UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

RONNIE MAURICE STEWART, *et al*.,	)	
Plaintiffs,	)	
v.	)	Civil Action No. 1:18-cv-152 (JEB)
ALEX M. AZAR II, *et a*l.,	)	
Defendants.	)	

PROPOSED BRIEF OF AARP, AARP FOUNDATION, JUSTICE IN AGING, NATIONAL ACADEMY OF ELDER LAW ATTORNEYS, AND DISABILITY RIGHTS EDUCATION AND DEFENSE FUND AS AMICI CURIAE IN SUPPORT OF PLAINTIFFS' MOTION FOR PARTIAL SUMMARY JUDGMENT

Regan Bailey (D.C. Bar # 465677)
Eric Carlson
JUSTICE IN AGING
1441 I Street, NW, Suite 1100
Washington, DC 20005
T: (202) 683-1990
T: (213) 674-2813
rbailey@justiceinaging.org
ecarlson@justiceinaging.org

René H. Reixach, Jr.
WOODS OVIATT GILMAN LLP
on behalf of the NATIONAL ACADEMY OF ELDER LAW ATTORNEYS
700 Crossroads Building
2 State Street
Rochester, New York 14614
T: (585) 987-2858
rreixach@woodsoviatt.com

Maame Gyamfi (D.C. Bar # 462842)
Counsel of Record
Kelly Bagby (D.C. Bar # 462390)
AARP FOUNDATION
601 E Street, NW
Washington, DC 20049
T: (202) 434-6291
T: (202) 434-2103
mgyamfi@aarp.org
kbagby@aarp.org

Silvia Yee
Carly A. Myers
DISABILITY RIGHTS EDUCATION AND DEFENSE FUND
3075 Adeline Street, Suite 210
Berkeley, CA 94703
T: (510) 644-2555
syee@dredf.org
cmyers@dredf.org

Counsel for Amici Curiae

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INTERESTS OF AMICI CURIAE

All five proposed amicus curiae organizations appeared previously in this action as amicus curiae. *See* Doc. 36 & 36-1 (filed April 6, 2018).

AARP is the nation's largest nonprofit, nonpartisan organization dedicated to empowering Americans 50 and older to choose how they live as they age. With nearly 38 million members and offices in every state, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, AARP works to strengthen communities and advocate for what matters most to families, with a focus on health security, financial stability, and personal fulfillment. AARP's charitable affiliate, AARP Foundation, works to end senior poverty by helping vulnerable older adults build economic opportunity and social connectedness. AARP and AARP Foundation advocate for access to quality and affordable health care across the country by, among other things, frequently appearing as friend of the court on issues affecting older Americans. *See, e.g.*, *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012).

Justice in Aging is a national, nonprofit law organization that uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. Justice in Aging conducts training and advocacy regarding Medicare and Medicaid, and provides technical assistance to attorneys from across the country on how to address problems that arise under these programs. Justice in Aging frequently appears as friend of the court on cases involving health care access for older Americans.

The National Academy of Elder Law Attorneys, Inc. (NAELA) is a professional organization of attorneys concerned with the rights of the elderly and disabled, providing a professional center, including public interest advocacy, for attorneys whose work enhances the lives of people with special needs and of all people as they age. Its member attorneys represent

Kentuckians who are affected by the Kentucky HEALTH waiver granted by the Department of Health and Human Services (hereafter, "Kentucky HEALTH"), and appear frequently as friend of the court. *See, e.g.*, *Hughes v. McCarthy*, 734 F.3d 473, 480-81 (6th Cir. 2013) (Sixth Circuit noting agreement with position advanced by NAELA as friend of court).

The Disability Rights Education and Defense Fund (DREDF) is a national law and policy center that protects and advances the civil and human rights of people with disabilities through legal advocacy, training, education, and development of legislation and public policy. DREDF is committed to increasing accessible and equally effective healthcare for people with disabilities and eliminating persistent health disparities that affect the length and quality of their lives. DREDF has significant experience in Medicaid law and policy, given that disabled individuals disproportionately live in poverty and depend on Medicaid services and supports.

All Amici are national organizations affected by Defendants' approval of Kentucky HEALTH. At least fifteen other states have requested waivers involving work or "community engagement" requirements, and at least seven other states have requested waivers authorizing eligibility "lock-outs" for failure to pay premiums.[1] The Court's ruling will have a nationwide impact on the extent to which low-income persons have access to health care, and whether such health care will be subject to the types of restrictions established by Kentucky HEALTH.

Kentucky HEALTH applies to Medicaid coverage for Kentuckians from age 19 to 64 whose eligibility is not dependent upon meeting federal Medicaid law's definition of "disabled." AR 25510. As organizations that focus on the interests of older Americans and persons with disabilities, Amici have an interest in Kentucky HEALTH and in this litigation for two reasons.

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[1] *See* Kaiser Family Foundation, *Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State* (current through Jan. 9, 2019), https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#Table2.

First, Kentucky HEALTH is likely to harm Kentuckians with chronic conditions and functional impairments who are not classified as "disabled" under Medicaid law. Second, Amici have an interest in older persons and persons with disabilities, chronic conditions, and/or functional impairments who receive services in Medicaid programs outside Kentucky; and this Court's decision will affect Health and Human Services' (HHS) ability and willingness to grant similar waivers in other states. This Court's ruling will have a dramatic impact on Medicaid beneficiaries across the country, regardless of the beneficiary's age and level of disability.

INTRODUCTION

Defendants are federal officials who have granted the State of Kentucky (Intervenor in this action) a broad waiver of certain long-standing Medicaid protections. Contrary to the allegations of Defendants and Intervenor, Kentucky HEALTH does not "assist in promoting the objectives" of the Kentucky Medicaid program. *See* 42 U.S.C. § 1315(a). Rather Kentucky HEALTH would terminate or reduce Medicaid coverage for tens of thousands of low-income Kentuckians from ages 19 to 64. The challenged aspects of Kentucky HEALTH are punitive, and they do nothing to improve health care for Kentucky's Medicaid beneficiaries.

