January 26, 2018

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

Re: KanCare 2.0: Section 1115 Demonstration Renewal Application (#11-W-00283/7)

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 under-served people. We appreciate the opportunity to provide these comments on the proposed: KanCare 2.0: Section 1115 Demonstration Renewal Application.

NHeLP recommends that the Department of Health & Human Services (HHS) not approve KanCare 2.0. By many measures, the KanCare waiver has been unsuccessful. Indeed, CMS itself noted substantial failures in the state's ability to oversee the managed care organizations (MCOs) and ensure that individuals are actually receiving care. In its January 13, 2017 letter, CMS noted that the MCOs largely fail to provide the person-centered planning that is a central feature of KanCare.[1] Given this and other failings, CMS concluded that the KanCare program "is substantively out of compliance with Federal statutes and regulations," and described serious concerns that "affect beneficiaries' receipt of services necessary to stay in the community, beneficiaries' ability to access needed care, and the State's ability to ensure the health and welfare of beneficiaries." [2]

[1] Letter from James G. Scott, Associate Regional Administrator for Medicaid and Children's Health Operations, Centers for Medicare and Medicaid Services, to Susan Moiser, Secretary and State Health Officer, Kansas Department of Health and Environment (Jan. 13, 2017).
[2] *Id.*

Instead of addressing these systemic failings, KanCare 2.0 proposes to shift even more "coordinating" responsibility to the MCOs without sufficient oversight or safeguards for beneficiaries. As a result, KanCare's shortcomings will likely be exacerbated in KanCare 2.0. Specifically, we have concerns regarding:

- The failure to meet the need for increased state oversight of managed care entities and the ability to compel those entities to make changes;
- The lack of any objective, quality control measures—such as maximum caseloads or minimum qualifications—for the MCOs' plan of service coordinators;
- The continued reliance on MCOs, rather than independent coordinators, to draft and approve plans of service, which creates potential conflicts of interest without adequate protections;
- The failure to describe the mechanisms by which the State will ensure due process and monitor beneficiary protections throughout the system; and
- The proposal's failure to create adequate policies to promote self-directed care options.

Moreover, while NHeLP generally supports addressing social determinants of health, KanCare 2.0 focuses instead on "social determinants of independence." From what we can tell, the State contrived this term out of thin air; it is not recognized by any academic discipline, published literature, or evidence. The changes proposed under that heading—work requirements, extended lockout periods, lifetime limits, and a coercive incentive for beneficiaries to discontinue a Social Security disability determination—are punitive measures that will only create further harm to beneficiaries, cause thousands to lose Medicaid coverage, and reduce access to necessary medical care.

Finally, in just three sentences, Kansas requests a sweeping waiver of the IMD exclusion. Such a sparse description precludes any meaningful public comment, and we ask that the State's request for an IMD waiver not be approved. We do not believe that a blanket waiver of the IMD exclusion is consistent with the purpose of the Medicaid Act, and it would not be an experiment, demonstration or pilot.

In sum, these changes, separately and together, do not comply with the requirements of § 1115 of the Social Security Act and will harm Medicaid enrollees' access to vital health care services.

**I. HHS authority and § 1115**

To be approved pursuant to § 1115, Kansas'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.[3]

The purpose of Medicaid is to enable states to furnish medical assistance to individuals whose income is too low to meet the costs of necessary medical care and to furnish rehabilitation and other services to help these individuals attain or retain the capacity for independence and self-care.[4] Kansas's proposal cannot be approved because it is inconsistent with the provisions of § 1115.

**Incomplete Application with Insufficient Detail and Information**

Throughout its application, Kansas has failed to provide sufficient detail to enable meaningful public comment.[5]

Most notably, Kansas did not include any enrollment estimates as required by federal regulations.[6] This failure is particularly concerning, given that Kansas has proposed numerous punitive measures that will certainly cause beneficiaries to lose coverage. Kansas also did not submit an adequate draft evaluation for its work requirements proposal, as referenced in CMS's January 11, 2018 letter to State Medicaid Directors.[7] For instance, none of the hypotheses listed or data collected would address the potential impact of work requirements on enrollees who are not receiving service coordination. Nor does the evaluation address "the impact of the demonstration on Medicaid beneficiaries and on individuals who experience a lapse in eligibility or coverage for failure to meet the program requirements or because they have gained employer-sponsored insurance," as described in the January 11 letter.[8] In fact, the State offers no hypotheses or evaluations related to its punitive lifetime limits, MediKan or TransMed proposals at all.

Furthermore, throughout the application the State asserts that it is "considering" additional proposals without specifying whether it is in fact requesting a waiver and without providing the requisite detail to even identify the affected populations.

Finally, as noted throughout these comments, many of the proposals lack sufficient detail and are ambiguous, precluding meaningful public comment. Even where public comments specifically requested clarification, such as the length of the proposed lockout in the TransMed program, the State provided no additional detail and made no changes.[9] There is simply not sufficient information to understand the various programs being proposed, how people might be excluded from Medicaid, or how they will affect low-income Kansans more broadly. The lack of

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[3] 42 U.S.C. § 1315(a).
[4] *See* 42 U.S.C. § 1396-1.
[5] 42 C.F.R. § 431.408(a)(1)(i).
[6] 42 C.F.R. § 431.408(a)(1)(i)(C)(requiring "An estimate of the expected increase or decrease in annual enrollment").
[7] SMD 18-002, "Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries," 9 (Jan. 11, 2018) https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf.
[8] *Id*.
[9] Application packet, at 303 of PDF.

information means that the public cannot meaningfully comment on what the State has proposed.

Accordingly, CMS should not have certified Kansas's application as complete, pursuant to 42 C.F.R. § 431.416(a), and it should require Kansas to resubmit a complete application and provide an additional public comment period.

**Work Requirements**

Kansas is seeking to impose a work requirement on able-bodied adults. The application states that the requirements vary based on household composition. For a one-adult household, the hours required are "20 or 30 hours" a week "depending on whether there is a child under the age of six."[10] The State does not elaborate on this requirement, but we understand it to mean that a one-adult household with a child under six would be subject to a 20-hour per week work requirement, while a single-adult without a child under six would be required to work 30-hours per week.[11] A two adult household must meet minimum weekly requirements of "35 or 55 hours" per week, with a maximum of 40 hours per week for any individual. The State's application does not explain how it will determine how many hours between 35 and 55 a given household must complete each week.

