FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

September 15, 2017

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

Re: Comments regarding MaineCare 1115 Demonstration Project Application

Dear Secretary Price:

Families USA appreciates the opportunity to provide comments on Maine's 1115 waiver application for MaineCare, dated August 1, 2015.

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 in the MaineCare application 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 compliance with 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. Many of the items contained in Maine's request fall short on one or more of those requirements and should not be approved as submitted. Others are inconsistent with Medicaid law and should likewise be denied.

Comments on specific requests in the MaineCare waiver application

Asset limitations.

The state is requesting to apply an eligibility asset test to "all MAGI households that are not excluded as part of the existing state plan." This request is contrary to the law, does not serve any demonstration purpose, and should be denied.

[1] 42 U.S.C. section 1315(a) (codification of section 1115)

Eligibility asset tests are not allowed by law and cannot be approved by waiver. The law is clear on this point. Social Security Act section 1902 (e)(14)(A), under the heading "Income Determined Using Modified Gross Income" states:

> Notwithstanding subsection (r) or any other provision of this subchapter, except as provided in subparagraph (D), for purposes of determining income eligibility for medical assistance under the State plan ***or under any waiver of such plan*** and for any other purpose applicable under the plan or waiver for which a determination of income is required, including with respect to the imposition of premiums and cost-sharing, a State shall use the modified adjusted gross income of an individual and, in the case of an individual in a family greater than 1, the household income of such family [emphasis added].[2]

The exceptions outlined in subparagraph D include those qualifying as medically needy, those qualifying because of a disability, those 65 and older. The exceptions do not include the individuals and households that are the subject of this waiver request.

Furthermore, with regard to asset tests, Social Security Act section 1902 (e)(14)(C), under the subheading "No asset tests," states:

> A State shall not apply any assets or resources test for purposes of determining eligibility for medical assistance under the State plan ***or under a waiver of the plan*** [emphasis added].[3]

Section 1902 (e)(14)(F) further clarifies that the Secretary cannot to waive the requirement that a state use modified adjusted income for eligibility determinations, including its prohibition on application of an asset tests. The subheading, "Limitations on secretarial authority," reads:

> The Secretary shall not waive compliance with the requirements of this paragraph except to the extent necessary to permit a State to coordinate eligibility requirements for dual eligible individuals (as defined in section 1915(h)(2)(B) under the State plan or under a waiver of the plan and under title XVIII and individuals who require the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded.[4]

[2] Social Security Act 1902 (e)(14)(A) [42 USC 1396 a (e)(14)(A)].
[3] Social Security Act 1902 (e)(14)(C) [42 USC 1396 a (e)(14)(C)].
[4] Section 1902 (e)(14)(F) [42 1396a(e)(14)(F)].

Maine's request does not fall within any of the exceptions that would allow the Secretary to waive the prohibition on asset tests.

That Maine does not believe that prohibiting asset tests is "aligned with MaineCare's program goals" is immaterial. Maine supports its request by stating that current Medicaid law requiring that states use the Modified Adjusted Gross Income formula to determine eligibility for certain populations is not in line with the state's program goals. In accepting federal Medicaid funds (over $1.6 billion in federal funds in 2016), Maine has agreed to abide by federal Medicaid requirements.[5] That includes abiding by federal law related to eligibility determinations.

Maine's assertion that an asset test is necessary to preserve limited financial resources is also immaterial. Maine asserts that an asset is necessary "to preserve limited financial resources for the state's most needy individuals, to ensuring long-term fiscal sustainability for the MaineCare program."[6] Maine has agreed to accept significant federal funds for its MaineCare program, with the federal match at 62.8% in 2016. In accepting these funds, Maine has agreed to abide by federal requirements. There are many options available to Maine to reduce program costs that are consistent with Medicaid law and that do not require a waiver, as well as options to raise revenue within the state so more state funds would be available to fund the program. Seeking to sidestep Medicaid law under the guise of "preserving limited financial resources" is an inappropriate use of waiver authority and should be denied.