To properly consider a waiver request, the federal government must assess 1) whether the project truly is an "experimental, pilot, or demonstration project;" 2) whether the project is likely to assist in promoting the Medicaid program's objectives; and 3) the length of time for which the project is necessary. *Newton-Nations v. Betlach*, 660 F.3d 370, 380 (9th Cir. 2011). In this litigation, a crucial issue has been, and continues to be, the true objectives of the Medicaid program. The most concise statement of Medicaid objectives is found in 42 U.S.C. § 1396-1. This Court has cited this statute to identify "two related objectives: allowing states, 'as far as practicable,' to 'furnish (1) medical assistance' and (2) 'rehabilitation and other services'

designed to 'help individuals retain a capacity for independence." *Stewart v. Azar*, 313 F. Supp. 3d 237, 260 (D. D.C. 2018) (quoting section 1396-1).

Amici agree with Plaintiffs' description of how Defendants have failed each of these requirements. *See* Doc. 91-1 at 11-51. First, Amici addresses the suggestion by Defendants and Intervenor that certain waiver provisions are justified by the fact that they will apply only to "able-bodied" persons. *See* AR 1029, 1670, 1865, 1934, 2080, 2519, 8179, 8535, 8537, 8539-40, 8542, 8546-47, 8562, 8566-67, 8575-76, 8578, 25505, 25513, 25516, 25518-19, 25533, 25579-80, & 25590-91. In fact, Kentucky HEALTH will harm many Kentuckians who have chronic conditions or functional impairments. They will be more likely to lose Medicaid coverage because of the complexities of their illnesses, and more susceptible to harm caused by that lack of coverage.

Amici then address three particular provisions of Kentucky HEALTH: 1) elimination of the Medicaid protection that allows for coverage for certain pre-application months, 2) elimination of non-emergency medical transportation, and 3) the six-month enrollment "lock-outs." Then, Amici explain why administrative errors likely will magnify the harm to low-income Kentuckians. Finally, Amici point out that faulty waiver design cannot be overcome by after-the-fact program evaluation, or threats to eliminate Medicaid eligibility entirely for the age 19 to 64 population.

ARGUMENT

I. KENTUCKY HEALTH WILL HARM VULNERABLE KENTUCKIANS WHO DEPEND ON MEDICAID FOR THEIR HEALTH CARE COVERAGE.

A. Kentucky HEALTH Primarily Affects Adults from Ages 19 to 64, But It Is Misleading for Defendants and Intervenor to Broadly Describe this Population as "Able-Bodied."

Kentucky HEALTH by its terms affects five separate Medicaid eligibility groups: parents and other caretaker relatives, pregnant women, former foster care youth, transitional medical assistance, and the "new adult group." AR 6754. This "new" group is the population of adults who gained eligibility through the Affordable Care Act's expansion of Medicaid eligibility, and by Intervenor's subsequent decision to offer coverage to this group. AR 25510; *see* 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII); Pub. L. No. 111-148, Title II, § 2001 (2010) (provision of Affordable Care Act). The new group is comprised of persons between ages 19 and 64 who are not considered "disabled" under federal Medicaid law, and who qualify based on having income of no more than 138% of the federal poverty level. *Id.* Because this "new" group comprises the largest percentage of persons subject to Kentucky HEALTH, and because the other groups (such as the pregnant women) are excused from some requirements, this brief will discuss Kentucky HEALTH primarily as affecting the "new" group of beneficiaries. AR 25516-17, 25520. This brief will refer to these beneficiaries as the "expansion" population, because they gained eligibility through the recent expansion of Medicaid through the Affordable Care Act.

In seeking Kentucky HEALTH, Intervenor has characterized the affected population as "able-bodied." *See supra* at 4. As explained in this brief, the term "able-bodied" hides many harms that likely would result if Kentucky HEALTH were implemented. Although Medicaid eligibility rules may classify a person as "disabled" or "not disabled," disability in real life is a

continuum. A Medicaid beneficiary may not be formally "disabled" under Medicaid law, but nonetheless face significant health-related challenges. Data from the National Center for Health Statistics shows that approximately 40% of working-age Medicaid beneficiaries "have broadly defined disabilities, most of whom are not readily identified as such through administrative records." AR 20310 (H. Stephen Kaye, *How Do Disability and Poor Health Impact Proposed Medicaid Work Requirements?*, Community Living Policy Ctr. 2 (Feb. 2018)). Similarly, data from the March 2017 Current Population Survey (reflecting 2016 health insurance coverage) show that, among Kentucky's non-elderly Medicaid population who are not receiving Supplemental Security Income due to disability, 51% cited being ill or disabled as the reason for not being employed. AR 25928 (Rachel Garfield et al., *Understanding the Intersection of Medicaid and Work*, at 10 (Appendix Table 2), Kaiser Family Foundation, (Jan. 2018)).

Other data sources are in accord. Among Medicaid beneficiaries not classified as aged or disabled, 52 percent reported serious difficulty with mobility, and 51 percent noted serious difficulty with cognitive functioning. Forty-two percent experienced serious difficulty with independent living tasks (e.g., shopping). Another 21 percent reported serious difficulty with daily living activities such as dressing or bathing. AR 26298 (MaryBeth Musumeci et al, *How Might Medicaid Adults with Disabilities Be Affected by Work Requirements in Section 1115 Waiver Programs?*, Kaiser Family Foundation, (Jan. 2018)); *see also* AR 25818-19 (Rachel Garfield et al., *Implications of Work Requirements in Medicaid: What Does the Data Say?*, Kaiser Family Foundation (June 2018)) (prevalence of chronic conditions among non-working Medicaid beneficiaries).

Medicaid law classifies a beneficiary as either "aged" (age 65 or older) or not. *See, e.g.*, 42 U.S.C. § 1396d(a)(3). But in reality some beneficiaries in their 50s or early 60s face many of

the same health challenges that confront beneficiaries formally classified as "aged" (i.e., age 65 and older). Many health problems are hidden by Intervenor's use of the term "able-bodied" to describe the population of persons who are under age 65 and not classified as disabled.