Under § 1115 and other relevant law, HHS has no authority to approve any waiver permitting Kansas to condition Medicaid eligibility on compliance with work activities. 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.[12]

Section 1115 cannot be used to short-circuit these Medicaid protections because there is no basis for finding that work requirements are likely to assist in promoting the objectives of the Medicaid Act.[13] 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

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[10] Application at 11.

[11] One of the exemptions listed from the work requirements, however, is for "caretakers for dependent children under six years." Application at 10. But the state does not explain the difference between a "caretaker" and "one-adult household" for purposes of evaluating whether the proposed work requirement would apply to a particular individual with a child under six.

[12] *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 were not getting immunizations or check-ups or were missing school because regulation was inconsistent with Medicaid and TANF statutes).

[13] 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.

independence or self-care.[14] Conditioning Medicaid eligibility on completion of work activities gets it exactly backwards by blocking access to care and services that help individuals be able to work. Research confirms that Medicaid coverage allows individuals to obtain and maintain employment.[15] For example, more than half of individuals enrolled in the Medicaid expansion in Ohio reported that Medicaid coverage has 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.[16] Imposing work requirements will reverse this progress and cause individuals to lose coverage.[17]

Kansas cites two studies documenting the correlation between unemployment and poor health in its attempt to justify the punitive work requirement as a means of improving health outcomes.[18] First of all, Kansas's application oversimplifies the complex and nuanced relationship between employment and health.[19] Second, neither study suggests that *requiring* work as a condition of eligibility is likely to promote health outcomes. In fact, the Robert Wood Johnson study Kansas cites shows that the quality of employment matters. Stable, high-paying jobs in safe working environments might be associated with better health outcomes, but the

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[14] 42 U.S.C. § 1396-1.

[15] Jesse Cross-Call, "More Evidence Medicaid Expansion Boosts Health, Well-Being," Center on Budget and Policy Priorities (Jan. 8, 2018), https://www.cbpp.org/blog/more-evidence-medicaid-expansion-boosts-health-well-being?utm_source=CBPP+Email+Updates&utm_campaign=3434e0fd00-EMAIL_CAMPAIGN_2018_01_12&utm_medium=email&utm_term=0_ee3f6da374-3434e0fd00-111113873; Renuka Tipirneni et al., Institute for Healthcare Policy and Innovation, University of Michigan, *Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches*, (2017), available at http://ihpi.umich.edu/news/medicaid-expansion-helped-enrollees-do-better-work-or-job-searches; Louija Hou et al., "Working Paper No. 22170: The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Well-Being," National Bureau of Economic Research, (2016), available at http://nber.org/papers/w22170; Nicole Dissault, Maxim Pinkovskiy, and Basit Zafar, *Is Health Insurance Good for Your Financial Health?* Liberty Street Economics Blog, June 6, 2016 online at http://libertystreeteconomics.newyorkfed.org/2016/06/is-health-insurance-good-for-yourfinancial-health.html#.V4lHI6It7VJ.

[16] 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.

[17] LaDonna Pavetti, Michelle Derr, and Emily Sama Martin, *Assisting TANF Recipients Living with Disabilities to Obtain and Maintain Employment: Conducting In-Depth Assessments*, (2008); Robert Rector, Heritage Foundation, *Work Requirements in Medicaid Won't Work. Here's a Serious Alternative* (2017), available at: http://www.heritage.org/health-care-reform/commentary/work-requirements-medicaid-wont-work-heres-serious-alternative; Hannah Katch, Center on Budget and Policy Priorities, *Medicaid Work Requirements Would Limit Health Care Access Without Significantly Boosting Employment*, (2016), available at: http://www.cbpp.org/research/health/medicaid-work-requirement-would-limit-health-care-access-without-significantly.

[18] NHeLP raised similar critiques in a letter, and attached Statement of Review, responding to CMS's January 11, 2018 letter to State Medicaid Directors. Letter from Jane Perkins, Legal Director, Nat'l Health Law Program, to Brian Neale, Dir., Ctrs. For Medicare & Medicaid Servs. (Jan. 11, 2018), http://www.healthlaw.org/component/jsfsubmit/showAttachment?tmpl=raw&id=00P0W00000ozROSUA2. (requesting that CMS extend place NHeLP's letter and attached statement of review into the administrative record).

[19] Erin C.Strumpf, Thomas J.Charters, SamHarper, and ArijitNandi, *Did the Great Recession affect mortality rates in the metropolitan United States? Effects on mortality by age, gender and cause of death*, 189. Soc. Sci & Med. 11 (Sept. 2017), *available at* https://www.sciencedirect.com/science/article/pii/S0277953617304495

"working poor" status "is associated with health challenges as well."[20] That same study further explains that the increased access to health insurance that comes with stable employment accounts for a large part of the link between employment and health.[21] Further reducing access to health insurance among low-wage earners will not improve health outcomes.

Moreover, the State's application fails to acknowledge the important distinction between correlation and causation. For instance, Kansas cites a 2014 Gallup poll, which suggests a link between long-term unemployment and depression. But many social determinants correlate with health outcomes and improved mental health. For instance, access to steady housing is associated with improved health outcomes, while homelessness is associated with significantly worse outcomes.[22] Of course, requiring people to have a home to maintain their Medicaid benefits – particularly if a state provided no appreciable extra help – would hardly be expected to improve their health outcomes. It would just kick homeless people off the program and exacerbate their problems.

Likewise, while the Gallup poll shows a correlation between unemployment and depression, it does not automatically follow that increased employment will reduce or treat depression. In fact, the study expressly notes that "[t]he causal direction of the relationship, though, is not clear from Gallup's data," and one explanation is that depression makes it harder to find and maintain a job.[23] Even setting aside this criticism, the straightforward conclusion from the evidence Kansas cites is that terminating Medicaid benefits for failing to meet a mandatory work requirement is likely to leave many individuals suffering from depression without access to preventive services, medicines for chronic conditions, and other non-emergency care—a concern which Kansas does not address.

