FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

August 17, 2018

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

Re: Comments on Kentucky HEALTH 1115 Demonstration Request

Submitted electronically via Medicaid.gov

Dear Secretary Azar:

Families USA appreciates the opportunity to provide additional comment on the Commonwealth of Kentucky's Kentucky HEALTH waiver application.

Families USA is a national health care advocacy organization with the mission of supporting policies and policy changes that will expand access to affordable healthcare, with a focus on access for lower income individuals.

We are extremely supportive of Kentucky's decision to accept federal funding to extend Medicaid to more low-income parents and adults, a choice that has demonstrably improved health insurance coverage, health care access, and financial stability for hundreds of thousands of Kentuckians. We share the Governor's goal of achieving long-term improvements in the health of Kentucky's residents, giving them opportunities to take an active role in their health care, and we support programs that help get people back to work. However, many of the program elements in the waiver request are in conflict with those goals, are inconsistent with Medicaid's objectives, and must be denied. We address those program elements below.

These comments supplement our October 4, 2016 and August 2, 2017 comments on the initial and modified Kentucky HEALTH waiver requests. We respectfully request that these comments and the complete articles cited be incorporated into the record.

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Comments on Specific Provisions in the Waiver Request

Community engagement and employment initiatives

Families USA supports programs that help individuals work. By improving enrollees' health and financial security, Medicaid is one such program. Threatening people with loss of health insurance, and cutting people off health insurance, will not promote work. It will have the opposite effect. The work requirement and associated paperwork will cause Medicaid enrollees across the board—those who are working, not working, or unable to work—to lose coverage.

And while Medicaid has been shown to support work and improve financial stability among enrollees, fundamental to this analysis is Medicaid's purpose: Medicaid is a health insurance program for low-income people. Its objective, noted in the District Court opinion in Stewart –v- Azar, is to help states furnish medical assistance to their citizens.[1] Predicating eligibility for Medicaid coverage on employment or community service work is contrary to the program's statutory purpose and therefore the request must be denied.

Conditioning Medicaid eligibility on work is contrary to Medicaid law

The relevant statutory provisions for this analysis are section 1115 and section 1901 of the Social Security 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." [2]

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…."[3] In the context of the statute, it is absolutely clear that "independence or self-care" refers to federal funding enabling states to provide care that can help individuals attain or retain independence that has been compromised because of *health related* conditions.

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[1] Ronnie Maurice Stewart, *et al.* v. Alex M. Azar II, *et al.,* Memorandum Opinion, United States District Court for the District of Columbia, Civil Action No.18-152 (JEB) June 29, 2018 online at https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv0152-74.

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

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

While HHS has recently updated its Medicaid.gov website to redefine the objectives of the Medicaid program to include work, that website change 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. Medicaid's objective is to help states *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 to Medicaid 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 application, Kentucky is asserting that work will improve individual health and that is a rationale for adding a work requirement to Medicaid. The data showing a positive connection between work and health is far from conclusive.[4] However, even if there were a conclusive positive connection, 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,

[4] Larisa Antonisse et al., The Relationship Between Work and Health: Findings from a Literature Review (Washington, DC: Kaiser Family Foundation, August 2018) online at https://www.kff.org/medicaid/issue-brief/the-relationship-between-work-and-health-findings-from-a-literature-review/.

with far more conclusive data than is available connecting work and health: diet[5]; exercise[6]; marital status[7]; social engagement,[8] to list only a few 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 within the program's objectives simply because one or more of those activities has 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 between work and health is complicated and inconclusive

Kentucky's community service request is based on assertions that there is strong documentation of a near universal and positive correlation between work and health. That is not the case. (We reiterate here that even if it were the case, the Secretary lacks the authority to add requirements to the Medicaid program that are unrelated to, and would have a predictable outcome that is in opposition to, that program's objectives.)

- Literature studying the connection between work and health is not conclusive. While some studies show a positive connection between work and health, others show no relationship.[9] Studies also show that whether work has a positive impact on health is significantly affected by the quality and stability of that work.[10] Low-wage jobs, the type that Medicaid enrollees

[5] 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/.

