January 4, 2019

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

Re: Virginia COMPASS 1115 Demonstration Extension Application – Creating Opportunities for Medicaid Participants to Achieve Self-Sufficiency

Dear Secretary Azar:

Thank you for the opportunity to submit comments on Virginia's Section 1115 Demonstration Extension Application.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions across the country. Our organizations have a unique perspective on what individuals need to prevent disease, cure illness and manage chronic health conditions. The diversity of our groups and the patients and consumers we represent enables us to draw upon a wealth of knowledge and expertise and serve as an invaluable resource regarding any decisions affecting the Medicaid program and the people that it serves. We urge the Department of Health and Human Services (HHS) to make the best use of the recommendations, knowledge and experience our organizations offer here.

Our organizations are committed to ensuring that Medicaid provides adequate, affordable and accessible healthcare coverage. Our organizations strongly support Virginia's Medicaid expansion which will make coverage available to 400,000 low-income individuals and families in the state. This coverage will help patients access medications to manage chronic conditions, preventive services like cancer screenings, and many other treatments needed to stay healthy.

Several 1115 waiver proposals submitted to and approved by the Centers for Medicare and Medicaid Services (CMS) in recent months have jeopardized patients' access to quality and affordable healthcare coverage.[1] Virginia's proposed waiver similarly threatens access to healthcare by creating new financial

and administrative barriers that could lead patients with serious, acute and chronic conditions to lose their healthcare coverage. The state's own estimates suggest that 21,600 beneficiaries would lose coverage from the work requirements alone and given the experience with implementation in Arkansas that we describe below, this is likely an underestimate. Our organizations therefore ask CMS to reject the following provisions of the 1115 waiver that will jeopardize patients' access to quality and affordable healthcare.

Work and Community Engagement Requirements

The Virginia COMPASS 1115 Demonstration Extension Waiver seeks to add a work and community engagement requirement for some Medicaid enrollees. This would increase the administrative burden on all Medicaid patients. Individuals will need to either attest that they meet certain exemptions or the number of hours they have worked.

Increasing administrative requirements will likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt or not. Arkansas is currently implementing a similar policy requiring Medicaid enrollees to report their hours worked or their exemption. As of December, six months into implementation, the state has terminated coverage for 16,932 individuals and locked them out of coverage until January 2019.[2] In another case, after Washington state changed its renewal process from every twelve months to every six months and instituted new documentation requirements in 2003, approximately 35,000 fewer children were enrolled in the program by the end of 2004.[3] Battling administrative red tape in order to keep coverage should not take away from patients' or caregivers' focus on maintaining their or their family's health.

Failing to navigate these burdensome administrative requirements could have serious – even life or death – consequences for people with serious, acute and chronic diseases. If the state finds that individuals have failed to comply with the new requirements for three months within a 12-month period, they will be locked out of coverage until they demonstrate their compliance. People who are in the middle of treatment for a life-threatening disease, rely on regular visits with healthcare providers or must take daily medications to manage their chronic conditions cannot afford a sudden gap in their care.

Our organizations are also concerned that the current exemption criteria may not capture all individuals with, or at risk of, serious and chronic health conditions that prevent them from working. While our organizations are pleased that the state will accept self-attestation of exemptions, exempt enrollees will still have to understand how to report exemptions and it is unclear how often they will need to do so, creating opportunities for administrative error that could jeopardize their coverage. An analysis of Arkansas's experience implementing similar requirements revealed that the process for reporting exemptions has been complex and has created confusion for enrollees.[4] No exemption criteria can circumvent this problem and the serious risk to the health of the people we represent.

Administering these requirements will be expensive for Virginia. States such as Michigan, Pennsylvania, Kentucky and Tennessee have estimated that setting up the administrative systems to track and verify exemptions and work activities will cost tens of millions of dollars.[5] Virginia's fiscal impact statement estimated that the changes to the IT system would cost approximately $8 million.[6] These costs would divert resources from Medicaid's core goal – providing health coverage to those without access to care.

Ultimately, the requirements outlined in this waiver do not further the goals of the Medicaid program or help low-income individuals improve their circumstances without needlessly compromising their access to care. Most people on Medicaid who can work already do so.[7] A study published in *JAMA Internal*

Medicine, looked at the employment status and characteristics of Michigan's Medicaid enrollees.[8] The study found only about a quarter were unemployed (27.6 percent). Of this 27.6 percent of enrollees, two thirds reported having a chronic physical condition and a quarter reported having a mental or physical condition that interfered with their ability to work. In another report looking at the impact of Medicaid expansion in Ohio, the majority of enrollees reported that that being enrolled in Medicaid made it easier to work or look for work (83.5 percent and 60 percent, respectively).[9] Terminating individuals' Medicaid coverage for non-compliance with these requirements will therefore hurt rather than help people search for and obtain employment. Our organizations urge HHS to reject Virginia's request for work and community engagement requirements.

Premiums and Cost-Sharing

One feature of the Virginia COMPASS program is to charge premiums to some Medicaid expansion enrollees. Premiums will range from $5 - $10 per month. If an enrollee fails to pay a month's premium, following a three-month grace period, coverage will be suspended until the enrollee is able to pay the premium. Additionally, enrollees above 100 percent of the federal poverty level will be required to contribute, through the monthly premiums, either $50 or $100 depending on income level and participate in a healthy behavior activity to access a premium account to pay for non-covered medical or health-related services. This program is unnecessarily confusing and will not promote coverage.

