AMA
AMERICAN MEDICAL ASSOCIATION

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The Honorable Seema Verma
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Re: Kentucky HEALTH Section 1115 Demonstration Waiver

Dear Administrator Verma:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am pleased to submit comments on the Kentucky HEALTH Section 1115 demonstration waiver proposal (Kentucky HEALTH). In light of the *Stewart v. Azar* decision, we have limited our comments to those provisions of the waiver that we believe will cause coverage losses and impede the provision of medical assistance to low-income patients.

The AMA believes everyone deserves quality health care. As physicians, we regularly confront the effects of lack of access to adequate care and know that Medicaid is an important—and often the only—source of consistent care for low-income individuals. The AMA encourages policymakers to work together to identify realistic coverage options and, in doing so, believes it is important for states to develop and test new Medicaid models that best meet the needs and priorities of low-income patients.

While encouraging state flexibility, we emphasize the need for safeguards to protect low-income patients and emphatically support Medicaid's role as an indispensable safety net for the most vulnerable patients. We are concerned that several elements of the Kentucky HEALTH proposal may jeopardize the health and welfare of Medicaid enrollees because, by the state's own estimates, the waiver's eligibility restrictions would cause tens of thousands of low-income patients to lose Medicaid coverage.

The medical literature demonstrates the importance of Medicaid coverage for improving the health and welfare of low-income patients, particularly when compared to uninsured patients. Medicaid coverage is associated with improved long-term health, lower rates of mortality, better health outcomes and fewer hospitalizations, better educational outcomes and greater financial security.[1] Studies on access to care and

[1] Benjamin D. Sommers, Katherine Baicker &Arnold M. Epstein, Mortality and Access to Care among Adults after State Medicaid Expansions, 367 NEJM 11, 1025-34 (Sep. 2012); Henry J. Kaiser Family Foundation, What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight on the Evidence (Aug. 2013); Alisa Chester & Joan Alker, Georgetown University Health Policy Institute Center for Children and Families, Medicaid at 50: A Look at the Long-Term Benefits of Childhood Medicaid (Jul. 2015).

the health impacts of Medicaid expansion are especially compelling. Patients in Medicaid expansion programs are:

- More likely to have a usual source of care;[2]
- Less likely to have undiagnosed diabetes and high cholesterol;[3]
- More likely to receive regular treatment for chronic conditions;[4]
- More likely to seek preventive care;[5]
- More likely to report being in good health;[6] and
- Less likely to report unmet health care needs and to skip medications because of cost.[7]

Coverage is an especially important tool for addressing the opioid epidemic in Kentucky, which has seen the largest drop in the uninsured rate for opioid-related hospitalizations in the country since expanding Medicaid.[8] Too often, patients suffer from untreated substance use disorders (SUD). In fact, research showed that in 2014, 89 percent of Kentuckians needing addiction treatment did not receive it.[9] But Medicaid drastically expands access to treatment. A recent study from the Kaiser Family Foundation demonstrated that individuals with Medicaid were twice as likely to receive treatment for an opioid use disorder as the uninsured.[10] An earlier analysis by the Government Accountability Office also found that enrollment in Medicaid increased the availability of behavioral health treatment for newly eligible enrollees.[11] These findings bear out in Kentucky where coverage gains following Medicaid expansion corresponded with a 700 percent increase in alcohol and drug use treatment services provided to Medicaid

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[2] Adele Shartzer, Sharon K. Long & Nathaniel Anderson, Access to Care and Affordability Have Improved Following Affordable Care Act Implementation; Problems Remain, 35 Health Affairs 1, 161-168 (Jan. 2016).

[3] Laura Wherry & Sarah Miller, Early coverage, access, utilization, and health effects associated with the Affordable Care Act Medicaid expansion: A quasi-experimental study, 164 Annals of Internal Medicine 12, 795-803 (Apr. 2016)

[4] Benjamin D. Sommers, Robert J. Blendon & E. John Orav, Both the Private Option and Traditional Medicaid Expansions Improved Access to Care for Low-Income Adults, 35 Health Affairs 1, 96-105 (Jan. 2016).

[5] Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Impacts of the Affordable Care Act's Medicaid Expansion on Insurance Coverage and Access to Care, Issue Brief (Jun. 20, 2016); Final Report: Study of the Impact of the ACA Implementation in Kentucky, State Health Access Data Assistance Center, University of Minnesota (Feb. 2017).