B. Kentucky HEALTH Will Roll-Back Recent Coverage Improvements and Place Kentuckians with Chronic Conditions or Functional Impairments at Risk of Serious Harm.

Intervenor anticipates that Kentucky HEALTH will lead to a significant decline in Medicaid enrollment. Intervenor estimates losses of 238,000 months of coverage in the first year, rising to 699,000 months in the third year and 1.14 million months in the fifth year. AR 25618. These lost *months* are equivalent to approximately 19,833, 58,250, and 95,000 cumulatively lost enrollees in the first, third, and fifth year.

Defendants and Intervenor have been unable to counter the reasonable assumption that the vast majority of these lost enrollees will become uninsured. Intervenor's public notice acknowledges that "program non-compliance" is one reason for enrollment that will "fluctuate," but does not detail how its estimates were developed. *Id*. Given the lack of explanation, it is reasonable to assume that the lost enrollees will lose health insurance due, at least in part, to Kentucky HEALTH's various administrative roadblocks, financial obligations, and enrollment lock-outs. Intervenor suggests that persons might "transition to commercial coverage," but provides no reason to explain why that might be true. *Id*. Certain persons may increase their incomes beyond the Medicaid limit of $1,436.35 monthly, but such increases likely would occur regardless of the implementation of Kentucky HEALTH.[2] Intervenor's evidence does not begin

[2] The federal poverty level for 2019 is $12,490 annually, or $1,040.83 monthly. Thus, the maximum income for expansion Medicaid eligibility is $1,436.35 monthly (12,490 ÷ 12 X 138% = 1,436.10). *See* https://aspe.hhs.gov/poverty-guidelines. Federal Register publication of the guidelines has been delayed by the current partial shutdown of the federal government.

to show that the decreased enrollment is the result of increased income, rather than the combined effect of Kentucky HEALTH's administrative roadblocks, duties, and lock-outs.

Furthermore, Intervenor's estimates may well underestimate the danger. The Arkansas Medicaid program recently implemented a waiver similar to Intervenor's. Based on Arkansas data, researchers estimate that Kentucky HEALTH would result in 26 to 41 percent of the age 19 to 64 Medicaid population losing coverage —86,000 to 136,000 persons. Leighton Ku & Erin Brantley, *Updated Estimates of the Effects of Medicaid Work Requirements in Kentucky*, GW Health Policy Matters, George Washington University (Revised Jan. 8, 2019). This loss is predicted to occur within one year, as opposed to the five-year period used in Intervenor's estimates. *Id*.

Thus, Kentucky HEALTH threatens a devastating set-back. Providing Medicaid to the age 19 to 64 population has led to significant improvements in health care coverage rates. A recent study surveyed Kentuckians from age 19 through 64, with incomes not exceeding 138% of the federal poverty level. In 2013, 40.2 percent of this low-income population was uninsured, but this percentage fell to 12.4%, 8.6% and then 7.4% in 2014, 2015 and 2016, respectively. AR 20351 (Benjamin Sommers et al., *Three-Year Impacts of the Affordable Care Act: Improved Medical Care and Health Among Low-Income Adults*, 36 Health Affairs, No. 6, 1119 (2017)).

Furthermore, the increased level of insurance coverage led to health care improvements. Preventive care improved from 2013 to 2016, indicated by increases of 26, 27, and 19 percent in annual check-ups, annual cholesterol checks, and annual blood sugar checks. *Id.* Similar improvements were seen in the quality of care for persons with preexisting health care conditions. High-risk patients—those patients with histories of heart disease, stroke, diabetes, or hypertension—experienced a 111 percent increase in cholesterol checks. *Id.* Likewise, patients

with diabetes saw a seven percent increase in blood sugar checks. Persons with chronic conditions were 113 percent more likely to receive regular care to address that condition. *Id*.

Kentucky HEALTH, however, may well reverse many of these gains, with a significant burden falling on expansion population beneficiaries in their 50s and 60s, or on younger expansion population beneficiaries with chronic conditions or functional impairments. These people, as well as parent/caretakers with chronic conditions or in the 50-64 range in Kentucky's "traditional" Medicaid population, are not eligible for Medicare because they are not 65 years of age and (in most cases) do not meet programmatic definitions of "disabled," but they are relatively more likely to be facing significant health problems. *See* 42 U.S.C. § 1395c (Medicare eligibility standards).

Prevalence of chronic conditions, including both physical and mental health conditions, increases markedly with age. Based on health care expense data, the Agency for Healthcare Research and Quality found that 57% percent of persons from ages 55 through 64 have at least two chronic conditions. AR 20658-59, 20662 (Steven Machlin et al., *Agency for Healthcare Research and Quality, Statistical Brief #203: Health Care Expenses for Adults with Chronic Conditions, 2005*, (May 2008)). An additional 20.3% of these persons have one chronic condition, while only 22.7% of this population have no chronic conditions. *Id.* AARP came to similar conclusions in an analysis of data for the age 50-64 population, finding that 72.5% of this population have at least one chronic condition, and almost 20% experience some sort of mental illness. AR 20503-504, 20508 (AARP Public Policy Institute, *Chronic Care: A Call to Action for Health Reform* (March 2009)).

The National Institute on Aging and National Institutes of Health reached similar results based on surveys of tens of thousands of respondents. Sixty percent of respondents from the age

of 55 to 64 reported at least one health problem, with 25% reporting at least two problems. For the purposes of this study, a "problem" was defined as being linked to one of six categories: hypertension, diabetes, cancer, bronchitis/emphysema, heart condition, and stroke. AR 20383 (Nat'l Institute on Aging and Nat'l Institutes of Health, *Growing Older in America: The Health & Retirement Study* (March 2007)).