There is no demonstration purpose served by applying an asset test to eligibility. For decades prior to the passage of the Affordable Care Act, asset tests were part of the Medicaid eligibility determination process, including in Maine. Similarly, decades' worth of data has examined the impact of removing asset tests in Medicaid programs (both impact on eligibility determinations, program efficiency, and administrative costs).[7] Based on decades of experience, Congress chose to develop a new eligibility formula that excludes asset tests, and chose to explicitly prohibit the Secretary from waiving that formula. Given the decades of experience with asset tests, there is no demonstration purpose that could possibly be served

---

[5] Federal and State Share of Medicaid Spending for Maine, 2016, available online at Kaiser State Health Facts, http://www.kff.org/medicaid/state-indicator/federalstate-share-of-spending/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D, accessed September 11, 2017.

[6] MaineCare 1115 waiver application, page 15.

[7] Vernon Smith, et al., *Eliminating the Medicaid Asset Test for Families: A Review of State Experiences,* (Washington, DC.: Kaiser Family Foundation, 2001) online at https://kaiserfamilyfoundation.files.wordpress.com/2001/04/2239-eliminating-the-medicaid-asset-test.pdf.

by Maine's request. The request seeks to waive statute that is explicitly not subject to waiver, and in any event fails to meet the most basic 1115 waiver requirements.

Community engagement and work requirement.

The state is requesting to add a work or community engagement requirement for adults under 65.

Granting a work requirement is outside of the Secretary's authority under the requirements of section 1115 and would therefore be an abuse of the Secretary's discretion. The request should be denied. There are alternative approaches to achieving the state's goals that are consistent with the Medicaid statute and within the Secretary's authority.

Approving a work requirement would not further the objectives of the Medicaid program, which is a basic requirement of 1115 waiver approval, and should therefore 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.[8]

The objectives of the Medicaid program are 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…."[9] Adding a work requirement would not further those goals and, furthermore, by resulting in a certain number of otherwise eligible individuals losing coverage, it would be in conflict with those goals.

Maine states that the purpose of the requested work requirement is to "increase employment and wage earnings of able-bodied adults."[10] While it is unlikely that the proposed program would have that effect (discussed in detail below), that is immaterial. 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.

The Secretary does not have the authority to rewrite the Medicaid statute and redefine the program's objectives through waiver.

Maine's states goal for the program, "to promote financial independence and transition to employer sponsored or other commercial health insurance" is not a goal of the Medicaid program. Maine outlines its goals for the work requirement in terms of promoting financial

[8] Social Security Act sec. 1115 [42 U.S.C. 1315(a)].

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

[10] P. 5 of the submitted MaineCare application

independence and transitioning individuals to employer coverage. Those are not goals of the Medicaid program (outlined above).

Regardless of the merits of promoting financial independence, withdrawing medical assistance from 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, not the "financial independence" listed as a goal for the Maine waiver. "Independence" as used in the state's request refers to no longer receiving Medicaid coverage—a construction entirely alien to section 1901 and to the Medicaid statute as a whole.

A work requirement would be conflict with CMS's criteria for determining whether a demonstration will further the goals of the Medicaid program. CMS has outlined the general criteria used to determine whether a demonstration will further Medicaid program objectives. Those are whether the demonstration will:

- Increase and strengthen overall coverage of low-income individuals in the state;
- Increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state;
- Improve health outcomes for Medicaid and other low-income populations in the state; or
- Increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.[11]

A work requirement would not meet those goals. 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.[12]

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

[11] Medicaid.gov, "About Section 1115 Demonstrations," accessed September 11, 2017 at https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html.

[12] 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-withoutsignificantly

residency. Approval would represent a radical change to the Medicaid program. It is outside the 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.

The community service requirement may violate other federal laws. Maine's proposal includes an option for enrollees to complete the work requirement with "workfare or volunteer community service" in lieu of paid work. Particularly in areas where the employment market is tight, this requirement would essentially require that enrollees work without pay for a non-cash benefit (health coverage) that they may or may not use over a given period of time. Even for those who do use the benefit, compensation will go to health care providers, not the enrollee. Including unpaid work as an option may be a violation of the Fair Labor Standards Act (FLSA). (It is unclear whether another ill-defined option—participation in a "Department approved work program"—is likewise a potential FLSA violation.)

