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THE VOICE FOR HEALTH CARE CONSUMERS

November 26, 2019

Department of Health and Human Services
Nebraska Medicaid
ATTN: HHA Waiver
301 Centennial Mall South
P.O. Box 95026
Lincoln, Nebraska 68509-5026

Dear Dr. Van Patton:

Families USA appreciates the opportunity to provide comments on Nebraska's proposed Heritage Health Adult Expansion Section 1115 Demonstration Waiver. Please note I am submitting these comments both on behalf of the organization as well as an a national Medicaid expert, having been in Senior leadership roles at the Centers for Medicare and Medicaid Services, Centers for Medicaid Services.
Families USA is a national, non-partisan health care policy and advocacy organization that supports policies and programs at the state and federal levels to ensure the best health and health care are equally accessible and affordable to all, with a particular focus on actions that affect lower-income individuals.

In my expert opinion, multiple elements of this proposed 1115 waiver are both legally problematic and poor policy choices for the state. We support Nebraska's decision to cover dental, vision, and over-the-counter medication benefits, but these vital benefits should not be contingent on burdensome administrative requirements or other provisions that limit access to coverage. The specific provisions of this proposal are discussed in greater detail below.

Comments on Specific Provisions in the Amendment Request

1. Work and Wellness Requirements

The waiver proposes to provide "Prime" benefits – that is dental, vision, and over-the-counter medication – only to beneficiaries who comply with a multitude of reporting requirements related to "Wellness Activities," "Personal Responsibility," and "Community Engagement."[1] These work and wellness requirements are confusing and onerous for beneficiaries, administratively burdensome and costly for the state, and potentially illegal.

"Community Engagement"

Following in the misguided footsteps of other states, the proposed waiver requires non-exempt beneficiaries to report their participation in qualifying "community engagement" activities.[2]

[1] http://dhhs.ne.gov/Documents/HHAWaiverDraftApp.pdf, page 12.
[2] http://dhhs.ne.gov/Documents/HHAWaiverDraftApp.pdf, page 15.

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The state emphasizes that beneficiaries will not lose eligibility if they do not report participation in "community engagement" and other required activities. However, under the proposed two-tiered benefits system, beneficiaries will still lose benefits if they do not report.[3] Therefore, this provision of the waiver still conditions benefits on a work reporting requirement.

A work reporting requirement is contrary to Medicaid law.

Section 1115 of the Social Security Act 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."[4]

Medicaid's objectives or purpose is outlined in Section 1901 of the Social Security Act. 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…."[5] 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 physical independence.

While HHS has updated its Medicaid.gov website to redefine the objectives of the Medicaid program, that has no legal import. Statutory language has precedence over any website language, no matter how official the website.

- A work reporting requirement is unrelated to Medicaid's objectives as defined in statute. The language in the statute is clear. Federal Medicaid dollars are to be used to *furnish* medical, rehabilitation, and long-term services. Requiring work or community service as a condition of receipt of benefits 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 services from otherwise eligible low-income people if they do not meet the work reporting requirement. It is therefore outside of CMS's authority to approve under section 1115 authority.

  In his recent ruling to vacate the approval of Arkansas' work reporting requirement, Judge Boasberg affirmed that a work reporting requirement is unrelated to Medicaid's objectives. Boasberg ruled that, "the Secretary's approval of the Arkansas Works Amendments is arbitrary and capricious because it did not address – despite receiving substantial comments on the matter—whether and how the project would implicate the "core" objective of Medicaid: the provision of medical coverage to the needy."[6]

  Similarly, Judge Boasberg ruled in his decision to vacate the approval of New Hampshire's work reporting requirement, ""Medicaid, both as enacted and as later expanded by the ACA, reflects Congress's desire to "mak[e] healthcare more affordable" for "needy populations." […] Congress

