PUBLIC INTEREST LAW
CENTER OF PHILADELPHIA
AFFILIATED WITH THE LAWYERS COMMITTEE FOR CIVIL RIGHTS UNDER LAW

October 25, 2013

VIA EMAIL: RA-PW HEALTHY PA@pa.gov
Department of Public Welfare
Office of the Secretary
Heath &Welfare Building
625 Fouste Street
Harrisburg, PA 17120

Re: September 16, 2013 Concept Paper Entitled: Healthy Pennsylvania: Reforming Medicaid

Ladies and Gentlemen:

I am writing to you on behalf of the Public Interest Law Center of Philadelphia ("PILCOP") to provide comments upon the above referenced Concept Paper which you released on September 16, 2013.

Preliminarily, we understand the Concept Paper in general to propose that, instead of expanding Pennsylvania's Medicaid Program for those people newly made eligible beginning in January 1, 2014 under the Affordable Care Act (ACA) (the "expansion population") you propose, pursuant to Section 1115 of the Social Security Act (42 U.S.C. § 1315(a)), to seek a waiver from the law to finance medical insurance coverage of the expansion population by paying or subsidizing their premiums to purchase coverage in the Qualified Health Plans ("QHPs") available through the insurance exchange established under ACA to individuals whose incomes generally exceed the levels of the expansion population.

To date, only the states of Arkansas and Iowa have filed such waiver applications, and CMS has, with modifications on 9/27/13, approved Arkansas' application but not yet acted on Iowa's.

In preparing the comments set forth below, we have relied to a considerable extent on the following studies prepare by the National Health Law Program.

1. Letter dated September 6, 2013 to CMS re Arkansas' Health Care Independence Program, hereafter cited as "9/6/13 NHELP Arkansas Letter"
2. Letter dated September 26, 2013 to CMS re: Iowa Wellness Plan §1115 Demonstration hereafter cited as "9/26/13 NHELP Iowa Letter"; and
3. Paper entitled "Medicaid Expansion Work Requirements dated 10/4/13 hereafter cited as "10/4/13 NHELP Paper on Work Requirements".

For your convenience we attached these three studies.

Set forth below are our comments on particular aspects of the Pennsylvania's Concept Paper.

1. The development of applications to obtain section 1115 waivers requires a considerable time during which Medicaid will not be expanded. The Arkansas 1115 Medicaid waiver concept was first publically announced February 28, 2013, the waiver application was not submitted until August 2, 2013 and not approved by CMS until September 26, 2013. In other words, section 1115 waiver applications may take many months to proceed to completion. There's little public evidence DPW has proceeded much beyond the concept phase with its waiver application so it appears Pennsylvania is not on track to expand Medicaid pursuant to a waiver much before 2015 at the earliest. During the time Pennsylvania takes to prepare and, possibly, get approval on its application, none of the more than 500,000 plus newly eligible low income individuals in the expansion population will have insurance and the hundreds of millions of federal dollars which would be paying 100% of the cost of that insurance beginning January 1, 2014 will be foregone by the Commonwealth.

2. CMS's grant of a section 1115 waiver application is discretionary. Therefore, Pennsylvania can't be certain that CMS will grant any 1115 waiver applications it makes. This means Pennsylvania could well find itself, after the end of many months of work on a waiver application, with nothing to show for time spent seeking the waiver.

3. CMS's guidance provides that states which opt in to Medicaid expansion may at any time withdraw from it. See point 25 of CMS's December 10, 2012, "Frequently Asked Questions on Exchanges, Market Reforms and Medicaid." Given that fact, given the delays and uncertainties outlined in points 1 and 2 above, we believe that

Pennsylvania should at least opt into Medicaid expansion – with its 100% federal reimbursement – effective at the earliest date on or after January 1, 2014 while its waiver application is being prepared and prosecuted. If the waiver is then granted, Pennsylvania can then withdraw from Medicaid expansion under ACA and, in the meantime, not have given up the insurance coverage of hundreds of thousands of low income adults and the hundreds of millions of federal dollars it will lose by not expanding at the earliest possible time.

4. The Concept Paper proposes to impose an, as yet unspecified, work search requirement upon able bodied adults in the expansion population. The Concept Paper fails to say how if at all, this work search requirement would be coordinated with the work search requirement for unemployment compensation benefits or with TANF (Temporary Assistance for Needy Families). Moreover, imposition of a work search requirement simply has no basis in Medicaid law and we think that it will not be approved as part of any waiver. See generally 10/4/13 NHELP Paper on Work Requirements. The Arkansas waiver application approved by CMS September 26, 2013 had no work search requirement.

5. DPW's Concept Paper would require imposition of a premium upon individuals in the expansion population with incomes above 50% of FPL ($5,745 for a single person) up to a total of $25 per month for persons at 133% of FPL. But Medicaid law does not normally allow imposition of monthly premiums (as distinct from "cost sharing") upon enrollees of with incomes under 150% of FPL, see §1916 (c) of the Social Security Act. See generally 9/26/13 NHELP Iowa Letter at pp.5-6. Considerable research shows that, imposing such premiums on low income people, keeps a significant proportion from enrolling. See studies published in 2005 by Bill J. Wright and in 1999 -2000 by Leighton Ku and Teresa Coughlin cited in 9/26/13 NHELP Iowa Letter pp 6-7 & nn 10, 11 and 12. The Arkansas waiver application granted 9/27/13 by CMS doesn't impose premiums on the expansion population.

6. Under the scheme set up by the ACA, people under 65 years of age with incomes up to 138% of FPL are entitled to enroll in Medicaid. Medicaid, in turn, contains certain critical procedural protections such as availability of a fair hearing with respect to denials, 42 U.S.C. §1396a (a) (3), and continuation of disputed benefits until resolution of

disputes. It is unclear from the Concept Paper whether the QHPs into which the Medicaid expansion population will be diverted will have such protections as required by law. Because Medicaid dollars would be paying for premiums to put the expansion population into QHPs through the private insurance exchanges, a waiver application must assure the expansion population of the procedural protections of Medicaid even if the QHP's policies don't have comparable safeguards. Moreover, the expansion population must ultimately have, with respect to issues arising under their policies recourse to a tribunal operated by DPW, not by one of the QHP's. See 9/27/13 CMS approval of Arkansas Application, Section IX at p.14; see 9/26/13 NHELP Iowa Letter at pp.11-12; see 9/6/13 NHELP Arkansas Letter at p. 3.

7. Your Concept Paper proposes imposition on the expansion population of a $10.00 charge for non emergency use of the emergency room. But current Medicaid regulations limit to no more than $8.00 the charge for non-emergent use of the ER for enrollees under 150% of FPL. See 9/26/13 NHELP Iowa Letter at p. 8 and authorities there cited. In addition, the Concept Paper fails to set forth what safeguards Pennsylvania would propose to make sure such a charge is not imposed on persons who may reasonably have believed they had an emergency condition, such as chest pain, even though upon medical examination, the situation was not determined to be emergent. Id at pp. 8-9.

Sincerely,

James Eiseman, Jr.

James Eiseman, Jr.
Senior Attorney

Encls.

NHeLP
NATIONAL HEALTH LAW PROGRAM

September 6, 2013

VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Arkansas Health Care Independence Program ("Private Option") Demonstration

Dear Sir/Madam:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. We appreciate the opportunity to provide comments to Arkansas' proposed Health Care Independence Program § 1115 demonstration.

NHeLP recommends that HHS not approve the Arkansas request for section 1115 authority to conduct premium assistance, exactly as requested. Instead, first, we urge HHS to address a number of concerns in the proposal and encourage Arkansas to bring it to a legally approvable form. We urge HHS to work with Arkansas to achieve a Medicaid Expansion that will serve future Medicaid enrollees well, including those inside Arkansas benefiting from this proposal and those in other states who may pursue similar proposals.

Second, we ask that before HHS takes action on this waiver request, it take steps to address its own "stewardship of federal Medicaid resources." GAO, *Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lack of Transparency* at 32 (June 2013). As the GAO recently concluded, "HHS's [budget neutrality] policy is not reflected in its actual practices and, contrary to sound management practices, is not adequately documented....[T]he policy and processes lack transparency regarding criteria." *Id.* We request that HHS zealously enforce its stated policies and the legal limits of Medicaid section 1115 demonstration law, to ensure progress in Arkansas

without opening the door to policies that ignore the fundamental nature of Medicaid as an entitlement program.

A. Introduction: Legal Authority

Arkansas has submitted an application to conduct a section 1115 demonstration program to use individual market premium assistance to implement a Medicaid Expansion. The stated authority to conduct *individual* market premium assistance underlying this application is 42 U.S.C. § 1396d(a). However, the statute and legislative history create serious questions about the validity of this claimed authority. Section 1396d(a) defines "medical assistance" and, for the most part, is a listing of services that can or must be included in this definition. By contrast, Congress has dealt with premium assistance in other, specific provisions of the Act. Congress has authorized states to conduct *group* or *employer* coverage premium assistance, which are unambiguously and carefully detailed in statute at sections 1396e and 1396e-1. Notwithstanding two very recent policies from HHS (in regulatory and sub-regulatory guidance), there is no history of statutory or regulatory guidance for section 1396d(a) authority. Given the uncertainty of the statutory authority and the untested regulatory framework, we believe it is incumbent upon HHS to be extremely cautious and exacting in the approval of any such authority, and even more so for related waivers. HHS should hold tightly to the principles announced in its March 2013 Question and Answer document. And under these circumstances HHS must also be unmistakably clear as to the waiver authorities being granted and their legal limits.