Another marker of health need is an increase in health care expenses. In an examining employer-sponsored health care, the Health Cost Institute documented how health care expenses rise significantly with age. For persons from ages 55 to 64, average annual health care expenses were 44% higher than for persons age 45 to 54, and 116% higher than for persons age 26 to 44.[3]

Finally, health status tends to vary with income, with lower-income persons experiencing more chronic conditions. For persons of at least age 50 with income below 200 percent of the federal poverty level, seventy percent report fair to poor health and/or at least one chronic condition. Sara Rosenbaum et al., *Medicaid Work Demonstrations: What Is at Stake for Older Adults?*, Commonwealth Fund, (March 2018). This percentage increases to 83 percent by age 55. Notably, these percentages in each case are at least 20 percentage points higher than the rates for persons with incomes exceeding 200 percent of the federal poverty level. *Id.*

All these data demonstrate how low-income beneficiaries in their 50s and 60s—along with some younger low-income beneficiaries with chronic conditions or functional impairments —will be deprived of needed health care under the restrictions imposed by Kentucky HEALTH.

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[3] Health Care Cost Institute, *2016 Health Care Cost and Utilization Report Appendix*, at 1 (Table A1) (Jan. 2018), https://www.healthcostinstitute.org/images/pdfs/2016-HCCUR-Appendix-1.23.18-c.pdf. Annual health care expenses for the 55 to 64 population, the 45 to 54 population, and the 26 to 44 population were $10,137, $7,026, and $4,695, respectively. (10,137 ÷ 7,026 = 144%; 10,137 ÷ 4,695 = 216%).

Lost months of Medicaid coverage have a human cost: less preventive care, greater decline, and avoidable deterioration in physical and mental health.

II. DEFENDANTS IMPEDE MEDICAID OBJECTIVES BY WAIVING THE PROTECTION THAT ALLOWS FOR COVERAGE PRIOR TO THE APPLICATION MONTH.

A. Coverage Prior to the Application Month Protects Low-Income People Who Have Suffered Injury or Another Health Setback.

Defendants waived the important patient protection that allows Medicaid coverage to begin up to three months prior to the application month, for months during which the applicant met Medicaid eligibility standards. AR 6741, 6748 & 6756. Defendants similarly have waived pre-application coverage for eight other states. Such a waiver applies to the Medicaid expansion population in Arkansas, Indiana and New Hampshire, to a non-expansion Medicaid population in Florida, Maine and Utah, and to both the expansion population and a non-expansion population in Arizona, Iowa, and New Mexico. *See* Medicaid Waiver Tracker, *supra* at 2 n.1.[4]

Waiver of pre-application coverage seriously impedes Medicaid objectives, by denying Medicaid coverage for persons who cannot afford health care expenses or private health insurance. In 1973, Congress enacted section 42 U.S.C. § 1396a(a)(34), which requires a state Medicaid program to provide coverage for up to three months prior to the application month, as long as the person met eligibility requirements during those months. Before then, states had the *option* of offering such coverage, and 31 states in fact did so. S. Rep. No. 92-1230, at 209 (1972) (contained within Vol. 3 of Amendments to The Social Security Act 1969-1972, p. 221 of

[4] The newly-elected governor of Maine recently rejected the previously-approved waiver, stating that the demonstration "would leave more Maine people uninsured without improving their participation in the workforce." *In Lieu of Medicaid Restrictions, Governor Mills Directs DHHS & Labor to Promote Work Opportunities*, https://www.maine.gov/governor/mills/news/lieu-medicaid-restrictions-governor-mills-directs-dhhs-labor-promote-work-opportunities-2019.

1273). In recommending that all states be required to provide this coverage, a Senate committee report noted that the amendment would "protect[] persons who are eligible for [M]edicaid but do not apply for assistance until after they have received care, either because they did not know about the [M]edicaid eligibility requirements or because the sudden nature of their illness prevented their applying." *Id.*; *see also Cohen ex rel. Cohen v. Quern*, 608 F. Supp. 1324, 1332 (N.D. Ill. 1984) (quoting from Senate report).

This accommodation to applicants made (and continues to make) good sense. In states that did not offer coverage prior to the month of application, injured persons often were unable to receive needed health care. The Secretary of Health, Education, and Welfare explained the problem in testimony supporting the legislative amendment:

> Providers have been reluctant in many instances to care for potential Medicaid eligibles because frequently the patient has not applied for Medicaid prior to his illness and, therefore, the providers would not be eligible to receive payment for their services.

Statement by Elliot L. Richardson, Sec'y of HEW, before the Sen. Fin. Comm., at 11 (July 14, 1970) (contained within Vol. 8 of Amendments to The Social Security Act 1969-1972, p. 1262 of 1267). This problem is no less vexing today, as lack of health care coverage continues to limit persons' access to needed health care.

Today, the right to pre-application coverage is established through sections 1396a(a)(34) and 1396d(a) (which defines Medicaid's "medical assistance" as including up to three pre-application months). Notably, Congress has rejected recent legislative efforts to amend sections 1396a and 1396d to eliminate this protection. H.R. 1628, 115th Cong. § 114(b) (2017); H.R. 180, 115th Cong. § 1 (2017); H.R. 5626, 114th Cong. § 1 (2016); S. Amdt.270 to S.Amdt.267, 115th Cong., Tit. I of Better Care Reconciliation Act of 2017, § 127(a). (2017), within 163 Cong. Rec. S4196, S4205 (July 25, 2017). This failed legislation supports Plaintiffs' argument that

Defendants, in approving Kentucky HEALTH, have inappropriately taken over a legislative function in an effort to fundamentally transform Medicaid. *See* Doc. 91-1 at 25-26, 32.

B. Due to Injury or Unfamiliarity with the Health Care System, Low-Income Persons Often Do Not Apply for Medicaid Coverage Within the First Month in Which Care Was Provided.