[3] http://dhhs.ne.gov/Documents/HHAWaiverDraftApp.pdf, page 4.
[4] Social Security Act, section 1115 [42 U.S.C. 1315].
[5] Social Security Act Sec. 1901. [42 U.S.C. 1396].
[6] https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv1900-58, page 26.

therefore designed a scheme "to address not health generally but the provision of care to needy populations."[7]

- Adding a work reporting requirement is beyond the Secretary's authority to "waive" requirements in section 1902. Section 1115 gives HHS the authority to waive requirements in Section 1902. It does not allow states 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.[8] Section 1902 does not mention engaging in work or community service. States do 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 proposal, Nebraska states that its goal for adding a work reporting requirement is to improve beneficiaries' health and self-management.[9] However, the mere connection between an activity and health status is not a basis for making receipt of Medicaid benefits conditional upon an individual's participation in that activity. There are numerous activities that have been shown to improve physical and mental health. Diet[10], exercise[11], marital status[12], and social engagement[13] are only a few of the nearly endless activities that can impact individual health. It is gross regulatory overreach and a misuse of federal and state funds to add extra-statutory conditions that are not within the program's objectives simply because one or more of those activities have been shown to be related to individual health.

  Medicaid is a program to furnish medical assistance: it is a health *insurance* program. Health insurance protects people from financial loss associated with medical costs. That is not synonymous with health. That distinction holds true for Medicaid, Medicare, employer sponsored coverage, and any health insurance program. Following a path of adding reporting requirements to Medicaid simply because they arguably promote health is far beyond the program's objectives and could turn the program into a virtual a la carte menu of extra-statutory

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[7] https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2019cv0773-47, page 24.
[8] Social Security Act, section 1115 [42 U.S.C. 1315].
[9] http://dhhs.ne.gov/Documents/HHAWaiverDraftApp.pdf, page 5.
[10] 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-closelyrelated/.
[11] 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/
[12] 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-marriagehealth-synthesis-recent-research-evidence-research-brief.
[13] 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/.

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.

Judge Boasberg affirmed that promoting health is not a freestanding objective of Medicaid in his ruling to vacate the approval of Kentucky's work reporting requirement waiver. In his decision, Boasberg notes that, were health to be considered a freestanding objective of Medicaid, "nothing would prevent the Secretary from conditioning coverage on a special diet or certain exercise regime."[14] He also notes that, "Even if health were such an objective, approving Kentucky HEALTH on this basis would still be arbitrary and capricious."[15] If approved, the same could be said for Nebraska's proposal to add a work reporting requirement.

- Like the work requirement waivers in other states, if approved, this waiver will be vulnerable to legal challenges. To date, the four states (KY, AR, NH, and IN) that have implemented work reporting requirement waivers have had the approval of these waivers challenged in court or have lawsuits pending. In three of those states (KY[16], AR[17], and NH[18]) the court has ruled to vacate their approval, and in the fourth state (IN[19]), the case has yet to be heard. Most recently, Michigan is also facing a lawsuit challenging its work reporting requirement, which has not yet been implemented.[20]

A work reporting requirement will cost millions of dollars to implement.

Last month, the United States Government Accountability Office (GAO) released a report that included five states' estimates of the administrative costs associated with implementing their approved work reporting requirement waivers.[21] Estimated costs varied from $6 million to $271 million for IT systems changes, beneficiary outreach, contracting and other administrative costs.[22] Much of these costs do not appear to be allowable for enhanced federal match and would therefore require significant state spending.

Nebraska's administrative costs will likely exceed those of the states the GAO analyzed, since the Nebraska is proposing to implement several reporting requirements, not just "community engagement." Determining compliance with these requirements will require a myriad of systems and entities. In particular, there will be significant administrative costs and burdens associated with determining which Medicaid beneficiaries are eligible for Employer-Sponsored Insurance (ESI) coverage and tracking their enrollment in that coverage, especially since ESI falls outside the Medicaid program. Implementation of this provision will require substantial and costly data matching and interagency collaboration.