[6] 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/

[7] 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.

[8] 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/.

[9] Larisa Antonisse, *op cit.*

[10] Larisa Antonisse, *op cit.,*; Peter Butterworth et al., "The Psychosocial Quality of Work Determines Whether Employment Has Benefits for Mental Health: Results From a Longitudinal National Household Panel Survey,"

will by definition be engaged in, are less stable and therefore less likely to promote health.[11] Low-wage jobs often have associated and documented health risks, such as: erratic shift-work; exposure to toxic chemicals; non-standard or part-time working relationships (which are associated with higher job related stress); and, risks associated with manual labor. A significant body of research has found that when it comes to the relationship between employment and health, not all jobs are equal. Any positive connection between work and health is more spurious when looking at the health impact of low-wage work.[12]

- Selection bias may affect results. Studies associating work and health may reflect the fact that healthier people are more likely to be working than are people with health problems, rather than showing any cause and effect connection between work and health. Multiple studies have documented the fact that people with health problems are less likely to work. The difficulty of controlling for this fact can cause an overestimation of any positive health effects of work.[13]

Access to affordable health insurance and health care promotes individuals' ability to work

Threatening to or taking health insurance away from people who do not meet a work mandate will not increase their employment opportunities. It will however, reduce their health coverage and access to health care. That can negatively affect individuals' ability to get and keep employment.

Kentucky's proposed program that is ostensibly about connecting people with work may, in fact, make it more difficult for people to obtain and retain employment.

- Medicaid coverage makes it easier for individuals to keep work. In a comprehensive assessment of Ohio's Medicaid expansion program, 52.1 percent of expansion enrollees said that Medicaid coverage made it easier for them to get and keep employment.[14]

Occupational and Environmental Medicine 68 no. 11 (2011): pp. 806-812; Joseph Grzywacz and David Dooley, "'Good jobs' to 'bad jobs': replicated evidence of an employment continuum from two large surveys," Social Science and Medicine 56 no. 8 (April 2003): 1749-1760, https://www.ncbi.nlm.nih.gov/pubmed/12639591; and, Tae Jun Kim and O von dem Knesebeck, "Perceived job insecurity, unemployment and depressive symptoms: a systematic review and meta-analysis of prospective observational studies," *International Archives of Occupational and Environmental Health* 89 no. 4 (May 2016): 561-573, https://www.ncbi.nlm.nih.gov/pubmed/26715495.

[11] *Ibid.*

[12] Sarah Burgard, et al., "Bad Jobs, Bad Health? How Work and Working Conditions Contribute to Health Disparities," American Behavioral Sciences 2013 Aug; 57(8): 10, online at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3813007/. .

[13] Larisa Antonisse, *op cit.*

[14] Loren Anthes, "The Return on Investment in Medicaid Expansion: Supporting Work and Health in Rural Ohio," *Say Ahhh! Blog,* Georgetown University Health Policy Institute, January 2017 online at https://ccf.georgetown.edu/2017/01/10/the-return-on-investment-of-medicaid-expansion-supporting-work-and-health-in-rural-ohio/.

- Medicaid coverage supports work search activities. In surveys of unemployed Medicaid expansion enrollees in Ohio and Michigan, the majority (74.8 percent in Ohio and 55 percent in Michigan) said that having Medicaid coverage made it easier for them to look for work.[15] Workers earning low wages may be at greater risk for disease and injury than workers earning high wages," write J. Paul Leigh, PhD, and Roberto De Vogli, PhD, MPH, of University of California Davis School of Medicine. [16]They believe that low wages should be considered among the psychosocial factors -- such as long work hours and high job strain -- identified as occupational risks to health.

Access to affordable health insurance can be a pathway out of poverty

Like all insurance, Medicaid helps protect people from medical costs and debt. That helps improve enrollees' financial security. Arguments that a work requirement linked to coverage disenrollment will help improve individuals' economic security do not hold up. Medicaid coverage in and of itself improves individuals' financial security. Taking Medicaid away will hurt families' financial security.