[6] Benjamin D. Sommers et al., Mortality and Access to Care among Adults after State Medicaid Expansion, 367 New Eng. J Med. 1025 (September 13, 2012); Benjamin Sommers, Atul Gawande & Katherine Baicker, Health Insurance Coverage and Health—What the Recent Evidence Tells Us, 377 New Eng. J Med. 6, 586-93 (Aug. 2017).

[7] Adele Shartzer, Sharon K. Long & Nathaniel Anderson, Access to Care and Affordability Have Improved Following Affordable Care Act Implementation; Problems Remain, 35 Health Affairs 1, 161-168 (Jan. 2016); Benjamin D. Sommers, Robert J. Blendon & E. John Orav, Both the Private Option and Traditional Medicaid Expansions Improved Access to Care for Low-Income Adults, 35 Health Affairs 1, 96-105 (Jan. 2016).

[8] Matt Broaddus, Peggy Bailey & Aviva Aron-Dine, Center on Budget and Policy Priorities, Medicaid Expansion Dramatically Increased Coverage for People with Opioid-Use Disorders, Latest Data Show (Feb. 2018).

[9] amfAR, The Foundation for AIDS Research, Opioid & Health Indicators Database, Percent Needing but Not Receiving Addiction Treatment. Available at http://opioid.amfar.org/indicator/pctunmetneed.

[10] Julia Zur & Jennifer Tolbert, Henry J. Kaiser Family Foundation, The Opioid Epidemic and Medicaid's Role in Facilitating Access to Treatment (Apr. 2018).

[11] United States Government Accountability Office, Behavioral Health. Options for Low-Income Adults to Receive Treatment in Selected States (Jun. 2015).

expansion enrollees between 2014 and 2016.[12] We strongly encourage the Centers for Medicare & Medicaid Services (CMS) to ensure those suffering from SUD continue to have the coverage options they need to seek treatment.

Given what is known from the literature about the health benefits of Medicaid coverage, we strongly caution against restrictive policies that will cause coverage losses. Lack of coverage and corresponding access to care puts beneficiaries at risk of harm and is contrary to the intent of Congress and the overriding purpose of the Medicaid Act to furnish medical assistance to needy individuals.

Community engagement requirements

We are particularly concerned about the provisions in the Kentucky HEALTH proposal that require certain enrollees to participate in mandatory community engagement hours, provisions commonly known as work requirements. The AMA opposes work requirements as a condition of Medicaid eligibility; we believe that such requirements will negatively affect access to care and lead to significant negative consequences on individuals' health and well-being. As physicians, we are especially concerned about interrupting the continuity of care for our patients who are subject to the requirements and expect increased rates of churning in and out of the program. With these new policies, we fear that physicians will have to consider a patient's employment outlook in making long-term treatment decisions. Employment status should not determine whether anyone receives the health care he or she needs. Moreover, a recent literature review by the Kaiser Family Foundation concluded that, "taken as a whole, the large body of research on the link between work and health indicates that proposed policies requiring work as a condition of Medicaid eligibility may not necessarily benefit health among Medicaid enrollees and their dependents, and some literature also suggests that such policies could negatively affect health."[13]

We also want to emphasize that coverage losses will not only impact the "able-bodied" adult Medicaid recipients in Kentucky. Evidence has demonstrated that children are more likely to be enrolled in Medicaid if their parents are also enrollees.[14] Disabled Medicaid beneficiaries are also likely to be negatively impacted by the community engagement requirements in the Kentucky HEALTH waiver.[15] Further, we caution against the assumption that individuals who lose Medicaid coverage under Kentucky HEALTH will obtain coverage elsewhere. Few employment opportunities for low-income workers offer employer-sponsored insurance that is affordable for individuals and families living in or just above poverty and subsidized coverage is unavailable to those under the poverty line. Studies have shown that most Medicaid enrollees were uninsured prior to enrollment and the AMA is concerned that most will be uninsured again if their Medicaid coverage is terminated.[16]

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[12] Foundation for a Healthy Kentucky, Substance Use and the ACA in Kentucky (Dec. 2016).
[13] Larisa Antonisse & Rachel Garfield, Henry J. Kaiser Family Foundation, The Relationship Between Work and Health: Findings from a Literature Review (Aug. 2018).
[14] Georgetown University Health Policy Institute Center for Children and Families, Health Coverage for Parents and Caregivers Helps Children (Mar. 2017).
[15] Leighton Ku & Erin Brantley, Medicaid Work Requirements: Who's At Risk?, Health Affairs Blog (Apr. 2017), available at https://www.healthaffairs.org/do/10.1377/hblog20170412.059575/full/.
[16] Larisa Antonisse, Rachel Garfield, Robin Rudowitz & Samantha Artiga, Henry J. Kaiser Family Foundation, The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review (Mar. 2018).