Despite the astronomical costs associated with implementing these waivers, the GAO found that states were not required to provide projections of administrative costs when requesting approval of these

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[14] https://www.courtlistener.com/recap/gov.uscourts.dcd.192935/gov.uscourts.dcd.192935.132.0_2.pdf, page 27.
[15] *Idem*, page 28.
[16] https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv0152-74
[17] https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv1900-58
[18] https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2019cv0773-47
[19] https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2019/09/Complaint_Rose-v-Azar-REDACTED.pdf
[20] https://healthlaw.org/wp-content/uploads/2019/11/Michigan-1115-Complaint-Redacted.pdf
[21] https://www.gao.gov/assets/710/701885.pdf
[22] *Id.*

waivers.[23] Therefore, in the interest of transparency with regards to state and federal spending, we request that the state include projections of administrative costs associated with implementing this waiver.

Historically, beneficiaries have had low awareness and understanding of work reporting requirements.

Earlier this year, New Hampshire halted implementation of its work reporting requirement due to lack of awareness among thousands of beneficiaries. Despite extensive efforts to inform beneficiaries of the work reporting requirement, the state failed to obtain compliance information for nearly 17,000 beneficiaries who were subject to the work reporting requirement and are therefore at risk of losing coverage.[24] Other states like Indiana[25] and Arizona have followed suit and suspended implementation of their work reporting requirements.[26] Nebraska will likely face these same challenges, resulting in thousands losing access to vital benefits.

"Wellness Initiatives"

In addition to the "community engagement" work reporting requirements, Nebraskans enrolled in the Heritage Health waiver must also participate in "Case and Care Management," attend an annual health visit, and select a primary care provider (PCP) as part of the state's "wellness initiatives."[27] There is evidence to suggest that beneficiaries often have limited understanding and awareness of these requirements and completion of these requirements depends largely on providers and managed care organizations[28, 29]

As part of "Case and Care Management," enrollees must complete a health risk screening and social determinants of health assessment annually to receive "Prime" benefits.[30] While beneficiaries may be willing to complete these assessments, whether or not they are completed is ultimately determined by their provider and their managed care plan. A Mathematica report notes that in Iowa, a state that incentivizes its Medicaid beneficiaries to complete annual wellness visits and Health Risk Assessments (HRAs), beneficiaries' completion of HRAs depends on the actions of their primary care provider. [31] Even if a beneficiary makes an appointment with their PCP to complete an HRA, the PCP may not complete the questionnaire. The report notes that "providers are unwilling to use visit time to complete HRAs,

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[23] *Id.*
[24] https://www.dhhs.nh.gov/medicaid/granite/documents/ga-ce-findings.pdf
[25] https://www.in.gov/fssa/files/Gateway_to_Work_suspension_announcement.pdf
[26] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/Health-Care-Cost-Containment-System/az-hccc-postponement-ltr-ahcccs-works-10172019.pdf
[27] http://dhhs.ne.gov/Documents/HHAWaiverDraftApp.pdf, pages 13 and 14.
[28] https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/beneficiaries-understanding-incentives.pdf
[29] https://www.mathematica.org/our-publications-and-findings/publications/incentives-to-change-health-behaviors-beneficiary-engagement-strategies-in-indiana-iowa-and-michigan
[30] http://dhhs.ne.gov/Documents/HHAWaiverDraftApp.pdf, page 13.
[31] https://www.mathematica.org/our-publications-and-findings/publications/incentives-to-change-health-behaviors-beneficiary-engagement-strategies-in-indiana-iowa-and-michigan

even for financial rewards, because they do not consider the assessments clinically relevant."[32] Even if a beneficiary completes an HRA with their PCP, the PCP's office may not notify the managed care plan, and/or the managed care plan may not notify the State.

If, as stated in the application, managed care plans are indeed "responsible for providing Case and Care Management services to Heritage Health beneficiaries,"[33] then these managed care plans should be held accountable for completion of these assessments, not beneficiaries who risk losing benefits due to administrative issues beyond their control.