- Medicaid is associated with improved finances for people covered by the program. Two studies of the impact of Medicaid expansion on financial health found that Medicaid expansion is associated with a significant reduction in unpaid medical bills, a decline in credit card debt, and a decline in debts sent to collections.[17]

- Medicaid coverage improves finances and reduces fiscal stress. Ohio's assessment of Medicaid expansion enrollees found that Medicaid coverage helped enrollees' finances: 22.9 percent of expansion enrollees said their financial situation improved. Medicaid also made it easier for enrollees to afford other life essentials: 58.6 percent said Medicaid coverage made it easier for them to purchase food; 48.1 percent said it made it easier for them to pay rent or a mortgage; and 44.8 percent of enrollees with medical debt said that with Medicaid expansion, they saw that debt end.[18]

- Medicaid coverage can be a path out of poverty. When Oregon extended Medicaid coverage to previously uninsured low-income adults in 2008 (before the Medicaid expansion), the individuals gaining coverage reported improved financial security.[19]

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[15] Jessica Gehr, "The Evidence Builds: Access to Medicaid Helps People Work," CLASP, December 2017 online at https://www.clasp.org/sites/default/files/publications/2017/04/The-Evidence-Builds-Access-to-Medicaid-Helps-People-Work.pdf.

[16] Leigh JP, De Vogli R. Low wages as occupational health hazards [Editorial]. *J Occup Environ Med*. 2016;58(5): 444–7, online at https://www.ncbi.nlm.nih.gov/pubmed/27158950.

[17] Dee Mahan, et al., "Medicaid Expansion Improves People's Financial Stability, Families USA blog September 2016, online at http://familiesusa.org/blog/2016/09/medicaid-expansion-improves-people's-financial-stability

[18] Lauren Anthes, *op cit.*

[19] Katherine Baicker, et al., "The effects of Medicaid Coverage—Learning from the Oregon Experiment," *New England Journal of Medicine,* 2011; 365:683-685, online at https://www.nejm.org/doi/full/10.1056/NEJMp1108222.

Greater financial security and stability reduces individuals' risk of homelessness and is a foundation for moving out of poverty.[20]

The community service requirement's paperwork/work documentation requirements will make it harder for <u>all</u> enrollees to keep Medicaid

Kentucky's proposal would require paperwork from a broad swath of adults on Medicaid. Enrollees who are already working will need to document hours worked at regular intervals. Those who are exempt from the work requirement will need to prove that they are exempt. Those who are not currently working will need to document hours in community service, job training, or hours spent applying for jobs. All stand to lose coverage if they don't keep up with the paperwork requirement.

When states add paperwork requirements to Medicaid, enrollment falls.[21] That will happen with Kentucky's proposed work requirement as well, and enrollment will fall across the board—including for working adults, people with medical conditions who cannot work but do not qualify for SSI disability, and family caregivers.

The resulted coverage losses will be across the board, an outcome that is not only contrary to the objectives of the Medicaid program, but inconsistent even with Kentucky's state purpose of its proposed waiver program.

Even in terms of its stated goals, the program would not necessarily 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.[22] In fact, individuals with the most significant barriers to employment often do not find work.[23] There is no reason to believe that results will be any different in a work requirement attached to Kentucky's Medicaid program. There is no data supporting the theory that taking health insurance away from low-income people will improve their health, finances, or employment prospects. In fact, data indicates that the outcomes would be the opposite.

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[20] *Oregon Study Shows Obtaining Medicaid Improves Financial Security*, National Health Care for the Homeless Council online at https://www.nhchc.org/2013/05/oregon-study-s.

[21] Margot Sanger-Katz, "Hate Paperwork: Medicaid Recipients will be Drowning in It," *New York Times*, January 18, 2018 online at https://www.nytimes.com/2018/01/18/upshot/medicaid-enrollment-obstacles-kentucky-work-requirement.html.

