FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

August 1, 2017

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

Dear Secretary Price:

Families USA appreciates the opportunity to provide comments on the amendments Arkansas submitted for review on June 30, 2017 relating to its section 1115 demonstration project, known as Arkansas Works.

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 are extremely supportive of Arkansas's decision to accept federal funds to expand its Medicaid program. That decision has had an extremely positive impact Arkansans' access to health insurance and medical care.[1]

However, we have concerns with some of the substantive changes Arkansas is requesting to its program. Based on the best available evidence, these changes would increase the number of uninsured in the state, have a negative impact on the health of state residents. Some of our concerns can be addressed through the waiver approval process. Some of the requested elements do not comport with federal law and should be denied.

Comments on Specific Provisions in the Amendment Request

1. *Modifying income eligibility for expansion adults to less than or equal to 100 percent of federal poverty level.*

Arkansas is requesting to reduce the upper income eligibility limit for the state's Medicaid expansion to an amount that is less than the statutory requirement for Medicaid expansions entitled to the enhanced

[1] Hayes, Susan L. et al., "A Long Way in a Short Time: States' Progress on Health Care Coverage and Access, 2013–2015," The Commonwealth Fund, http://www.commonwealthfund.org/publications/issue-briefs/2016/dec/state-progress-coverage-and-access.

federal match.[2] The Secretary does not have the authority to approve an enhanced federal match for expansions that do not extend coverage to 133 percent of poverty.[3] This request should be denied.

A. Congress intended that the enhanced match only apply 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.

The statutory language clearly defines the expansion group as a whole, consisting of "*all individuals….* who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of title XVIII, 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." The group was defined clearly without permissive language or flexibility. 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).

B. The Secretary lacks the legal authority to approve a "partial expansion" at enhanced match. 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 National Federation of Independent Business decision.

The Supreme Court decision in *National Federation of Independent Business v. Sebelius*[4] (*NFIB*) made expanding Medicaid an option for states. 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

[2] PL 111-148, sec 2001 (a)(3); Social Security Act sec 1905 (y) [42 USC sec. 1396d(y)].
[3] This and all future references include a 5 percent income disregard, as outlined for Medicaid coverage in PL 111-148, sec. 2001.
[4] *NFIB –v- Sebelius,* 567 U.S. 519 (2012).

our opinion precludes Congress from … requiring that states accepting such funds comply with the conditions on their use."[5]

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."[6]

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

There is nothing in *NFIB* to authorize partial expansion.

C. *The Secretary does not have the authority to approve enhanced federal funding for Medicaid expansions that do not meet the requirements of section 1905 of the Social Security Act.*

The enhanced match for the Medicaid expansion is codified in section 1905 of the Social Security Act and cannot be waived under section 1115 authority, and clearly requires that the enhanced match is only available to states that extend Medicaid coverage up to 133 percent of the poverty line.

The principle that federal matching percentages in section 1905 are not subject to 1115 waiver is legally unquestioned and a cornerstone of CMS Medicaid policy.

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…."[7]

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.

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.

D. *A partial expansion serves no demonstration purpose and does not promote the objectives of the Medicaid program.*

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

States have the option to extend coverage to low-income adults at the regular federal match and have had that option for years. Many states have taken up that option, both before and subsequent to the passage of the Affordable Care Act. There is utterly no demonstration purpose to be served by allowing Arkansas to cover fewer adults—essentially exercising an option that has been available for well before the Affordable Care Act's Medicaid expansion and enhanced federal match—and receive a higher federal match for doing so. There is also no justification to support how this change would in any way promote the objectives of the Medicaid program.

The most logical assumption is that this request is made principally to reduce state spending while continuing to receive higher federal matching payments. Not only is the receipt of enhanced federal payments not supported by the statute and outside of the Secretary's authority (see discussion above), but approval of a waiver for the purpose of a state saving money without a clear research or demonstration value is an abuse of the Secretary's discretion.[8]

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.[9] States, including Arkansas, have the option to extend adult coverage and cap that coverage at less than 133 percent of poverty at the regular matching level.

