

September 15, 2017

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

Dear Secretary Price:

The undersigned organizations appreciate the opportunity to comment on the MaineCare 1115 Demonstration Project (“the proposal”).

We urge you to reject this proposal because it fails to meet the statutory requirements for an 1115 demonstration and poses a significant danger to the health of low-income Mainers. By the state’s own estimates, as many as 4,600 Mainers could lose coverage due to the proposed policies, and the true number is likely to be significantly higher. It is clear from the state’s proposed goals, hypotheses, and policies that this proposal would not promote the objectives of the Medicaid program.

MaineCare’s Proposed Goals Are Inappropriate and Fail to Promote the Objectives of the Medicaid Program

Criteria developed by the Centers for Medicare & Medicaid Services guide the HHS Secretary in determining whether proposals for 1115 demonstration projects promote the objectives of the Medicaid program as required under section 1115. Under these criteria, a demonstration project must:

- Increase and strengthen overall coverage of low-income individuals in the state;
- Increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid beneficiaries and low-income populations in the state;
- Improve health outcomes for Medicaid beneficiaries and other low-income populations in the state; *or*
- Increase the efficiency and quality of care for Medicaid beneficiaries and other low-income populations through initiatives to transform service delivery networks.¹

The goals and hypotheses in Section VIII of Maine’s proposal along with the state’s proposed policies fail to meet these criteria. Limiting eligibility and requiring Medicaid beneficiaries to “grow accustomed” to paying monthly premiums would not improve health outcomes or expand access to care. Similarly, prior research in other low income benefit programs has shown that imposing work requirements on low-income populations does not increase long-term employment or reduce poverty, and would instead prevent eligible individuals from maintaining Medicaid eligibility. Research has also shown that cost-sharing reduces access to needed care among those in poverty.

Maine attempts to justify reinstating an asset test for large numbers of beneficiaries, which as explained below is not permissible under the Medicaid statute, as well as changes in the treatment of

¹ Centers for Medicare & Medicaid Services, accessed on September 7, 2017, <https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html>.

annuities as a way “to preserve limited financial resources for the State’s most needy individuals, ensuring long-term fiscal sustainability for the MaineCare program.” This too is an improper purpose for an 1115 waiver. The financing structure of the Medicaid program ensures that all eligible individuals can participate and receive covered services. Maine has a statutory obligation to provide all mandatory benefits to all those who are eligible. Saving money by cutting eligibility or benefits does not promote the objectives of the Medicaid program.

Work Requirements and Time Limits Would Harm People Who Cannot Work

Maine’s proposal would limit eligibility to 3 months in any 36-month period for many low-income adult beneficiaries. The time limit is tied to a work requirement in that adults under age 65 subject to the requirement would lose coverage after three months of non-compliance with the work and reporting requirements, and remain ineligible until they comply. Individuals who can demonstrate that they are pregnant, in a substance use disorder treatment facility, caring for a dependent child under six years old, providing caregiver services, “physically or mentally unable to work,” or receiving disability benefits would be exempt. MaineCare would have flexibility to authorize an additional month of eligibility beyond the three months in “exceptional circumstances” which are not defined.

Maine asserts, without evidence, that earned income would increase for people leaving the program after the state starts limiting Medicaid coverage to three months out of a 36-month period for people who do not work or engage in work-related activities for at least 20 hours a week. The state’s focus on increased wages shows that its proposal is not designed to promote the objectives of Medicaid, which are to ensure that people can obtain needed health care. Moreover, limiting benefits to three months likely wouldn’t lead to increased wages for those who lose coverage but would harm such individuals — and the resulting loss of health coverage could make it harder for them to secure and retain jobs.

Federal law does not permit work requirements in Medicaid. The law defines the factors states can consider in defining who is eligible for Medicaid, and it does not require an individual to be working or seeking work as a permissible factor in determining Medicaid eligibility.² Several states have requested authority to impose work requirements in Medicaid; none have been approved.³

The Secretary should reject the state’s proposal for three primary reasons: a) work requirements are contrary to the goal of Medicaid and would harm Maine’s Medicaid beneficiaries b); Maine’s own data show that the state’s SNAP time limit, which is the model for their Medicaid proposal, significantly harmed families and failed to reduce poverty; and c) the policy would be administratively complex, costly, and likely result in inaccurate determinations of eligibility.