[22] 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.

[23] *Ibid.*

The community service requirement may violate other federal laws

As we noted in our comments on the initial and modified waiver applications, the proposed community service requirement may violate additional laws. 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.[24] Essentially the requested program would require individuals to work without pay in exchange for health coverage, a non-cash benefit, the use of which is unpredictable and depends on health care needs at any given time. We continue to urge CMS to solicit input from the Department of Labor regarding this aspect of Kentucky's 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.

The proposed community service program is in conflict with the Commonwealth's stated goals

The Commonwealth's assertion (page three of its application) that "[O]nly by helping members engage in their healthcare and their communities will the Commonwealth achieve long term improvements in the health of its citizens" is in conflict with the very structure of the program for which it is seeking approval. Its work/community engagement requirement would bar individuals from health coverage if they do not comply. It is not possible for individuals to remain engaged in their health care when their very access to that care is terminated.

The proposed work requirement would worsen issues of substance use disorders among state residents

In its waiver request, Kentucky states that it seeks to use Medicaid and the waiver program to address substance use disorder (SUD) among state residents. However, the proposed work requirement (and other program elements such as paperwork requirements and program lock-outs for failure to pay premiums) would worsen, not ameliorate, that serious public health issue.

Medicaid is a lifeline for many people with SUDs. Medicaid expansion has significantly increased coverage rates for people with an SUD and reduced the share of uninsured hospitalizations for SUDs in expansion states from 20 percent in 2013 to 5 percent in 2015.[25] Losing Medicaid coverage could be detrimental to the health of people with SUDs. That is contrary to the goal of

[24] In Kentucky, 25 counties have unemployment rates exceeding 7 percent, significantly higher than the national average of 4.4 percent. A driver of high unemployment is lack of jobs in many areas of Kentucky. See US Department of Labor, Bureau of Labor Statistics, Local Area Unemployment for Kentucky, May 2017 at https://data.bls.gov/timeseries/LNS14000000; and, Bill Estep, "In Eastern Kentucky, 'there's so many people unemployed fighting over so few jobs,'" *Lexington Herald Leader,* March 1, 2014 at http://www.kentucky.com/news/hot-topics/article44474187.html.

[25] U.S. Department of Health and Human Services, "Continuing Progress on the Opioid Epidemic: The Role of the Affordable Care Act," January 11, 2017, https://aspe.hhs.gov/system/files/pdf/255456/ACAOpioid.pdf

furnishing medical care to low-income state residents and contrary to the stated objectives of the waiver proposal articulated by the state.

- Exemptions will leave out many people with substance use disorders (SUD). By definition, the "medically frail"[26] exemption includes people with "chronic" SUDs, but that suggests people must have had multiple episodes of substance use or that their illness has persisted for a long time. Many people with SUDs will not meet this standard.

- The treatment accommodation falls short. Kentucky's waiver allows for people with substance use disorders to count the hours of qualifying treatment received toward the state's requirement that beneficiaries document that they worked, searched for a job, or volunteered for at least 80 hours each month. But Kentucky's accommodation falls short because people with Medicaid coverage may not be in active treatment or may not be in treatment for an average of 80 hours per month. Moreover, it is not clear what is defined as qualifying treatment.

    - The National Survey on Drug Use and Health estimates that in 2016, about 15 percent of all unemployed U.S. adults needed SUD treatment (defined as services in an inpatient hospital, rehabilitation facility, or mental health center) but only 2.5 percent got care.[27]
    - It's likely that a narrow range of treatment options, such as inpatient care or care at a mental health clinic, will qualify as "medical treatment," and that several evidence-based behavioral health services delivered in the home or other informal setting may not.