Premiums both increase the number of enrollees who lose Medicaid coverage and discourage eligible people from enrolling in the program.[10] When Oregon implemented a premium in its Medicaid program, with a maximum premium of $20 per month, almost half of enrollees lost coverage.[11] For individuals with serious and chronic conditions, maintaining access to comprehensive coverage is vital to ensure they continue to maintain access to their physicians, medications and other treatments and services they need.

Indiana implemented a similar payment structure in a previous waiver demonstration. The evaluation report[12] from the waiver demonstration found that over half of Medicaid enrollees failed to make at least one payment. The report also found that 29 percent of Medicaid eligible individuals either never enrolled because they did not make a payment or were disenrolled for failure to make payments. Coverage losses on this scale, especially for patients needing access to life-saving and life-sustaining treatment, would be dire. For example, if a patient with cancer had to stop treatment for failure to pay a premium, he or she could face dire and even deadly consequences.

Ultimately, all of these changes will create confusion and significant barriers for patients that will jeopardize their access to needed care. Our organizations urge HHS to reject the addition of premiums and increased cost-sharing.

Co-Payments for Non-Emergent Use of the ED

The Virginia 1115 Demonstration Extension application includes a proposal to charge certain enrollees a five dollar copayment for non-emergent use of the emergency department (ED). This policy could deter people from seeking necessary care during an emergency. Delays in care could have harmful impacts on the short- and long-term health of individuals with serious, acute and chronic diseases.

People should not be financially penalized for seeking lifesaving care for a breathing problem, a heart attack, hyperglycemia, complications from a cancer treatment or any other critical health problem that requires immediate care. When people do experience severe symptoms, they should not try to self-

diagnose their condition or worry that they can't afford to seek care. Instead, they must have access to quick diagnosis and treatment in the ED.

Evidence suggests cost-sharing may not result in the intended cost savings.[13] Research demonstrates that low-income individuals served by Medicaid are more price sensitive compared to others, more likely to go without needed care, and more likely to experience long-term adverse outcomes. A study of enrollees in Oregon's Medicaid program demonstrated that implementation of a copay on emergency services resulted in decreased utilization of such services but did not result in cost savings because of subsequent use of more intensive and expensive services.[14] This provides further evidence that copays may lead to inappropriate delays in needed care. Our organizations urge HHS to reject this punitive cost-sharing for non-emergent use of the emergency department.

Our organizations believe healthcare should affordable, accessible, and adequate. The Virginia COMPASS program does not meet that standard and we urge HHS to reject these provisions. Thank you for the opportunity to provide comments.

Sincerely,

American Heart Association
American Lung Association
Arthritis Foundation
Chronic Disease Coalition
Epilepsy Foundation
Global Healthy Living Foundation
Hemophilia Federation of America
Leukemia & Lymphoma Society
March of Dimes
National Alliance on Mental Illness
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Psoriasis Foundation
United Way Worldwide

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[1] American Lung Association, A Coordinated Attack: Reducing Access to Care in State Medicaid Programs, July 2018. Accessed at http://www.lung.org/assets/documents/become-an-advocate/a-coordinated-attack.pdf.
[2] Robin Rudowitz, MaryBeth Musumeci, and Cornelia Hall, "A Look at November State Data for Medicaid Work Requirements in Arkansas," Kaiser Family Foundation, December 18, 2018. Accessed at: https://www.kff.org/medicaid/issue-brief/a-look-at-november-state-data-for-medicaid-work-requirements-in-arkansas/.
[3] Tricia Brooks, "Data Reporting to Assess Enrollment and Retention in Medicaid and SCHIP," Georgetown University Health Policy Institute Center for Children and Families, January 2009.
[4] MaryBeth Musumeci, Robin Rudowitz and Cornelia Hall, "An Early Look at Implementation of Medicaid AWork Requirments in Arkansas," Kaiser Family Foundation, October 8, 2018, https://www.kff.org/medicaid/issue-brief/an-early-look-at-implementation-of-medicaid-work-requirements-in-arkansas/?utm_campaign=KFF-2018-October-Medicaid-Arkansas-Work-Requirements.
[5] Michigan House Fiscal Agency, Legislative Analysis of Healthy Michigan Plan Work Requirements and Premium Payment Requirements, June 6, 2018, http://www.legislature.mi.gov/documents/2017-2018/billanalysis/House/pdf/2017-HLA-0897-5CEEF80A.pdf; House Committee on Appropriations, Fiscal Note for

HB 2138, April 16, 2018, http://www.legis.state.pa.us/WU01/LI/BI/FN/2017/0/HB2138P3328.pdf; Misty Williams, "Medicaid Changes Require Tens of Millions in Upfront Costs," Roll Call, February 26, 2018, https://www.rollcall.com/news/politics/medicaid-kentucky.

[6] Joint Legislative Audit and Review Commission. Fiscal Impact Review. Bill number: HB 338 (Committee Substitute) Medicaid work requirement. Accessed at: http://lis.virginia.gov/cgi-bin/legp604.exe?181+oth+HB338JH1110+PDF

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