B. Single State Agency

In addition to premium assistance authority concerns, Arkansas's request, as currently written, fails to ensure that the single state Medicaid agency will remain in charge of the Medicaid program for affected populations, as the Medicaid Act requires.[1] The application does not provide the general public or HHS with information and specifics establishing that the single state Medicaid agency will continue to make administrative and policy decisions for the program. By law, the single state Medicaid agency must be in control and accountable for Medicaid coverage. While Arkansas may not formally delegate away Medicaid authority, it in effect surrenders control over the majority of benefits for an entire category of enrollees (and possibly multiple categories in the future). Arkansas will not control many benefits package details, authorization criteria, and provider contracts and terms established by the plan. The application envisions a memorandum of understanding between the Medicaid agency and the private insurance companies. However, the establishment of an MOU relationship between the state and QHPs, as suggested in the proposal,[2] does not resolve the concern that the QHP would act as an independent entity with its own authority, including discretion, contrary to what Medicaid law permits. NHeLP is very supportive of HHS requiring written agreements between the involved entities to satisfy the legal requirement for a single state agency, clearly delineating roles and responsibilities, with the ultimate authority and

[1] 42 U.S.C. § 1396a(a)(5).
[2] Arkansas 1115 Waiver Application, page 49.

responsibility housed in the Medicaid agency. However, the application is sparse on details and the mere presence of an MOU at some point in the future does not satisfy this requirement. HHS should require more of Arkansas as a condition of approval. While assuring consumer protections, this would also address some of the GAO's conclusions that find HHS processes lack the supporting evidence required to justify deviations from historical requirements. GAO, supra. at 32.

C. Notice and Appeals

Although Arkansas' proposal does provide for "notice and appeals," it only requires the process to comply with the QHPs standards, processes, and entities, even when the service is a Medicaid covered service being provided, using Medicaid money (to pay the premium), to a Medicaid enrollee. As written, the waiver request raises serious questions regarding its legality under the Medicaid Act, 42 U.S.C. § 1396a(a)(3), and regulations, 42 C.F.R. part 431.200. The waiver also appears to ignore some of the Constitutional requirements of *Goldberg v. Kelly*, 397 U.S. 254 (1970), which are immutable, minimum requirements that cannot be waived or ignored. As the *Goldberg* Court recognized, the low income status of the adults and parents covered by the waiver means that they have a "brutal need" for public assistance. *Id.* at 261. To comply with the Medicaid Act, the regulations, and the Constitution, the Arkansas waiver program needs to clarify the required content of notices, see *Goldberg*, 397 U.S. at 268-69 ("The opportunity to be heard must be tailored to the capacities and circumstances of those who are to be heard."); 42 C.F.R. 431.200. It must describe the circumstances under which benefits will continue pending appeal, *see Goldberg*, 397 U.S. at 264 ("[O]nly a pre-termination evidentiary hearing provides the recipient with due process"). It cannot, as currently proposed, rest upon a paper review or discretionary testimony (App. at 13); rather, the program must ensure that enrollees are able to be heard through testimony and witnesses by an impartial decision-maker, see Id. at 270 ("It is not enough that a welfare recipients may present his position to the decision maker in writing or second-hand through his caseworker.").

Finally, serious single state agency issues would be raised if the insurance company rather than the single state Medicaid agency made the final decision on appeal. *See, e.g., K.C. ex rel. Africa H. v. Shipman*, 716 F.3d 107 (4th Cir. 2013) (holding health plan contractor insurer could not override agency decision and that "[o]ne head chef in the Medicaid kitchen is enough").

Arkansas must be required to allow all enrollees access to the Medicaid appeals system for all Medicaid covered services, without exceptions or unwanted delays. We do not object, or believe it would be legally impermissible, for HHS to allow an *optional* and *additional* plan review process that could operate concurrently to the Medicaid process for Medicaid services. In all such cases, a favorable decision from the Medicaid entity would control, and such decisions could not be delayed because of the plan level process. Unless Medicaid enrollees are guaranteed access to a Medicaid appeals system, we do not believe the § 1115 application is approvable or could be legally implemented.

D. Cost-sharing

We support the commitment to follow all Medicaid cost-sharing requirements as broadly stated in this Arkansas section 1115 application.[3] This feature is in fact a required one, since section 1115 demonstration authority cannot legally waive the requirements of sections 1396o and 1396o-1, or any other such provision lying outside of 42 U.S.C. 1396a.[4] It is unclear what cost-sharing waiver authority the state was initially seeking, but any individual premium assistance proposal must comply in full with sections 1396o and 1396o-1, and related regulation, and this remains true with or without a waiver.[5] We believe this is the intent of the proposed section 1115 waiver, though we note there is ambiguous language which confuses the intent. *See* Arkansas 1115 Waiver Application, page 1, stating that "Private Option beneficiaries will ... have cost sharing obligations consistent with both the State Plan and with the cost-sharing rules applicable to individuals with comparable incomes in the Marketplace." We believe this language could only be legal if it is meant to always apply the Medicaid Act protections except where the Marketplace protections for a given service are *more* stringent. Furthermore, we note that the application does not include enough details to confirm how the demonstration will comply with other key Medicaid Act cost-sharing requirements which HHS must ensure remain intact:

- While the application indicates there will be no cost-sharing for individuals below 100% FPL in year one, it indicates that cost-sharing will be added for the 50% to 100% population after year one through an amendment. Those levels of cost-sharing are not specified – and we have concerns that the state will use the amendment process so skirt the full 42 U.S.C. §1396o(f) requirements. The population groups who are being enrolled in this waiver are described in the Medicaid Act and, thus, can no longer be considered "expansion populations." As such, the requirements of §1396o(f) will apply to the State's decision to impose cost sharing over and above that which is already allowed under the Medicaid Act, see §§ 1396o and 1396o-1 (describing states' flexibility to impose nominal cost sharing on individuals below 100% FPL). Any effort by the State to impose cost sharing above the statutorily authorized options and limits must meet the five tightly circumscribed criteria of §1396o(f) and be implemented only after public notice and comment. We urge HHS to clarify with the state that (1) any "amendment" imposing higher cost-sharing is subject to full section 1396o(f) requirements, and (2) HHS will also require the state to meet the full section 1115 transparency requirements (See also Part G below for more details).
- The application indicates that the QHPs will be required to track the cumulative cost-sharing paid by enrollees and comply with the 5% aggregate cap on cost-sharing in law. The application sets the cap at 100% of FPL for individuals above 100% of FPL, which is a sensible administrative approach. However, when/if

[3] See e.g., Arkansas 1115 Waiver Application, pages 11, 15.
[4] See 42 U.S.C. §1315(a)(1).
[5] Waivers could only be permissible following the legal requirements for waivers contained *within* section 1396o.

cost-sharing is established for populations below 100% FPL, no such line at 100% would be acceptable for them. The state would need to draw a lower administrative line for those populations.

- Under law, the 5% limit must be applied on a monthly or quarterly basis. Arkansas notes as much in its responses to comments received.[6] However, earlier in the same application Arkansas writes that "QHPs will monitor Private Option beneficiaries' aggregate amount of copayments to ensure that they do not exceed the *annual* limit." (Emphasis added). HHS must clarify that Arkansas must require QHPs to evaluate this on, at most, a quarterly basis. This includes a method to track the cost-sharing levels, identify and provide notice to individuals who have met their threshold, and ensure that providers understand that these individuals are not liable for the cost-sharing.
- While the application does indicate that "Arkansas will make adjustments to the cost-sharing cap for Private Option enrollees in two adult households," it does not indicate what this adjustment will be. This must be clarified to explicitly indicate that the combined cost-sharing for the entire Medicaid household must never exceed 5% of that household's income.
- Under the proposed demonstration, states would not directly contract with the QHPs, who would in turn contract with providers for a wide range of enrollees, many of whom are not Medicaid enrollees. Under these circumstances, in a demonstration where QHP providers will collect cost-sharing at point of service, it is difficult to understand how Arkansas Medicaid will enforce the requirement for non-enforceable cost-sharing for all individuals below 100% FPL (and some individuals above that limit). Arkansas' application does not address this requirement and how it will be enforced. The application should not be approved unless and until this is clarified.
- Arkansas' application mentions the state will pursue "health savings accounts" (HSA), though no further details are provided. State descriptions of HSAs typically include a monthly "contribution". Such a contribution, if charged regularly without respect to utilization, is in fact merely a premium called by a different name and illegal under Medicaid law for populations below 150% FPL.
- The waiver is confusing regarding cost sharing and coverage associated with non-emergency use of the emergency room (App. at 44).
    - In the comments section, it takes the position that non-ER use of the ER is not a covered service; however, this is not correct. While the state can, under the law, impose a copayment, it does not follow that a service that is otherwise described as an EHB/ABP (e.g., physician visit) is not a covered service because an individual accessed it through an ER. Arkansas has improperly equated the *service* (which is covered) with a policy for the *preferred site* for delivering the service. If the recipient chooses the improper site, Congress has established that the penalty is a copayment, not that it is a non-covered service.
    - Furthermore, the comment section appears to adopt a $20 copayment for non-emergency use of the ER. This would violate the statutory limits for

[6] Arkansas 1115 Waiver Application, page 43.

nominality set out in sections 1396o and 1396o-1 and implemented in the newly finalized federal regulations at 42 C.F.R. § 447.54, which cap the copayment at $8.00 for individuals under 150% FPL.[7] This maximum should be tightly guarded and never waived by HHS. Emergency room copayments have been heavily studied; they would not serve an experimental purpose. Prior research indicates that instituting higher copayments on ER use in the Medicaid context does not effectively reduce expenditures.[8] Furthermore, non-urgent use of the ER is uncommon (only 10% of Medicaid ER visits) and roughly as prevalent in Medicaid as in privately insured populations.[9] There are many valid systemic reasons low-income populations may occasionally need to use an ER on a non-emergent basis. Some Medicaid enrollees are far more likely to face barriers to accessing primary care that lead them to seek out the ER.[10] In some cases, those enrolled in MCOs with weak provider networks go to ERs to obtain access to specialty care that is unavailable through FQHCs or other alternative primary care sites. In addition, primary care providers tell their patients, when in doubt, go to the ER, with many leaving a message to that effect on their office voice mails during off hours. The prudent layperson responds to all these situations by going to the ER to obtain care.