- Red-tape will be particularly difficult for people with substance use disorders. Red tape and paperwork requirements have been shown to reduce enrollment in Medicaid across the board (see discussion above) and are particularly likely to affect people with substance use disorders.[28]

[26] 42 C.F.R. §440.315, Accessed at: https://www.ecfr.gov/cgi-bin/text-idx?SID=7becf6352680464a4659264a26d0eebf&mc=true&node=se42.4.440_1315&rgn=div8

[27] Rebecca Ahrnsbrak, Jonaki Bose, Sarra Hedden, Rachel N. Lipari, and Eunice Park-Lee, "Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health," Substance Abuse and Mental Health Services Administration, September 2017, https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.pdf

[28] Margot Sanger-Katz, "Hate Paperwork? Medicaid Recipients Will Be Drowning in It," *The New York Times,* January 18, 2018, https://www.nytimes.com/2018/01/18/upshot/medicaid-enrollment-obstacles-kentucky-work-requirement.html

Voluntary referrals to work programs put people back to work without taking their health care away

There are ways for states to connect Medicaid enrollees to work without taking health coverage away, and working within the program's statutory objectives of providing health coverage for low-income people.

As part of its Medicaid expansion, Montana incorporated a ***voluntary*** referral to a state job counseling program with no Medicaid disenrollment penalty. With the combined Medicaid expansion/job referral program, the state has seen employment gains among the Medicaid expansion population that are ab ove the US average for that income group, and above the gains for higher income groups in the state.[29] Kentucky could adopt a similar voluntary program.

Lock-outs for renewal paperwork/missing change of circumstance reporting requirements

Kentucky has asked for coverage lock-outs if individuals fail to promptly renew Medicaid eligibility or fail to report changes in circumstances, whether material to Medicaid eligibility or not, within a set number of days. The request, if granted, would make it harder for individuals to retain health insurance through Medicaid, a result that is in conflict with the program's objective of furnishing medical care.

Medicaid is the only type of health insurance that requires annual documentation for redetermination of eligibility

The redetermination process can result in many people briefly losing coverage, and then coming back on Medicaid once they resolve documentation or mailing address issues affecting the renewal process. This is often called "churn." Percentages of people churning on and off Medicaid at renewal generally range from 25 percent to as high as 50 percent. In contrast, Medicare, employer sponsored insurance, and marketplace coverage all renew automatically. Therefore, the argument that Kentucky's prompt paperwork requirement readies people for private insurance does not stand up to scrutiny. It is nothing short of paperwork harassment designed to knock individuals off the Medicaid rolls.

Lock-outs tied to failure to renew eligibility will result in huge coverage losses

A lock-out at renewal for failure to provide documentation will mean that a large percentage of Medicaid-eligible individuals will be shut out of coverage. This will dramatically increase the number of uninsured state residents—just as a policy would if it were applied to Medicare coverage.

[29] *The Economic Impact of Medicaid Expansion in Montana,* April 2018 prepared by Bureau of Business and Economic Research, University of Montana online at https://mthcf.org/wp-content/uploads/2018/04/BBER-MT-Medicaid-Expansion-Report_4.11.18.pdf.

A lock-out policy for failure to complete renewal paperwork fails to recognize the multiple challenges facing low-income residents

Low-income Medicaid enrollees can face multiple challenges to completing the sometimes-lengthy redetermination processes, including difficulty receiving mail, lack of a fixed address, and chronic or intermittent homelessness. Medicaid is likely to be all the more important during a time in which someone has difficulty completing redetermination paperwork—for example, during an episode of acute illness.

Lock-outs will interfere with treatment for people with mental illness or needing substance use treatment

Continuity of care is particularly important in treating people with substance use disorders or mental illness. These are also individuals who may have greater difficulty complying with paperwork time lines. Locking people out of coverage will undercut state efforts to provide comprehensive addiction and mental health treatment.[30]

Disenrollment (and lock-out) for failure to report changes in circumstances is, at its core, a policy to cut people off coverage

Locking Kentucky residents out of Medicaid coverage for failure to report a change in circumstances promptly is nothing short of paperwork harassment. It is a policy that has the sole purpose of cutting people from coverage. Lock-outs are designed to punish people when they are already facing hardship, making it even more difficult for them to get back on their feet.