Amici routinely witness the importance of this Medicaid protection. Needless to say, many hospitalizations are unplanned. Our members and clients suffer strokes, auto accidents, and falls, among other setbacks, and unexpectedly find themselves in hospitals and nursing homes, often struggling with terrifying new medical realities. It is little surprise that many do not file a Medicaid application within the initial month, particularly when the "month" of admission may just be a day or two before one month turns into another. Under Kentucky HEALTH, a woman could be hit by an uninsured driver on the evening of January 30, and be liable for thousands of dollars of hospital expenses due to the "failure" to file a Medicaid application within 36 hours, when January becomes February. A comparable fact pattern was present in a Sixth Circuit decision involving Section 1396a(a)(34): an emergency hospitalization had led to pre-Medicaid-application health care bills totaling approximately $50,000. *Schott v. Olszewski*, 401 F.3d 682, 685 (6th Cir. 2005) (more than $40,000 in unpaid bills, and more than $8,000 in reimbursement due to patient for bills she had paid herself).

Amici also observe in practice how the complexity of the system causes delays in filing a Medicaid application. One complexity is particularly common for persons of age 65 or older (who are not included in Kentucky HEALTH, but who have lost pre-eligibility coverage in a waiver granted by Defendants to the State of Iowa). When first admitted to a nursing home, many older persons initially assume that their nursing home care expenses will be covered by

their Medicare coverage.[5] That assumption, however, can be dangerously inaccurate—Medicare coverage for nursing home care is much more restrictive than generally believed. Medicare coverage requires that the nursing home care follow an inpatient hospital stay of at least three nights, and is available only when in the nursing home the person on a daily basis receives skilled therapy services or extraordinary nursing services as a specific follow-up to the hospital services. 42 C.F.R. §§ 409.30(a), 409.31(b), 409.32. Also, Medicare can pay the entirety of nursing home charges only for the initial 20 days; days 21 through 100 have a daily co-payment (for 2019) of $170.50 (over $5,100 monthly). 42 C.F.R. § 409.61(b). Finally, most persons do not receive anything close to 100 days of coverage, due primarily to Medicare contractor determinations that the person no longer needs the required level of therapy or skilled nursing services.[6]

C. Because Medicaid Beneficiaries By Definition Cannot Afford Private Insurance, Medicaid Policies Regarding Coverage Effective Dates Should Not Be Based on Private Insurance Practices.

Intervenor justifies waiver of pre-application coverage by making comparisons to private insurance, which generally does not become effective until the applicant pays the relevant premium. Intervenor claims that "[e]liminating Medicaid retroactivity encourages individuals to obtain and maintain health insurance coverage, even when the individual is healthy," and further

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[5] *See, e.g.*, T. Thompson et al., *Long-Term Care: Perceptions, Experiences, and Attitudes Among Americans 40 or Older*, Associated Press-NORC Ctr. for Public Affairs Research, 7 (2013), http://www.apnorc.org/PDFs/Long%20Term%20Care/ AP_NORC_Long%20 Term%20Care%20Perception_FINAL%20REPORT.pdf (survey shows Americans "overestimate the long-term care services that Medicare will cover").

[6] In 2016, the average length of stay under Medicare was only 27.6 days. Medicare Payment Advisory Commission (Med PAC), *A Data Book: Health Care Spending and the Medicare Program*, 112, Chart 8-4 (June 2016), http://www.medpac.gov/docs/default-source/data-book/june-2016-data-book-health-care-spending-and-the-medicare-program.pdf.

asserts that this elimination is "consistent with the commercial market and federal Marketplace policies." AR 25521.

This Court has criticized Defendants' previous conclusory statements that elimination of retroactive eligibility will facilitate private insurance. *See Stewart*, 313 F. Supp. 3d at 265. The flaws of Intervenor's claims, in both the original and current application for waiver, are in the premises that underlie them—that Medicaid beneficiaries can afford private insurance, and that Medicaid should emulate private insurance policies. But persons are eligible for Medicaid precisely because they cannot afford private health insurance. Limiting Medicaid coverage does not incentivize purchase of private health insurance, but instead leads inexorably to more uninsured persons, deficient health care, and unpaid health care bills, as evidenced by Kentucky's high rate of uninsured persons prior to the Medicaid expansion.

Accordingly, Medicaid should not be administered like private insurance. Medicaid coverage is based on financial need, not on payment of premiums—indeed, the federal Medicaid statute either prohibits premiums or, for persons with incomes above 150% of the federal poverty level, caps total cost sharing at 5% of income. 42 U.S.C. §§ 1396o(c)(1), 1396o-1(b)(1)-(2); *see also* Doc. 91-1 at 23-25. Accordingly, Intervenor has no pro-health-care policy reason to deny Medicaid coverage for health care received within three months prior to the application month, since such coverage only is available for months in which the person meets financial eligibility requirements. 42 U.S.C. § 1396a(a)(34); 42 C.F.R. § 435.915(a)(2).

If, for example, a patient applies for Medicaid coverage in May, and his low-income financial situation met Medicaid financial eligibility standards for the preceding February and all subsequent months, a safety-net health care program should authorize coverage starting in February. Put another way, eliminating pre-application coverage for February, March and April

would frustrate Medicaid's objectives. The patient might not be able to obtain needed services in February, March or April or, if he received care, would face unaffordable bills. The health care provider also would be injured, with no way to obtain reimbursement for services provided.

Furthermore, Defendants or Intervenor cannot credibly claim that their consistency-with-private-market arguments are justified by the fact that Intervenor plans to impose premiums, which are a standard feature of private insurance plans. As explained in Plaintiffs' brief supporting their Motion for Summary Judgment, imposition of premiums impedes the objectives of Kentucky's Medicaid program, and should not be allowed. Doc. 91-1 at 23-25.

Even assuming that premiums could be lawfully assessed, they should not justify the proposed elimination of pre-application coverage. Premiums undoubtedly increase the financial pressure on low-income persons who already cannot afford private health insurance. It would be a perverse turn of reasoning if one harmful policy (imposition of premiums) was used to prop up another harmful policy (elimination of pre-application coverage). And whether or not premiums are assessed, Medicaid beneficiaries cannot afford private insurance, and often need coverage within the three months preceding the application month.