E. Cost-effectiveness

Where Congress has unambiguously created authority for premium assistance, in Section 1396e[11] and 1396e-1[12], it has explicitly required premium assistance programs to be cost-effective. Recent regulations implementing section 1396d(a) premium assistance authority create a similar requirement for "comparable" costs.[13] Furthermore, HHS requires section 1115 demonstrations to be "budget neutral." As we have noted, the GAO has published repeated and serious concerns with HHS's failure to enforce its policies regarding cost-effectiveness. See GAO, *Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lack of Transparency* (June 2013) (citing previous reports). HHS, therefore, must (1) not approve a section 1115 application for individual market premium assistance which does not establish that the demonstration will be of similar cost to Medicaid state plan enrollment for the same population and (2)

[7] *See* 42 U.S.C. §§1396o(a)(3) and 1396o-1(e).
[8] Neil T. Wallace et al., *How Effective are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan*, 43 Health Serv. Research 515 (2008).
[9] Anna S. Sommers et al., Ctr. For Studying Health System Change, Research Brief No. 23, *Dispelling Myths About Emergency Department Use: Majority of Medicaid Visits Are For Urgent or More Serious Symptoms* (2012).
[10] Paul T. Cheung et al., *National Study of Barriers to Timely Primary Care and Emergency Department Utilization Among Medicaid Beneficiaries*, 60 Annals of Emergency Medicine 4 (2012).
[11] § 1396e(c)(1)(B)(i).
[12] § 1396e-1(a).
[13] 42 CFR § 435.1015(a)(4).

not approve a section 1115 application that is not inconsistent with HHS's stated policies.

The pending request is problematic on a number of fronts. First, and most importantly, Arkansas' cost model assumes the state would otherwise raise payment rates to private market levels in its fee-for-service program. This assumption is simply unreasonable considering the below-market Medicaid rates paid in Arkansas today, other state Medicaid programs generally, and past expansions of the Medicaid program. The section 1396a(a)(30)(A) requirements which Arkansas cites in the individual market premium assistance context have applied with equal force in all states throughout Medicaid's history, and have never led to full compliance with private market rates by Arkansas or other states. Allowing states to justify section 1396d(a) comparability or section 1115 budget neutrality by reference to rates with no basis in Medicaid reality eviscerates the cost-effectiveness requirement.

In addition, although recent regulations clearly require an adequate accounting of administrative costs,[14] it is unclear from the proposal whether Arkansas' assumptions about costs properly evaluate the administrative costs associated with wrapping around benefits and cost-sharing for such a large number of enrollees, and monitoring and enforcing that wrap-around requirement. In fact, Arkansas sets out *reduction* in administrative costs based on reduced churning as a hypothesis to be tested in this demonstration, without even mentioning the serious administrative costs associated with wrap around in this context.

At the very least, the proposal should clarify any unique circumstances in Arkansas (e.g., extremely low managed care penetration in Medicaid) which make these assumption less unreasonable, and prevent unrealistic calculations from becoming the norm.

F. EPSDT

The EPSDT discussion needs to clarify that the Arkansas program will ensure that all state plan services will be covered as a wraparound service, when needed to "correct or ameliorate" the enrollee's condition. Ensuring EPSDT through a wraparound feature is going to be difficult enough; the approval documents need to set the ground rules clearly.

In this application, Arkansas suggests numerous possibilities for how this demonstration might be expanded or altered in future years – for example, Arkansas contemplates adding children to the demonstration in subsequent years. Given the broad EPSDT services requirement applicable to all Medicaid-eligible children which is not "closely aligned with the benefits available on the Marketplace," children cannot be "the individuals in the new Medicaid *adult* group who must enroll in benchmark coverage" to which HHS has circumscribed premium assistance.[15] (Emphasis added) Moreover,

[14] See 42 CFR § 435.1015(a)(4).
[15] "Medicaid and the Affordable Care Act: Premium Assistance," HHS FAQ, March 2013, page 2.

HHS should clarify that neither EPSDT children nor any other group that is traditionally eligible or §1396u-7 benchmark-exempt can be such new Medicaid adults who can mandatorily enrolled into individual market premium assistance through a waiver.

G. Waiver transparency

Arkansas' suggestions about future changes to its proposed section 1115 demonstration raise the concern these changes will be made through section 1115 amendment processes which, according to some interpretations, may not be subject to transparency protections which apply to new section 1115 proposals. The changes suggested by Arkansas are significant, and HHS must require such changes to comply with the full transparency requirements. Any other outcome would violate the intent of section 1115(d) by allowing states to skirt the Congressionally-mandated transparency requirements for section 1115 demonstrations that "impact on eligibility, enrollment, benefits, cost-sharing, or financing with respect to" State Medicaid programs by allowing the state to furtively implement changes through amendments as opposed to applications or renewals.[16]

H. Medical frailty

Arkansas' section 1115 proposal is ambiguous about the proper application of medical frailty. Arkansas indicates that it will apply §1396u-7 medically frail exemptions, but then may attempt to further qualify when they will apply such exemptions.[17] HHS must not approve any section 1115 waiver until it is clear that Arkansas would not limit medical frailty exemptions more than permitted under law.

Arkansas' application states that there will be no comment period for the medically frail definition, though there will be a notice and comment period for a State plan amendment (SPA) on the ABP, and this SPA would include details about medical frailty. The application also says that the will be no appeals process for medical frailty decisions. This raises legal concerns. The Medicaid regulations give the individual the right to apply for the eligibility category of their choice. If an individual wants to apply as medically frail and is denied as medically frail, then their claim for assistance has been denied and appeal rights should attach. We note that in some cases the definition of medically frail is not open to reasonable dispute (e.g., individuals in a drug treatment program), and individuals must have some method to challenge state denials that are patently erroneous in fact or law.

The Arkansas proposal projects that approximately 10% of the new adult population will qualify as medically frail.[18] We understand this number to be an estimate, as opposed to

[16] 42 U.S.C. §1315(d)(1).
[17] See Arkansas 1115 Waiver Application, page 10: "[I]ndividuals determined to be medically frail/have exceptional medical needs *for which coverage through the Marketplace is determined to be impractical, overly complex, or would undermine continuity or effectiveness of care* will not be eligible for the Demonstration." (Emphasis added). It is unclear if the language in italics is intended to narrow the exception or merely describe the population.
[18] Arkansas 1115 Waiver Application, page 10.

a target. HHS should explicitly prohibit the state from applying a 10% standard for medical frailty, as such a standard could otherwise become an impermissible cap.

I. Auto-assignment

Arkansas predicts many enrollees will be auto-assigned into plans,[19] and yet this auto-assignment has only been designed to fairly distribute market share among the QHPs (although future assignment methodologies will factor in things like quality). The auto-assignment process should be in the best interests of beneficiaries, as required by 42 U.S.C. § 1396a(a)(17). Thus, it should account for the enrollee's previous provider history, provider capacity/limits within each plan, and limited English proficiency. It should also account for geographic location/zip code; otherwise the non-emergency transportation wraparound service could be unnecessarily used, generating unnecessary costs.

J. Prior authorization

Arkansas requests waiver of § 1396a(a)(54) to "permit the State to require that requests for prior authorization for drugs be addressed within 72 hours, rather than 24 hours"[20] as is required under section 1396r–8(d)(5)(A). Recent Medicaid regulations confirm that ABP benefit packages are subject to section 1396r–8 requirements for drugs that are covered by the ABP.[21] Although section 1396a does *reference* section 1396r–8, such reference does not change the fact that section 1396r–8 places *independent requirements* on the ABP. The requirements in section 1396r–8 lie outside of section 1396a and are thus not waivable under section 1115 of the Act. Arkansas cannot waive, and must comply with, the section 1396r–8 requirement to respond to prior authorization requests in 24 hours for drugs covered under the ABP which are subject to section 1396r–8. These requirements, set by Congress, are reasonable and necessary, given the importance of commencing and maintaining medication regimens as soon as possible after the prescription is written (whether there is an emergency or not).

K. Hypotheses

A section 1115 demonstration is just that – a demonstration – and it must demonstrate something. The Arkansas proposal is to be commended for at least including hypotheses (eleven of them) to be tested. However, many (eight) of these eleven hypotheses are seriously flawed.

In the first instance, five[22] of the eleven "hypotheses" are not in fact related to the "premium assistance" authority that this demonstration calls into question. There is no evidence that the QHPs individuals will be enrolled into will be a significantly different or

[19] See Arkansas 1115 Waiver Application, page 27.
[20] Arkansas 1115 Waiver Application, page 30.
[21] 42 CFR §440.345(f).
[22] These include the first three "access" hypotheses and the two "quality" hypotheses. See Arkansas 1115 Waiver Application, pages 4-5, 7-8,

novel delivery system as compared to the standard use of health plans (i.e., managed care) in Medicaid. These hypotheses are indistinguishable from familiar managed care hypotheses, and there is nothing "demonstrable" about managed care in Medicaid considering that (1) the Medicaid Act already includes state plan authority to operate managed care, (2) Medicaid managed care is decades old, (3) the majority of current Medicaid enrollees nationally *already* are in managed care, and (4) it is likely that the overwhelming majority of state Medicaid Expansion enrollees will be enrolled through managed care. There is nothing novel about delivery system hypotheses around health plans, and need to demonstrate something already available in the Act, and which has been and is being extensively tested.

Earlier we addressed two[23] of the other hypotheses – those related to reduced administrative costs and comparability of total costs. These hypotheses are simply not tenable in their current formulation. In particular, we note that the cost-effectiveness hypothesis is problematic and that Arkansas attempts to have it both ways: Arkansas assumes that it would need to increase fee-for-service rates to justify its grossly flawed cost-effectiveness calculation, and at the same time, assumes no such rate increase for fee-for-service throughout the other hypotheses (and demonstration discussion) declaring the access virtues of premium assistance. This hypothesis therefore not only fails as a justification, but the false assumptions within it distort the entire proposal. And again, this is the type of section 1115 activity that the GAO has previously and repeatedly criticized. It should not be continued here.