Moreover, the vast majority of individuals enrolled in Medicaid already work or have good reason for not working.[24] A recent study by the Kaiser Family Foundation found that adult Medicaid enrollees who were not receiving disability benefits and did not have a job were not working because they were: going to school (18%); taking care of their home or family (28%); retired (8%); unable to find work (8%); or dealing with illness or disability (35%).[25] Recent data from Kansas shows that 68% of adult enrollees not receiving disability benefits (82%of those

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[20] Robert Wood Johnson Foundation, Issue Brief: How Does Employment—or Unemployment—Affect Health? (2013) https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf403360
[21] *Id.*
[22] "Homelessness & Health: What's the Connection?" National Health Care for the Homeless Council (June 2011) https://www.nhchc.org/wp-content/uploads/2011/09/Hln_health_factsheet_Jan10.pdf (collecting studies).
[23] Steve Crabtree, "In U.S., Depression Rates Higher for Long-Term Unemployed," Gallup (2014) http://news.gallup.com/poll/171044/depression-rates-higher-among-long-term-unemployed.aspx. See also, e.g., C. McLean, Worklessness and Health: What Do We Know about the Causal Relationship, 1st Edition, Health Development Agency, London, (2005)
[24] 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).
[25] *Id*.

under 45) are already working, either part or full-time.[26] In fact, only 14% of the adult enrollees not receiving disability benefits live in a family without a worker.[27]

Among the small subset of individuals not already working, an estimated 42% have barriers to work because they are ill or disabled.[28] Further data suggests that illness and poor health are the main factors keeping individuals from working. While 81% of individuals who reported being in "excellent" or "very good" health were working, that number dropped to 62% for individuals in "good" health, and to just 38% for individuals in "fair/poor" health.[29] Individuals in fair or poor health face additional barriers if they choose to work and may require extra support and accommodations. But this proposal seems to add a work mandate without significantly boosting available resources for supports. That punitive approach will disproportionately cause people already in fair or poor health to lose access to coverage and end up worse off.

For these reasons, we have significant concerns that the harms from work requirements will fall disproportionately on individuals with chronic health conditions. While Kansas' application states that work requirements will apply only to "able-bodied adults," it offers no exemption for individuals who are unable to meet the work requirements due to a health condition, whether chronic or acute. Instead, it proposes only narrow exemptions such as "members who have disabilities *and* are receiving Supplemental Security Income (SSI)" and certain specific diagnoses: "members with TBI, human immunodeficiency virus (HIV), or in the Breast and Cervical Cancer Programs."[30] The State notes that it "may consider an exception process for members who have certain behavioral health conditions," without describing which conditions, what procedures it would use, or what documentation would be required.

Evidence from other programs shows that, even when there is an explicit exemption for individuals unable to comply due to health conditions, in practice, individuals with disabilities are not exempted as they should be and are more likely than other individuals to lose benefits.[31] Even though an individual may not have a disability that meets the strict SSI standard, she may still face substantial barriers to work and will lose coverage due to the work requirement. We strongly support efforts to provide resources and accommodations to help people find and maintain a job. But a stringent work requirement will not help accomplish this goal. People with disabilities have low employment and wage levels and experience discrimination at various

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[26] Rachel Garfield, Robin Rudowitz, and Anthony Damico, Understanding the Intersection of Medicaid and Work, Appendix, Kaiser Family Foundation (Dec. 07, 2017): https://www.kff.org/report-section/understanding-the-intersection-of-medicaid-and-work-appendix/. (Table 1, "Own Status" column, showing that 47% are working full time and 21% are working part time; Table 4a, showing that 82% of enrollees ages19-45 are working).
[27] *Id.* at Table 1 ("Family Work Status").
[28] *Id.* at Table 2.
[29] *Id.* at Table 4b.
[30] Application at 10-11 (listing exemptions).
[31] *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"); Vicki Lens, *Welfare and Work Sanctions: Examining Discretion on the Front Lines*, 82 Soc. Serv. Review 199 (2008).

stages of employment, including at hiring, when employees with disabilities that would not affect their job performance are 26% less likely to be considered for employment.[32] In addition, people with disabilities are also nearly twice as likely to be employed part time because they cannot find a job with more hours or their hours have been cut back as compared to people without a disability.[33] Numerous redundant and consistent 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.[34]

Evidence from the Supplemental Nutrition Assistance Program (SNAP) demonstrates similar outcomes. Researchers have expressed concern that states regularly fail to exempt from work requirements many of the nearly 20% of all SNAP participants who have a disability but receive no disability benefits.[35] One study from Franklin County, Ohio found that one-third of individuals required to participate in a SNAP employment and training program to keep their benefits reported a physical or mental limitation. Additionally, almost 20% of the individuals had filed for SSI or SSDI within the previous two years.[36] In another example, when Georgia reinstated the SNAP work requirement and time limits for "able-bodied adults without dependents" in 2016, the State found that 62% of nearly 12,000 individuals subject to the requirement were disenrolled after only three months.[37] State officials acknowledged that hundreds of enrollees had been wrongly classified as "able-bodied" when they were actually unable to work.[38]

Because conditioning Medicaid eligibility on completion of the work requirement will disproportionately harm 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.[39] These laws make it illegal for states to take actions that have a discriminatory impact on people with disabilities, and they cannot be waived under § 1115 or under any other authority of the Secretary.[40]

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[32] Ameri, Mason and Schur, Lisa and Adya, Meera and Bentley, Scott and McKay, Patrick and Kruse, Douglas L., *The Disability Employment Puzzle: A Field Experiment on Employer Hiring Behavior* (September 2015), *available at* https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2663198.
[33] U.S. Bureau of Labor Statistics, Persons with a Disability: Labor Force Characteristics—2016 (June 21, 2017), https://www.bls.gov/news.release/pdf/disabl.pdf.
[34] *See, e.g.*, Yeheskel Hasenfeld et al., *The Logic of Sanctioning Welfare Recipients: An Empirical Assessment* Departmental Paper, University of Pennsylvania School of Social Policy and Practice (2004), http://repository.upenn.edu/cgi/viewcontent.cgi?article=1028&context=spp_papers.
[35] *See* 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).
[36] Ohio Association of Foodbanks, *Comprehensive Report: Able-Bodied Adults Without Dependents* (2015), http://admin.ohiofoodbanks.org/uploads/news/ABAWD_Report_204-2015-v3.pdf.
[37] *Correction: Benefits Dropped Story*, U.S. News & World Report, (May 26, 2017), https://www.usnews.com/news/best-states/georgia/articles/2017-05-25/work-requirements-drop-thousands-in-georgia-from-food-stamps.
[38] *Id*.
[39] 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).
[40] See *Burns-Vidlak v. Chandler*, 939 F. Supp. 765, 772 (D. Haw. 1996).

Evidence also shows that work requirements may exacerbate health disparities for people of color. In one study based on experimental survey and actual case data, researchers found that African American beneficiaries were more likely to be sanctioned for noncompliance than white beneficiaries,[41] raising concerns that Kansas's proposal will increase racial disparities in the state.

