

January 17, 2020

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

Dear Secretary Azar:

The undersigned organizations appreciate the opportunity to comment on Nebraska's proposed section 1115 demonstration project, known as the Heritage Health Adult (HHA) program. Rather than quickly implementing Medicaid expansion as approved by voters in November 2018, Nebraska is pursuing this demonstration that would provide a less comprehensive benefit package to beneficiaries who don't satisfy a work requirement and a set of "wellness" activities. Once fully implemented, we count nine different requirements that a beneficiary would have to meet. Nebraska's proposal also proposes to waive retroactive coverage for those eligible under expansion and a large number of *currently* eligible Medicaid groups, including some of the program's most vulnerable beneficiaries like people with disabilities and individuals needing treatment for breast and cervical cancer.

Nebraska says the purpose of its proposed demonstration is to improve the health of beneficiaries and reduce the cost of care generally, but evidence from other states that have pursued similar demonstrations shows it is unlikely the demonstration would achieve these goals. For example, Indiana has a similarly complex tiered benefit Medicaid waiver and evidence has consistently showed that its program hasn't led to more efficient use of health care services or improved health outcomes; the main outcome is confusion among beneficiaries about which services Medicaid covers and what steps they have to take to maintain access to those services. We therefore urge CMS to reject Nebraska's demonstration request.

A Work Requirement and a Complex Incentive Structure Will Deny Needed Health Services to Thousands of Nebraskans

Under Nebraska's proposal, upon enrollment most Medicaid expansion beneficiaries would receive the "Basic" benefit package that covers services provided through the state plan, except for dental, vision, and over-the-counter medications. Beneficiaries would move to the "Prime" package that covers these additional services if they demonstrate participation in wellness activities and, beginning in the second year of the demonstration, meet a stringent work requirement.

The Basic and Prime benefit tiers Nebraska proposes are similar to the structure of Indiana's Medicaid expansion waiver, where beneficiaries living in poverty are provided an enhanced benefit package if they make a monthly premium payment into a "POWER" account, while beneficiaries with income above the poverty line lose coverage if they don't pay their premiums. Only 60 percent of respondents to a survey said they had heard of the POWER Accounts, according to a 2016 evaluation of Indiana's program. Those who said they'd heard of the accounts were asked whether they have one, and only about three-quarters of those who had heard of the accounts said they did. This means that fewer than half of all enrollees (three-quarters of the 60 percent who had heard of the accounts) even knew they had an account, when *all* enrollees have one. Large shares of respondents also showed a lack of understanding when answering a series of true-false questions

about their POWER Accounts.¹ This is similar to the beneficiary experience under Iowa’s Medicaid expansion waiver where individuals with incomes above the poverty line have to complete a health risk assessment and, if they don’t, their coverage is terminated if they don’t pay a monthly premium. A survey of those who lost coverage found that only a third said they were aware of the requirements before losing coverage.²

A study from the Kaiser Family Foundation based on interviews with beneficiaries and providers in Arkansas found beneficiaries were unaware of the requirement that they work 80 hours a month in order to maintain their Medicaid coverage and didn’t understand the steps they needed to take to demonstrate compliance.³ This goes a long way in explaining why more than 18,000 people lost coverage under the state’s waiver. Similar research from the Urban Institute indicates the majority of beneficiaries did not understand the requirements or did not think they were subject to the requirements. As a result, many individuals only discovered they were disenrolled when they sought medical care.⁴ A similar situation occurred in New Hampshire where many beneficiaries reportedly didn’t know about the work requirement or received confusing and often contradictory notices about whether they were subject to it.⁵ These problems are likely to be worse under Nebraska’s proposal because the state intends to keep beneficiaries in the Basic plan if they fail to meet the work requirement after just one month in addition to having to meet other the other wellness requirements.

Under Nebraska’s proposal, managed care plans will be responsible for helping beneficiaries comply with the wellness activities that will keep them eligible for Prime coverage, like by providing case management. Beneficiaries must also attend an annual health visit, select a primary care provider, and not miss more than three appointments in a year in order to receive Prime coverage. Research shows that states that created similarly complex incentives programs had trouble identifying and engaging beneficiaries to participate due to inaccurate contact information, changes in beneficiaries’ eligibility or health status, and difficulties identifying eligible individuals.⁶ It is thus

¹ The Lewin Group, “Indiana Healthy Indiana Plan 2.0: Interim Evaluation Report,” July 6, 2016, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-interim-evl-rpt-07062016.pdf>.

² Natoshia M. Akelson, *et al.*, “Purged from the Rolls: A Study of Medicaid Disenrollment in Iowa,” *Health Equity*, 2019, <https://www.liebertpub.com/doi/pdf/10.1089/heq.2019.0093>.

³ MaryBeth Musumeci, Robin Rudowitz, and Barbara Lyons, “Medicaid Work Requirements in Arkansas: Experience and Perspectives of Enrollees,” Kaiser Family Foundation, December 18, 2018, <https://www.kff.org/medicaid/issue-brief/medicaid-work-requirements-in-arkansas-experience-and-perspectives-of-enrollees/>.