Yet one[24] more hypothesis – predicting lower Marketplace rates – is not valid because, though possibly true in fact, it is not relevant to a Medicaid demonstration evaluation. It deals with impacts to people outside of Medicaid, not Medicaid enrollees.

We do believe that there are three[25] hypotheses that are possible valid bases for this demonstration:

- A premium assistance program *might* demonstrate that there will be fewer gaps in insurance coverage due to reduced churning.
- A premium assistance program *might* demonstrate that there will be enhanced continuity of providers due to reduced eligibility and plan churning. (We note that continuity of plan enrollment should not be a measure of success, since consumers want continuity of *providers*, not insurers, and insurers regularly change their covered providers).
- A premium assistance program *might* demonstrate higher take up rates than similar fee-for-service and managed care programs.

We note, however, that it is not enough for Arkansas to have these (and other) hypotheses written down. This must truly be a demonstration and the hypotheses must

[23] The first two "cost" hypotheses. See Arkansas 1115 Waiver Application, pages 6-7.
[24] The fourth "cost" hypothesis. See Arkansas 1115 Waiver Application, page 8.
[25] The last two "access" hypotheses and the third "cost" hypothesis. See Arkansas 1115 Waiver Application, pages 5-7.

be tested using a well-designed experiment followed by comprehensive analysis. There is not enough described in the current proposal to indicate this will be the case. We note that the analytic data provided by many of these hypotheses will only allow 'apples to oranges' comparisons permitting no clear conclusions to be deduced. For example, the evaluation approaches repeatedly rely on comparisons between very different populations – such as comparing higher-income premium assistance populations (which excludes the medically frail) to lower-income fee-for-service populations (which includes numerous vulnerable categorical groups). CMS must not approve this proposal until Arkansas has clarified the methodology for the demonstration analysis. It is essential to the demonstration function that the demonstrations be valid *and* well-tested. In our view, only three of Arkansas' hypotheses pass the former requirement, and none apparently pass the second. Furthermore, we urge HHS to preserve the character of the demonstration process, in accordance with HHS guidance, by only considering "approving a limited number of premium assistance demonstrations."[26]

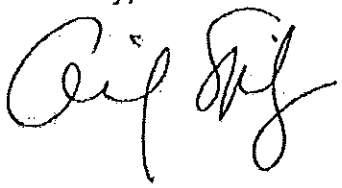
L. Habilitative services

We note that the list of covered benefits does not include any items that are habilitative services.[27] Habilitative services must be covered by the ABP as incorporated through the EHB standard.

Conclusion

In summary, we have numerous concerns with the legality of Arkansas' section 1115 premium assistance demonstration application, as proposed. We urge HHS to address these concerns prior to issuing any approval. If you have questions about these comments, please contact Jane Perkins (perkins@healthlaw.org) or Leonardo Cuello (cuello@healthlaw.org). Thank you for consideration of our comments.

Sincerely,



Emily Spitzer,
Executive Director

[26] "Medicaid and the Affordable Care Act: Premium Assistance," HHS FAQ, March 2013, page 1.
[27] Arkansas 1115 Waiver Application, page 13.

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September 26, 2013

VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Iowa Wellness Plan §1115 Demonstration Application

Dear Sir/Madam:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. We appreciate the opportunity to provide comments to both of Iowa's proposed § 1115 Demonstration Applications, the Iowa Wellness Plan (IWP) and the Marketplace Choices Plan (MCP).

NHeLP recommends that HHS not approve the IWP and the MCP applications for § 1115 authority exactly as requested. The applications include provisions that clearly or arguably are not authorized by any law. We urge HHS to address these problems and require Iowa to bring the proposals to a legally approvable form. We urge HHS to work with Iowa to achieve a Medicaid Expansion that will serve future Medicaid enrollees well, including those inside Iowa benefiting from these proposals and those in other states who may pursue similar proposals. We request that HHS zealously enforce its stated policies and the legal limits of Medicaid § 1115 demonstration law, to ensure progress in Iowa without opening the door to policies that ignore the fundamental nature of Medicaid as an entitlement program.

Second, we ask that before HHS takes action on this request, it take steps to address its own "stewardship of federal Medicaid resources." GAO, *Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lack of Transparency* at 32 (June 2013). As the GAO recently concluded, "HHS's [budget neutrality] policy is not reflected in its actual practices and, contrary to sound management practices, is not adequately

documented....[T]he policy and processes lack transparency regarding criteria." *Id.*

A. Legal Authority for Premium Assistance

In its MCP application, Iowa proposes to conduct a § 1115 demonstration program to use individual market premium assistance to implement a Medicaid Expansion. It is our understanding that Iowa proposes to conduct *individual* market premium assistance relying on authority at § 1905(a). However, the statute and legislative history create serious questions about the validity of this claimed authority. Section 1905(a) defines "medical assistance" and, for the most part, is a listing of services that can or must be included in this definition. By contrast, Congress has dealt with premium assistance in other, specific provisions of the Act. Congress has authorized states to conduct *group* or *employer* coverage premium assistance, which are unambiguously and carefully detailed in statute at §§ 1906 and 1906A. Notwithstanding two very recent policies from HHS (in regulatory and sub-regulatory guidance), there is no history of statutory or regulatory guidance for § 1905(a) authority. Given the uncertainty of the statutory authority and the untested regulatory framework, we believe it is incumbent upon HHS to be extremely cautious and exacting in the approval of any such authority, and even more so for related waivers. HHS should hold tightly to the principles announced in its March 2013 Question and Answer document. And under these circumstances, HHS must also be unmistakably clear as to the waiver authorities being granted and their legal limits.

B. Single State Agency

In addition to premium assistance authority concerns, Iowa's request, as currently written, fails to ensure that the single state Medicaid agency will remain in charge of the Medicaid program for affected populations, as the Medicaid Act requires.[1] The application does not provide the general public or HHS with information and specifics establishing that the single state agency will continue to make administrative and policy decisions for the program. By law, the single state agency must be in control and accountable for developing and implementing Medicaid coverage. While Iowa may not formally delegate away Medicaid authority, it in effect surrenders control over the majority of benefits for an entire category of enrollees. As currently proposed, Iowa will not control many benefits package details, authorization criteria, and provider contracts and terms but will leave these to health plans. The application only envisions a "written agreement" between the state and the issuers "outlining expectations" of the state. Such an agreement does little to reduce the concern that the health plan would act as an independent entity with its own authority contrary to what Medicaid law permits. NHeLP is very supportive of HHS requiring written agreements between the involved entities to satisfy the legal requirement for a single state agency, clearly delineating roles and responsibilities, with the ultimate authority and responsibility housed in the Medicaid agency. However, the application is sparse on details and the mere presence of a written agreement "outlining expectations" does not satisfy this requirement. HHS should require more of Iowa as a condition of approval. While assuring consumer protections and enabling ongoing reporting and monitoring, this would also address

[1] 42 U.S.C. § 1396a(a)(5).

some of the GAO's conclusions that find HHS processes lack the supporting evidence required to justify deviations from historical requirements. GAO, supra. at 32.

C. Limits of § 1115 Waiver Authority

Prior to addressing specific features of the requested waivers, we believe it is important to address one repeated misapplication of § 1115 authority within these waiver applications. § 1115 explicitly circumscribes waiver authority in Title XIX to requirements contained in § 1902.[2] Anything outside of § 1902 is not legally waivable through the 1115 demonstration process. Despite this legal fact, Iowa repeatedly requests waiver of requirements that lie outside of § 1902. These waiver requests, sometimes explicit and other times necessitated by their objectives, include attempts to skirt requirements in § 1906, § 1916, § 1916A, § 1927, and § 1937. None of these waiver requests are permissible because the substantive requirement rests outside of 1902 and independently requires state compliance. In other words, any reference to the provision in section 1902, which could be waived, does not and cannot also waive the independent, freestanding requirements of these Medicaid Act provisions. Such waivers are also patently contrary to all of HHS' stated regulation and policy on premium assistance.[3]

In particular, Iowa also seeks to waive several requirements contained within § 1937. However, as Iowa designs a Medicaid Expansion implementing § 1937 benefits, it cannot waive § 1937 requirements which lie outside of § 1902. Iowa attempts to avoid this problem by identifying citations in § 1902(a) to waive – but none of these change the fact there is an independent requirement at § 1937. Consequently, Iowa cannot properly waive EPSDT (protected at § 1937(a)(1)(A)(ii)), FQHC or RHC services (protected at § 1937(b)(4)), any EHB services including maternity care and pediatric dental and visions services (protected at § 1937(b)(5)), or family planning services and supplies (protected at § 1937(b)(7)). Moreover, placed outside of 1902 by Congress these provisions have been repeatedly amended to be strengthened, thus evidencing their core roles as objectives of the Medicaid Act.

Finally, Iowa cannot, in this proposal, circumvent these requirements in § 1937 by requesting waiver of § 1902(k)(1). Iowa's MCP proposal (along with IWP) is predicated on receiving enhanced matching funds (100% FMAP in 2014) for its Medicaid Expansion population. However, under § 1903(i)(26), Iowa cannot receive any matching funds for the Medicaid Expansion population that are not tied to coverage of § 1937 benefits. To put it simply, HHS cannot waive elements of § 1937 *and* pay enhanced FFP.

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[2] SSA, § 1115(a)(1).

[3] *See* 42 C.F.R. § 435.1015(a)(2), requiring the agency to furnish "all benefits for which the individual is covered under the State plan that are not available through the individual health plan." In the preamble to this regulation, HHS clearly explained that it "will only consider demonstrations under which states make arrangements with the health plan to provide wraparound benefits and cost sharing assistance." 78 Fed. Reg. 42186. *See also* "Medicaid and the Affordable Care Act: Premium Assistance," HHS FAQ, March 29 2013, page 2, stating that "HHS will only consider proposals that ... [m]ake arrangements with the QHPs to provide any necessary wrap around benefits and cost sharing."

D. EPSDT

Iowa has requested § 1115 demonstration authority to waive the EPSDT requirement for the 19 and 20-year olds who may enroll in the IWP and MCP. HHS cannot approve a waiver of EPSDT because EPSDT is specifically required in § 1937 and broadly required by Medicaid law.