Intervenor claims that it wants to encourage Medicaid enrollment when persons are healthy, but its efforts to emulate private coverage are counterproductive. Medicaid works for its low-income population by, among other things, not requiring premiums and by providing for coverage up to three months prior to the month of application. By changing these features, Intervenor will not move Medicaid beneficiaries into private insurance. Instead, it will make it more likely that many low-income Kentuckians will be denied care or saddled with unaffordable bills, and that health care providers will not be reimbursed for care provided. In turn, this will push private insurance even further out of reach — not pull it closer.

III. DEFENDANTS IMPEDE MEDICAID OBJECTIVES BY ELIMINATING NON-EMERGENCY MEDICAL TRANSPORTATION.

Defendants also have waived the requirement that the Medicaid program ensure necessary transportation to and from health care services. Under federal law, "necessary" transportation can include both emergency and non-emergency transportation, 42 C.F.R. § 431.53, but Kentucky HEALTH has eliminated non-emergency medical transportation ("NEMT") for persons in the Medicaid expansion population. Kentucky HEALTH also eliminates non-emergency transportation for methadone treatment services for nearly all Medicaid beneficiaries, including those deemed "medically frail." However, NEMT is retained for pregnant women, "medically frail" beneficiaries (other than for methadone treatment), or any persons eligible for Medicaid prior to the enactment of the Affordable Care Act. AR 6762-63.

Many low-income people simply cannot afford to buy a car or hire a transportation service, and some lack access to affordable and reliable public transit. These issues—particularly when compounded by physical accessibility barriers—make the non-emergency medical transportation benefit especially critical for persons with chronic conditions or functional impairments. Indeed, the Government Accountability Office ("GAO") found that "excluding the NEMT benefit would impede . . . enrollees' ability to access health care services, particularly individuals living in rural or underserved areas, as well as those with chronic health conditions." AR 20484 (GAO-16-221, *Medicaid: Efforts to Exclude Nonemergency Transportation Not Widespread, but Raise Issues for Expanded Coverage* (Jan. 2016)).

Furthermore, lack of non-emergency medical transportation has consequences. When transportation is unavailable, the person does not receive needed health care, and the risk of hospitalization or nursing home admission increases.

For these reasons, Kentucky HEALTH's elimination of NEMT conflicts with the objectives of the Medicaid program. Intervenor relies in part on data showing that, from June 2014 through June 2015, the Kentucky "expansion" population of more than 400,000 beneficiaries utilized less than 140,000 non-emergency trips, but this data does nothing to justify Intervenor's position. AR 25546. Virtually any Medicaid benefit is utilized by only a minority of beneficiaries, but that hardly justifies eliminating the benefit. In this case, the crucial fact is that, if Kentucky HEALTH is implemented, there may be approximately 140,000 instances annually where a low-income Kentuckian will not be able to obtain needed transportation to a health care appointment. In most of these instances the person affected will have a chronic condition or functional impairment.

IV. DEFENDANTS IMPEDE MEDICAID OBJECTIVES BY APPROVING PUNITIVE SIX-MONTH ENROLLMENT LOCK-OUTS.

Kentucky HEALTH also authorizes six-month enrollment lock-outs to penalize persons who otherwise meet eligibility standards. AR 6742, 6756, 6759-60, 6770. The punitiveness of this provision is striking—for such transgressions as not timely submitting documentation, otherwise eligible persons are barred for Medicaid eligibility for up to six months.

Amici recognize that Intervenor legally may improve access to private health care coverage or, under the proper circumstances, terminate eligibility for failure to submit required information, provided that the beneficiary receives all due process protections. *See, e.g.*, 42 C.F.R. §§ 431.200-250 (right to notice and administrative hearing), 435.916 (redeterminations of eligibility). Medicaid law, however, does *not* allow for denying eligibility to otherwise eligible people, and thus imposition of enrollment lock-outs is inconsistent with Medicaid objectives.

Under Kentucky HEALTH, lock-outs can be imposed in three situations: when a beneficiary did not timely report changed circumstances, did not timely submit documentation

for renewing eligibility, or did not pay a premium within 60 days of the due date. AR 6742. The premium-related lock-out applies only to those beneficiaries with incomes exceeding $1,040.83 monthly. *See supra* at 7 n.2 (poverty levels for 2019). Kentucky HEALTH provides exceptions from enrollment lock-out for certain groups. Lock-outs are not imposed on pregnant women, former foster care youth, and "medically frail" beneficiaries: these persons are not required to pay premiums, and are excused from lock-out related to changed circumstances or renewals. AR 6760. A beneficiary facing certain circumstances can be exempted from a lock-out. These circumstances include hospitalization, death of a family member, eviction, natural disasters, and domestic violence. AR 6758. With these exemptions, however, comes the administrative burden of proving that one is eligible for the exemption. Finally, a beneficiary subject to a lock-out can reenroll prior to the expiration of the lock-out period by paying required premiums and completing a re-enrollment education course on health or financial literacy, although this reenrollment right is available only once every twelve months. AR 6772-73.

As was true in the waiver of pre-application coverage, the State based its lock-out request on inapt comparisons with private insurance. A stated goal is to "encourage individuals to become active consumers of healthcare who are prepared to use commercial health insurance." AR 25520. In accord, Kentucky HEALTH purportedly "will implement key commercial market and Marketplace policies in order to introduce these critical concepts to Kentucky HEALTH members." *Id*. One such concept supposedly is the "client-specific open enrollment period."

> … Specifically, if an individual is disenrolled from the program in accordance with current practice for failing to comply with annual eligibility redetermination requirements, the individual will be required to wait six months for a new open enrollment period. This policy will educate members of the importance of meeting commercial market open enrollment deadlines, while also allowing members to rejoin the program at any time prior to the six-month date by completing a financial or health literary course.

AR 25512-13.