A. Work requirements are contrary to the goal of Medicaid.

² Jane Perkins, “Medicaid Work Requirements: Legally Suspect,” National Health Law Program, March 2017.

³ MaryBeth Musumeci, “Medicaid and Work Requirements,” Kaiser Family Foundation, March 23, 2017, <http://www.kff.org/medicaid/issue-brief/medicaid-and-work-requirements/>; *see also*: Department of Health and Human Services, Letter to Mr. Tom Betlach, September 30, 2016, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/Health-Care-Cost-Containment-System/az-hccc-demo-ext-09302016.pdf>.

Work requirements are contrary to the core mission of Medicaid to provide health coverage to low-income people so they can get the health care services they need. Maine has not expanded Medicaid, so the people subject to the work requirement would primarily be low-income parents and people eligible for family planning services and HIV care — two groups who rely on consistent access to care and medication. The extension of eligibility to people with HIV and those receiving family planning services are intended in part to provide services that avoid future health care costs. Limiting eligibility to these groups for three months would totally undermine the purpose of providing them with coverage and undermine their health.

Research shows that most people with Medicaid coverage who can work do so, and for people who face major obstacles to employment, harsh requirements such as limiting their eligibility for coverage will not help overcome them. Nearly 8 in 10 non-disabled adults with Medicaid coverage live in working families, and nearly 60 percent are working themselves. Of those not working, more than one-third reported that illness or a disability was the primary reason, 28 percent reported that they were taking care of home or family, and 18 percent were in school.⁴

By imposing a time limit on Medicaid eligibility for those who are unemployed, the proposal would harm Mainers who are unable to work. Many adults with Medicaid coverage have health conditions that prevent them from working. For example, an individual with an opioid addiction who loses his job and can't find a placement in a residential treatment facility would not be exempted and could therefore lose access to Medicaid — and any outpatient treatment he was receiving.

The proposal also does nothing to increase the availability of appropriate jobs across the state, or to provide Medicaid beneficiaries with transportation, childcare, education, job search services, or training that may help them find and hold a job. For example, Medicaid beneficiaries living in rural areas without job opportunities or transportation, or American Indians living on a reservation with few available jobs, could lose their Medicaid benefits under this proposal.

The proposal would also harm those who *are* working. The complex rules and required monthly tracking would likely lead to errors and coverage terminations for those who are working or participating in a job training program. If a beneficiary does not understand that they must report participation or an eligibility worker fails to properly record whether each month counts against a beneficiary's time limit, working individuals may erroneously lose coverage and face additional burdens in proving their eligibility.

Maine's proposal could end up keeping people from gaining employment: without health services, making it much more difficult for them to find and hold a job. Ohio's Department of Medicaid found that three-quarters of Medicaid beneficiaries who received care under the state's Medicaid expansion and those who were looking for work reported that Medicaid made it easier to

⁴ Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, February 2017, <http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/>.

do so. For those who were currently working, more than half said that Medicaid made it easier to keep their jobs.⁵

B. Maine has already demonstrated the harm of a time limit in SNAP.

The state claims that “When Maine implemented work requirements for able-bodied adults without dependents in SNAP, the earned income of those who left SNAP rose 114% in just one year.” The state’s data don’t support the claim that wages rose dramatically for those subject to the time limit. The authors of the Maine report and the accompanying materials from the Maine Department of Health and Human Services overstate the impact of the time limit by failing to take into account the fact the changes would have occurred even without it. Moreover, there is evidence that hardship among those who lost benefits increased.

In October 2014, Maine began limiting adults without dependent children to just three months of SNAP unless they were working, or could find a spot in a work training program or a place to perform sufficient community service. As a result, thousands of adults lost their food assistance after three months. A Heritage Foundation report cited Maine Department of Health and Human Services data showing that the number of “able-bodied adults without dependents on food stamps” dropped by 80 percent (from about 13,300 in late 2014 to 2,700 in March 2015).⁶ State data show that work rates among those who lost benefits barely increased after the time limit took effect.