As described in Part C above, § 1937(a)(1)(A)(ii) requires that all Medicaid ABP plans cover EPSDT. This requirement should apply to both the IWP demonstration population below 100% FPL and the MCP population above 100% FPL, since both groups are ultimately eligible for an ABP (unless medically frail).

EPSDT waiver is also not permitted under Medicaid law more broadly. No feature of a § 1115 application can be approved if it is inconsistent with the objectives of the Medicaid Act.[4] Congress designed Medicaid with a sweeping requirement to cover EPSDT for children out of the recognition that research has repeatedly documented that poverty-level children need a range of enabling and developmental interventions. On numerous occasions since introducing it in 1967, Congress has amended the Medicaid Act EPSDT provisions – to strengthen them and require states to do more to address the ills that low-income and vulnerable children disproportionately face. Young people are one of the core populations of the Medicaid program and to diminish EPSDT – the most essential and enduring feature of coverage for children and youth – is clearly inconsistent with the objectives of the Medicaid program.

Iowa justifies this request based on a need to promote consistency with the commercial market. Yet, HHS has already made clear that, *even in the case of individual market premium assistance*, when a state explicitly purchases private coverage for an individual, the *state must wrap around* required EPSDT services. This is confirmed in regulation at 42 C.F.R. §435.1015(a)(2) and premium assistance guidance from HHS issued in March 2013. We urge CMS: Do not back away from this clearly articulated principle. Rather, be clear that waiver of EPSDT is not permitted for premium assistance (in this case, above 100% FPL) under HHS' own regulations and guidance, and it would be an unfair result to not extend the same protection to *more vulnerable* individuals in non-premium assistance expansions (in this case, below 100% FPL).

E. Federally qualified health centers/Rural health clinics

In its MCP application, Iowa requests permission to waive §§ 1902(a)(10)(A), 1902(a)(15), and 1902(bb), to "not cover all" FQHCs/RHCs and to limit reimbursement to QHP rates. On this topic we endorse and incorporate herein all of the comments of the National Association of Community Health Centers, opposing these FQHC/RHC waivers. We believe these waivers are not permissible because:

- Iowa cannot waive § 1937 FQHC/RHC requirements through § 1115, since those requirement lie outside of § 1902.[5]

[4] SSA, § 1115(a).
[5] *See* § 1937(b)(4) and 42 C.F.R. § 440.365.

- § 1903(i)(26), forbids payment of any FFP for Medicaid Expansion enrollees unless they receive § 1937 benefits.
- In any event, Iowa's waiver requests do not include § 1902(k), the provision that actually requires compliance with § 1937 benefits.
- Iowa's state notice and comment proposals never included provisions to waive FQHC/RHC services.

We note, finally, that Iowa's proposal discusses waiver of FQHC/RHC *providers* and *rate rules*, but is silent as to the core legal requirement, which is to provide all FQHC/RHC *services*.[6] Thus, even if the requested waivers were approvable, HHS would need to require Iowa to demonstrate how it would successfully provide all of these *services* with reduced health center networks and rates.

F. Cost-sharing generally

Iowa's § 1115 application contains numerous cost-sharing features (each discussed below) which are not approvable under § 1115. Specifically, the proposals all repeatedly violate three core requirements for § 1115 demonstrations:

- Iowa repeatedly attempts to waive requirements of §1916 and 1916A through § 1115 without using the only appropriate legal channel for such waivers, compliance with the waiver requirements of §1916(f). As mentioned earlier, § 1115 demonstration authority is only available for waiver of provision inside §1902 – not free-standing provisions like §1916 and §1916A.[7]
- An § 1115 demonstration is precisely that, a demonstration. Iowa's repeated requests for §1115 authority around cost-sharing are not approvable because, as proposed, they will not test anything. The principal feature Iowa seeks to waive – premiums for low-income enrollees – has already been tested repeatedly and consistently shown to *depress* enrollment – including for the very population of adults that is the focus of the Iowa proposals.
- Section 1115 demonstrations must also be "likely to assist in promoting the objectives" of the Medicaid program. The objective of the Medicaid program is to *furnish* health care to low income individuals. Many of the cost-sharing elements in Iowa's proposal cannot be approved because they, to the contrary, *reduce* access to care. The Medicaid Act, particularly § 1916A, already provides States like Iowa with a great deal of flexibility to impose premiums, cost sharing, and similar charges. Yet, Iowa and other states seek to run past these options, never using them, to implement proposals that the research has already established are harmful to low-income people – provisions that will clearly result in interrupted care, lost opportunities, and churning.

[6] *See* § 1937(b)(4)(A), requiring provision of all "services" described in 1905(a)(2), which itself also refers to "services" offered by FQHCs/RHCs.
[7] SSA, § 1115(a)(1).

G. Monthly Contribution

One of the central features of both the IWP and MCP proposals is a monthly contribution system to begin in 2015 (for applicants above 50% of FPL). Iowa proposes this contribution on a tiered system that approximates 3% of income. The drafters of the proposals appear to deliberately obscure the description of the fee in an attempt to make it straddle the premium and cost sharing requirements. This attempt to bypass the requirements of the Medicaid Act should not be allowed. Iowa has clearly proposed a premium and the premium requirements thus apply. Medicaid law does not normally allow monthly premiums for enrollees with income below 150% of FPL.[8] Such a monthly charge – whether called a "contribution," "fee," "assessment," or any other name – is a "similar charge" to a premium and thus prohibited under law.[9] The possibility for a consumer to obtain a waiver of the premium for complying with prevention requirements does not cure the illegality of otherwise imposing the premium. Nor would the legal problem be cured by a "hardship waiver," even if such standard were adequately defined in the applications, which it is not. HHS cannot legally approve these requests.

The illegality of allowing such premiums is even clearer because Iowa has not requested – in prior notice or these applications – any demonstration authority for charging Medicaid enrollees premiums. (*See* Iowa Wellness Plan §1115 application, page 38-39, requesting waiver of quarterly 5% aggregate cap and nominal copay limits, but not prohibition on premiums). Clearly, Iowa could never apply a premium to a state plan population exempt from premiums *without* some kind of waiver. However, the waiver of Medicaid premium prohibitions for individuals below 150% of federal poverty would also not be legally permissible under the §1115 demonstration authority Iowa seeks *with* this application. As discussed in Part B above, only requirements established in §1902 may be waived under §1115. Although §1902(a)(14) references the authorities of §§1916 and 1916A, this does not change the fact that §1916 and 1916A are free standing requirements which lie outside of §1115.

We also do not believe that the monthly contribution is consistent with the objectives of the Medicaid Act or serves any valid demonstration purpose. Premiums are a well-established barrier to individuals obtaining and maintaining insurance coverage, and this is why Congress generally prohibits them for low-income Medicaid populations (who, by definition, cannot afford life's basic necessities, much less an insurance premium).[10] For example, in 2003, Oregon experimented with charging sliding scale premiums ($6-$20) and higher copays on some groups in an already existing § 1115 demonstration for families and childless adults below poverty. Nearly *half* the affected demonstration enrollees dropped out within the first six months after the changes.[11] Another multi-state study of low-income health programs found that premiums amounting to 1% of family income reduce enrollment by nearly 15%, while premiums set to 3% of family income, as proposed in Iowa's demonstration, cut enrollment in

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[8] § 1916(c). There are very limited exceptions to this rule, for certain populations, not broadly applicable to the Medicaid Expansion population. *See, e.g.*, § 1916(d)

[9] § 1916A(a)(3)(A).

[10] Premiums have only been permitted in exceptional categories, such as for states expanding coverage to workers with disabilities.

[11] Bill J. Wright et al., *The Impact of Increased Cost Sharing on Medicaid Enrollees*, 24 Health Affairs 1106, 1110 (2005).

half.[12] Clearly, allowing Iowa to implement premiums would serve to depress enrollment – perhaps drastically -- while thwarting the objectives of Medicaid and demonstrating nothing.

Cost-sharing and premiums are bad health care policies and we broadly oppose them because of the harm they cause consumers. But *some* forms of cost-sharing, while not good policy, are at least permissible under law. Iowa's requested premiums are both bad policy *and* illegal. If Iowa is insistent on pursuing a flawed theory of "personal responsibility," HHS must work with the state to transform the illegal premium scheme into a system of permissible nominal cost-sharing, including full compliance with related regulations, such as those concerning non-enforceable cost-sharing.

H. Termination for non-payment

Even if, *arguendo*, HHS permitted monthly contributions per Iowa's applications, the IWP and MCP schemes are still not legal because of the consequences for non-payment.

- If HHS allowed Iowa to use § 1115 alone to waive the limitation on premiums below 150%, it would not follow that Iowa should be allowed to terminate anyone for nonpayment.
- If Iowa transitioned from the monthly contributions to a system based on incurred cost-sharing, that might comply with the statutory bar against premiums, but it would not change the fact that termination for non-payment is also not allowed for cost-sharing and – perhaps more important – that to implement such cost sharing the state would need to obtain a waiver pursuant to 1916(f).

Therefore, we believe there is no legal way for Iowa to broadly terminate individuals below 150% FPL for failure to pay monthly contributions (or cost-sharing). Under Medicaid law, Iowa could only apply and enforce such monthly contributions for some individuals *over* 150%.

We also believe that termination for non-payment is patently contrary to the objectives of Medicaid (furnishing care low-income individuals) and serves no valid demonstration purpose. Furthermore, considering that one of Iowa's central stated purposes for its § 1115 requests is to *reduce* churn, it is a glaring contradiction for Iowa to pursue this termination for non-payment policy which is a clear churn *accelerator* – we noted earlier that premiums at 3% of income have been found to cut enrollment in half.[13] Finally, this termination policy, when combined with the attempt to eliminate retroactive coverage, means that many terminated individuals will go without coverage *exactly* when they try to access the health system (*e.g.*, after an accident or acute event), which will harm providers and promote "cost-shifting," also contrary to the stated goals of this demonstration.