Recognizing that encouraging work is a priority of this Administration, the AMA offers several suggestions about how a community engagement requirement could be structured to mitigate the harm to patients. First and foremost, we urge CMS to dispense with mandatory hourly and activity requirements. Other states have successfully linked voluntary job training incentive programs with Medicaid, and we believe a similar incentive-based model would serve the interests of Kentucky better than a punitive model. Instead of a focus on the number of hours worked or engagement in specific activities, we urge Kentucky and CMS to focus on robust social supports to help move people out of poverty and into stable employment.

Absent a voluntary work incentive program, implementation should be executed in a manner that eases the administrative burden on patients and providers and protects access to care. Several of the exemption categories should be strengthened to protect vulnerable patients, including the following:

- Pregnant women should be exempt for the entire duration of their pregnancy as well as at least 90 days postpartum or for as long as a physician deems appropriate.
- Beneficiaries with a physical or mental condition that prevents them from obtaining or maintaining stable employment, as determined by a medical professional, should be exempt, not only those with acute conditions.
- Part-time students should be exempt in addition to full-time students to account for the life circumstances that may prevent a low-income individual from pursuing full-time education.
- Individuals being released from incarceration should be given a lengthy grace period to find employment or other qualifying community engagement activities.
- Applicants, in addition to recipients, of Supplemental Security Income (SSI) on the basis of disability should be exempt.
- Victims of domestic violence and natural disasters should be exempt.

We are pleased that the Kentucky HEALTH proposal provides an accommodation for individuals in treatment for a SUD, but we suggest that individuals undergoing SUD treatment, as determined by a medical professional, ought to be exempt rather than having to report SUD treatment monthly as a qualifying activity.

Finally, beneficiaries who demonstrate good faith efforts to find employment should be able to maintain coverage. Too many barriers to stable employment exist and individuals should not be punished for factors beyond their own control.

Retroactive eligibility

The AMA strongly urges CMS to disapprove Kentucky's request to waive 90-day retroactive Medicaid eligibility for Kentucky HEALTH applicants. Retroactive eligibility is a vital element of the Medicaid safety net, designed to protect vulnerable, low-income patients from further financial hardship and encourage them to seek care when needed, rather than risk exacerbating a health condition by delaying care. This important provision compensates for errors and delays that frequently occur during the Medicaid enrollment process and protects against cost-shifting to providers who would otherwise be forced to absorb the cost of unpaid medical bills incurred by patients who are otherwise eligible for assistance. We do not agree that limiting this important financial protection aligns with the Medicaid Act's objectives to improve health and facilitate the provision of needed health care services.

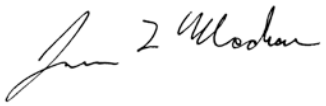
Lock-out periods

We are also concerned that enrollees who fail to promptly make premium payments or comply with annual eligibility redetermination requirements will be disenrolled from the Medicaid program and barred from reenrolling for six months. As you may know, the AMA House of Delegates recently adopted new policy opposing lock-out periods in Medicaid. We recognize that many of our Medicaid patients lead complicated, difficult lives, and we should value empathy over rigid adherence to red tape. While we understand that some programmatic rules are necessary to ensure the efficient administration of the Medicaid program, lock-outs are overly punitive and will increase the number of uninsured residents in Kentucky while increasing the burden of uncompensated care on the health care system. This proposed policy fails to consider the harsh reality faced by those living in poverty for whom income and hardship can be unpredictable. Withdrawing the security provided by Medicaid disadvantages patients at the very time when they need it most. We urge you to disapprove the lock-outs in the Kentucky HEALTH waiver and ensure that patients who are terminated for failure to comply with administrative rules can promptly reapply for coverage.

Conclusion

The AMA appreciates the opportunity to provide our comments on the Kentucky HEALTH waiver proposal. We urge CMS to reconsider the impact that the restrictive elements of the proposal could have in potentially costing tens of thousands of patients their access to critical medical care. Please contact Margaret Garikes, Vice President, Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409 with any questions.

Sincerely,



James L. Madara, MD

cc: Kentucky Medical Association