⁴ Ian Hill, and Emily Burroughs, “Lessons from Launching Medicaid Work Requirements in Arkansas,” Urban Institute, October 2019, <https://www.urban.org/research/publication/lessons-launching-medicaid-work-requirements-arkansas>.

⁵ Dave Solomon, “Spreading the word on Medicaid work requirement proves challenging,” *Union Leader*, June 16, 2019, https://www.unionleader.com/news/health/spreading-the-word-on-medicaid-work-requirement-proves-challenging/article_740b99e7-9f48-52d4-b2d8-030167e66af8.html; Jason Moon, “Confusing Letters, Frustrated Members: N.H.’s Medicaid Work Requirement Takes Effect,” New Hampshire Public Radio, June 18, 2019, <https://www.nhpr.org/post/confusing-letters-frustrated-members-nhs-medicaid-work-requirement-takes-effect#stream/0>.

⁶ Melinda Buntin, John Graves, and Nikki Viverette, “Cost Sharing, Payment Enforcement, and Healthy Behavior Programs in Medicaid: Lessons from Pioneering States,” Vanderbilt University, June 2017.

highly likely that providers and beneficiaries will be confused about their responsibilities under Nebraska’s proposal, and that the demonstration will not achieve its stated goals.

While Nebraska says the goals of its waiver proposal are to improve health outcomes and improve financial security among beneficiaries, there is substantial evidence that Medicaid coverage itself accomplishes these goals. For example, a recent study found Medicaid expansion saved the lives of at least 19,200 adults aged 55-64 from 2014-2017. Other studies found that expansion increased the share of low-income adults getting regular check-ups and other preventive care and decreased the share of adults screening positive for depression, among other positive health outcomes.⁷ Medicaid expansion is also associated with improved postpartum coverage than can help reduce maternal mortality.⁸ And studies have found that Medicaid expansion is a powerful anti-poverty tool as it reduced medical debt by \$1,140 per person among those who gained Medicaid coverage⁹ and reduced evictions among low-income renters.¹⁰

Medicaid coverage has also been shown to support employment. Surveys of Medicaid expansion beneficiaries in Ohio and Michigan, for example, show that coverage has made it easier for people who are unemployed to find work, and for people who have a job to maintain their employment. A recent study examining the impact of Michigan’s Medicaid expansion found that 69 percent of enrollees said having health insurance through Medicaid helped them do a better job at work and the majority of those who were out of work reported that having Medicaid made them better able to look for a job.¹¹ Another Michigan study shows that expansion particularly benefits people with chronic health conditions — finding that 76 percent of survey respondents with a behavioral health condition who were employed reported that having Medicaid coverage improved their ability to perform well at work.¹²

Waiving Retroactive Eligibility Will Send Low-Income Beneficiaries into Medical Debt and Increase Providers’ Uncompensated Care Costs

Nebraska proposes to waive retroactive eligibility not just for individuals gaining coverage through the Medicaid expansion, but also a number of groups currently eligible for Medicaid in the state, including parents, medically needy individuals, people with disabilities and seniors. Retroactive

⁷ Matt Broaddus and Aviva Aron-Dine, “Medicaid Expansion Has Saved at Least 19,000 Lives, New Research Finds,” Center on Budget and Policy Priorities, November 6, 2019, https://www.cbpp.org/research/health/medicaid-expansion-has-saved-at-least-19000-lives-new-research-finds#_ftn13.

⁸ Sarah Gordon, *et al.*, “Effects of Medicaid Expansion on Postpartum Coverage And Outpatient Utilization,” *Health Affairs*, January 2020, <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00547>.

⁹ Luoia Hu, *et al.*, “The Effect of the Affordable Care Act Medicaid Expansions on Financial Wellbeing,” *Journal of Public Economics*, May 2018, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6208351/>.

¹⁰ Heidi Allen, *et al.*, “Can Medicaid Expansion Prevent Housing Evictions?,” *Health Affairs*, September 2019, <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05071>.

¹¹ Tipirneni, R. *et al.* “Changes in Health and Ability to Work Among Medicaid Expansion Enrollees: A Mixed Methods Study” *Journal of General Internal Medicine*, December 5th, 2018.

¹² Tipirneni, R. *et al.*, “Association of Expanded Medicaid Coverage with Health and Job-Related Outcomes Among Enrollees with Behavioral Health Disorders,” *Psychiatric Services*, September 25, 2019, <https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201900179>.

eligibility prevents gaps in coverage and increases financial security for both beneficiaries and health care providers by retroactively covering individuals for up to 90 days, assuming the individual is eligible for Medicaid during that time. In proposing to waive retroactive coverage Nebraska hypothesizes without any evidence that the availability of retroactive eligibility causes healthy people to wait to enroll in coverage until they are sick, therefore driving up costs when they get coverage. Eliminating the provision, the state posits, will therefore bring down costs and improve continuity of coverage.