Kansas has not expanded Medicaid under the Affordable Care Act, which means the population most affected by the work requirements would be parents and caretakers. Most jobs available to enrollees are low-wage positions with volatile schedules.[42] As noted above, low-wage, stressful jobs can be harmful to any individual's wellbeing.[43] Such employment can also jeopardize the quality of parenting because of the demands on parents' time, energy, and attention. Studies find that when mothers start a low-wage, repetitive job, the quality of their children's experiences at home deteriorates, becoming less stimulating and nurturing, impacting a child's development and long-term outcomes.[44]

In addition, the multiple, unstable childcare arrangements that many families rely on when they have low-wage work with uncertain schedules can harm a child's health development.[45] Numerous studies find a relationship between childcare stability, attachment, and child outcomes including effects on social competence, behavior outcomes, cognitive outcomes, language development, school adjustment, and overall child well-being.[46] The effect of parental low wage jobs and childcare instability may particularly impact children living in poverty.[47] Medicaid for children, particularly the EPSDT provision, "assure[s] that individual children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible."[48] Notably, Kansas' proposal is completely silent on increasing resources for affordable, quality childcare. To implement work requirements in Medicaid despite evidence that such requirements would likely cause harm to children and their development would be contrary to purpose of the Medicaid Act.

The work requirements will also pose a barrier to coverage even for individuals who are working or qualify for an exception.[49] Data shows that most low-income workers have jobs with

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[41] Sanford F. Schram, Joe Soss, Richard C. Fording and Linda Houser, *Deciding to Discipline: Race, Choice, and Punishment at the Frontlines of Welfare Reform*, 74 Am. Soc. Rev. 398 (2009).
[42] Liz Ben-Ishai, CLASP, *Volatile Job Schedules and Access to Public Benefits*, September 2015, http://www.clasp.org/resources-and-publications/publication-1/2015.09.16-Scheduling-Volatility-and-Benefits-FINAL.pdf;
[43] Toby Parcel and Elizabeth Menaghan, *Effects of Low-Wage Employment on Family Well-being,* 7(1) WELFARE TO WORK 116 (Spring 1997);
[44] *Id.*
[45] Gina Adams and Monica Rohacek, Urban Inst, *Child Care Instability: Definitions, Context, and Policy Implications* (Oct. 2010), https://www.urban.org/sites/default/files/publication/29446/412278-Child-Care-Instability-Definitions-Context-and-Policy-Implications.PDF.
[46] *Id.* at 7.
[47] *Id.* at 8.
[48] CMS, COVERAGE IN THE MEDICAID BENEFIT FOR CHILDREN AND ADOLESCENTS 1 (2014), https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf.
[49] *See e.g.*, Julia B. Isaacs, Michael Katz, and David Kassabian, *Changing Policies to Streamline Access to Medicaid, SNAP, and Child Care Assistance*, Urban Institute, March 2016, http://www.urban.org/sites/default/files/publication/78846/2000668-Changing-Policies-to-Streamline-

variable and unpredictable schedules, for instance in construction, retail, or food service, which not only can contribute to worsening health outcomes, as described above, but can make it difficult to comply with the State's weekly-hours requirements.[50] Moreover, even individuals who do comply with the weekly-hours requirements will have to verify their hours every month to maintain their eligibility. Creating additional verification requirements has no relationship to private insurance policies, and will inevitably lead to increased disenrollment solely for failure to complete paperwork.[51]

Furthermore, individuals who do comply with work requirements will, by design, end up in a coverage gap. Kansas has set the income limit for parents and caretakers at just 38% FPL. Thus, the income limit for a family of two is $6171 annually, or just under $119 a week. But, an individual who works 20 hours a week at the federal minimum wage would earn $145 a week, or $7540 annually, leaving their family ineligible for Medicaid or any other affordable health insurance option. The outcome is the same for a family of four.[52] But despite being ineligible for Medicaid, these families would not earn enough to qualify for premium tax credits on the exchange, and many low-wage jobs offer no health coverage.[53] According to one estimate, the chances of their finding employment that includes health insurance at all is only 30% and the chances of finding *affordable* employer-sponsored health insurance is even lower. In other words, many individuals and families who comply with Kansas' work requirements will inevitably end up in a coverage gap and become uninsured.[54]

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Access-to-Medicaid-SNAP-and-Child-Care-Assistance-Findings-from-the-Work-Support-Strategies-Evaluation.pdf

[50] Susan J. Lambert, Peter J. Fugiel and Julia R. Henly, *Precarious Work Schedules among Early-Career Employees in the US: A National Snapshot*, University of Chicago, (2014) available at https://ssascholars.uchicago.edu/sites/default/files/work-scheduling-study/files/lambert.fugiel.henly_.precarious_work_schedules.august2014_0.pdf; Stephanie Luce, Sasha Hammad and Darrah Sipe, Retail Action Project, *Short Shifted,* September 2014, http://retailactionproject.org/wp-content/uploads/2014/09/ShortShifted_report_FINAL.pdf; Liz Ben-Ishai, CLASP, *Volatile Job Schedules and Access to Public Benefits*, September 2015, http://www.clasp.org/resources-and-publications/publication-1/2015.09.16-Scheduling-Volatility-and-Benefits-FINAL.pdf

[51] Margot Sanger-Katz, "Hate Paperwork? Medicaid Recipients Will Be Drowning In It," N.Y. Times (Jan. 18, 2018) https://www.nytimes.com/2018/01/18/upshot/medicaid-enrollment-obstacles-kentucky-work-requirement.html?nytapp=true&_r=0; Tazra Mitchell and LaDonna Pavetti, *Life After TANF in Kansas: For Most, Unsteady Work and Earnings Below Half the Poverty Line*, Center on Budget and Policy Priorities (Jan. 23, 2018).

[52] Community Catalyst, "Work Requirements: A one-Way Ticket to the Coverage Gap. An analysis of the incompatibility of work requirements with income eligibility levels in Medicaid non-expansion states," (Jan. 2018) at 5 https://www.communitycatalyst.org/resources/publications/document/2018/Community-Catalyst_Work-Requirements-and-Medicaid-Eligibility-in-Non-Expansion-States-Analysis.pdf.

[53] According to Kaiser Family Foundation, only 30% of households with incomes below 100% FPL received an offer of employer-sponsored insurance compared to almost 80% of households with incomes above 400% FPL. *See* Kaiser Family Foundation, "Trends in Employer-Sponsored Insurance Offer and Coverage Rates: 1999-2014," (Mar. 2016) https://www.kff.org/private-insurance/issue-brief/trends-in-employer-sponsored-insurance-offer-and-coverage-rates-1999-2014/.