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[12] Leighton Ku and Teresa Coughlin, *Sliding-Scale Premium Health Insurance Programs: Four States' Experiences*, 36 Inquiry 471, 476 (Winter 1999-2000).
[13] Leighton Ku and Teresa Coughlin, *Sliding-Scale Premium Health Insurance Programs: Four States' Experiences*, 36 Inquiry 471, 476 (Winter 1999-2000).

I. 5% Aggregate Cap

To be clear, we oppose the premium requirements of these proposals. However, we want to address yet one more problem with them. Iowa has request §1115 demonstration authority to apply the 5% aggregate cap on Medicaid premiums and cost-sharing on an annual basis in both the IWP and MCP. While Medicaid law does provide states the flexibility to tabulate the aggregate cap on a monthly or quarterly basis, it does not allow the aggregate limit to be applied *annually*. Iowa therefore seeks waiver authority to allow annual calculation of the aggregate cap, but as described above, the requirements of §1916 and §1916A cannot be ignored or waived for the populations subject to the waiver (as they are state plan populations described in the Medicaid Act). HHS cannot approve this change to the aggregate cap. We note there is no clear reason why Iowa would need annual caps to accomplish the objectives of this waiver – quarterly caps would not be a barrier towards the state's goals. Furthermore, considering that low-income individuals have little disposable income and the impacts of cost-sharing on this population are well known, applying the aggregate cap on a yearly basis would not be consistent with the objectives of Medicaid or serve any demonstration purpose.[14]

J. Copayments for Non-emergent ER Use

Iowa has requested §1115 demonstration authority to charge heightened copays of $10 per visit for non-emergent use of the ER in both the IWP and MCP. Such copays are only permissible for individuals above 150% of FPL; individuals below 150% can only be charged nominal copayments.

- The Medicaid Act clearly and consistently protects individuals living below 100% FPL, in particular. Recent regulations give states exceptional permission to charge as much as $8 for non-emergent ER visits.[15] Yet, Iowa wants to ignore the law and charge the lowest income enrollees $2 more. These people already will have "skin in the game," and CMS should approve no more than an $8 copay for non-ER use of the ER. Any higher copay must be obtained through 1916(f)'s public notice and comment process and five tightly circumscribed requirements for a copayment waiver.
- For individuals from 100% to 150% FPL, the maximum permissible charge for non-emergent use of the ER is also set at $8.[16] The heightened $10 copayment is thus also impermissible for this population, for the same reasons as described for the population below 100% FPL.

[14] To be clear, we would like to provide an example as to why an annual cap would be detrimental. An individual at 60% FPL would earn $6,894 per year. Her 5% aggregate cost-sharing cap would be $29 per month or $86 per quarter. If she used minimal health care during the year, but had one health crisis month with high-utilization (ex. multiple ER trips), she is protected by a limit of $29 for that month or $86 for that quarter, and that might be her total cost-sharing responsibility for the full year. If an annual limit was used, however, she could pay as much as $345. This would be the equivalent of what she would pay if they if she had the same crisis *every* quarter. Put another way, under the law, her cost for *one event* is limited to 5% of the cost of a quarter, but under an annual cap, her cost is 5% of er annual income.
[15] 42 C.F.R. § 447.54.
[16] 42 C.F.R. § 447.54.

We also urge HHS to require Iowa, if it does impose a legal copayment, to explain how it will ensure compliance with statutory requirements that, prior to charging any copay for non-emergent use of the ER, there must be an "actually available and accessible" alternate care option and that the facility must provide notice that the care to be provided is non-emergent care subject to additional charges, identify the alternative care option, and provide the enrollee with a referral.[17]

Finally, Iowa suggests (at page 28 of the MCP application) that it will consider retroactive claims data to identify non-emergent use of the ER. However, we note that emergent use of the ER should be defined by the perception of possibility of a dangerous condition by a reasonably prudent layperson. Going to the ER because of chest pain, reasonably suggesting a heart attack, should not subject an individual to a retroactive copayment just because the claim ultimately paid was for a different non-emergent condition. And, if at the time the individual sought care in the ER, they should not be charged the non-ER copayment amount if there were not actually available and accessible alternatives.

K. Cost-sharing for Family Planning and Family Planning Services and Supplies, Preventive Services including Prenatal Care, and Maternity Care

The Application makes no mention of cost-sharing for family planning services and supplies or prenatal care. Section 2303(c) of the Affordable Care Act (ACA) clarified that Medicaid benchmark and benchmark-equivalent coverage is required to cover family planning services and supplies without cost-sharing. Additionally, section 2713 of the Public Health Service Act, which HHS has made clear applies to ABPs, requires plans to cover certain preventive services, including contraception and prenatal care, without cost-sharing.[18] HHS should confirm with the state that the QHPs will cover family planning services and supplies and prenatal care without cost-sharing. Table 3: Iowa Essential Health Benefit Benchmark Plan Covered Benefits notes that plans will be required to cover "ACA required preventive services." However, the corresponding footnote 5 refers only to "screenings" and not "services." CMS should clarify that all of § 2713's preventive *services and* screenings will be covered without cost-sharing.

Further, federal Medicaid law requires Iowa to exempt pregnant women potentially impacted by this Application from cost-sharing or premiums for all pregnancy-related services.[19] We urge HHS to confirm with the state that QHPs will comply with the requirement that pregnant women pay no cost-sharing or premiums for pregnancy-related services throughout their pregnancies and through the end of the month of the 60th day postpartum.

L. Non-emergent Transportation

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[17] § 1916A(e)(1).

[18] ACA § 1001, 42 U.S.C. § 300gg-13(a)(1)-(4) (amending § 2713 of the Public Health Services Act); *see also* Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment; Final Rule, 78 Fed. Reg. 42160, 42224 (July 15, 2013).

[19] 42 U.S.C. §§ 1916(a)(2)(B), 1916(b)(2)(B); 42 C.F.R. § 447.53(b)(2).

Medicaid requires coverage of non-emergent transportation.[20] Iowa has requested § 1115 authority to not provide non-emergent transportation to either IWP or MCP enrollees and states the reason for this is to ascertain whether or not it will "pose a barrier" for enrollees. In essence, Iowa is questioning whether, in a rural state with long distances to providers, it will create an access barrier to individuals in and slightly above poverty to *not* provide them with transportation assistance. This demonstration should not be approved because the answer is already self-evident; it will undoubtedly create a barrier. In any event, transportation as a barrier to medical care is already well understood (and has been since Medicaid was passed in 1965) such that waiver of this requirement cannot possibly be testing anything novel. Furthermore, since reducing transportation will only reduce access to medical coverage, this also does not comply with the objectives of the Medicaid program as required by § 1115(a). Allowing the state to ignore Medicaid's requirements for this important enabling service would be a dangerous step toward Medicaid losing its essential quality as a program designed to meet the needs of low income people.

M. Retroactive Eligibility

Medicaid requires states to provide retroactive coverage for enrollees.[21] Iowa has requested § 1115 demonstration authority to waive this requirement. This waiver should not be allowed because there is no demonstrative value to the request. The entirely predictable result will be: (1) more low-income individuals experiencing medical debt collections and bankruptcy; (2) more providers – especially safety net hospitals – incurring losses; and (3) more individuals experiencing gaps in coverage when some providers refuse to treat them because the providers realize they will not be paid retroactively by Medicaid. This policy has dubious hypothetical benefits and very concrete harms. In particular, the gaps in coverage it would *create* are a glaring contradiction to the purported purpose for Iowa's IWP and MCP, which is to *prevent* gaps created by churn.

We note that Iowa's proposed policy objective in requesting waiver of retroactive eligibility is to coordinate eligibility with the Marketplace, which can effectuate eligibility on the first day of the following month (and some cases the first day of the second following month). To achieve this goal, Iowa would – in addition to waiving retroactive eligibility – need to *also* waive Medicaid point-in-time eligibility.[22] Subjecting Medicaid applicants to prospective waiting periods to effectuate enrollment would lead to tragic health outcomes and even more significant losses for providers. HHS should not approve any waiver of point-in-time eligibility. In any event, Iowa should not be allowed to waive such a critical and enduring feature of the Medicaid program without specifically requesting authority to waive this requirement, which it has not done.

N. Freedom of Choice

[20] *See* 42 C.F.R. § 431.53 and State Medicaid Manual § 2113.
[21] § 1902(a)(34); 42 C.F.R. § 435.914 (redesignated at §435.915 in 77 Fed. Reg. 17143).
[22] The MCP proposal suggests, though does not explicitly confirm, that Iowa might plan to enroll individuals in FFS Medicaid until the Marketplace enrollment is effective. *See* MCP application, page 12.

The MCP application request to limit access to family planning providers violates federal law and should be rejected. The application requests that HHS waive § 1902(a)(10)(A) to "enable Iowa to not cover all family planning providers." However, it appears that the state actually seeks to waive § 1902(a)(23)(B) which guarantees Medicaid beneficiaries have freedom of choice of family planning services and supplies and are entitled to go out-of-network regardless of whether there are available in-network family planning providers.[23] Allowing Iowa to waive this requirement would impermissibly restrict beneficiaries' access to family planning providers. HHS and a number of district and federal circuit courts of appeal have consistently made clear that states must cover family planning services and supplies provided by any qualified provider, including out-of-network providers.[24] We therefore urge HHS to deny the State's request and require it to allow beneficiaries to go out-of-network for family planning services without cost-sharing or referrals, *regardless of the availability of in-network providers.* To this end, HHS should make clear that any waiver of § 1902(a)(23) (or § 1902(a)(10)(A)) does not include any waiver of § 1902(a)(23)(B) requirements.[25] In all cases, HHS should not approve any waiver request that does not include a specific and accurate description of the Medicaid requirement to be waived and an explanation of the authority and reason for that specific waiver.

