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September 16, 2017

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

RE: ***MaineCare 1115 Demonstration Project Application***

Dear Secretary Price:

We appreciate the opportunity to comment on the MaineCare 1115 Demonstration Project Application. The National Health Law Program (NHeLP) protects and advances the health rights of low-income and underserved individuals. One of the oldest non-profits of its kind, NHeLP advocates, educates, and litigates at the federal and state levels.

NHeLP recommends that HHS not approve the MaineCare 1115 Demonstration Project Application. This application is fundamentally flawed; it exceeds the bounds of § 1115 waivers and would be harmful to low-income people who need Medicaid coverage to obtain health care.

I. HHS authority and § 1115

To be approved pursuant to § 1115, Maine's application must:

- propose an "experiment[], pilot or demonstration,"
- waive compliance only with requirements in 42 U.S.C. § 1396a,
- be likely to promote the objectives of the Medicaid Act, and
- be approved only "to the extent and for the period necessary" to carry out the experiment.[1]

The purpose of Medicaid is to enable states to furnish medical assistance to individuals who are too poor to meet the costs of necessary medical care and to furnish such assistance

[1] 42 U.S.C. § 1315(a).

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and services to help these individuals attain or retain the capacity for independence and self-care.[2] As explained below, Maine's proposals to impose work requirements, charge individuals a premium and impose a lock-out period for failure to pay, charge emergency room copayments, eliminate retroactive eligibility, reinstate the asset test, eliminate presumptive eligibility, and penalize protected annuities cannot be approved because, separately and together, they are inconsistent with the provisions of § 1115.

II. Work Requirements and Lock-Out Penalty

Maine proposes requiring "able-bodied" adults aged 19-64 to engage in at least 20 hours of work or other approved activities each week.[3] Failure to engage in these activities after three months during a 36-month period will result in termination of MaineCare coverage. Individuals will only be able to regain eligibility by waiting until the end of the 36-month period or by engaging in approved work or other activities.

The Secretary must deny this proposal. Maine and HHS lack the statutory authority to impose work requirements; the requirements are contrary to the objectives of Medicaid; and they have no legitimate experimental purpose.

Under § 1115 and other relevant law, HHS has no authority to approve a waiver permitting Maine to condition Medicaid eligibility on compliance with work activities (and, thus, has never done so). Work requirements are an illegal condition of eligibility beyond the Medicaid eligibility criteria clearly enumerated in federal law. Medicaid is a medical assistance program, and although states have flexibility in designing and administering their Medicaid programs, the Medicaid Act requires that they provide medical assistance to all individuals who qualify under federal law. As courts have held, additional eligibility requirements are illegal.[4]

Work requirements cannot be imposed through the Secretary's waiver authority because those requirements are directly at odds with the objectives of the Medicaid Act.[5] As noted earlier, the purpose of Medicaid is to enable states to furnish medical assistance to low-income individuals who cannot afford the costs of medically necessary services and to furnish "rehabilitation and other services to help [such individuals] attain or retain capability for independence or self-care.[6] Conditioning Medicaid eligibility on completion of a work requirement gets it exactly backwards by blocking access to the care and services that help individuals attain and retain independence or self-care and, as a result, be able to work. Research confirms that Medicaid coverage allows individuals to obtain and maintain

[2] See 42 U.S.C. § 1396-1.
[3] MaineCare 1115 Demonstration Project Application, August 1, 2017 (hereinafter "Application").
[4] See, *e.g.*, *Camacho v. Texas Workforce Comm'n,* 408 F.3d 229, 235 (5th Cir. 2005) (enjoining Texas regulation that terminated Medicaid coverage of TANF recipients who were substance abusers or whose children did were not getting immunizations, check-ups, or were missing school because regulation was inconsistent with Medicaid and TANF statutes).
[5] By contrast, as far back as the 1970s, states obtained Section 1115 waivers to test work requirements in the AFDC program (which, unlike Medicaid, does have work promotion as a purpose of the program). These waivers required states to conduct "rigorous evaluations of the impact," typically requiring the random assignment of one group to a program operating under traditional rules and another to a program using the more restrictive waiver rules. United States Dep't of Health & Human Servs., *State Welfare Waivers: An Overview*, http://aspe.hhs.gov.hsp/isp/waiver2/waivers.htm.
[6] 42 U.S.C. § 1396-1.