This reasoning, however, conflicts with the purpose of the Medicaid program, as this Court has recognized. *See Stewart*, 313 F. Supp. 3d at 262. Relatedly, this reasoning also fails to recognize Medicaid beneficiaries' low-income reality. Again, Medicaid exists precisely to provide health care coverage for persons who otherwise cannot afford such coverage. Intervenor has noted the rapid growth in the Kentucky Medicaid "expansion" population—persons from age 19 to 64 whose coverage was authorized by the Affordable Care Act—and data show that introduction of coverage in Kentucky for the "expansion" population reduced the uninsured rate from 40.2% to 7.4% among the eligible population. AR 25505-506; *see also* AR 20351 (Sommers, *supra*). Medicaid beneficiaries do not rely upon Medicaid coverage because they are unfamiliar with private coverage—rather, they cannot *afford* private coverage.

To defend imposition of penalty periods, Intervenor confuses findings from an interim report on the Indiana Medicaid program, claiming that "less than 6% of the individuals (2,677) [in the Indiana Medicaid program] were disenrolled for non-payment, and the majority (56%) were able to obtain health insurance during this six month period." AR 25551. One major flaw of Intervenor's rationale is the failure to distinguish between differing components of the Indiana Medicaid program. In Indiana, the failure to pay premiums had different consequences depending on whether the person's income was between 100% and 138% of the federal poverty limit (FPL), or whether it was no more than 100% FPL. Non-payment resulted in disenrollment with a six month lock-out for the population with incomes from 100% to 138% FPL, but not for the persons whose incomes were no greater than 100% of FPL—who were downgraded to a more limited benefit package. AR 4859.

The interim report on the Indiana program found disenrollment of 2,677 persons (5.9% of enrollment) from the 100% to 138% FPL group, and downgrading of coverage for 21,445 persons (8.2% of enrollment) within the no-more-than-100%-of-FPL group. Intervenor relies on a finding that, of 75 surveyed persons who lost health care coverage from the 100% to 138% FPL group, 42 persons (56%) had acquired other coverage. AR 4895-97. Notably, the sample size is relatively small, so Intervenor overstates the findings to the extent that it suggests that the study gathered data regarding each of the persons subject to an enrollment lock-out. AR 25551.

More importantly, the data from Indiana do not support imposing lock-outs. The data indicate that 44% of Indiana Medicaid beneficiaries in the 100%-to-138% group were locked out of Medicaid *without* having alternative health care coverage. Such deprivation of health care coverage is inconsistent with Medicaid objectives.

V. KENTUCKY HEALTH'S UNFAIRNESS WOULD BE MAGNIFIED BY FORESEEABLE ADMINISTRATIVE ERRORS.

As discussed above, Kentucky HEALTH imposes significant and unfair obligations upon low-income Kentuckians, with the evident intent to reduce Medicaid enrollment. The many negative impacts will only be exacerbated by predictable administrative errors and bottlenecks: "[r]ed tape and paperwork requirements have been shown to reduce enrollment in Medicaid across the board, and people coping with serious mental illness or physical impairments may face particular difficulties meeting these requirements." Ctr. on Budget and Policy Priorities, *Taking Away Medicaid for Not Meeting Work Requirements Harms Older Americans* 2 (Dec. 5, 2018), https://www.cbpp.org/research/health/taking-away-medicaid-for-not-meeting-work-requirements-harms-older-americans.

Research on the Temporary Assistance for Needy Families (TANF) program (which provides cash benefits) found that beneficiaries with disabilities and poor health are more likely

to lose benefits due to an inability to navigate the system. AR 25961, 25963-64 (Yeheskel Hasenfeld, et al., *The Logic of Sanctioning Welfare Recipients: An Empirical Assessment*, Social Service Review (June 2004), https://repository.upenn.edu/cgi/viewcontent.cgi?referer= https://www.google.com/&httpsredir=1&article=1028&context=spp_papers). In accord, a review of the research finds that the existence of exemptions does not necessarily ameliorate problems, since a beneficiary may likely have difficulty understanding and obtaining the exemption. AR 4726 (Heather Hahn et al., *Work Requirements in Social Safety Net Programs*, Urban Institute (Dec. 2017) https://www.urban. org/sites/default/files/publication/95566/work-requirements-in-social-safety-net-programs.pdf).

In a similar vein, a recent nationwide report from the U.S. Agriculture Department found that implementing work requirements for the Supplemental Nutrition Assistance Program (SNAP) was an "administrative nightmare" that was "error prone" in multiple states. AR 20634 (U.S. Dep't of Agric., Office of the Inspector Gen., *FNS Controls Over SNAP Benefits for Able-Bodied Adults Without Dependents*, 5 (Sept. 29, 2016), https://www.usda.gov/oig/webdocs/27601-0002-31.pdf). In several instances, the Department found that SNAP benefits were terminated even though the beneficiary qualified for an exemption. *Id.*

Kentucky HEALTH imposes numerous administrative obligations, all of which make it more likely that a beneficiary will lose coverage inappropriately. For example, under the work requirements, beneficiaries must report at least 80 hours of work or other "community engagement" per month. AR 6775. A beneficiary can be disqualified by misunderstanding what constitutes a qualifying activity or failing to provide adequate documentation pursuant to the strict deadlines. Jennifer Wagner & Judith Solomon, *States' Complex Medicaid Waivers Will*

Create Costly Bureaucracy and Harm Eligible Beneficiaries, Ctr. on Budget and Policy Priorities, 6 (May 23, 2018), https://goo.gl/eyqtWq.

Another example involves the "medically frail" exemption to work requirements. Already, the qualifications for medically frailty has generated significant confusion. Deborah Yetter, *"It's a mess": Kentucky Medicaid Unclear on "Medically Fragile" Meaning*, Louisville Courier Journal (Dec. 6, 2018), https://www.courier-journal.com/story/news/2018/12/06/kentucky-medicaids-medically-fragile-meaning-unclear/2217346002/. Some persons are not qualifying as "medically frail" despite having a serious and complex medical condition. *Id.* Other people are not qualifying despite people with similar conditions qualifying for the status. *Id.* Some distinctions have seemed arbitrary —one psychiatric health center reported that 28 out of 44 applications for "medically fragile" status were denied despite all 44 patients having generally similar circumstances. *Id*.