Evidence indicates a work requirement will not accomplish Maine's stated goals for the program. The state asserts that a work requirement will increase employment and move enrollees to employer sponsored coverage.

However, that is not likely to be the result. Evidence from work requirements in other social services programs indicates that they do not result in sustained employment and any employment increases fade over time.[13] In fact, individuals with the most significant barriers to employment often do not find work.[14] Rather, Medicaid coverage itself can have the effect of increasing enrollees' ability to engage in sustained employment and improve their financial situation.

- In a survey of Medicaid expansion enrollees, 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.[15]
- Two studies, one completed by researchers and economists from the Federal Reserve Bank of Chicago and a second completed by researchers and economists from the Federal Reserve Bank of New York, found that health insurance coverage through Medicaid was associated with improved financial health (reduced credit card debt, lower third party

[13] 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
[14] *Ibid.*
[15] 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.

collection rates).[16] Instituting a work requirement will mean that some individuals will lose coverage. Removing health coverage will not improve the fiscal (or physical) health of those loosing coverage.

The state's objective of increasing employer coverage through the work requirement is also not supported by evidence. First, among adults eligible for Medicaid, a large percent are already working.[17] However, most Medicaid enrollees work in industries- like retail, home health care and food service—that routinely do not offer employer sponsored insurance (or if they do, it is unaffordable for low-wage workers).[18] Just 12 percent of workers earning the lowest 10 percent of wages had employer-provided health insurance in 2016.[19] The work requirement will not change that.

Instituting a work requirement would be administratively costly. 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; is unnecessary given that the majority of those in the target population who can work, do; and, will likely worsen health by cutting individuals off from coverage. The added administrative program costs coupled with the predictable negative health impact this proposal would have on Medicaid eligible Mainers further underscore the fact that this proposal does not further the objectives of the Medicaid program.

There is an alternative approach that would not conflict with the objectives of the Medicaid program. 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 below.

<u>Develop an evidence based work supports program based on the needs of Maine residents that is not tied to Medicaid eligibility.</u>

---

[16] Luojia Hu, et al., "The Effect of the Patient Protection and Affordable Care Act Medicaid Expansion on Financial Well-Being," National Bureau of Economic Research Working Paper 22170 published April 2016, online at http://nber.org/papers/w22170; and, Nicole Dussault, et al, "Is Health Insurance Good for Your Financial Health?" *Liberty Street Economics,* June 16, 2016 online at http://libertystreeteconomics.newyorkfed.org/2016/06/is-health-insurance-good-for-your-financial-health.html#.V2fhz_krLct.

[17] Rachel Garfield, et al., *Understanding the Intersection of Medicaid and Work*, (Washington, DC: Kaiser Family Foundation, February 2017) online at http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.

[18] Alanna Williamson, et al., *ACA Coverage Expansion and Low-Income Workers* (Washington, DC: Kaiser Family Foundation, June 2016) online at http://www.kff.org/report-section/aca-coverage-expansions-and-low-income-workers-issue-brief/; and, John Schmitt, *Health Insurance Coverage for Low-Wage Workers, 1979-2010 and Beyond* (Washington, DC: Center for Economic and Policy Research, 2012) online at http://cepr.net/publications/reports/health-insurance-coverage-for-low-wage-workers-1979-2010-and-beyond.

[19] Jessica Gher, *Doubling Down: How Work Requirements in Public Benefit Programs Hurt Low-Wage Workers,* (Washington, DC: CLAPS, June 2017) online at http://www.clasp.org/resources-and-publications/publication-1/Doubling-Down-How-Work-Requirements-in-Public-Benefit-Programs-Hurt-Low-Wage-Workers.pdf.

For the reasons outlined above, 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 Maine and among different groups of enrollees. It would be designed to provide targeted and appropriate support based on individual circumstances and regional barriers to work. Data shows that voluntary work supports rather than mandatory work search or benefit termination provisions are more successful at helping enrollees find and maintain work.[20]

This alternative approach would likely yield more sustained results than coverage termination.[21] It would be consistent with the Medicaid program objectives and be a constructive way to connect people to work while ensuring that they retain their access to vital health services. Medicaid enrollment can be used as a point in time to connect individuals to such a program.