employment. For example, more than half of individuals enrolled in the Medicaid expansion in Ohio reported that Medicaid coverage made it easier to continue working. Among enrollees who did not have a job, three-quarters reported that Medicaid coverage made it easier for them to look for one.[7]

Moreover, the vast majority of individuals enrolled in Medicaid already work or have good reason for not working.[8] A recent study by the Kaiser Family Foundation found that 35% of adult Medicaid enrollees who were not receiving disability benefits and did not have a job reported illness or disability as their primary reason for not working.[9]

While the application indicates that the work requirements will not apply to individuals who are receiving disability benefits or who are physically or mentally unable to work, evidence from other programs with similar exemptions shows that, in practice, these exemptions are expensive to administer and ineffective.[10] Individuals with disabilities are not exempted as they should and are more likely than other individuals to lose benefits.[11]

Numerous studies of state Temporary Assistance for Needy Families (TANF) programs have found that participants with physical and mental health issues are disproportionately likely to be sanctioned for not completing the work requirement.[12] Such individuals may not understand what is required of them, may find it difficult to complete the necessary paperwork or to travel to appointments to be assessed for an exemption.

In fact, a study of Maine's own TANF program revealed that "hardship" extensions were not effective at protecting individuals with a disability. Data provided by Maine Department of Health and Human Services (DHHS) indicates that while nearly 90% of parents receiving TANF for five years or longer have a disability themselves or are caring for a disabled family member, only 17% of families terminated due to the time limits

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[7] Ohio Dep't of Medicaid, *Ohio Medicaid Group VII Assessment: A Report to the Ohio General Assembly*, (2017), http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf. Additional evidence disproves Maine's apparent assumption that Medicaid serves as a deterrent to work. Medicaid enrollment fluctuates with the economy - enrollment increases during economic recessions and the resultant losses in jobs and employer-sponsored insurance. Kaiser Family Foundation, *The Role of Medicaid in State Economies: A Look at the Research*, January 2009, at 2 *available at https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7075_02.pdf*.

[8] Rachel Garfield, Kaiser Family Found., *Understanding the Intersection of Medicaid and Work* (2017), http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work (finding that almost 80% of adults who are enrolled in Medicaid, but do not receive SSI, live in families with at least one worker, and almost 60% are working themselves).

[9] *Id*.

[10] *See, e.g.,* Hannah Katch, "Medicaid Work Requirement Would Limit Health Care Access Without Significantly Boosting Employment," Center on Budget and Policy Priorities (July 2016), *available at* https://www.cbpp.org/research/health/medicaid-work-requirement-would-limit-health-care-access-without-significantly (noting that "State experience in implementing the TANF work requirements suggests that adding similar requirements to Medicaid could cost states thousands of dollars per beneficiary.").

[11] *See, e.g.*, Andrew J. Cherlin et. al., *Operating within the Rules: Welfare Recipients' Experiences with Sanctions and Case Closings*, 76 Soc. Serv. Rev. 387, 398 (finding that individuals in "poor" or "fair" health were more likely to lose TANF benefits than those in "good," "very good," or "excellent health").

[12] *See, e.g.*, Yeheskel Hasenfeld et al., *The Logic of Sanctioning Welfare Recipients: An Empirical Assessment* (June 2004) (Departmental Paper University of Pennsylvania School of Social Policy and Practice), http://repository.upenn.edu/cgi/viewcontent.cgi?article=1028&context=spp_papers.

received a disability-related extension.[13] Several beneficiaries reported being denied disability-related extensions, though they were in the process of applying—and were ultimately approved—for SSI benefits.[14] Furthermore, beneficiaries reported being discouraged from applying for extensions by DHHS caseworkers and confusion about the process for applying for hardship extensions.[15]

Similar problems have been found in the Supplemental Nutrition Assistance Program (SNAP). This is particularly relevant, as the MaineCare work requirement is intended to mirror the work requirement in Maine's SNAP program. Researchers have expressed concern that states might incorrectly determine that many of the nearly 20% of SNAP participants who have a disability, but do not receive disability benefits, are subject to the work requirement.[16] One study from Franklin County, Ohio found that one-third of individuals referred to a SNAP employment and training program in order to keep their benefits reported a physical or mental limitation, and 25% of these individuals indicated that the condition limited their daily activities. Additionally, almost 20% of the individuals had filed for SSI or SSDI within the previous two years.[17] We also note that the proposed MaineCare waiver provision is broader than the comparable SNAP program. Maine proposes including individuals up to age 64, while the comparable SNAP provision stops at age 49. The expanded scope of Maine's proposal raises further concerns about individuals with chronic conditions.