The proposed waiver lacks detail on requirements related to selecting a primary care provider (PCP) and attending annual visits and is sure to result in lack of awareness and participation among beneficiaries. According to another report from Mathematica, less than a third of beneficiaries in Iowa's similar Medicaid waiver were aware of the state's incentives to complete annual wellness visits in 2014 and 2015. In 2015, only 31% of beneficiaries in that state were aware of the state's tiered dental benefit.[34] In Nebraska, this likely lack of awareness among beneficiaries will prevent them from accessing vital benefits.

"Personal Responsibility Activities"

The "personal responsibility activities," along with the reporting requirements related to "community engagement" and "wellness initiatives," places additional burden on beneficiaries. Beneficiaries who are unable to attend three scheduled appointments in six months lose access to "Prime" benefits for a full 12 months.[35]

Many Nebraskans enrolled in Medicaid work jobs with irregular schedules and may be unable to keep their medical appointments. Given that beneficiaries are required to log 80 hours of "community engagement" each month and can only miss three appointments, those who work irregular schedules that conflict with medical appointments are put in a no-win situation where they cannot keep their benefits. They must decide between missing medical appointments to comply with the "community engagement" requirement, and missing work to comply with the "personal responsibility" requirements. In both cases, they can only comply with one requirement and risk losing their benefits for failing to complete the other.

As part of the proposed "Personal Responsibility Activities," beneficiaries who elect to receive Medicaid instead of their employer-sponsored insurance (ESI) will also be locked out of "Prime" benefits for 12 months.[36] We are concerned with the potential administrative costs and burdens associated with determining who is eligible for ESI coverage and tracking enrollment in that coverage, especially since ESI falls outside the Medicaid program. Implementation of this provision will require substantial data matching and interagency collaboration. Failure to properly implement this provision could have devastating consequences for beneficiaries. If the state erroneously determines that an individual

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[32] https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/beneficiaries-understanding-incentives.pdf

[33] http://dhhs.ne.gov/Documents/HHAWaiverDraftApp.pdf, page 13.

[34] https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/beneficiaries-understanding-incentives.pdf

[35] http://dhhs.ne.gov/Documents/HHAWaiverDraftApp.pdf, page 15.

[36] *Id.*

qualifies for ESI and locks them out of "Prime" benefits, that individual will lose access to vital health care.

Beneficiaries will also be locked out of "Prime" benefits for 12 months if they do not notify Medicaid within 10 days of a change of status that impacts their eligibility.[37] Other states have given beneficiaries 10 days to verify a change in status, and many beneficiaries have been unable to provide necessary information to the state within that short time frame. For example, in Texas, the state Medicaid agency routinely checks state income data to determine Medicaid eligibility and gives beneficiaries only 10 days to verify that eligibility determination. As a result, thousands of beneficiaries have lost eligibility for failing to verify eligibility in time.[38] Similarly, in Nebraska, the state plans to use electronic data sources like the state wage index to ensure timely reporting of eligibility.[39] Beneficiaries who cannot verify their eligibility against the state's data within 10 days risk losing vital benefits.

2. Dental, Vision, and Over-the-Counter Medication Benefits

We support the state's decision to expand dental, vision, and OTC medication benefits to beneficiaries. These benefits are vital for ensuring overall health. Many medications used to treat serious and chronic medical conditions are available over-the-counter. Medicaid coverage of OTC medications makes them accessible for Nebraskans who would otherwise be unable to afford them. Serious and chronic conditions can negatively impact oral and ophthalmic health. At the same time, untreated dental and vision issues can contribute to more serious health issues.[40, 41] Access to dental and vision benefits help patients and their providers to prevent, identify, and treat those serious conditions.