Premium payments and lock-out periods.

The request to add premium payments with potentially indefinite non-payment lock-out penalties is inconsistent with the objectives of the Medicaid program and should be denied.

The premium proposal is inconsistent with the objectives of the Medicaid program. Maine requests approval for premium payments with a lock-out penalty for nonpayment of 90 days or until any unpaid premiums are paid (for individuals without the financial wherewithal to pay premiums, this could be indefinitely).

Copious data shows that for the low-income population Medicaid serves, premiums as a condition of eligibility are a barrier to obtaining and maintaining coverage.[22] A survey of studies of the impact of premiums on Medicaid enrollees' ability to obtain and keep Medicaid

[20] LaDonna Pavetti, "Work Requirements Don't Cut Poverty, Evidence Shows," Center on Budget and Policy Priorities, June 2016.
[21] *Id.*
[22] Samantha Artiga, *The Effect of Premiums and Cost-Sharing on Low-Income Populations: Updated Review of Research Findings,* (Washington, DC: Kaiser Family Foundation, June 2017, online at http://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

coverage cites over two dozen studies showing that premiums increase disenrollment, and make it difficult for individuals to enroll at all. [23]

Policies that have been shown to make it harder for individuals to access or retain Medicaid coverage not only would not further, but would impede, the program's objectives, outlined above. This request, therefore, is not appropriate for approval under 1115 authority and should be denied.

The premium proposal does not serve any demonstration purpose. As outlined above, there is substantial data showing the negative impact of premiums on individuals' ability to obtain and keep Medicaid coverage. Given the wealth of studies, the requested premium program would serve utterly no demonstration purpose. Approval would be an inappropriate use of Secretarial authority.

Higher emergency room copayments.

Maine requests imposing a higher ($10) copayment on ER use for a set list of diagnoses. This use of set list of diagnoses does not provide adequate assurances that copayments will not be charged for emergency services, serves no demonstration purpose, and should be denied.

The request does not adequately distinguish "emergency" and "non-emergency" use of the ER. Medicaid law does not allow copayments for emergency use the ER.[24] While we support appropriate use of ER services, the use of a blanket list of diagnoses to determine emergency versus non-emergency care is overly broad and in violation of section 1916 of the Social Security Act.

It is quite possible that some of the diagnoses listed (ear infections, headaches, acute respiratory infections, asthma) could produce severe pain or other serious symptoms that would lead a reasonable person to seek emergency care, or lead a prudent physician to recommend his or her patient seek emergency room care. The request does not allow for distinctions, or exceptions when an individual has been directed to an emergency room by a physician.

---

[23] Samantha Artiga, *The Effect of Premiums and Cost-Sharing on Low-Income Populations: Updated Review of Research Findings,* (Washington, DC: Kaiser Family Foundation, June 2017, online at http://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

[24] Social Security Act, section 1916. **[**42 U.S.C. 1396o**].**

The request does not further the objectives of the Medicaid program and serves no demonstration value. The program proposed and the use of an inadequate list of diagnoses that do not allow for medical interpretation, will invariably result in individuals with true emergencies delaying care, potentially to the detriment of their health and resulting in higher costs to the state and the federal government. This will not further the objectives of the Medicaid program.

Furthermore, there is a wide body of research showing that, contrary to Maine's assertions, copayments create barriers to care and, for low-income individuals in particular, reduce use of *appropriate* as well as inappropriate care.[25]

The request does not meet the requirements of 1916(f). The relevant section of the Social Security Act for this waiver request is section 1916(f). Under that section, as state requesting such a waiver must meet the following criteria:

1. The state's proposal will test a previously untested use of copayments;
2. The waiver period cannot exceed two years;
3. The benefits to the enrollees are reasonably equivalent to the risks;
4. The proposal is based on a reasonable hypothesis to be tested in a methodologically sound manner; and
5. Beneficiary participation in the proposal is voluntary.