In light of these documented problems, Maine's assertion that "[t]he Department will monitor the implementation of these exemptions and carefully consider any internal processes to avoid any unintended consequences" rings hollow.[18] And, because conditioning Medicaid eligibility on completion of the work requirement will disqualify individuals with chronic and disabling conditions, the requirement implicates the civil rights protections contained in the Americans with Disabilities Act (ADA) and § 504 of the Rehabilitation Act.[19] These laws make it illegal for states to take actions that have a discriminatory impact on people with disabilities, and they cannot be waived or ignored under § 1115 or under any other authority of the Secretary.[20]

In addition, extensive research reveals that a mandatory work requirement does not effectively increase self-sufficiency. Numerous studies of cash assistance programs have already established that a work requirement does little to increase stable, long-term

[13] McLaughlin, J.C. & Butler, S.S., "Families in focus: Moving beyond anecdotes: Lessons from a 2010 survey of Maine TANF families." Augusta, Maine: Maine Equal Justice Partners and Maine Women's Lobby; Sandra S. Butler, "TANF Time Limits, One Year Later: How Families are Faring," www.mejp.org/sites/default/files/TANF-Time-Limits-Study-March2014.pdf.

[14] McLaughlin, J.C. & Butler, S.S., "Families in focus: Moving beyond anecdotes: Lessons from a 2010 survey of Maine TANF families." Augusta, Maine: Maine Equal Justice Partners and Maine Women's Lobby.

[15] *Id.*

[16] Michael Morris et al., Burton Blatt Inst. at Syracuse Univ., *Impact of the Work Requirement in Supplemental Nutrition Assistance (SNAP) on Low-Income Working-Age People with Disabilities,* 4, 14 (2014).

[17] Ohio Association of Foodbanks, *Comprehensive Report: Able-Bodied Adults Without Dependents* (2015), http://admin.ohiofoodbanks.org/uploads/news/ABAWD_Report_204-2015-v3.pdf.

[18] Application at 38.

[19] 42 U.S.C. § 12312; Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 (prohibiting recipients of federal funds from discriminating on the basis of disability).

[20] See *Burns-Vidlak v. Chandler*, 939 F. Supp. 765, 772 (D. Haw. 1996).

employment and does not decrease poverty.[21] In fact, work requirements have had the reverse effect leading to an increase in extreme poverty in some areas of the country, as individuals who do not secure employment lose their eligibility for cash assistance.[22]

In its application, Maine appears to rely on a preliminary evaluation of its SNAP work requirement as evidence that a mandatory work requirement is effective.[23] However, two recent analyses show that the evaluation was based on flawed and unreliable data, and as a result, reached flawed and misleading conclusions.[24] By contrast, evidence from Wisconsin's SNAP employment and training program is instructive.[25] Between April 1, 2015 and March 31, 2017, only approximately 18,299 participants gained employment. This number includes both the SNAP recipients who were required to participate in the program and voluntary enrollees. Over the same time period, the work requirement and time limit for childless adults caused more than three times the number of participants—over 70,000 individuals—to lose access to critical food assistance.[26]

A far better, evidence-based approach would be to connect MaineCare enrollees to properly resourced voluntary employment programs, an activity that does not need waiver approval from CMS. Studies show that these voluntary employment programs increase employment and income among low-income individuals. For example, a rigorous evaluation of Jobs Plus, a voluntary employment program for public housing residents, found that the program produced substantial and sustained gains in earnings when fully implemented.[27] The State also has the option to offer supportive employment services under § 1915(i) of the Social Security Act.

In summary, the proposed work requirements stand Medicaid's purpose on its head by creating barriers to coverage and the pathway to health that the coverage represents. The end result of this policy will be fewer people with MaineCare coverage and more people seeking uncompensated care in hospitals and FQHCs. There will be more gaps in coverage, meaning more expensive treatment when eligibility is eventually regained. Hospitals and community health centers will suffer financially as they are expected to treat more people with chronic or acute illness with less funding.

