal program costs. Utah would need to develop a whole new system to track months towards the time limit, send notices to clients, and determine whether a beneficiary qualified for an exemption in that month. In Indiana's 1115 waiver application, it requested $90 in federal expenditure authority per person per month to implement its work requirement program.[19] Adding new complicated requirements to Medicaid eligibility, including determining exemptions and tracking the hours of work, which often vary from month to month, would be a major step in the wrong direction.

<u>Emergency department copays.</u> The state's request fails the requirements of section 1916(f) of the Social Security Act and must be denied.

The state requests to charge Medicaid enrollees $25 for non-emergency use of emergency rooms (ERs).

The state's request is incomplete and fails the necessary requirements of Section 1916(f) for the Social Security Act. In order to charge ER copays for non-emergent ER visits that exceed the amount allowed by statute, the state must request a waiver of 1916(f) for a waiver of cost sharing authority. A waiver of cost sharing authority is outside the scope of Section 1115. The Secretary has no legal authority to waive these cost sharing requirements unless the state meets each condition of 1916(f). Utah's proposal fails to meet the requirements of 1916(f) and therefore must be denied.[20]

In order to comply with section 1916(f), the state must meet several criteria. The increased cost sharing must (1) test a unique and previously un-tested use of co-payments, (2) be limited to two years, (3) provide benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients, (4) be based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including--(5) either the use of control groups of similar recipients of medical assistance in the area, or a voluntary structure. The state fails on all five requirements of Section 1916(f).

- The proposal is not unique. Increased cost-sharing for use of the ER is far from unique, as it is already being tested in Indiana.
- The state provides no indication that benefits will be equal to the risk to recipients. There is real risk to low- income Medicaid enrollees who deter necessary care because of cost sharing requirements. This issue is not addressed in the state's waiver.
- There is no indication the co-pays are structured as a hypothesis with the use of control groups, nor is participation in the account deductions voluntary.

The requirements that must be met for the Secretary to grant cost-sharing changes under the applicable section of the Social Security Act are clearly not met. Therefore, this request must be denied.

There are public policy arguments against this request. To charge enrollees living below the poverty line a very high copay for what may very well be an appropriate use of the emergency room will discourage ill enrollees who may be advised by their doctor to go to the ER (someone with COPD, a heart condition or recovering from surgery, for example) from seeking necessary and appropriate care.[21]

Waiver of Early and Periodic Screening, Diagnosis and Treatment (EPSDT). The state requests to waive EPSDT for 19 and 20 year olds.

Waiving EPSDT is not cost effective and should be denied. A waiver of EPSDT for 19 and 20 year olds is a misguided policy and the state should reconsider its waiver request. There is a real health benefit to extending EPSDT to age 21. The brain does not develop fully until children

reach about age 25.[22] 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, but would make it more difficult for these young adults to receive the care they need.

Presumptive Eligibility

The presumptive eligibility process allows uninsured individuals to enroll immediately at a hospital without completing a full application. This expedited process helps prevent delays in care, and payment for hospitals, and ensures that low-income uninsured people get the care they need when they need it and that hospitals do not avoid uninsured enrollees when they present, often at the hospital for the catastrophic illness for the first time. The result of waiving presumptive eligibility will be higher uncompensated care for hospitals and greater medical debt for Utahns.

Eligibility changes. Request to change eligibility without federal approval is in conflict with the requirements for 1115 waivers.

Utah is requesting authority to make changes to the "adults without dependent children" program eligibility through state rulemaking rather through the standard waiver amendment process.

Federal law requires that waiver applications, amendments, and extensions go through an approval process; it is not within the Secretary's discretion to change that. The request must be denied. By accepting federal dollars to conduct a Medicaid program, the state agrees to abide by federal Medicaid law. That includes abiding by the requirements of Section 1115 for waiver approval.

Section 1115 is clear that "in the case of any experimental, pilot, or demonstration project which, *in the judgement of the Secretary…"* [emphasis added]. The Secretary cannot judge what is not submitted. Any new application, amendment or extension must go through the approval process set out by federal law, irrespective of the state law or desire. It is not within the authority of the Secretary to waiver the requirements of section 1115. This request must be denied.

Time limits run contrary to the intent of HB 437. The state's request not only does not meet the requirements of section 1115 and is in conflict with Medicaid law, but it also runs contrary to the Utah's HB 437. HB 437 specifically targeted homeless Utahns. According to National Coalition for the Health Care for the Homeless, "poor health is both a cause and a result of homelessness."[23] Homeless people are more likely to forego necessary treatment, to use the

emergency room for primary care needs, and are six times more likely than those who are housed to become ill.[24] By establishing a lifetime cap on Medicaid coverage, the state will ultimately reverse progress in the state's efforts to combat homelessness. Those getting treatment for chronic disease, perhaps for the first time, will lose access to care just as they may be making progress a stable living situation.

Thank you for the opportunity to comment. Should you have any questions, please don't hesitate to contact

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