There’s no evidence that the adults who found work wouldn’t have found it anyway in an improving economy, as many low-income adults work when they can, often in low-wage jobs with high turnover. One survey of food pantry users in Maine found that over half of those who were cut off due to the limit were looking for work but couldn’t find it; more than three-quarters reported increased visits to the food pantry in the year they lost benefits.⁷

Work requirements have been evaluated in the Temporary Assistance for Needy Families (TANF) program, and have failed to increase long-term employment or reduce poverty among those subject to the requirement. The same result would be likely in Medicaid.⁸

C. A work requirement would be administratively complex and costly to implement.

⁵ Ohio Department of Medicaid, “Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly,” <http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf>.

⁶ Robert Rector, Rachel Sheffield, and Kevin D. Dayaratna, “Maine Food Stamp Work Requirement Cuts Non-Parent Caseload by 80 percent,” The Heritage Foundation, Backgrounder No. 3091, February 8, 2016, <http://www.heritage.org/research/reports/2016/02/maine-food-stamp-work-requirement-cuts-non-parent-caseload-by-80-percent>; *see also* Dottie Rosenbaum and Ed Bolen, “SNAP Reports Present Misleading Findings on Impact of Three-Month Time Limit,” Center on Budget and Policy Priorities, December 2016, <https://www.cbpp.org/research/food-assistance/snap-reports-present-misleading-findings-on-impact-of-three-month-time>.

⁷ *Ibid.*

⁸ LaDonna Pavetti, “Work Requirements Don’t Cut Poverty, Evidence Shows,” Center on Budget and Policy Priorities, June 2016.

Administering a work requirement will also be burdensome and costly for MaineCare. The policy would require new procedures, system changes, and considerable time from eligibility workers. The state would also need to establish systems for verifying exemptions, screening, tracking, and sanctions.

The administrative challenges associated with implementing work requirements and time limits would be more pronounced in Medicaid than SNAP and TANF, which have struggled with implementation. SNAP and TANF require substantial interactions with participants, including interviews and frequent reporting. Even with this more intensive case management model, states have encountered obstacles to accurately applying these policies. Medicaid currently has a streamlined eligibility determination process which relies heavily on online applications and electronic data verification. State experience implementing work requirements in TANF also suggests that adding similar requirements to Medicaid could cost states thousands of dollars per beneficiary.⁹

States' administration of the SNAP time limit was error prone, applied inaccurately, and led to eligible individuals being denied benefits.¹⁰ When first implemented, FNS did a study and found that policies were "difficult to administer and too burdensome for the States." One of the biggest shifts was tracking benefit receipt over time, rather than circumstances in a single month, which was a fundamental change to program administration.¹¹

Premiums and Cost-Sharing Create Barriers to Care

MaineCare's proposal would require individuals and families with incomes above 50 percent of the poverty line to pay between \$10 and \$40 in monthly premiums. If they aren't able to pay or aren't aware of the requirement, they would be locked out of coverage for 90 days or until any unpaid premiums are paid.

Maine's hypothesis for imposing premiums on low-income Medicaid beneficiaries is, "Members will become accustomed to paying monthly premiums." This hypothesis is inconsistent with the objectives of Medicaid and the criteria for waivers defined by CMS. No state has ever been allowed to bar people with incomes below the poverty line from coverage for failure to pay premiums. Moreover, a robust body of research shows that imposing premiums on low-income individuals creates a barrier to care and fails to improve health outcomes.

⁹ Gayle Hamilton et al., "National Evaluation of Welfare-to-Work Strategies: How Effective Are Different Welfare-to-Work Approaches? Five-Year Adult and Child Impacts for Eleven Programs," Manpower Demonstration Research Corporation, December 2001, Table 13.1.