[54] Community Catalyst, "Work Requirements: A one-Way Ticket to the Coverage Gap. An analysis of the incompatibility of work requirements with income eligibility levels in Medicaid non-expansion states," (Jan. 2018) https://www.communitycatalyst.org/resources/publications/document/2018/Community-Catalyst_Work-Requirements-and-Medicaid-Eligibility-in-Non-Expansion-States-Analysis.pdf.

As this evidence demonstrates, imposing work requirements would inevitably lead to a large numbers of individuals, including those who are already working or exempt, losing Medicaid coverage.[55] This outcome is directly at odds with the objectives of the Medicaid Act. Furthermore, it is well-documented that gaps in coverage substantially worsen health outcomes,[56] and the increase medical debt and financial insecurity.[57]

In addition to the dramatic harms work requirements would cause, extensive research reveals that a mandatory work requirement does little or nothing to increase stable, long-term employment and does not decrease poverty.[58] 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 also lose their eligibility for cash assistance.[59]

Kansas's assertion that the work requirements in its TANF program have been successful at increasing employment is not supported by the available data. For instance, in 2013, only 9.6% of recipients left the TANF program due to finding employment, while almost four times as many individuals (36%) left as a result of sanctions or a failure to comply with the verification and eligibility procedures.[60] One study concluded that the TANF program in Kansas resulted in no measurable uptick in employment associated with leaving the program. Instead,

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[55] Leighton Ku and Erin Brantley, *Medicaid Work Requirements: Who's At Risk?* Health Affairs Blog, Apr. 12, 2017, http://healthaffairs.org/blog/2017/04/12/medicaid-work-requirements-whos-at-risk/)

[56] Benjamin D. Sommers, Atul A. Gawande, and Katherine Baicker, *Health Insurance Coverage and Health — What the Recent Evidence Tells Us*, 377 New England Journal of Medicine 586 (2017), available at http://www.nejm.org/doi/full/10.1056/NEJMsb1706645; A.G. Hall, J.S. Harman, and J. Zhang, *Lapses in Medicaid coverage: impact on cost and utilization among individuals with diabetes enrolled in Medicaid*, 48 Medical Care 1219 (2008), available at https://www.ncbi.nlm.nih.gov/pubmed/19300311?dopt=Abstract; Andrew Bindman, Amitabha Chattopadhyay, and G. M. Auerback, *Interruptions in Medicaid Coverage and Risk for Hospitalization for Ambulatory Care-Sensitive Conditions*, 149 Annals of Internal Medicine 854 (2008), available at https://www.ncbi.nlm.nih.gov/pubmed/19075204?dopt=Abstract.

[57] Georgetown University Health Policy Institute, Center for Children and Families, "Medicaid: How Does it Provide Economic Security for Families," (Mar. 2017) http://ccf.georgetown.edu/wp-content/uploads/2017/03/Medicaid-and-Economic-Security.pdf.

[58] 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); 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 (2001).

[59] 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); Dorothy Rosenbaum & Ed Bolen, Ctr. On Budget & Policy Priorities, *SNAP Reports Present Misleading Findings on Impact of Three-Month Time Limit* (2016), https://www.cbpp.org/sites/default/files/atoms/files/12-14-16fa.pdf; Stephen Freedman et al., "National Evaluation of Welfare-to-Work Strategies: Two-year Impacts for Eleven Programs," Manpower Development Research Corporation, June 2000, http://www.mdrc.org/publication/evaluatingalternative-welfare-work-approaches.

[60] Characteristics and Financial Circumstances of TANF Recipients, Fiscal Year 2013, Administration for Children and Families, Department of Health and Human Services, Table 43, https://www.acf.hhs.gov/sites/default/files/ofa/tanf_characteristics_fy2013.pdf.

employment was common among TANF parents, but unsteady, resulting in inconsistent earnings and periods of unemployment.[61]

Moreover, even for those who are able to find work, employment in low-wage jobs has not lead to significant increases in income.[62] Kansas parents who reported they were employed when they left TANF in 2014 had an average monthly income of $1,107, which would equal $13,284 annually (or 80% of the FPL for a family of two).[63] Notably, as discussed above, for families of two to six, that income would place the family in a coverage gap without access to Medicaid coverage or premium tax credits to purchase private health insurance.

A more recent analysis of state-collected data on employment and earning of Kansas parents leaving TANF cash assistance between October 2011 and March 2015 suggests, however, that the long-term results in Kansas are actually much worse than previous evidence suggested. In Kansas, almost two thirds of parents had "deep poverty earnings," (earnings below 50 percent FPL), in the year after exiting TANF.[64] Four years after exiting the program, the numbers were nearly the same.[65] Focusing in on the group of parents who left due to work sanctions paints an even more desperate picture: The median earnings for this group, four years after leaving TANF, were especially low: $2,175 (or 11 percent FPL).[66] More than one-third of them had no earnings, nearly 7 in 10 had no earnings or earnings below the deep-poverty level, and more than 8 in 10 had no earnings or earnings below the poverty level.[67] For parents who were terminated from TANF due to time limits, median income was even lower, just $1,370 (7 percent FPL).[68]

The TANF-to-poverty ratio provides further evidence that the reduction in Kansas' TANF caseload does not translate to economic improvement for Kansas's low-income families. Instead, it simply means that TANF is reaching fewer people. Kansas has one of the lowest TANF-to-poverty ratios in the country, with just 10% of the families with children in poverty receiving TANF assistance.[69] In fact, between 1996 and 2016 the number of families with children living in deep poverty in Kansas has grown from 14,400 to 16,100.[70] In short, TANF's

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[61] Tazra Mitchell and LaDonna Pavetti, *Life After TANF in Kansas: For Most, Unsteady Work and Earnings Below Half the Poverty Line*, Center on Budget and Policy Priorities (Jan. 23, 2018).

[62] For instance, in 2012, among Kansans who had a job, 26.4% made between 0%-100% FPL; 46% made between >100% - 200% FPL; 15.9% made between >200% - 300%; and only 11.6% make >300%. *See* Rebecca Thiess, *The Future of Work: Trends and Challenges for Low-Wage Workers*, Economic Policy Institute (Apr. 27, 2012), http://www.epi.org/publication/bp341-future-of-work/ .