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[21] LaDonna Pavetti, Ctr. on Budget & Pol'y Priorities, *Work Requirements Don't Cut Poverty, Evidence Shows* (2016); Sandra K. Danziger et al., *From Welfare to a Work-Based Safety Net: An Incomplete Transition*, 35 J. Pol'y Analysis & Management 231, 234 (2016).
[22] *Id.*
[23] *See* Application at 5 (asserting that earned income increased for SNAP members following work requirements); "Welfare to Work: Preliminary Analysis of Work Requirements on the Wage and Employment Experiences of Able- Bodied Adults Without Dependents (ABAWDs) in Maine." Governor's Office of Policy and Management, Apr. 19, 2016.
[24] *Incomplete and Misleading: Analysis of the Maine Office of Policy and Management's "Welfare to Work" Study* by James Mayall, May 2017, published by the Maine Center on Economic Policy; and *SNAP Reports Present Misleading Findings on Impact of Three-Month Time Limit*, by Dottie Rosenbaum Ed Bolen, Dec. 14, 2016, *available at* http://www.cbpp.org/research/food-assistance/snap-reports-present-misleading-findings-on-impact-of-three-month-time.
[25] *FoodShare Employment and Training (FSET) Program Cumulative Data*, Wisc. Dep't of Health Servs. (May 5, 2017), https://www.dhs.wisconsin.gov/initiatives/fset-cumulative.htm.
[26] *Id.*
[27] Howard Bloom et al., MDRC, *Promoting Work in Public Housing: The Effectiveness of Jobs-Plus* (2005), https://www.doleta.gov/research/pdf/jobs_plus_3.pdf; James A. Riccio, MDRC, *Sustained Earnings Gains for Residents in a Public Housing Jobs Program: Seven-Year Findings from the Jobs-Plus Demonstration* (2010), http://files.eric.ed.gov/fulltext/ED514703.pdf.

III. Premiums and Lock-Out Penalty

Maine's proposal to impose premiums is not a proper use of a § 1115 waiver. Beginning at 51% FPL, Maine seeks to impose premiums on able-bodied individuals between the ages of 19-64, including parents, children ages 19 & 20, adults seeking family planning services, and former foster care children. Under the proposal, non-payment of the premiums bars coverage for 90 days, or until the amount is paid, whichever comes first.

As with the work requirements, Maine's proposal exceeds statutory limits on § 1115 waivers, does not promote the objectives of the Medicaid Act, and is not experimental.

As stated above, § 1115 only permits the Secretary to waive compliance with the requirements of 42 U.S.C. § 1396a. But the statutory authorizations for premiums are contained in independent, free-standing requirements set forth at 42 U.S.C. §§ 1396o, 1396o-1. While these statutes provide states with a great deal of flexibility to impose premiums and cost sharing, they prohibit imposing premiums on persons with incomes below 150% FPL. The Secretary should deny this request because he does not have the authority to grant it under § 1115.

The premiums are also not experimental and not likely to advance the objectives of the Medicaid Act. An ample body of research already clearly demonstrates that the imposition of premiums on very low-income populations only reduces access to coverage.[28] This longstanding and redundant research consistently reaches the same conclusion: premiums cause low-income individuals to lose health care coverage, and they increase expenditures when sick but uninsured individuals delay care until they need emergency, urgent, and/or acute care.[29] Most recently, the Kaiser Family Foundation reviewed the research from 65 studies and noted that this research finds that premiums create significant barriers to low-income people obtaining Medicaid coverage, with those living below the poverty level particularly affected because they are most likely to become uninsured and to have great health care needs.[30] Given the numerous and well-established studies on the impact of premiums on low-income people, there is no experimental value to Maine's proposal to implement premiums.[31]

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[28] "Research examining the impact of premiums in public programs has found that participation falls off sharply as the premium amount increases" Julie Hudman & Molly O'Malley, KAISER COMM'N ON MEDICAID & THE UNINSURED, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations* (Mar. 2003), http://www.academia.edu/6759690/Health_Insurance_Premiums_and_Cost-Sharing_Findings_from_the_Research_on_Low-Income_Populations; *see* also Judith Solomon, Ctr. on Budget & Pol. Priorities, *Ensuring Affordable Health Insurance Coverage and Health Care Services in an Insurance Exchange* (May 21, 2009), http://www.cbpp.org/sites/default/files/atoms/files/5-21-09health2.pdf ("Research has shown that as premiums rise, fewer low-income people participate in health insurance voluntarily.").