¹⁰ USDA Office of Inspector General, FNS Controls over SNAP Benefits for Able-Bodied Adults Without Dependents, September 2016, <https://www.usda.gov/oig/webdocs/27601-0002-31.pdf>

¹¹ Mathematica Policy Research, Inc., Imposing a Time Limit on Food Stamp Receipt: Implementation of the Provisions and Effects on Food Stamp Participation (2001)

A recent report from the Kaiser Family Foundation looked at research from 65 papers published between 2000 and March 2017 on the effects of premiums and cost sharing on low-income people enrolled in Medicaid and CHIP. The authors concluded that premiums are a barrier to obtaining Medicaid and CHIP coverage, with the largest effect among those with incomes below poverty. The research shows that while some individuals losing Medicaid or CHIP coverage move to other coverage, others become uninsured. Those with lower incomes are most likely to become uninsured. Once uninsured, people face increased barriers to accessing care, greater unmet health needs and increased financial burdens.¹²

In Oregon, for example, nearly half of adults disenrolled from Medicaid after premiums increased to a maximum of \$20. Many former enrollees became uninsured and faced barriers to obtaining care.¹³ Similarly, a recent study of the Healthy Indiana Plan, which requires adults to pay between \$1 and \$100 in monthly premiums to enroll in a more comprehensive plan, found that 55 percent of eligible individuals either did not make their initial payment or missed a payment.¹⁴

Moreover, recent research shows that state savings from premiums are limited. Studies find that potential increases in revenue from premiums are offset by use of more expensive services, such as emergency room care, costs in other areas, such as resources for uninsured individuals, and administrative expenses.¹⁵ For example, a recent study looking at Arkansas' Independence Accounts found that they were not cost effective to implement. The state collected \$426,457 from eligible enrollees, but spent \$595,135 in co-payment protections.¹⁶ In addition to spending more than it collected, the state spent \$9 million to contract with a vendor to manage the accounts.¹⁷

The research is clear that premiums decrease participation in Medicaid and increase uninsurance and hardship. States should no longer be permitted use 1115 waiver demonstrations to test the effect of premiums in Medicaid.

Emergency Department Copayments Would Deter Needed Care

¹² Samantha Artiga, Petry Ubri and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017, <http://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/>.

¹³ *Op cit.*, Artiga, Ubri, and Zur 2017.

¹⁴ *Ibid.*, see also The Lewin Group, "Healthy Indiana Plan 2.0: POWER Account Contribution Assessment, Prepared for Indiana Family and Social Services Administration (FSSA)," March 2017. Premiums in Healthy Indiana are generally set at 2 percent of household income or \$1 a month for people with incomes below 5 percent of the poverty line.

¹⁵ *Op cit.*, Artiga, Ubri, and Zur 2017.

¹⁶ By making monthly contributions to their accounts, enrollees were "protected," or not required to pay co-payments for services rendered in the subsequent. The \$595,135 represents state spending to offset the enrollee's co-payment obligation.

¹⁷ Joseph Thompson, et al., "Arkansas Experience with Health Savings Accounts in a Medicaid Expansion Population," Arkansas Center for Health Improvement, June 27, 2017, <https://academyhealth.confex.com/academyhealth/2017arm/meetingapp.cgi/Paper/18272>.

The proposal also requests authority to charge a \$10 copayment for emergency department (ED) use for specific diagnoses the state claims are “non-emergent.” Maine states its hypothesis for this policy as, “Non-emergency utilization of the ED will decrease as members are held responsible for an enhanced copayment.” However, this hypothesis is inconsistent with a significant body of prior research showing that imposing copayments creates a barrier to accessing appropriate care. Moreover, under section 1916(f) of the Social Security Act, a state requesting such a waiver must meet the following five criteria:

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

Maine’s proposal does not meet the criteria for a waiver under section 1916(f); in fact, the state does not even acknowledge the criteria for a cost-sharing waiver in its proposal. Moreover, the proposed list of diagnoses that would require beneficiaries to pay the copayment include many diagnoses and symptoms that could indicate emergent conditions. For example, the proposal lists “severe persistent asthma, uncomplicated” as a non-emergent condition. The definition of this condition includes peak expiratory flow readings (in other words, difficulty breathing).¹⁸ However, Mayo Clinic’s guidelines recommend emergency department treatment if peak expiratory flow readings are reduced.¹⁹ Severe persistent asthma is one of many problematic diagnoses listed by the state as “non-emergent.” This proposal could prevent Mainers from getting the emergency care they need.