For predictable reasons, creating massive new administrative systems matched with new documentation and reporting requirements has resulted in the improper disenrollment of public benefit beneficiaries. The State of Indiana provides one example. The State of Indiana upended its public assistance program systems and contracted with IBM to manage it. Indiana eventually sued IBM alleging breach of contract when IBM failed to implement the system properly. IBM's failures included: incorrectly categorizing documents, inaccurate and incomplete data gathering of recipient and applicant information, failing to mail correspondence properly, not responding to or resolving help-ticket requests, and untimely application processing times. Despite individual beneficiaries' efforts to comply with state requirements, they were disenrolled due to the faulty administrative systems. *State v. IBM*, 51 N.E. 3d 150, 152-53, 157 (Ind. 2016); *see* Virginia Eubanks, *Automating Inequality: How High-Tech Tools Profile, Police, and Punish*

the Poor, 43-44, 49-58 (2018 St. Martin's Press New York) (Medicaid-eligible Indiana residents losing coverage due to state's system failures).

It is foreseeable that eligible Kentuckians will experience similar administrative barriers to coverage based on the state's new waiver processes and systems. The result: unnecessary administrative burdens that deny Medicaid coverage to people who desperately need health care.

VI. KENTUCKY HEALTH CANNOT BE JUSTIFIED BY AFTER-THE-FACT MONITORING, OR THREATS TO TERMINATE MEDICAID FOR PERSONS AGE 19 TO 64.

Although this Court found that Defendants acted arbitrarily and capriciously in approving the initial version of Kentucky HEALTH, Intervenor submitted a second waiver proposal that is little different than the original proposal, and Defendants again attempt to redefine Medicaid objectives to deemphasize the provision of health care. AR 6720, 6723; *see Stewart*, 313 F. Supp. 3d at 272. The principal change is adding various monitoring and evaluation activities to Kentucky HEALTH, but these additions do nothing to remedy the inappropriateness of the proposed requirements and limitations. AR 6723, 6728, 6793-97. After-the-fact program evaluations can be little consolation to a beneficiary who no longer has health care coverage.

Defendants also argue that, if Kentucky HEALTH is not approved, Intervenor will eliminate Medicaid expansion coverage for the age 19 to 64 population. Defendants' approval letter makes this point clearly: "Kentucky has repeatedly stated that if it is unable to move forward with its Kentucky HEALTH demonstration project, it will discontinue coverage for the ACA expansion population, a choice it is entitled to make." AR 6870; *see also* AR 6873, 6875.

This is an improper consideration, since Intervenor is effectively holding the expansion population hostage in an effort to modify the program in a way contrary to proper Medicaid objectives. The fact that a Medicaid program is optional does not authorize a state to disregard

Medicaid law. *See, e.g.*, *Doe v. Chiles*, 136 F.3d 709, 714 (11th Cir. 1998); *NB* ex rel. *Peacock v. District of Columbia*, 794 F.3d 31, 35 (D.D.C. 2015).

Furthermore, even assuming that financial distress could justify the granting of an otherwise inappropriate waiver, neither Defendants nor Intervenor respond to this Court's request in its June 2018 ruling for details regarding Intervenor's supposed budgetary difficulties, or an explanation as to why the expansion population should be on the chopping block. The federal government covers 90% of the expansion population expense, but only 71.82% of expenses generally for Kentucky's adult Medicaid beneficiaries. 42 U.S.C. § 1396d(y)(1)(E) (90% federal financial participation (FFP) for expansion population); 83 Fed. Reg. 61157, 61159 (Nov. 28, 2018) (71.82% FFP for Kentucky); *see Stewart*, 313 F. Supp. 3d at 271. Notably, the Kentucky government has not persuaded its citizens either on the merits of Kentucky HEALTH: recent polling found that roughly two-thirds of Kentuckians oppose attempts to scale back Medicaid, or to end current coverage of non-emergency medical transportation, along with dental and vision care. Mason-Dixon Kentucky Poll (Dec. 2018), https://files.constantcontact.com/b5743304701/b0e1f2b2-fa47-4da7-8f53-c9223c5453b3.pdf.

CONCLUSION

If implemented, the Kentucky HEALTH will harm low-income persons with functional impairments and chronic conditions of all ages, but especially those ages 50 to 64. The results will be more low-income people without health care and without the ability to maintain function and independence. Because these effects contravene the stated purposes of the Medicaid Act, the Court should grant Plaintiffs' motion for summary judgment.

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Respectfully submitted,

/s/ Maame Gyamfi

Maame Gyamfi (D.C. Bar #462842)
Counsel of Record
Kelly Bagby (D.C. Bar #462390)
AARP FOUNDATION
601 E Street, NW
Washington, DC 20049
T: (202) 434-6291
mgyamfi@aarp.org
kbagby@aarp.org

Regan Bailey (D.C. Bar #465677)
Eric Carlson
JUSTICE IN AGING
1441 I Street, NW, Suite 1100
Washington, DC 20005
T: (202) 683-1990; T: (213) 674-2813
rbailey@justiceinaging.org
ecarlson@justiceinaging.org

René H. Reixach, Jr.
WOODS OVIATT GILMAN LLP
on behalf of the NATIONAL ACADEMY OF ELDER LAW ATTORNEYS
700 Crossroads Building, 2 State Street
Rochester, NY 14614
T: (585) 987-2858
rreixach@woodsoviatt.com

Silvia Yee
Carly A. Myers
DISABILITY RIGHTS EDUCATION AND DEFENSE FUND
3075 Adeline Street, Suite 210
Berkeley, CA 94703
T: (510) 644-2555
syee@dredf.org
cmyers@dredf.org

Counsel for Amici Curiae

CERTIFICATE OF SERVICE

I hereby certify that on January 24, 2019, I electronically filed the foregoing Proposed Brief of AARP, AARP Foundation, Justice In Aging, National Academy of Elder Law Attorneys, and Disability Rights Education and Defense Fund As *Amici Curiae* In Support Of Plaintiffs' Motion For Partial Summary Judgment with the Clerk of the Court for the United States District Court for the District of Columbia by using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

/s/ Maame Gyamfi
Maame Gyamfi