2. ***Adding a work requirement to the Medicaid statute is outside the Secretary's authority to approve***

The waiver seeks to link Medicaid eligibility to an individual satisfying a work requirement. Granting a work requirement would be an abuse of the Secretary's Section 1115 demonstration authority and should be denied. The requested program is beyond the statue's objectives and the Secretary's authority to approve, and is in conflict with Arkansas' stated goals. There are alternative approaches to achieving the state's goals that are consistent with the Medicaid statute and within the Secretary's authority.

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.[10] A work requirement is fundamentally in conflict with the core Medicaid objective of furnishing medical assistance to low-income people and is therefore outside of the Secretary's authority to approve.

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-care…."[11]

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[8] *Beno –v- Shalala,* 30 F3rd 1057 (9th Circuit 1994).
[9] 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.
[10] Social Security Act sec. 1115 [42 U.S.C. 1315(a)].
[11] Social Security Act Sec. 1901. **[**42 U.S.C. 1396**].**

The state's work requirement is in conflict with those goals. According to the state, the purpose of the requested work requirement is to "promote independence through employment."[12] Regardless of the merits of that goal, withdrawing medical assistance for otherwise eligible low income people is antithetical to the objective of furnishing medical assistance and rehabilitation services as stated in Section 1901.

It is clear from section 1901 that the term "independence" is referring to improved physical function that can be achieved through medical rehabilitation services. That is not what the Commonwealth means by "independence" in the context of its work program. "Independence" used in that context refers to no longer receiving Medicaid coverage—a construction entirely alien to section 1901 and to the Medicaid statute as a whole.

The program would place a barrier to coverage and care for otherwise statutorily eligible individuals. The presence of the requirement itself will be a barrier to enrollment, causing some eligible working individuals to forego applying for coverage, and will make it more difficult for some statutorily eligible individuals to maintain coverage.[13]

A. *Even in terms of its stated goals, the program would not increase sustained employment.*

Evidence from work requirements in other social services programs indicates that they do not result in sustained employment and any employment increases faded over time.[14] In fact, individuals with the most significant barriers to employment often do not find work.[15]

Rather, the work requirement gets it entirely backwards. In surveying beneficiaries of the Medicaid expansion, Ohio reported that three-quarters of beneficiaries who were looking for work said Medicaid made it easier for them to do so. For those who were currently working, more than half said that Medicaid made it easier to keep their jobs.[16] Providing people Medicaid rather than taking it away will be the best way facilitate increased, sustained employment.

B. *A work requirement is a radical change to the Medicaid program; approving such a change through the 1115 waiver process would be an abuse of 1115 waiver authority.*

A work requirement would create a new eligibility requirement in addition to the current statutory requirements surrounding categorical eligibility, immigration and citizenship status and state residency. Approval would represent a radical change to the Medicaid program. It is outside the

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[12] P. 7 of the submitted application

[13] Hannah Katch, *Medicaid Work Requirement Would Limit Health Care Access Without Significantly Boosting Employment* (Washington, DC: The Center on Budget and Policy Priorities, July 2016), available online at http://www.cbpp.org/research/health/medicaid-work-requirement-would-limit-health-care-access-without-significantly

[14] 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

[15] *Ibid.*

[16] Ohio Department of Medicaid, "Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly," http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf.

Secretary's discretion to make such radical changes through an 1115 waiver. Rather, imposition of an entirely new eligibility criterion must be undertaken through the legislative process—and indeed Congress recently considered precisely such a change.

We urge the Secretary to work with the state to develop a more constructive approach that would not have terminating health coverage as one of its core elements. We have outlined a suggested approach in the next section of our comments.

The proposed program would expend significant administrative resources to set up a program that is not supported by the evidence on long-term employment gains among public benefit recipients, and will likely worsen health by cutting individuals off from coverage. It will be targeting only a small number of individuals since most adults covered by Medicaid either work or would fall into one of the program exemptions.

C. *Alternate suggestions for improving workforce participation*

1. Develop an evidence based work supports program based on the needs of Arkansas residents that has less risk of coverage termination and the adverse consequences thereof, and a greater chance of success at improving workforce participation.