Lock-outs will create disruptions in care, leading to poor health outcomes and increased costs for Kentucky residents

The vast majority of Medicaid enrollees locked out of coverage will become uninsured, with those below 100 percent of the poverty level particularly at risk, because they do not have access to marketplace coverage. Multiple studies have found that regular and ongoing access to health care reduces preventable hospitalizations for people with chronic diseases such as diabetes and heart disease.[31] The direct, foreseeable consequence of this policy will be worse health for Kentucky's lowest-income residents.

Premiums with lock-outs

Kentucky seeks to apply premiums to Medicaid enrollees and disenroll and lock individuals out of coverage for failure to pay. This outcome is contrary to the program objective of furnishing medical care to low-income residents, serves no demonstration purpose, and should be denied.

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[30] Jacob Drieher, et al., "The association between continuity of care in a community and health outcomes: A population based study," Isreali Journal of Health Policy Research, 2012, 1:21. Online at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3424831/.

[31] Andrew Bindman, "Preventable Hospitalizations and Access to Care," *JAMA,* July 26 , 1995 online at https://jamanetwork.com/journals/jama/article-abstract/389289?redirect=true; Xuanping Zhang, et al., "Access to Health care and Control of ABCs of Diabetes," *Diabetes Care* 2012 Jul; 35(7): 1566-1571. https://doi.org/10.2337/dc12-0081 .

Premiums in Medicaid cause people to drop coverage, which will increase the number of uninsured in the state

There is copious data showing that premium payments in Medicaid reduce enrollment, increase disenrollment, and increase the number of uninsured in states.[32] States' implementation of Medicaid premiums has been associated with an increased in uninsured patients, and increases in emergency department use by the uninsured.[33] Coupling premium payments with program lock-out would predictably increase the punitive impact of the proposed program and its associated coverage losses. These outcomes are contrary to Medicaid's objective of furnishing medical care to low-income people. Additionally, the impact of premiums on coverage retention is well established; there is no experimental or demonstration element to this aspect of the state's waiver request.

Given that the request to add premiums with lock-outs to Medicaid is contrary to the program's objectives and serves no experimental or demonstration purpose, this request does not meet the statutory requirements for exercise of 1115 authority and must be denied.

Making dental benefits conditional

Kentucky is asking for permission to make enrollees' dental coverage conditional on premium payments, participation in health education classes, or other enrollee activities. Dental care should be a standard part of coverage, not conditional on enrollees meeting other requirements.

Dental coverage improves Medicaid enrollees' overall health and employability

Cutting dental coverage is penny-wise and pound-foolish, and runs counter to Kentucky's efforts to increase employment among Medicaid enrollees.

- Untreated dental disease can have a negative impact on overall health. Difficulty eating, sleeping, and chronic pain all have significant health implications beyond oral health.[34] Poor

[32] David Machledt, et al., *Medicaid Premiums and Cost Sharing* (Washington, DC: National Health Law Program, March 2014 online at http://www.healthlaw.org/about/staff/david-machledt/all-publications/Medicaid-Premiums-Cost-Sharing#.WqcdLSVG0W4http://www.healthlaw.org/about/staff/david-machledt/all-publications/Medicaid-Premiums-Cost-Sharing; Brenda Solaner,, "Medicaid and CHIP Premiums Increase Disenrollment,: *Pediatrics* March 2016 online at http://www.pnhp.org/news/2016/march/medicaid-and-chip-premiums-increase-disenrollment.

[33] Samatha Artiga, et al, *The Effects of Premiums and Cost-Sharing on Low-Income Populations: Updated Review of Research and Findings* (Washington, DC: Kaiser Family Foundation, June 2017) online at https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/print/.