Maine’s proposal not only fails to meet the statutory criteria for a cost-sharing waiver, it would harm beneficiaries. The review of the literature on premiums and cost-sharing discussed above found that even small levels of cost sharing, in the range of \$1 to \$5, are associated with reduced use of care, including necessary services. The review cites numerous studies that have found that cost sharing has negative effects on individuals’ abilities to access needed care and health outcomes, and increases financial burdens for families.²⁰

Federal Law Doesn’t Allow the Asset Test Maine is Proposing

The proposal would impose a \$5,000 asset test on beneficiaries even though the Affordable Care Act (ACA) explicitly prohibits the Health and Human Services (HHS) Secretary from granting waivers to allow them.²¹ The ACA eliminated asset tests and made other changes to Medicaid rules

¹⁸ Michigan Medicine, University of Michigan, Quick Reference Charts for the Classification and Stepwise Treatment of Asthma, https://www.med.umich.edu/1info/FHP/practiceguides/asthma/EPR-3_pocket_guide.pdf.

¹⁹ Mayo Clinic, Asthma Attack – Symptoms and Causes, <http://www.mayoclinic.org/diseases-conditions/asthma-attack/symptoms-causes/dxc-20257812>.

²⁰ Op cit., Artiga, Ubri, and Zur 2017.

²¹ Social Security Act, Title XIX, Section 1902(e)(14)(F)

for most beneficiaries to align eligibility for Medicaid, the Children’s Health Insurance Program, and subsidized marketplace coverage for children and adults in order to create a system where people can easily transition between insurance affordability programs as their incomes and circumstances change. Allowing an asset test in Medicaid would undermine this system, and states cannot vary from the ACA’s rules.

Retroactive Eligibility and Presumptive Eligibility are Crucial for Beneficiaries and Providers

MaineCare’s proposal would end Medicaid payments for medical costs that beneficiaries incurred up to three months before enrolling in Medicaid if they were eligible for Medicaid during that period. The state also proposes to prevent hospitals from enrolling uninsured adults (other than pregnant women) into temporary Medicaid coverage while they complete the Medicaid eligibility determination process.

Retroactive coverage helps prevent medical bankruptcy. It also reimburses hospitals and other safety net providers for care they have provided during the period, helping them continue to meet their daily operating costs and maintain quality of care. While this Medicaid protection may only affect a small number of individuals, the amounts can be significant. For example, data from Indiana showed that, on average, individuals with medical bills incurred prior to enrollment owed \$1,561 to providers, which Medicaid would pay.²²

Similarly, the presumptive eligibility process allows uninsured adults to enroll immediately in coverage by answering a set of questions at the hospital or other safety net provider. If the individual appears eligible, the hospital can make a “presumptive” eligibility determination, which helps prevent a delay in care while the state conducts a full eligibility determination. During this temporary coverage period, providers (including hospitals, doctors, and pharmacies) receive full Medicaid reimbursement for services they provide, even if the individual is later found ineligible for Medicaid. Eliminating presumptive eligibility could be financially devastating for uninsured individuals admitted to the hospital who are eligible for Medicaid particularly if coupled with elimination of retroactive coverage, and it would harm hospitals by increasing uncompensated care.

Thank you for your willingness to consider our comments. We urge you to reject the MaineCare proposal and protect the Mainers who rely on Medicaid. If you need additional information, please contact Judy Solomon (Solomon@cbpp.org) or Joan Alker (jca25@georgetown.edu).

American Heart Association
Center on Budget and Policy Priorities
Children's Defense Fund
Disability Rights Maine
Epilepsy Foundation

²² July 29, 2016 letter from the Centers of Medicare and Medicaid Services to the state of Indiana, available at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf>.

Epilepsy Foundation New England
First Focus
Georgetown University Center for Children and Families
HIV Medicine Association
Justice in Aging
Maine Chapter, American Academy of Pediatrics
National Association of Community Health Centers
National Center for Law and Economic Justice
National Council for Behavioral Health
National Disability Rights Network
National Health Care for the Homeless Council
National Multiple Sclerosis Society
National Partnership for Women & Families
Service Employees International Union