[63] Meg, Wingerter, "Do 'welfare to work' numbers add up?" Kansas Health Institute (Apr. 14, 2016), http://www.khi.org/news/article/numbers-dont-support-welfare-to-work-claim.

[64] Tazra Mitchell and LaDonna Pavetti, *Life After TANF in Kansas: For Most, Unsteady Work and Earnings Below Half the Poverty Line*, Center on Budget and Policy Priorities (Jan. 23, 2018).

[65] *Id.*

[66] *Id.*

[67] *Id.*

[68] *Id.*

[69] Ife Floyd, LaDonna Pavetti, and Liz Schott, "TANF Reaching Few Poor Families," Center on Budget and Policy Priorities (Dec. 13, 2017), https://www.cbpp.org/research/family-income-support/tanf-reaching-few-poor-families.

[70] "Kansas' TANF Cash Assistance is Disappearing for Poor Families," Center on Budget and Policy Priorities https://www.cbpp.org/sites/default/files/atoms/files/tanf_trends_ks.pdf.

punitive work requirements in Kansas (and across the country) have not improved economic security for low-income families, instead leaving the majority of low-income families in deep poverty without access to benefits. Adding similar punitive work requirements to Medicaid will not improve health outcomes or financial well-being for these families: instead it will simply result in more uninsured individuals, who lack access to care and are risk of accruing more medical debt.

Kansas's proposal also runs afoul of laws that the Secretary is not authorized to waive. Kansas includes among the list of possible work activities, several unpaid options, including "work experience," and "supervised community service."[71] Requiring beneficiaries to work for the State, or other public entities, without paying them at least minimum wage violates the Fair Labor Standards Act, its implementing regulations, and Department of Labor guidelines.[72]

A far more productive (and permissible) approach would be to connect enrollees to properly resourced voluntary employment programs and supports, an activity that requires no waiver at all. 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.[73] The State also has the option to offer supportive employment services under §§ 1915(c) and (i) of the Social Security Act.

In summary, work requirements stand Medicaid's purpose on its head by creating barriers to coverage and the pathway to health that the coverage represents. This punitive policy would cover fewer people and increase the ranks of the uninsured. The obvious consequence? More delays in treatment, more gaps in coverage, poorer health outcomes and higher uncompensated care costs in hospitals and federally qualified health centers. For these and other reasons, HHS should deny Kansas's request to impose a work requirement on individuals who are seeking medical assistance through the Medicaid program.

**Lifetime Limits**

Kansas requests permission to limit lifetime enrollment to 36 months for individuals who are subject to the work requirements and comply with them.[74] Individuals subject to the work requirements and do not comply are limited to just three months of coverage in a 36-month period.[75]

Placing a time limit on Medicaid coverage is contrary to the objectives of the Medicaid Act. CMS acknowledged as much in 2016, flatly rejecting Arizona's request to impose a lifetime

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[71] Application at 12.
[72] *See* 29 U.S.C. § 206.
[73] 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.
[74] Application at 11.
[75] *Id.*

limit because it "could undermine access to care" and does "not support the objectives of the program."[76] Congress did not intend to limit Medicaid to temporary health care coverage. Instead, Congress designed the program to provide medical assistance to low-income individuals who cannot afford the costs of necessary medical care when and for as long as they have a medical necessity for such assistance. Indeed, Medicaid covers long-term care services – services that become more and more critical as people age or if they have a disabling or chronic condition. The Secretary may not now use § 1115 to allow Kansas to transform the basic purpose of its Medicaid program in a way that arbitrarily restricts access to coverage and services.

Notably, the time limit that Kansas proposes would disproportionately impact older individuals who might have hit the limit earlier in their lives. The policy would also disproportionately harm individuals who have serious or chronic health challenges that impede their ability to work, which is particularly concerning given that Kansas does not offer an exception for individuals with either acute or chronic health conditions that impede their ability to work. Medicaid offers dependable and affordable coverage that supports their ability to generate income (full-time or part-time) and may prevent them from otherwise becoming fully destitute. Because conditioning eligibility on an arbitrary time limit would likely disproportionately impact such individuals, as described above, approval of Kansas's proposal would violate the Americans with Disabilities Act and § 504 of the Rehabilitation Act – provisions that the Secretary is not authorized to waive under § 1115.

This proposal could also have harmful spillover effects for children whose parents or caretakers lose coverage under the lifetime limits. A recent study, using quasi-experimental data, shows that expanding coverage to parents and caretakers is associated with increased receipt of recommended pediatric preventive care for their children.[77] That study noted an "independent relationship between parental Medicaid enrollment and children's primary care use in low-income families" and cautions that "our results reveal the potential for reductions in adult Medicaid coverage to have unintended spillover effects on children's health care use."[78]

Finally, there is simply no experiment here. The outcome is predictable – individuals will lose access to affordable health insurance coverage and to medically necessary services and will experience harms to the financial and physical well-being. The time limit will also harm Kansas's provider infrastructure, as some providers will still have to treat uninsured patients without compensation.

**TransMed and Lockout Period**

Kansas also proposes to change its Transitional Medicaid Assistance (TMA) coverage by introducing optional "Independence Accounts." But TMA was established by Congress in

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[76] *See* Letter from Andrew M. Slavitt, Acting Admin., Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs. to Mr. Thomas Betlach, Dir. Az. Health Care Cost Containment Sys. 3 (Sept. 30, 2016).
[77] Maya Venkataramani, Craig Evan Pollack, Eric T. Roberts, *Spillover Effects of Adult Medicaid Expansions on Children's Use of Preventive Services*, 140 Pediatrics 1 (Dec. 2017), http://pediatrics.aappublications.org/content/140/6/e20170953.
[78] *Id.*

order to support families transitioning to work, by extending Medicaid coverage to families who became ineligible due to increased income from employment. According to the State, if an enrollee selects the Independence Account, it will "deposit funds into the Independence Account for the member for the 12 months of TransMed coverage, contingent upon the member's continued employment for all 12 months." At the end of the 12-month period, individuals will receive a debit card with which they can access funds from that account and "use for items specified by the State and approved by CMS." Individuals who "participate in this initiative would be prohibited form re-enrolling in Medicaid for a period of time to be determined by the State."[79]

The State's application leaves out almost all the key details, again precluding meaningful comment on this proposal. The State does not explain the amount to be deposited in the account; how frequently money will be deposited; what number of hours an individual must work each week (or month) to demonstrate "continued employment for all 12 months;" or whether the same activities which satisfy the work requirement qualify for purposes of accruing funds in the Independence Accounts, or whether this initiative is limited to unsubsidized, paid employment.