[29] *See*, *e.g.*, Samantha Artiga et al., KAISER FAM. FOUND., *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings* (June 1, 2017), http://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/; David Machledt & Jane Perkins, NAT. HEALTH LAW PROGRAM, *Medicaid Premiums & Cost Sharing and Premiums* (March 2014), http://www.healthlaw.org/publications/browse-all-publications/Medicaid-Premiums-Cost-Sharing.

[30] Artiga, Kaiser Fam. Found., *supra* n. 29.

[31] In another example, in 2003, Oregon experimented with charging sliding scale premiums ($6-$20) and higher copayments on some groups in an already existing § 1115 demonstration for families and childless adults living below poverty. Nearly *half* the affected demonstration enrollees dropped out within the first nine

Moreover, the lock-out penalty for failure to pay makes Maine's proposal even more harmful and illegal. This policy will unnecessarily increase the number of uninsured individuals. It will contradict any effort to promote continuity of care and will harm the provider infrastructure in Maine (as providers will continue to treat uninsured patients). Individuals will end up not getting care when it is most appropriate. Individuals will lose coverage, wait until their conditions worsen, then seek care in the Emergency Department or only then get back onto MaineCare when their health conditions are more expensive to treat. This policy creates a disincentive to obtaining timely and appropriate care. This proposal is counter-productive to the good efforts that DHHS has made through the development of health homes, the Emergency Department diversion project, ACOs, and the SIM initiative (*e.g.*, diabetes prevention initiative) to ensure that MaineCare delivers timely and appropriate cost-effective care in the best interests of recipients. And as discussed above, the Secretary does not have the legal authority to allow Maine to implement premiums for individuals below 150% FPL. Given this, the Secretary also lacks the authority to allow termination and lock-out for failure to pay monthly premiums.

IV. Emergency Department Copayments

Maine proposes to impose a $10 copayment on individuals who use the hospital emergency department (ED), if the ultimate diagnosis is listed on Appendix A (*e.g.*, using the ED for what is later diagnosed as severe asthma). That charge will be imposed even when a prudent layperson would have gone to the ED or when an individual's primary care provider advised them to go to the ED. These copayments should not be approved.

The copayments conflict with non-waivable provisions of the Medicaid Act. In provisions located outside of § 1396a, the Medicaid Act provides states with flexibility to establish copayments, but it also includes beneficiary protections.[32]

First, under Sections 1396o(a)(2)(D), 1396o(b)(2)(D), and 1396o-1(b)(3)(B)(vi)—non-waivable provisions—cost-sharing may not be imposed on "emergency services." Emergency services include services necessary to evaluate or stabilize any condition, for which a "prudent layperson" would understand the need for immediate medical attention.[33] But Maine's proposed copayments will be imposed even if the individual used the ED for an *emergency*. For instance, a person suffering a severe asthma attack, who prudently reports to the emergency department, would be charged the copayment based on the State's ultimate, post hoc diagnosis.[34] A copayment would likewise be imposed on an individual who suffers acute respiratory problems or difficulty breathing, if the State later codes the underlying diagnosis as COPD or bronchitis.[35] In short, the copayment will be imposed even when the "prudent layperson" standard is met. The Secretary cannot approve such copayments.

In addition, the proposed copayments fail to meet the five conditions set forth in 42

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months after the changes. Bill J. Wright et al., *The Impact of Increased Cost Sharing on Medicaid Enrollees*, 24 HEALTH AFFAIRS 1106, 1110 (2005).

[32] *See* 42 U.S.C. §§ 1396o, 1396o-1.

[33] 42 CFR § 447.51.

[34] Application at 20 (listing "severe persistent asthma, uncomplicated" as a diagnosis which triggers the copayment).

[35] Application at 20-21.

U.S.C. § 1396o(f) for approval of copayments that exceed the limits noted above. In particular: (1) The use of ED copayments has been extensively studied (as described below) and, therefore, does not "test a unique and previously untested use of copayments." 42 U.S.C. § 1396o(f)(1); (2) The waiver seeks to impose the payments for five years—well beyond the two year limit imposed by statute, *id.* § 1396o(f)(2); (3) The proposed copayments offer no benefits to MaineCare members, only risks of deterring appropriate ED use, contrary to the requirements of 42 U.S.C. § 1396o(f)(3); (4) The use of copayments applies to all members, without "the use of control groups of similar recipients of medical assistance in the area," *id.* § 1396o(f)(4); and (5) The copayments are not voluntary and provide no "provision for assumption of liability for preventable damage to the health of recipients . . . resulting from involuntary participation." *Id.* at § 1396o(f)(5). This statute prohibits the Secretary from authorizing Maine's proposed ED copayments.