Maine's proposal does not meet the criteria for a waiver under section 1916(f); in fact, the state does not even acknowledge the criteria for a cost-sharing waiver in its proposal.

Medicaid law allows states to impose an $8 copayment for non-emergency ER use. The use of a $10 payments based on a restrictive list that offers no room for medical interpretation serves no demonstration purpose.

Omitting retroactive coverage and presumptive eligibility.

Maine's request to waive Section 1902(a)(34) of the Social Security Act, which provides for three months retroactive coverage for newly eligible individuals, is not adequately justified by the state and does not promote the objectives of the Medicaid program. The harm that this waiver would cause is compounded by the fact that the state is also requesting to eliminate the option for qualified hospitals to make presumptive eligibility determinations.

[25] Samantha Artiga, *The Effect of Premiums and Cost-Sharing on Low-Income Populations: Updated Review of Research Findings,* (Washington, DC: Kaiser Family Foundation, June 2017, online at http://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/..

These requests, individually and particularly taken together, would put patients and providers (particularly safety-net providers) at risk, would reduce provider willingness to treat low-income individuals, and should be denied.

Retroactive coverage addresses a real policy need. Maine asserts that Medicaid should work like private coverage and omit retroactive coverage. However, the fact is that Medicaid coverage is not like private coverage. Individuals must meet income eligibility criteria and reapply annually. Many individuals do not know that they qualify until they have a medical event; the application process can take some time (MaineCare decisions can take 45 days unless additional information is needed, when they can take longer). Because eligibility is income based and income fluctuates, particularly for lower income individuals, people cycle on and off Medicaid coverage, often experiencing gaps in coverage. Retroactive eligibility helps to protect the assets of lower income individuals who are Medicaid eligible and also helps providers cover their operating costs and maintain quality of care.

Eliminating retroactive coverage will cause individuals to incur substantial medical bills while waiting for Medicaid coverage to begin. Data from Indiana illustrates the real financial harm to Medicaid eligible individuals that can occur if retroactive coverage is eliminated.

Indiana's HIP 2.0 demonstration waiver carved out a "transition program," the prior claims payment program. That program pays 90 days' claims prior to the effective eligibility date for a subset of 1931 parents and caretaker adults, effectively providing retroactive coverage for a subset of enrollees. The amounts paid under that program illustrate the important role that retroactive coverage provides to low-income individuals. Of those eligible for the prior claims payment program, 13.9 percent incurred costs averaging $1,561.[26] That is a considerable percent of enrollees who incurred costs in the 90 days prior to enrollment, and the average cost incurred were at level that would be a significant financial burden for the low-income individuals who qualify for Medicaid.

As the data from Indiana illustrates, retroactive coverage protects low-income individuals from medical debt. Medical debt contributes to half of all bankruptcies in the United States.[27] High

---

[26] July 29, 2016 letter from the Centers of Medicare and Medicaid Services to the state of Indiana, available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf.

[27] 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

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 and onto the private coverage the state encourages.

Without retroactive coverage, providers will have higher uncompensated care costs.
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. It protects hospitals that must treat Medicaid eligible-but-not-yet-enrolled individuals who present for emergency care.

Retroactive coverage payments make a real contribution of the operation of safety-net hospitals. According to several officials at a safety net hospital, eliminating retroactive eligibility would result in about a 5 percent loss of Medicaid revenue.[28] The Congressional Budget Office found a repeal of Medicaid retroactive coverage would result in a loss of $5 billion in federal funding for states and hospitals from 2017 to 2026.[29]

Granting this request would increase providers' uncompensated care. That would predictably place a greater financial burden on providers, particularly the safety-net providers and hospitals that most frequently treat lower income individuals (hospitals absorb sixty percent of the cost of uncompensated care in the medical community). [30] Increased uncompensated care costs can lead to fiscal strains that impede hospitals' ability to operate efficiently and effectively for all patients, including Medicaid enrollees.[31]

To the extent that MaineCare provider reimbursements are lower than other payers, added financial strain resulting from higher uncompensated care costs could lead providers to eschew MaineCare participation and focus on higher margin payers. Predictable fiscal stain and the potential for lower provider participation are outcomes that conflict with the objectives of the Medicaid program.