If the purported goal of waiving retroactive coverage is to test approaches to change behavior to ensure greater continuity of coverage, the state would have to undertake an expensive public education campaign targeted at individuals who might spend down or have a serious medical condition (a very large segment of the population) to ensure that they understood complex Medicaid eligibility rules and/or demonstrate that a large segment of the state's population already understands these rules and is making decisions based on this information. Nebraska's proposal does nothing of the kind, thus waiving retroactive eligibility cannot be considered a serious research and demonstration undertaking.

In fact, there is no evidence that retroactive coverage causes eligible people to wait to enroll in Medicaid. Oftentimes, individuals are not aware of their Medicaid eligibility until they encounter the health care system or experience a medical event. In some cases, especially for people with disabilities and seniors, people have to spend down their resources before they become eligible. These individuals often don't know exactly when to apply, because they don't know when their eligibility will begin.

Retroactive eligibility ensures that these and other individuals, who may be experiencing a series of health events prior to learning they may be eligible for Medicaid, do not become burdened by medical debt. *Without retroactive eligibility, some Nebraskans will likely face periods of uninsurance that could be costly not just to themselves, but to providers in the form of uncompensated care as well.*

Additionally, there is no evidence that retroactive eligibility negatively impacts state budgets as critics suggest. While Nebraska projects that waiving retroactive coverage will save money, the state's projected trend in per member per month spending growth remains the same. This means the lower expenditures are a result of an anticipated 5 percent drop in member months due to the elimination of retroactive coverage. The elimination of those months of retroactive eligibility will likely shift millions of dollars of bad debt and uncompensated care to providers along with reduced financial security for Medicaid beneficiaries due to medical debt. When the state of Ohio was considering waiving retroactive eligibility in 2016, a consulting firm advised that hospitals could wind up with as much as \$2.5 billion more in uncompensated care costs over the five-year waiver period.¹³ CMS ultimately disapproved the Ohio waiver amendment.

CMS has approved waivers of retroactive coverage in Arizona, Florida, Indiana, Iowa, and New Mexico, but hardly any data exists that shows the impact on beneficiaries and providers. When Iowa

¹³ Virgil Dickson, "Ohio Medicaid waiver could cost hospitals \$2.5 billion," *Modern Healthcare*, April 22, 2016, <https://www.modernhealthcare.com/article/20160422/NEWS/160429965/ohio-medicaid-waiver-could-cost-hospitals-2-5-billion>.

was first allowed to waive retroactive eligibility in 2017 it projected doing so would save the federal government \$36 million. But Iowa hasn't conducted an analysis of whether those cost savings materialized, or what the impact on providers and beneficiaries has been.¹⁴ CMS didn't require Iowa to conduct an evaluation of that aspect of the state's waiver and it was only this past November that CMS told Iowa that it would require an evaluation going forward.¹⁵

Given the potential harm to beneficiaries and providers and the lack of detail in Nebraska's proposal about any serious research effort to learn from this thinly veiled benefit cut, we urge CMS not to approve Nebraska's proposal.

Concerns Raised During the Public Comment Period Were Ignored by the State

As required by federal law, Nebraska held a 30-day public comment period on its demonstration proposal, which ended on November 26, 2019. The state received 430 written comments which were overwhelmingly opposed to the proposals to allow the state to condition a person's dental and vision benefits on meeting a work requirement, and on the proposal to waive retroactive eligibility. Commenters encouraged the state to instead implement the Medicaid expansion without a waiver. Despite the overwhelming opposition to the waiver and the specific issues raised in the comments, the state submitted a proposal to HHS with few substantive changes.

Our comments include citations to supporting research, including direct links to the research for HHS' benefit in reviewing our comments. We direct HHS to each of the studies cited and made available to the agency through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act.

Thank you for your willingness to consider our comments. If you need additional information, please contact Judy Solomon (Solomon@cbpp.org) or Joan Alker (jca25@georgetown.edu).

Autistic Self Advocacy Network
Center on Budget and Policy Priorities
Community Catalyst
Families USA
First Focus on Children
Georgetown University Center for Children and Families
Guttmacher Institute
HIV Medicine Association
March of Dimes
National Association of Community Health Centers
National Employment Law Project

¹⁴ Harris Meyer, "New Medicaid barrier: Waivers ending retrospective eligibility shift costs to providers, patients," *Modern Healthcare*, February 9, 2019, <https://www.modernhealthcare.com/article/20190209/NEWS/190209936/new-medicaid-barrier-waivers-ending-retrospective-eligibility-shift-costs-to-providers-patients>.

¹⁵ Centers for Medicare and Medicaid Services, Iowa Wellness Plan Demonstration Approval letter, November 15, 2019, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-wellness-plan-ca.pdf>.

National Health Care for the Homeless Council
National Multiple Sclerosis Society
Raising Women's Voices for the Health Care We Need