Finally, even if these affordability protections were waivable under § 1115, the proposed use of copayments is not experimental and is not likely to promote the objectives of Medicaid. Over the last 35 years, cost sharing has been one of the most heavily studied aspects of the Medicaid program. These studies have produced redundant, consistent findings: copayments harm low-income people by causing them to forego medically necessary care.[36] Moreover, studies of Medicaid and CHIP nonemergency ED copayments specifically, including peer-reviewed evaluations of nonemergency ED copayments, consistently show that: (1) Medicaid enrollees use the ED at comparable rates to private pay patients if you factor in their health status, and are no more likely to use the ED for non-urgent visits; and (2) copayments are ineffective at reducing nonemergency ED use.[37]

V. Eligibility Changes

Maine proposes to make several changes to the eligibility process, each of which will impose barriers to care and result in disenrollment from the program. Accordingly, these proposals do not promote the objectives of the Medicaid Act, and further, serve no experimental purpose.

A. Elimination of Retroactive Eligibility

The proposed waiver seeks elimination of retroactive eligibility under 42 U.S.C. § 1396a(a)(34), which requires retroactive coverage for the three months prior to the month of application, provided that the individual otherwise meets the eligibility requirements during the months and has incurred medical expenses. Maine's proposed eligibility change is alleged to be "consistent with private insurance coverage," designed to have providers determine insurance status at the time of delivering the service and not later, and to encourage people to enroll early to receive preventive care.

This proposal misunderstands the difference between MaineCare and private

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[36] *See* David Machledt & Jane Perkins, National Health Law Program, *Medicaid Premiums and Cost Sharing* (March 2014) available at http://www.healthlaw.org/publications/search-publications/Medicaid-Premiums-Cost-Sharing#.U5cW-ij3Ijw.

[37] *Id.*; Mona Siddiqui et al., *The Effect of Emergency Department Copayments for Medicaid Beneficiaries Following the Deficit Reduction Act of 2005*, 175 JAMA INTERNAL MED. 393 (2015); Karoline Mortensen, *Copayments Did Not Reduce Medicaid Enrollees' Nonemergency Use of Emergency Departments*, 29 HEALTH AFFAIRS 1643 (2010); David J. Becker et al., *Co-payments and the Use of Emergency Department Services in the Children's Health Insurance Program*, 70 MED. CARE RES. REV. 514 (2013).

insurance and is not likely to promote the objectives of the Medicaid Act. MaineCare eligibility is determined monthly and in each month the person must both be in a coverable group and meet the financial requirements for that group. Thus, a person who is a non-disabled, non-pregnant adult without children is not eligible until, for example, they become a parent, disabled, or pregnant. If any of these events occur towards the end of the month, the failure to file an application before the end of that month will result in no coverage under this policy. Thus, it is sheer chance, and not some notion of lack of personal responsibility, that very often controls whether it is appropriate to submit an application. The reality is not that people purposefully delay seeking care or coverage.

Moreover, elimination of retroactive eligibility places providers, such as hospitals and ambulance services, at financial risk. Without the ability to retroactively claim for care provided to Medicaid-eligible individuals, providers will see an increase in uncompensated care, making it challenging for them to keep their doors open to serve our most vulnerable citizens. For example, a hospital that treats a stroke victim on or towards the last day of the month is put at financial risk when the patient (who may be incapable of submitting an application) does not submit a MaineCare application until the next month, perhaps just a day or two away. As such, the hospital, although legally (and morally) obligated to provide treatment will not be paid for treating the stroke. An ambulance that transports a patient to a hospital will likely not be paid–either by a hospital or MaineCare–since the ambulance has no control over when a MaineCare application may be submitted and will not and cannot refuse to transport a person due to lack of insurance coverage.

This proposal, therefore, fails to meet the basic requirements for a § 1115 waiver. Making Medicaid "consistent with private coverage" is not evidence that such a proposal is likely to promote the objectives of the Medicaid Act. Nor does requiring hospitals and other providers to determine insurance status prior to delivering services promote the objectives of the Medicaid Act. Furthermore, failing to pay providers for giving care to a person made ineligible for coverage under this proposal would only weaken MaineCare's ability to maintain an adequate network of providers available to Medicaid members as required by federal law and would increase uncompensated care, thus harming the ability of providers to treat our most vulnerable residents. The result of this change would be more people subject to debt collection or declaring bankruptcy due to medical debt. It is hard to see what acceptable experimental purpose is being measured by this proposal and how the inevitable outcomes will promote the objectives of the Medicaid Act.