Before taking such a radical and costly step, a more measured approach is called for that is both consistent with the objectives of the Medicaid program and more likely to achieve the goals of addressing barriers to work that some enrollees confront. This would involve creating work and training programs, with Medicaid eligibility not conditioned on participation, and ensuring that those programs are structured to address the actual barriers to work that individuals are confronting. For example: Is lack of transportation an impediment to work? Or lack of child care? Or lack of appropriate skills for available jobs in the area? Or mental health challenges?

This approach would be built on an understanding of barriers to work in various regions of Arkansas and an understanding of what has and has not worked in other state programs to address barriers to work. It would be designed to provide targeted and appropriate support based on individual circumstances and acknowledging regional barriers to work. Such an investigation would likely find what we know from the Temporary Assistance for Needy Families (TANF) and other social programs—that voluntary work supports rather than mandatory work search or benefit termination provisions are more successful at helping enrollees find and maintain work.[17] For example, the voluntary employment program Jobs-Plus for public housing residents has significantly increased earnings for residents and increased employment for groups with historically low labor-force participation. [i]

[17] LaDonna Pavetti, "Work Requirements Don't Cut Poverty, Evidence Shows," Center on Budget and Policy Priorities, June 2016.

This alternative approach would likely yield more sustained results than coverage termination.[18] It would be consistent with the Medicaid program and be a constructive way to connect people to work while ensuring that they retain their access to vital health services.

2. Hardship exemptions, while well intentioned, will be difficult for enrollees to access and will add a layer of administrative burden negatively impacting the state and low-income Medicaid eligible Arkansans.

We appreciate the states' acknowledgement that many individuals will be unable to fulfill the proposed work requirements for important mitigation factors such as education, caregiving and lay-offs. However, we have great concern generally with the difficulty enrollees will have accessing the hardship exemptions, and the content of those exemptions. Overall, we believe the hardship exemptions are not an effective way to alleviate the harm of a work requirement, and that such a proposal must be denied by the Secretary.

The state offers no detail on how the exemptions will be implemented, other than to say enrollees will have to report work status monthly and apply and reapply for exemptions at various different intervals. This tracking and application represents a substantial administrative undertaking for the state, and will undoubtedly burden enrollees already undertaking education, caregiving and work search responsibilities. The entire history of eligibility policy in the Medicaid program indicates that documentation and reporting requirements pose major barriers to enrollment, and Arkansas's proposal will reverse the major strides that Medicaid has taken toward simplified eligibility determination processes.

That such reporting may be done electronically offers little help, as a significant number of low income people do not have access to computers or internet.[19] This is particularly the case in rural areas.

The exemption for community service or volunteering is particularly troublesome. By requiring work or receive an exemption through community service, the amendment application is tacitly requiring community service. This proposed community service requirement may violate additional laws outside of the Medicaid Act. In many cases, particularly in economically challenged areas of Kentucky where unemployment is high and jobs are scarce, individuals may have no option other than engaging in community service to maintain health coverage. Essentially the requested program would require individuals to work without pay in exchange for health coverage, a non-cash benefit that they may or may not use over a given period. We continue to urge CMS, as we did on our comments to Kentucky and Indiana, to solicit input from the Department of Labor regarding this aspect of Arkansas' proposal. In addition to being contrary to Medicaid law, the community service requirement in the request may be in violation of the Fair Labor Standards Act.

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[18] *Id.*

[19] Victoria Rideout and Vikki Katz, *Opportunity for All? Technology and Learning in Lower-Income Families,* The Joan Ganz Cooney Center (Feb. 3, 2016) http://www.joanganzcooneycenter.org/publication/opportunity-for-all-technology-and-learning-in-lower-income-families/ ; The Federal Communications Commission, *Broadband in Rural Areas*, BROADBAND.GOV, http://www.broadband.gov/rural_areas.html (las accessed August 10, 2018).