Iowa has also requested authority to cover individuals with available employer coverage through a health insurance premium payment model (i.e., premium assistance). However, Medicaid law already provides authority for states to conduct such premium assistance through § 1906. Iowa cannot use a § 1115 demonstration – which only allows waivers of provisions in § 1902 – to override Congress' clear intent for group/employer premium assistance to be governed by § 1906. As such, Iowa would also need to comply with the specific requirements in § 1906; for example, to wrap around all cost-sharing and to only use such premium assistance when cost-effective.

O. Appeals

Iowa's MCP application appears to request an "appeals" system which does not comply with Medicaid due process or the U.S. Constitution and cannot be approved in the current form by HHS. Regardless of the fact that Iowa may enroll some Medicaid-eligible individuals into private market coverage via premium assistance, these individuals remain Medicaid enrollees and subject to Medicaid due process protections.

While Iowa (in the MCP application) indicates it will retain the Medicaid appeals process for review of eligibility and monthly contribution payment decisions, it proposes to rely on the QHP appeals process for coverage and provider access decisions.[26] However, Medicaid enrollees must have access to the Medicaid appeals system, and the unique features of that system (including continued benefits), for all Medicaid covered services. It might be appropriate for Iowa to create an internal plan appeals process, so long as it does not interfere with the individual's right to obtain a timely decision, generally within

[23] Iowa Marketplace Choice Plan application, page 23. Section 1902(a)(10)(A) requires the State to provide coverage for family planning services and supplies to "all individuals" who meet eligibility requirements. § 1902(a)(10)(A). *See* § 1902(a)(23)(B).
[24] *See* CMS, State Medicaid Manual, § 2088.5.
[25] Iowa Marketplace Choice Plan application, page 23-24.
[26] Iowa Marketplace Choice Plan application, page 21.

90 days of the date of the request or within days in expedited circumstances. For any enrollee in Medicaid – whether in premium assistance or not – core Medicaid due process protections such as the right to notice, fair hearing, and aid paid pending appeal, must be preserved and can never be waived by HHS. This foundational principle should not be moved.

P. Due Process in ACOs

Iowa's proposal requests waiver of Freedom of Choice (§ 1902(a)(23)) to implement Accountable Care Organizations (ACOs). ACOs are a delivery system reform idea with some promise but many uncertainties, yet, if tested in a small number of reasonably-sized demonstrations, represent exactly the type of experiment that § 1115 is designed to test and evaluate. However, we believe Iowa's intent to utilize ACOs requires significantly more detail to be approved. Iowa must explain how this new system will comply with all other Medicaid requirements. Most importantly, we have serious concerns about violations of Medicaid due process requirements in the ACO context. If an individual's medical provider has a direct financial stake in the provision of a service, it is unclear how the individual can meaningfully pursue that treatment option if the doctor disagrees, or if the individual would even *find out* that treatment option is available. We believe HHS would need to develop clear policies to redress this and similar due process problems, including but not limited to requirements for providers to provide patients with clear information about all treatment options, the right for patients to request second opinions from doctors not aligned with the ACO, oversight specifically focused on identifying health care stinting, and continued benefits when services and care are denied or terminated. While Iowa could request § 1115 authority to waive § 1902(a)(23) freedom of choice, it cannot waive Constitutional due process requirements.

Q. Disease Management

We are supportive of attempts by Iowa to improve disease management for high-risk individuals. However, as described in the Iowa IWP proposal, it appears that the state may be considering disease management compliance as an additional hurdle for high-risk individuals to get an exemption from the monthly contribution requirement.[27] Setting aside the underlying illegalities of the monthly contribution scheme discussed earlier, HHS should clarify that Iowa cannot create additional barriers for the sickest populations. Such a policy would be discriminatory and not permissible under Medicaid law.

R. Facilitated-enrollment of Current IowaCare Enrollees

Enrollees in Iowa's current IowaCare § 1115 demonstration will be disenrolled and eligible for the new proposed IWP and MCP § 1115 demonstrations. Although Iowa makes clear it will provide notice to these enrollees, it is unclear if Iowa will facilitate enrollment of the members into the IWP and MCP demonstrations. Assuming the IowaCare program is terminated, HHS should require Iowa to facilitate enrollment of IowaCare enrollees into the new demonstrations. This process should include clear

[27] *See* Iowa Wellness Plan application, page 7.

requirements for notice as well as outreach, education, and consumer assistance to help individuals make informed plan selections. If individuals make no plan selection, then they should be auto-assigned into a plan that includes their PCP and other providers in network, and consider other factors such as geography and enrollment other family members. We note that Iowa and its budget neutrality vendor (Milliman) assume a 100% take-up rate for IowaCare enrollees; such assumptions could only be reasonable and the basis of good-faith budget neutrality calculations with a facilitated-enrollment system.[28] We note further that transition of current IowaCare eligibles was a top issue in state level comments.[29]

S. Hypotheses and Evaluation

Although the IWP and MCP proposals include numerous hypotheses to be tested, we believe that only a small number of them are requests to undertake activities that can be tested (as described above). In all cases, the hypotheses must be tested using a well-designed experiment followed by comprehensive analysis. HHS should not approve these proposals until Iowa has clarified the methodologies that will be used to conduct meaningful demonstration analysis. HHS also should not approve these proposals until it has clarified with the state and the public its own rule for oversight, monitoring and enforcement during the life of the proposal.

We also have serious concerns with some of the Milliman budget neutrality analysis. We have earlier mentioned the unclear assumption of a 100% take-up rate for current IowaCare enrollees. For example, page 5 of the MCP budget neutrality report states, "The provision of premium assistance for the Marketplace Choice Plans is cost effective, improves access to care, and reduces the impact of churn." There is no clear support for this conclusion, and it is unclear if this is a Milliman conclusion or merely the restating of Iowa's prediction (and this quote is the followed by what we understand to be a list of what Iowa "anticipates"). We urge HHS to scrutinize this report carefully. As we have noted, the GAO has published repeated and serious concerns with HHS's failure to enforce its policies regarding cost-effectiveness. See GAO, *Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lack of Transparency* (June 2013) (citing previous reports).

T. Pregnant Women

The applications include notices stating that IWP will cover individuals not eligible for comprehensive Medicaid under an existing Iowa Medicaid group.[30] It is not clear how this statement affects pregnant women because it is not clear from the materials that Iowa has submitted whether the state current provides comprehensive or only pregnancy-related benefits to this group. Consistent with its March 2012 rules, we urge HHS to confirm that Iowa will cover comprehensive benefits for pregnant women.[31]

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[28] *See* Iowa Wellness Plan application, page 19, and Milliman budget neutrality report, page 5; Iowa Marketplace Choice Plan Milliman budget neutrality report, p. 4.
[29] *See* Iowa Wellness Plan application, page 41-42; Marketplace Choice Application, page 41.
[30] *See* e.g., Iowa Marketplace Choice Plan application, page 46.
[31] *See* Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 77 Fed. Reg. 17144, 17148-49 (Mar. 23, 2012).

The MCP application makes no mention of what happens to women who become pregnant after enrollment in the Medicaid Expansion. We urge HHS to clarify with the state how it intends cover women who become pregnant after enrollment in the Medicaid Expansion, including how the state will ensure that these women have adequate and timely notice of their coverage options, including differences in benefits under the ABPs as compared to the State Plan benefit package.

The MCP application, though generally committing to compliance with the Essential Health Benefits requirements, entirely omits "maternity and newborn care" from the EHB Benchmark Plan Covered Benefits.[32] All ABPs must cover the ten EHB categories, including maternity care.[33] HHS must require the ABP to cover all ten EHB categories, including maternity care.

U. EHB Requirement for Pediatric Dental and Vision

The MCP application, though generally committing to compliance with the Essential Health Benefits requirements, entirely omits pediatric dental and vision from the EHB Benchmark Plan Covered Benefits.[34] All ABPs must cover the ten EHB categories, including pediatric dental and vision.[35] The Iowa proposals should be required to include these essential child health services.

V. Abortion Services Covered Under the Hyde Amendment

The Application makes no mention of abortion coverage required by the Hyde Amendment.These services must be covered in the same manner as any other medically necessary services for which federal financial participation is available. HHS must require the ABP to explicitly cover all abortions that comply with the Hyde Amendment exceptions.

W. Medically Frail

If Iowa has any Native Americans who are members of Federally recognized tribes, 42 C.F.R. 440.315(f) may require their addition to the medically frail group (based on their inclusion under 42 C.F.R. 438.50(d)(2)).

Conclusion

In summary, we have numerous concerns with the legality of Iowa's § 1115 demonstration application, as proposed. We urge HHS to address these concerns prior to issuing any approval. If you have questions about these comments, please contact Jane Perkins (perkins@healthlaw.org) or Leonardo Cuello (cuello@healthlaw.org). Thank you for consideration of our comments.

Sincerely,

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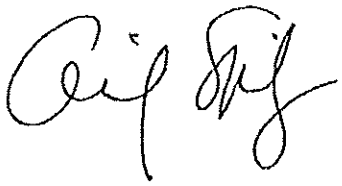
[32] *See* Iowa 1115 Waiver Application, page 15-18.
[33] ACA §§ 2001(c), 1302(b).
[34] *See* Iowa 1115 Waiver Application, page 15-18.
[35] ACA §§ 2001(c), 1302(b).



Emily Spitzer,
Executive Director

Medicaid Expansion Work Requirements

Prepared By: Corey Davis
Date: October 4, 2013

Q: My state is considering submitting a state plan amendment or waiver request to extend Medicaid coverage to the ACA Expansion population. It wants to include a requirement that individuals be working or looking for work to qualify for coverage. Is this permissible?

A. No. States should not be able to impose work requirements on ACA Expansion individuals under either traditional Medicaid rules or via a waiver or demonstration project.

Discussion

Federal Medicaid law imposes mandatory requirements that states must meet to qualify for federal Medicaid funding, including rules regarding administration, eligibility, scope of services, and procedural protections for enrollees.[1] Each state must submit a written plan to the Department of Health and Human Services (HHS) that describes the state's Medicaid program and includes assurances that it will operate the program in conformity with the federal Medicaid Act and related regulations.[2] The plan must be approved by the HHS Secretary before the state can receive federal funds for its implementation.[3]

Prior to 2014, Medicaid coverage was generally limited to low income women and children, people with disabilities, and the aged.[4] Beginning January 1, 2014, however, most citizens and qualified immigrants whose incomes do not exceed 138 percent of the federal poverty line will qualify for coverage if the state adopts the ACA Expansion.[5] The expansion will particularly benefit non-disabled, non-elderly adults.