More glaring is the absence of any description of how individuals will obtain insurance if they forgo traditional TMA. For instance, it is entirely unclear whether individuals who receive the funds from the independence accounts could use the funds to purchase private health insurance coverage in lieu of TMA: Will individuals be able to withdraw funds during the 12-month period? Or will funds only be available at the end of the 12-months of continued employment? Are the funds intended to serve as a form of premium assistance? Will Medicaid cost sharing protections apply? Is the account sufficiently funded to purchase insurance?

The lack of detail also undermines any potential experimental or demonstration value to this proposal. Experience from other states that have implemented health savings-type accounts has shown that these accounts are often costly and not well understood by beneficiaries.[80] CMS should not approve another health savings account waiver until the evidence from Indiana and Michigan is fully understood.

Finally, the State proposes a punitive penalty—precluding individuals who "participate in the initiative" from re-enrolling in Medicaid for "a period of time determined by the State." But the State does not give any details on how long this penalty would be. Regardless, *any* punitive lock-out penalty should be rejected. Imagine a mother who works for a rural hospital that closes halfway through her 12-month TransMed period. A lockout would prevent her from regaining Medicaid despite being financially eligible after losing income (through no fault of her own.) As the labor statistics and data cited above reveals, low-wage workers are especially likely to experience unstable employment, variable hours, and fluctuating incomes. Imposing a lockout on this population entirely ignores the economic realities and changing circumstances that cause people to require Medicaid coverage in the first place. This penalty is frankly cruel and entirely inconsistent with the objectives of the Medicaid Act. It has no experimental value: the obvious and expected outcome is loss of coverage.

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[79] Application at 14-15.

[80] Musumeci, M. et al. An Early Look at Medicaid Expansion Waiver Implementation in Michigan and Indiana January 31, 2017. Available at https://www.kff.org/medicaid/issue-brief/an- early-look- at-medicaid- expansion-waiver- implementation-in-michigan-and- indiana/

**MediKan**

Kansas also proposes changes to the services provided to individuals with disabilities. Kansas seeks to discourage individuals from applying for federal disability benefits through the Social Security Administration (SSA) by offering more generous Medicaid benefits to individuals who give up their application for a disability determination.

Individuals who choose to pursue a disability determination currently receive "MediKan benefits," for no more than 12 months. The State's new proposal would incentivize these individuals to discontinue their disability determination from SSA by offering a "broader array of health care and social support services than the traditional MediKan program," if they withdraw their SSA application. Kansas's proposal does not specify how the benefit packages would differ, but notes that beneficiaries who relinquish their rights to pursue disability benefits will "receive Medicaid benefits through a KanCare MCO and will receive employment support such as job skills training for a duration of 18 months."[81] According to the State, the goal of the broader benefits is to "provide a comprehensive benefit package," to the MediKan population that is intended to "stabiliz[e] their immediate health care needs and provid[e] preventative care."[82] The application, therefore, suggests that the only way the current MediKan population will be able to access the medical care to treat their "immediate health care needs," or to access *any* care for more than 12 months (if SSA denies or has not processed their application), is by relinquishing their right to a disability determination from the Social Security Administration.

This proposal is unlawful. Such a proposal directly interferes with the constitutional due process rights and statutory rights of individuals applying for social security benefits.[83] Nothing in the Medicaid Act permits a State to undermine these distinct rights. Nor does the Secretary have the authority to "waive" the constitutional, statutory, or regulatory protections governing the administration of Social Security disability benefits programs.

While Kansas casts the proposal as setting up a "voluntary choice," it is nothing short of coercion.[84] Individuals who pursue disability benefit applications are limited to only 12 months of coverage. But recent data shows that processing of disability applications routinely take much longer than that: Nearly 1.1 million disability claimants are stuck in "one of the federal government's biggest backlogs" as they wait for one of the 1,600 Social Security administrative law judges to decide on their case.[85] Nationally, when an initial decision denying disability is

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[81] Application at 13. The Application is ambiguous as to whether the 18-month limitation applies to the medical benefits, or whether the 18-month time period refers only to the duration of the employment supports. We understand the 18-month limit to refer only to the employment supports, and, as discussed in the text above, strongly oppose any attempt to place time limits on Medicaid benefits.
[82] Application at 14.
[83] *See Mathews v. Eldridge*, 424 U.S. 319 (1976); *Flatford v. Chater*, 93 F.3d 1296, 1304 (6th Cir. 1996); 42 U.S.C. § 421; 20 C.F.R. § 422.203; 20 C.F.R. § 422.203.
[84] *Cf. Lebron v. Sec'y of Florida Dep't of Children & Families*, 772 F.3d 1352, 1374 (11th Cir. 2014) (rejecting argument that mandatory "consent" to drug testing was voluntary, when it was "a condition to the receipt of benefits," and noting that "government 'may not deny a benefit to a person on a basis that infringes his constitutionally protected interests.'").
[85] Terrence McCoy, "597 days. And still waiting," Washington Post (Nov. 20, 2017) http://www.washingtonpost.com/sf/local/2017/11/20/10000-people-died-waiting-for-a-disability-decision-in-the-past-year-will-he-be-next/?utm_term=.5cd5c1d51f37.

appealed, the average length of time spent waiting for an administrative law judge's decision has increased from 353 days in 2012 to 596 days in 2017.[86] But appeals to an ALJ are often necessary; in recent years, as many as half of the decisions initially denying benefits have been reversed at a hearing or subsequent review.[87] As a result, even individuals who are in fact disabled and who ultimately qualify for disability benefits from SSA, face a very real risk of being left without access to health care while their disability benefit application is pending. Under the KanCare 2.0 framework, even individuals who are entitled to disability benefits from SSA will be encouraged to give up their applications with the promise of broader and more dependable health care benefits from the State. And if they choose that path, they may experience longer delays at SSA, with extremely serious consequences if they later have to start a disability determination for permanent support all over again. Incentivizing individuals to give up other statutory rights to disability benefits is far afield from the objectives of the Medicaid Act to furnish medical assistance and the Secretary should deny this request. (We will not repeat our concerns with individuals who take the MCO enrollment path actually getting the services and coverage promised.)