B. Reinstating the Asset Test

Until 2014, asset tests were a standard eligibility requirement for all eligibility categories, including those affected by this waiver (parents, children, and pregnant women), although, prior to that Maine, like most other states, had dropped its asset test for children. The Affordable Care Act (ACA) removed asset tests as an eligibility requirement for specified eligibility groups. Maine's only justification for reverting back to the old policy of asset tests is that it "does not believe that Modified Adjusted Gross Income (MAGI)-based methodology, with its disallowance for asset tests, is aligned with MaineCare's program goals."[38] Despite Maine's opinion, Congress has disagreed. Moreover, Congress expressly limited the Secretary's authority to grant waivers like the one Maine proposes.[39] Thus, the

[38] Application at 9.
[39] 42 U.S.C. §§ 1396a(e)(14)(C) and (F).

Secretary has no authority to grant this portion of Maine's waiver.

In addition, it is difficult to understand what experimental value this proposal could have. After decades of asset tests and research examining them, there is no experiment here. It is now well understood that asset tests are cumbersome to administer and complicated for applicants and recipients. In fact, prior to the changes in the Affordable Care Act (ACA), Section 1115 waivers were utilized to demonstrate the impact of *eliminating* asset tests, and those demonstrations did yield valuable information.[40] After considering the decades-long effect of asset tests, Congress eliminated asset tests for parents, children and pregnant women, among others, applying this policy to both state plan and waiver programs, and limited the States' and the Secretary's authority to revert to the old policy.

Therefore, the proposed waiver to reinstitute an asset test not only violates federal law, but it has no merit as an experiment. In addition, re-instituting an asset test will instead reduce access to needed health care among low- income families and further weaken their economic security, both factors that are linked to worse health outcomes.

C. Hospital Presumptive Eligibility

Maine proposes to eliminate the option for hospitals to make presumptive eligibility determinations. This waiver proposal will demonstrate nothing. No hospital in Maine currently provides for presumptive eligibility because DHHS has imposed such rigid requirements on the presumptive eligibility process that no hospital has elected the option. Given the State's failure to effectively implement the current presumptive eligibility law, nothing will be learned from waiving it. But, precluding its use altogether forecloses an opportunity for hospitals to experiment with initiatives that would promote coverage and increase the efficiency of care—criteria which CMS considers favorably in determining whether a Section 1115 waiver meets the purposes of the Medicaid Act.

D. Penalizing Protected Annuities

Finally, Maine proposes penalizing the purchase of certain annuities which Congress specifically sought to protect. We are particularly concerned about how the proposed waiver will impact couples with one spouse residing in a nursing home and one in the community ("community spouse"). The law permits community spouses to purchase annuities that meet certain requirements so that the community spouse can avoid total impoverishment as a result of the need for one spouse to reside in a nursing home. That is, the law permits community spouses to purchase an annuity and maintain a reasonable income stream, rather than be forced to spend down all of the couple's retirement savings before qualifying for Medicaid. Imposing a transfer penalty on such annuities will force more Maine couples into poverty towards the end of their life. This proposal, therefore, directly contradicts the objectives of the Medicaid Act and should be rejected.

Conclusion

[40] Vernon K. Smith, Eileen Ellis and Christina Chang, "Eliminating the Medicaid Asset Test for Families: A Review of State Experiences," Kaiser Commission on Medicaid and the Uninsured, April 2001, *https://kaiserfamilyfoundation.files.wordpress.com/2001/04/2239-eliminating-the-medicaid-asset-test.pdf.*

We strongly object to any efforts to use Section 1115 to skirt essential provisions that Congress has placed in the Medicaid Act to protect Medicaid beneficiaries and ensure that the program operates in the best interests of the population groups it is designed to protect. As demonstrated above, Maine's application contains numerous provisions that are inconsistent with the standards of Section 1115 and will negatively impact the health of Maine residents. We appreciate your consideration of our comments. If you have questions about these comments, please contact Sarah Grusin, grusin@healhtlaw.org, or me.

Respectfully Submitted,

/s/Jane Perkins
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