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[1] *See* 42 U.S.C. §§ 1396-1396w-5. Medicaid is an entitlement for individuals who qualify. *See* 42 U.S.C. §§ 1396a(a)(10), 1396a(a)(8), 1396d(a); *Bowen v. Roy*, 476 U.S. 693, 731 (1986).
[2] *See* 42 U.S.C. § 1396a(a) (listing required contents of state plan).
[3] *See generally* 42 U.S.C. § 1396a; 42 C.F.R. § 430.10.
[4] 42 U.S.C. §§ 1396a(a)(10)(A)(i)(III),(IV),(VI), 1396a(l)(1)(A)-(D), 1396(n)(1) (financial requirements); 42 U.S.C. §§ 1396a(a)(10)(A)(i)(II); 1396a(f), 42 C.F.R. § 435.120, 121 (people with disabilities); 42 U.S.C. §§ 1396d(p); 1396d(p)(2)(C)(iv), 1396d(p)(4); 42 C.F.R. § 435.121(b) (Medicare beneficiaries).
[5] 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (added by ACA § 2001(a)(1)). Although the ACA Expansion category remains a mandatory group, the Court in *NFIB v. Sebelius* ruled that HHS cannot terminate Medicaid funding for states that refuse to participate in the Expansion. *See*

Work Requirements Are Impermissible Under Traditional Medicaid Rules

Federal law clearly enumerates Medicaid eligibility criteria.[6] Although states have flexibility in designing and administering their Medicaid programs, the Medicaid Act requires that they provide assistance to all individuals who qualify under federal law.[7] Thus, for example, a court struck down a state's attempt to add eligibility requirements beyond those contained in federal law, including ensuring childhood immunizations, wellness check-ups, school attendance and refraining from substance abuse.[8] The court reasoned that since the Medicaid Act contains no such requirements, the state restrictions were inconsistent with and therefore preempted by federal law. A state "cannot add additional requirements for Medicaid eligibility," it declared.[9]

Notably, Congress has allowed only one group of Medicaid recipients to be terminated for failure to meet work requirements.[10] These individuals receive Medicaid because they would have qualified under rules governing the former AFDC program (now called Temporary Assistance to Needy Families, or TANF).[11] Under federal law, most TANF recipients must engage in work activities to receive TANF benefits. If those recipients lose their TANF benefits for failure to meet those requirements, federal law permits (but does not require) states to terminate their related Medicaid coverage as well.[12] Congress had the opportunity to create a similar requirement for ACA Expansion individuals, but did not do so, nor did it extend the TANF work requirement to ACA Expansion individuals.[13]

NFIB v. Sebelius, 132 S. Ct. 2566, 2607 (2012). HHS has clarified that states must extend coverage to the entire ACA expansion category to receive increased federal funds for that group. *See* CENTERS FOR MEDICARE AND MEDICAID SERVICES, FREQUENTLY ASKED QUESTIONS ON EXCHANGES, MARKET REFORMS, AND MEDICAID (2012), http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf.

[6] *See generally* 42 U.S.C. § 1396a.

[7] 42 U.S.C. §§ 1396a(a)(10)(A),(B).

[8] *Camacho v. Texas Workforce Comm'n*, 408 F.3d 229 (5th Cir. 2005), *aff'g*, 326 F. Supp. 2d 803 (W.D. Tex. 2004).

[9] *Id.* at 235. *See generally Carleson v. Remillard*, 406 U.S. 598 (1972) (invalidating state law that denied AFDC benefits to children whose fathers were serving in the military where no such bar existed in federal law governing eligibility).

[10] Various initiatives do exist to make it easier for certain people with disabilities to pursue work and still receive Medicaid, *see* 42 U.S.C. §§ 1396a(a)(10)(A)(ii)(XV), 1396a(r)(2; 42 C.F.R. §§ 1396a(a)(10)(A)(ii)(XVI), 1396d(v)(1)(D); 42 U.S.C. § 1396a (note).

[11] These "Section 1931" recipients must have qualified for the state's AFDC program under rules in effect on July 16, 1996. 42 U.S.C. § 1396a(a)(10)(A)(i)(I); 42 U.S.C. § 1396u-1(a).

[12] 42 U.S.C. § 1396u-1(b)(3)(A). Pregnant women, infants, and minors who are not head of household may not have their Medicaid terminated. *Id.* at (A), (B).

[13] *Id.* § 1396a(a)(10)(A)(i)(VIII). In fact, people who are dropped from the 1931 category will qualify for the Expansion category, if they are otherwise eligible.

Work Requirements Should Not Be Permitted Via Waivers

States may request permission from HHS to deviate from traditional Medicaid rules under certain very specific circumstances.[14] Section 1115 of the Social Security Act grants the HHS Secretary the authority to waive requirements found in § 1396a(a) of the Medicaid Act to the extent and for the period necessary for the state to carry out a specific experimental project.[15] These waivers may be granted only "(1) for experimental, demonstration or pilot projects, which (2) in the judgment of the Secretary are likely to assist in promoting the objectives of the Social Security Act and only (3) for the extent and period she finds necessary."[16]

HHS approved a number of Section 1115 work requirement waivers in the *AFDC context* in the 1970's and 1980's.[17] Under these waivers, states were required to conduct "rigorous evaluations of the impact of their demonstrations," typically requiring the random assignment of one group to a program operating under traditional rules and another to the more restrictive waiver rules.[18]

But Medicaid is not AFDC. While the AFDC program required states to establish a "job opportunities and basic skills" program and was explicitly intended to move recipients to gainful employment, the Medicaid Act has no such goal.[19] Rather, Medicaid's stated objective is clear: it is intended to provide "medical assistance [to eligible individuals] whose income and resources are insufficient to meet the costs of necessary medical services" and "rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care."[20] In the 48 years of Medicaid's existence, HHS has never approved a waiver permitting a work requirement.

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[14] *See* 42 U.S.C. § 1396n(b); 42 C.F.R. §§ 430.25, 431.55. *See* CMS, STATE MEDICAID MANUAL §§ 2108.A (cost effectiveness), 2108.B (access to services and quality of care).

[15] Some Medicaid provisions cannot be waived. For example, Medicare cost sharing requirements cannot be waived. *Id.* § 1396a(a)(10)(E). The spousal impoverishment protections cannot be waived. *Id.* § 1396r-5(a)(4). Transitional medical assistance coverage cannot be waived. *Id.* § 1396r-6(c)(1).

[16] *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994); *see* 42 U.S.C. § 1315(a) (§ 1115(a) of the Social Security Act).

[17] *See generally Aguayo v. Richardson*, 473 F.2d 1090 (2nd Cir. 1973). In fact, by the late 1980's "virtually all states" had applied for and received waivers to apply more stringent work requirements to AFDC populations than were required under federal law. RICHARD MOFFITT, NATIONAL BUREAU OF ECONOMIC RESEARCH, MEANS-TESTED TRANSFER PROGRAMS IN THE UNITED STATES: THE TEMPORARY ASSISTANCE FOR NEEDY FAMILIES PROGRAM 296 (2003), *available at* http://www.nber.org/chapters/c10258.pdf.

[18] UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, STATE WELFARE WAIVERS: AN OVERVIEW, http://aspe.hhs.gov/hsp/isp/waiver2/waivers.htm.

[19] 42 U.S.C. § 682(d)(1)(A) (repealed July 1, 1997).

[20] 42 U.S.C. § 1396-1.

Congress' objective in passing the Medicaid expansion is also clear: it is intended to provide nearly universal coverage for all qualifying adults with incomes below 138% of the poverty line.[21] The ACA also emphasizes access to care, particularly preventive care, and provides an efficient, streamlined system for determining eligibility and reducing "churning," the inefficient movement of people between programs and eligibility statuses.[22] Work requirements would require time-consuming and costly verification procedures, increase levels of churning, and reduce the number of people accessing preventive and other necessary care. None of those outcomes are consistent with the goals of the Medicaid Act or the ACA.

CMS has already addressed questions regarding its willingness to permit states to bar otherwise eligible members of the Expansion group from coverage, and has stated that it "does not anticipate" approving any 1115 waivers that impose enrollment caps or periods of ineligibility for the Expansion group because such barriers do not further the objectives of the Medicaid program.[23] A work requirement would be impermissible for the same reason.

Conclusion

The Medicaid Act provides flexibility in the operation of state Medicaid programs. However, federal law requires state Medicaid agencies to provide coverage to all people eligible under federal law. States are not permitted to add restrictions on eligibility, such as work requirements. When considering a waiver request, the Secretary's duty is to consider first the impact of the proposal on the persons the Medicaid Act "was enacted to protect" – in this case, the persons who would be covered by the ACA Expansion.[24] Work requirements would reduce access to preventive care, decrease efficiency, and complicate the ACA's goal of near-universal coverage under a streamlined system, in defiance of the goals of Congress, the Medicaid Act, and the ACA.

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[21] 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (added by ACA § 2001(a)(1)).

[22] *See generally* ACA § 1001 (reforms to individual and group markets, including coverage of many preventive services); ACA § 1311 (streamlined enrollment).

[23] CENTERS FOR MEDICARE AND MEDICAID SERVICES, AFFORDABLE CARE ACT: STATE RESOURCES FAQ (2013), http://www.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/Affordable-Care-Act-FAQ-enhanced-funding-for-medicaid.pdf. States may desire to impose work requirements for reasons of politics, money or morality, but waivers cannot be granted for those reasons. *See Beno,* 30 F.3d at 1069, Newton-Nations v. Betlach, 660 F.3d 370, 382 (9th Cir. 2011).

[24] *Beno,* 30 F.3d at 1070.