**IMD Exclusion**

With almost no explanation, Kansas seeks a broad, blanket waiver of the IMD exclusion.[88] But a waiver of the IMD exclusion is unnecessary, unwise, and unapprovable. First, the Secretary may only waive provisions in § 1396a, and the IMD exclusion is codified in § 1396d. Second, section 1115 clearly specifies that the Secretary may only waive provisions to the extent and for the period necessary to conduct its experiment. Blanket waivers may not be approved.

Third, the State has not identified a valid experimental purpose or design to justify its IMD waiver request. Payments for up to 30 days in IMDs are already permitted, but Kansas appears to be seeking permission to fund even longer-term stays. [89] Long-term treatment in IMDs is not a best practice for individuals with mental health diagnoses and those needing substance use disorder treatment.[90] Individuals with short-term stays are more likely to leave

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[86] *Id.*

[87] Social Security Administration, "Outcomes of Applications for Disability Benefits," Table 72 https://www.ssa.gov/policy/docs/statcomps/ssi_asr/2016/sect10.pdf (showing SSI "allowance" rates at the hearing level or above of 38% in 2014 and 45% in 2015); Social Security Administration, "Outcomes of Applications for Disability Benefits," Table 63 (showing SSDI "allowance" rates at the hearing level or above of 53.7 percent in 2014 and 48.8 percent in 2015).

[88] Application at 25.

[89] 42 C.F.R. § 438.6(e) (allowing payments to MCOs for up to 15 days in an IMD in any given month and permitting two consecutive months, meaning payment for an enrollee could be made for up to 30 consecutive days).

[90] A review of studies shows there is little difference in many outcome measures between short and long-term stays in large psychiatric hospitals, but there is a significant difference in regards to social functioning, thus creating an overall preference for short-term stays. O. Babalola et al., *Length of Hospitalisation for People with Severe Mental Illness,* 1 COCHRANE DATABASE OF SYSTEMATIC REVS., Art. CD000384 (2014). Treatment of substance use disorder does not require institutional placement or treatment but instead may occur in a variety of settings, a decision made by the treating clinician based on an array of factors. ASAM, The American Society of Addiction Medicine, ASAM Standards of Care for the Addiction Specialist Physician (2014), https://www.asam.org/docs/default-source/practice-

the hospital on their planned discharge date and have a greater chance of finding employment.[91] While NHeLP is supportive of states using Medicaid to increase access to SUD and mental health services, funding IMDs focuses on the crisis rather than the cause and diverts resources away from the necessary long-term fixes of appropriate community-based services. Moreover, Section 2707 of the Affordable Care Act authorized a three-year IMD demonstration, which has already produced data suggesting that funding inpatient institutional beds increased federal costs without decreasing delays in accessing care.[92]

In addition, Kansas's sparse proposal offers no assurances that there will be sufficient guardrails in place to avoid the harms that the IMD exclusion prevents. There is no information about establishing a process for monitoring, licensing, and investigating facilities to ensure quality care in facilities. There is no mention of increasing State staffing and resourcing to ensure that any and all facilities meet the licensure standards, provide quality care, and have any allegations of abuse and neglect investigated. There is no requirement that residential care be strictly limited to circumstances where outpatient and community-based services would not constitute effective treatment. There is no requirement that residential facilities develop treatment plans designed to achieve patient discharge at the earliest possible time. There is no indication of how inpatient and residential care will supplement and coordinate with community-based care in a robust continuum of care.

Allowing Kansas to increase its reliance on institutional placement is harmful to the individuals seeking treatment and the overall system of care in the state. Accordingly, no additional waiver of the IMD exclusion should be requested or granted, given the vague proposal and available evidence suggesting that increased access to inpatient treatment is not an effective solution.

Instead, the State could increase availability of community-based SUD and mental health treatment without pursuing a waiver of the IMD exclusion at all. Using those resources to develop less-expensive, community-based services could help meet the needs of the population much more effectively without the dangers of unnecessarily increasing institutional placements.[93] Moreover, the promotion of institutional placement in lieu of community-based

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support/quality-improvement/asam-standards-of-care.pdf?sfvrsn=338068c2_10; Corey Davis and Hector Hernandez-Delgado, Nat'l. Health Law Program, *Medicaid and the Affordable Care Act: Vital Tools in Addressing the Opioid Epidemic* (Feb. 7, 2017) , http://www.healthlaw.org/publications/browse-all-publications/Medicaid-ACA-Vital-Tools-Addressing-Opioid-Epidemic#.WmdbK6inE2w; *see also* SAMHSA, Treatments for Substance Use Disorders, https://www.samhsa.gov/treatment/substance-use-disorders (explaining that long-term residential treatment is uncommon, with shorter term residential treatment being much more common and partial hospitalization or intensive outpatient treatment serving as alternatives to inpatient or residential treatment).

[91] Babalola et al., *supra* note 81.

[92] Crystal Blyer, *et al*, Mathematica Policy Research, *Medicaid Emergency Psychiatric Services Demonstration Evaluation, Final Report* (Aug. 18, 2016).

[93] *See* Corey Davis and Hector Hernandez-Delgado, Nat'l. Health Law Program, *Medicaid and the Affordable Care Act: Vital Tools in Addressing the Opioid Epidemic* (Feb. 7, 2017), http://www.healthlaw.org/publications/browse-all-publications/Medicaid-ACA-Vital-Tools-Addressing-Opioid-Epidemic#.WmdbK6inE2w; *See also* SAMHSA, *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies* (2014), http://store.samhsa.gov/shin/content//SMA14-4848/SMA14-4848.pdf.; *see also* Susan D. Phillips et al., *Moving Assertive Community Treatment into Standard Practice (2001); Alan*

care could violate the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, and Section 1557 of the Affordable Care Act. These violations may be attributable both to the State that is administering the programs and, for the purposes of Sections 504 and 1557, to CMS for encouraging and approving the use of federal funds in this manner.

**Conclusion**

NHeLP strongly objects to any efforts to use § 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 described in the Act. As demonstrated above, Kansas's proposal is inconsistent with the standards of § 1115 and with other provisions of law. We appreciate your consideration of our comments. If you have questions about these comments, please contact Sarah Grusin (grusin@healthlaw.org) or me.

Respectfully submitted,

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*Rosen et al., Assertive Community Treatment—Issues From Scientific And Clinical Literature With Implications For Practice,* 44 J. of Rehabilitation Res. & Dev. 813, 815-816 (2007); Bazelon Center, *Supportive Housing: The Most Effective and Integrated Housing for People with Mental Disabilities* 1 (2010), http://www.bazelon.org/wp-content/uploads/2017/04/supportive-housing-fact-sheet.pdf.