---

[28] 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

[29] Congressional Budget Office Cost Estimate, The Better Care Reconciliation Act (June 26, 2017) https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52849-hr1628senate.pdf

[31] Gerry Ferrier, "Analysis of uncompensated hospital care using a DEA model of output congestion," Health Care Management Science, May 2006, Volume 9, issue 2, pp. 181-188, online at https://link.springer.com/article/10.1007/s10729-006-7665-8.

Policies that would predictably weaken providers and provider networks that serve low-income, Medicaid eligible individuals are in conflict with Medicaid's objectives and should be denied.

Maine's rationales for the request ignore the reality of Medicaid coverage, and are in opposition to the goals and objectives of the Medicaid program. Maine's lists several rationales for this request, none of which adequately support the request. Some confirm that the request would hinder, rather than support, Medicaid's objectives and should therefore be denied.

- Maine asserts that Medicaid coverage should align with private coverage and be effective on the first day of the month of enrollment. As noted above, unlike the commercial market, Medicaid beneficiaries must re-establish eligibility annually, leading to significant annual disenrollment at renewal even for people who are otherwise eligibility. This leads to gaps in Medicaid coverage, and retroactive payment can help to preserve access to care, providing financial protection to providers and patients, despite these gaps. There is no data supporting the assertion that eliminating retroactive coverage better prepares individuals for commercial coverage. Instead, the research bears out that repeal of retroactive coverage will lead to greater consumer debt and hospital uncompensated care, potentially lead to less provider participation in Medicaid, in opposition to the objectives of the Medicaid program. (See discussion above.)
- Maine asserts that omitting retroactive coverage will encourage individuals to seek coverage (and presumably care) when they are healthy rather than waiting until they are ill and have medical expenses. However, the state offers no evidence supporting the assertion that omitting retroactive coverage will in any way increase use of preventive services or increase enrollment. However, there is evidence that omitting retroactive coverage will lead to greater financial strains on individuals eligible for Medicaid (see discussion below0; omitting presumptive eligibility will likely reduce enrollment.
- The state asserts that providers should determine whether or not they want to treat a patient based on coverage at the time a patient presents, rather than "the potential for future retroactive coverage by MaineCare."[32] That statement ignores the fact that retroactive payments are essential to hospitals and often related to treatment of patients who present with emergencies (see discussion above). The statement seems to imply that providers should avoid treating low-income uninsured patients. Not only is that not always an option for hospitals (as is the case in individuals presenting for emergency care), but

[32] MaineCare waiver application page 11.

extraordinarily bad public health policy that risks the health and safety of state residents needing emergency care, and is in conflict with the objectives of the Medicaid program.[33]

The state's assertion that retroactive eligibility may be granted in some cases is vague, inadequate and does not remedy the fact that the proposed program would hamper, not further, the objectives of the Medicaid program. The state's assertion that retroactive eligibility "may be granted, as appropriate, for individuals whose existing MaineCare coverage lapses," does not provide sufficient details to give any assurance that the process will in any way mitigate the harm that the waiver would entail.

Suggestions to minimize harm if CMS moves forward with 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 be granted contingent on the results of an evaluation and under no circumstances be combined with elimination of presumptive eligibility determinations. Furthermore, additional details on the operations of the state's exception processes for retroactive coverage should be required.

The waiver of retroactive coverage should only be approved for six months to one year during which time the state should evaluate the waiver's 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 more lengthy approval.

Any waiver in retroactive coverage must also be coupled with a robust outreach and enrollment program, in addition to keeping the presumptive eligibility program in place.

Thank you for the opportunity to submit these comments. If you have any questions, or would like additional information, please do not hesitate to contact us.

Sincerely,

Dee Mahan
Director, Medicaid Initiatives

Andrea Callow
Associate Director, Medicaid Initiatives

[33] The Emergency Medical Treatment and Labor Act (EMTALA) requires that hospitals treat and stabilize emergency patients. CMS EMTALA overview online at https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html?redirect=/EMTALA/01_overview.asp.