However, because these benefits are so vital, Nebraskans who qualify for Medicaid coverage should not have to jump through hoops and navigate red tape to receive them. Instead of creating a two-tiered system that forces beneficiaries to comply with onerous reporting requirements to access these "Prime" benefits, the state should make these benefits available to all beneficiaries automatically upon enrollment. The state can do this by simply amending its state plan, without submitting a complicated and time-consuming 1115 waiver that adds work and wellness reporting requirements.

3. Waiver of Retroactive Eligibility

The proposal to waive retroactive eligibility limits coverage for new beneficiaries who are made responsible for the entire cost of their care prior to enrollment, even if they could have been determined eligible during their care visit or retroactively after receiving care.[42] Retroactive coverage keeps individuals from incurring high medical bills and medical debt by covering the medical bills they incurred in the three months before being determined eligible for Medicaid. Retroactive coverage also encourages doctors and hospitals to treat uninsured Medicaid eligible patients, because they will be compensated for the services they provided once the individual is enrolled.

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[37] *Id.*
[38] https://familiesusa.org/wp-content/uploads/2019/09/Return_of_Churn_Analysis.pdf
[39] http://dhhs.ne.gov/Documents/HHAWaiverDraftApp.pdf, page 15.
[40] https://www.ahajournals.org/doi/pdf/10.1161/JAHA.113.000657
[41] https://jamanetwork.com/journals/jamaophthalmology/fullarticle/1897292
[42] http://dhhs.ne.gov/Documents/HHAWaiverDraftApp.pdf, page 8.

4. Limited Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefits

Medicaid coverage of EPSDT services is required because low-income children and young adults have a distinct need for comprehensive care in order to lead healthy lives. EPSDT covers items such as vision and hearing screening and treatment (e.g., glasses or hearing aids), basic dental, medical, mental health, and developmental services for children and young adults. Congress designed Medicaid with the EPSDT requirement because low-income children and young adults have a distinct need for comprehensive care in order to lead healthy lives.[43] These services cannot and should not be waived.

It is unclear whether 19 and 20 year olds will continue to receive EPSDT benefits during their initial benefit tier period. According to the draft waiver application, "All beneficiaries newly eligible for Medicaid under the HHA program will receive the Basic benefits package for the initial six month benefit tier period."[44] This means that medically frail, pregnant women, and 19 and 20 year olds who are newly eligible must receive the Basic benefits package for 6 months prior to qualifying for the Prime package based on their exempted status. The Basic benefits package does not include EPSDT meaning 19 and 20 year olds effectively have to go without EPSDT for the first six months of their coverage.

On the other hand, the Nebraska Department of Health and Human Services' September 2019 Expansion Report notes that, "existing beneficiaries who will join expansion will receive Prime benefits for their first benefit tier review period."[45] It is unclear whether 19 and 20 year olds are considered "existing beneficiaries who will join expansion."

Conclusion

Overall, the state's proposal lacks a coherent, data supported rationale for its proposal, showing how approval of the waiver will further the objectives of the Medicaid program. Instead of seeking approval of this legally questionable waiver request that creates barriers to coverage for eligible beneficiaries, the state should fully expand its Medicaid program as soon as possible, regardless of whether or when this waiver is approved. Hard-working Nebraskans voted for Medicaid expansion over a year ago, they cannot and should not wait any longer. This proposed 1115 waiver is holding up expansion and if approved, will create additional barriers to coverage. Medicaid expansion and access to vital benefits should not be contingent on this waiver.

Thank you for your consideration of these comments. If you have any questions, please contact Emmett Ruff at ERuff@familiesusa.org or 202-628-3030.

Respectfully submitted,

Eliot Fishman
Senior Director of Health Policy at Families USA

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[43] https://www.macpac.gov/subtopic/epsdt-in-medicaid/
[44] http://dhhs.ne.gov/Documents/HHAWaiverDraftApp.pdf, page 4.
[45] https://nebraskalegislature.gov/FloorDocs/106/PDF/Agencies/Health_and_Human_Services__Department_of/696_20191031-080313.pdf