3. CMS should reject Arkansas' request to waive mandatory three-month retroactive eligibility.

Arkansas' request to waive Section 1902(a)(34) of the Social Security Act, which requires three months retroactive coverage for newly eligible individuals, does not provide any demonstration value and the state provides no justification for its request. Arkansas believes that the need for retroactive coverage is limited and that waiving this provision will not have a large impact on uncompensated care costs" (See Appendix C, p. 5) but provides no data to support this assertion.

> **A.** *Without retroactive coverage, many individuals who are admitted to the hospital for emergencies and other catastrophic illnesses may incur substantial medical bills while they wait for Medicaid coverage to kick in*.

Medical debt makes it harder for low income people to get ahead; it contributes to half of all bankruptcies in the United States.[20] High debt and bankruptcies make it harder for low-income people to obtain credit and do things that will help them get ahead, such as buying a car, which can expand job opportunities. By increasing enrollees' medical debt and the associated financial burdens and strain, this program changes would make it harder for enrollees to move off Medicaid, the opposite of the state's rational for the changes requested in this amendment.

> ***B.*** *Without retroactive coverage, providers may face huge uncompensated care costs and may be dis-incentivized to treat low-income Medicaid eligible patients.*

Actuarial analyses of Medicaid payments have shown that about 5 percent of Medicaid payments occur during the retrospective eligibility period.[21] Retroactive Medicaid coverage reduces hospitals' uncompensated care burden. According to several offices at a safety net hospital, eliminating retroactive eligibility would result in about a 5 percent loss of Medicaid revenue.[22] Retroactive coverage allows physicians and clinics to treat patients who are eligible for Medicaid when they are sick and need care and be assured they can get paid after the patient enrolls.

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[20] David U. Himmelstein, MD et al. *Medical Bankruptcy in the United States, 2007: Results of a National Study,* The American Journal of Medicine (2009) available online at http://www.pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf

[21] Lewin Group, *Assessment of Medicaid Managed Care Expansion Options in Illinois*, prepared for the Commission on Government Forecasting and Accountability (Lewin Group, May 3, 2005).

[22] The Commonwealth Fund, *The Financial Impact of the American Health Care Act's Medicaid Provisions on Safety-Net Hospitals* (June, 2017) available online at http://www.commonwealthfund.org/publications/fund-reports/2017/jun/financial-impact-ahca-on-safety-net-hospitals#/#8

Granting this request would result in more uncompensated care, which and hospitals absorb sixty percent of the cost of uncompensated care in the medical community. [23] That would predictably

reduce provider program participation. Policies that have the predictable effect of reducing provider participation, making it harder for enrollees to receive care, hinder rather than further the objections of the Medicaid program and are thus contrary to the purpose of 1115 waivers and should be denied.

C. *Suggestions to minimize the harm of a waiver of retroactive eligibility*

We strongly oppose any waiver of three month retroactive eligibility. However, if the state and CMS are determined to go this route, we suggest only a provisional approval contingent on the results of an evaluation. The waiver of retroactive coverage should only be approved for one year during which time the state should evaluate the waivers' effect on consumer medical debt and gaps in coverage as well as provider uncompensated care burden. Only after the results of this evaluation should CMS consider a five year approval as requested in Arkansas' waiver amendment application.

Any waiver in retroactive coverage must also be coupled with a robust outreach and enrollment program. Ensuring all eligible individuals are continuity enrolled in the program will help guard against the adverse effects of provider and beneficiary debt. It is critical that enrollment strategies including presumptive eligibility.

Under no circumstances should the state be allowed to have such a waiver go into effect beginning July 1, 2017. This will penalize individuals with high medical bills who have already been operating under the assumption that their bill will be covered by the Medicaid program. This would be tantamount to an unconstitutional ex post facto law.

We appreciate the opportunity to comment. Thank you for your consideration. Should you have any questions, please don't hesitate to contact Dee Mahan dmahan@familiesusa.org or Andrea Callow acallow@familiesusa.org.

Sincerely,

Dee Mahan, Director of Medicaid Initiatives

Andrea Callow, Associate Director of Medicaid Initiatives