[34] U.S. Department of Health and Human Services, *Oral Health in America: A Report of the Surgeon General*. (Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000) online at https://www.nidcr.nih.gov/research/data-statistics/surgeon-general#overview

oral health is also linked to complications for people with diabetes and heart and lung disease, and to poor birth outcomes.[35] And untreated dental disease is more than twice as common among lower-income adults as among adults with higher incomes.[36] For lower-income state residents, dental coverage can help improve overall health, and ultimately lower Medicaid costs.

- Access to dental services can improve employment prospects**.** Twenty-nine percent of low-income adults—nearly twice the rate of those with higher incomes—report that the state of their mouth negatively affects their ability to interview for a job.[37] By helping people improve their oral health and appearance, dental coverage can help promote enrollees' employment opportunities. Reducing their access to dental care can make it harder for them to get a job.

Eliminating non-emergency medical transportation

Non-emergency medical transportation **(**NEMT) is a required benefit for Medicaid expansions. Kentucky is asking to waive this. Eliminating NEMT will make it harder for Medicaid enrollees to get appropriate care at the appropriate time.

For Medicaid enrollees, lack of transportation is a major barrier to timely access to care.[38] Many do not have cars and, particularly in rural areas, do not have access to public transportation.[39] NEMT helps lower-income Kentucky residents get the health care they need *before* it becomes a more expensive emergency.

The benefits of NEMT are well documented. There is no experimental or demonstration purpose that waiving this benefit could serve.

- NEMT is cost effective: Reliable NEMT is correlated with fewer emergency visits. Studies have consistently shown that providing Medicaid enrollees with transportation to non-emergency care results in fewer missed appointments, shorter hospital stays, and fewer

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[35] Xiaojing Li, at al., "Systemic Diseases Caused by Oral Infection," Clinical Microbiology Review 2000 Oct; 13(4): 547–558 online at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC88948/

[36] Elizabeth Hinton, et al., *Access to Dental Care in Medicaid: Spotlight on Non-elderly Adults* (Washington, DC: Kaiser Family Foundation, March 2016) online at https://www.kff.org/medicaid/issue-brief/access-to-dental-care-in-medicaid-spotlight-on-nonelderly-adults/.

[37] U.S. Department of Health and Human Services, *Oral Health in America*, *op cit.*

[38] Paul Cheung, et al., "National Study of Barriers to Timely Primary Care and Emergency Department Utilization Among Medicaid Beneficiaries," *Annals of Emergency Medicine,* vol 60, issue 1, pages 4-10, July 2012 online at https://www.annemergmed.com/article/S0196-0644(12)00125-4/abstract?code=ymem-site .

[39] Sarah Rosenbaum, et al., *Medicaid's Medical Transportation Assurance: Origins, Evolution, Current Trends, and Implications for Health Reform*, George Washington University School of Public Health Services, July 2009 online at http://web1.ctaa.org/webmodules/webarticles/articlefiles/Medical_Transportation_Assurance_Report.pdf.

emergency room visits.[40] Alternatively, poor access to transportation is related to lower use of preventive and primary care and increased use of emergency department services.[41]

- NEMT can help Kentucky better address some serious health care needs. The majority of NEMT services are used for regularly scheduled, non-emergency medical trips for behavioral health services, substance abuse treatment, and dialysis treatment.[42] Without NEMT, patients with these conditions could miss appointments, making treatment less effective. That is in direct conflict with Kentucky's stated goal of addressing substance use disorder in the state. Chronically ill patients could end up sicker and hospitalized or institutionalized, leading to more expensive care or, in the case of missed dialysis, death. A report issued by the National Conference of State Legislatures called NEMT "a vital lifeline for a healthy community."[43] The state should not cut off that lifeline.

Eliminating retroactive coverage

Kentucky is asking to waive Medicaid's three-month retroactive coverage provision.

As noted above, Medicaid is the only type of health insurance that requires annual documentation for redetermination of eligibility. This process can result in many people briefly losing Medicaid coverage until they resolve documentation or mailing address issues connected to the renewal process. This is often called "churn." Percentages of people churning on and off Medicaid at renewal generally range from 25 percent to as high as 50 percent. Retroactive coverage helps to fill these gaps in coverage. Omitting this coverage will increase medical debt for Medicaid eligible individuals, as well as uncompensated care costs for the state's health care providers.

These effects are well documented.[44] There is no experimental or demonstration purpose this waiver would serve.

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[40] National Academies of Sciences, Engineering and Medicine, Cost-Benefit Analysis of Providing Non-Emergency Medical Transportation, Transportation Research Board, online at http://www.trb.org/Publications/Blurbs/156625.aspx.

[41] Community Transportation Association, *Medicaid Non-Emergency Medical Transportation Saves Lives and Money,* online at http://web1.ctaa.org/webmodules/webarticles/articlefiles/NEMTpaper.pdf

[42] MJS & Company, *Medicaid Expansion and Premium Assistance: The Importance of Non-Emergency Medical Transportation (NEMT) to Coordinated Care for Chronically Ill Patients* (Washington, DC: MJS & Co, 2014) online at http://web1.ctaa.org/webmodules/webarticles/articlefiles/NEMTreportfinal.pdf

[43] Amelia Myers, *Non-Emergency Medical Transportation: A Vital Lifeline for a Healthy Community* (Waashington, DC: National Conference of State Legislatures, 2014) online at https://www.apta.com/mc/legislative/previous/2015/program/agendas/Documents/NEMT%20-%20A%20Vital%20Lifeline%20for%20a%20Healthy%20Community.pdf

[44] MaryBeth Musumeci, et al., *Medicaid Retroactive Coverage Waivers: Implications for Beneficiaries, Providers and States* (Washington, DC: Kaiser Family Foundation, November 2017) online at https://www.kff.org/medicaid/issue-brief/medicaid-retroactive-coverage-waivers-implications-for-beneficiaries-providers-and-states/

Retroactive coverage helps Medicaid enrollees move out of poverty
The state contends that one of its key objectives is helping low-income Medicaid enrollees move out of poverty. Retroactive Medicaid coverage can help that happen. It keeps low-income, Medicaid-eligible individuals from incurring crippling medical debt that can make it impossible for them to get ahead.

Retroactive coverage reduces uncompensated care, and that helps Kentucky's health system
Eliminating retroactive coverage would result in an approximately five percent loss in Medicaid revenue for safety-net hospitals. Those hospitals—which are often teaching hospitals, major trauma centers, and major area employers—depend heavily on Medicaid revenue.[45] This proposal is a direct hit to critical hospitals in the state, and would hurt the health system for all state residents.

Program changes approved through an 1115 waiver cannot be justified on the basis of cost-savings without an identifiable research or demonstration value
In its application, Kentucky discusses program costs as an impetus for its waiver application. However, cost alone is insufficient justification for the Secretary to make program changes under 1115 authority; the changes must have an identifiable research or demonstration value.[46]

As outlined above, many of the elements in Kentucky's request do not have an identifiable research or demonstration value; furthermore, the evidence of their negative impact on coverage and access to care is well documented. Those elements in the waiver request that lack research or demonstration value must be denied.

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Medicaid's objective is set out in statute: it is to furnish medical assistance to low-income individuals. Using 1115 authority to fundamentally change the program's objectives, or approve programs or policies that are known to operate in opposition to those objective by causing coverage losses and denying otherwise eligible individuals health coverage, is an abuse of the Secretary's 1115 authority. Kentucky's request for approval of the items discussed above must be denied.

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[45] Alan Dobson, et al., *The Financial Impact of the American Health Care Act's Medicaid Provisions on Safety-Net Hospitals* (New York, New York: The Commonwealth Fund, June 2017) online at https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2017_jun_dobson_ahca_impact_safety_net_hosps_v2.pdf.

[46] Newton-Nations v. Betlach, 660 F.3d 370, 381 (9th Cir. 2011).

Thank you for the opportunity to submit these comments. If you have any questions, please contact Dee Mahan at Families USA, 202-628-3030 or at dmahan@familiesusa.org.

Respectfully submitted,

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