February 7, 2020

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

Re: Georgia "Pathways to Coverage" 1115 Demonstration

Dear Secretary Azar:

Thank you for the opportunity to submit comments on Georgia's "Pathways to Coverage" 1115 Demonstration.

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.

The purpose of the Medicaid program is to provide healthcare coverage for low-income individuals and families, and our organizations are committed to ensuring that Medicaid provides adequate, affordable and accessible healthcare coverage. Unfortunately, the Georgia Pathways plan is not a sufficient solution to improve access to quality and affordable healthcare for low-income Georgians. The state

estimates that approximately 50,000 individuals would gain coverage under the plan, whereas over 500,000 Georgians could access coverage if the state fully expanded its Medicaid program to 138 percent of the federal poverty level.[1]

Our organizations urge CMS to reject the Georgia Pathways program and offer the following comments on the waiver application.

Eligibility

Under the Georgia Pathways plan, only individuals with incomes below 100 percent of the federal poverty level ($1,810 per month for a family of three) who can prove that they work at least 80 hours per month would be eligible for Medicaid. This drastically limits the number of patients with serious and chronic health conditions who will receive access to the quality and affordable healthcare coverage that they need.

While no exemption criteria can prevent the potential coverage losses associated with work reporting requirements, Georgia has not proposed any exemption criteria that would allow individuals who are unable to meet the work reporting requirements to apply for coverage. This means that patients who have serious health conditions that prevent them from working 80 hours per month would have **no pathway to coverage** that could help them to treat these conditions. This discrimination against patients with health conditions that prevent them from working is unacceptable.

Once enrolled, individuals may be able to qualify for short-term exemptions in certain situations. Still, our organizations are concerned that these exemption criteria may not capture all individuals with serious and chronic health conditions that prevent them from working. Regardless, even exempt enrollees may have to report their exemption, creating opportunities for administrative error that could jeopardize their coverage. Again, no exemption criteria can circumvent these problems and the serious risk to the health of the people we represent.

For the first six months, members will have to report their hours and work activities monthly. This will put a significant administrative burden on enrollees, which will likely decrease the number of individuals with Medicaid coverage. For example, Arkansas also implemented a work reporting requirement where Medicaid enrollees had to report their hours worked or their exemption. During the first six months of implementation, the state terminated coverage for over 18,000 individuals.[2] Georgia has not provided an estimate of the coverage losses associated with this proposal in its waiver application.

Failing to navigate these burdensome administrative requirements could have serious – even life or death – consequences for people with serious chronic and acute health conditions. If the state finds that individuals have failed to comply for one month, their coverage will be suspended, and if the state finds that individuals have failed to comply for three months, they will be disenrolled. 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.

If individuals are able to meet the reporting requirements for six consecutive months, they will be exempt from further reporting and re-evaluated for eligibility during their annual redetermination. However, if individuals do not report a change in their employment status, they will be responsible for any capitation and cost-sharing expenses. This exposes already low-income individuals to enormous financial risk.

If Georgia truly cares about incentivizing and promoting employment, full Medicaid expansion, without a work reporting requirement, would be the best way to achieve this goal. In a report looking at the impact of Medicaid expansion in Ohio, the majority of enrollees reported that being enrolled in Medicaid made it easier to work or look for work (83.5 percent and 60 percent, respectively).[3] That report also found that many enrollees were able to get treatment for previously untreated health conditions, which made finding work easier. Preventing individuals from enrolling in Medicaid coverage until they comply with these requirements will therefore hurt rather than help people search for and obtain employment.

For this new eligibility category based on compliance with work reporting requirements, Georgia has requested to waive both retroactive coverage and presumptive eligibility. Retroactive coverage prevents gaps in coverage by covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that timeframe. This allows patients who have been diagnosed with a serious illness to begin treatment without being burdened by medical debt prior to their official eligibility determination. Similarly, presumptive eligibility allows hospitals to provide temporary Medicaid coverage to individuals likely to qualify for Medicaid. This is an important entry point for individuals who qualify for Medicaid but are not yet enrolled to receive access to coverage promptly and helps to protect patients from large medical bills. Our organizations oppose Georgia's requests to waive these protections.

Finally, Georgia would be the first state to require enrollees to comply with the work reporting requirement prior to enrolling in the Medicaid program with no opportunity to demonstrate a medical or other exemption. Changing the eligibility for Medicaid is the sole purview of Congress and cannot be waived. Our organizations oppose this policy.

<u>Financial Barriers</u>

For the few individuals who are able to meet this limited eligibility criteria, the proposal still creates numerous financial barriers that will jeopardize their coverage. Individuals with incomes above 50 percent of the federal poverty level will have to pay monthly premiums and will lose coverage if they fail to pay premiums for three months. This policy would likely both increase the number of enrollees who lose Medicaid coverage and also discourage eligible people from enrolling in the program. Research has shown that even relatively low levels of cost-sharing for low-income populations limit the use of necessary healthcare services.[4] For example, when Oregon implemented a premium in its Medicaid program, with a maximum premium of $20 per month, almost half of enrollees lost coverage.[5] For individuals with chronic and acute disease, maintaining access to comprehensive coverage is vital to access physicians, medications and other treatments and services needed to manage their health.

This policy will not only apply to – and jeopardize coverage for – new enrollees, but for individuals who are currently enrolled in Medicaid through the Transitional Medical Assistance (TMA) program. Again, the state provides no estimate of the loss of coverage due to the inability to pay premiums for this population. Additionally, it is unclear how the state may try to recoup capitation and other payments for any months that individuals do not pay their premiums and if, as with the work reporting requirement policy above, patients may be put at significant financial risk. The undersigned organizations believe that these premiums will create significant financial barriers for patients that jeopardize their access to needed care and therefore oppose this policy.

Georgia's premium proposal also includes an additional surcharge for tobacco users. Research is clear that these surcharges have not been proven effective in helping smokers quit and reducing tobacco use.

Recent studies from Health Affairs[6] and the Center for Health and Economics Policy at the Institute for Public Health at Washington University[7] have suggested that tobacco surcharges do not increase tobacco cessation but do lead individuals to forgo health insurance rather than paying the surcharge. Tobacco users often have expensive comorbidities. Charging a tobacco surcharge could cause those enrollees to go without coverage and access to preventive care (including tobacco cessation treatment), allowing comorbid health conditions to worsen and ultimately resulting in more expensive healthcare. Our organizations urge CMS to reject this surcharge.

Georgia's proposal also includes a number of copayments for individuals with incomes above 50 percent of the federal poverty level that could be a significant financial burden for patients. The most egregious of these is a $30 copay for non-emergency use of the emergency department (ED). This policy could deter people from seeking necessary care during an emergency.

People should not be financially penalized for seeking lifesaving care for a breathing problem, 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 cannot afford to seek care. Instead, they must have access to quick diagnosis and treatment in the ED.

Evidence suggests this type of cost sharing may not result in the intended cost savings.[8] 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.[9] This provides further evidence that copays may lead to inappropriate delays in needed care. Our organizations oppose this punitive proposal for a $30 copayment for non-emergent use of the ED.

<u>Reduced Benefits</u>

Individuals would be required to enroll in employer sponsored insurance (ESI) if it is available and determined to be cost effective for the state. However, the state would not provide any wraparound services for individuals regardless of the benefit package in their ESI. This means that if a patient's ESI does not cover important treatments for a chronic health condition, he or she will have no options to receive more comprehensive coverage. Additionally, the state would not help individuals with the costs of coinsurance or deductibles required in their ESI. Without this assistance, patients may be unable to afford maintenance medications for chronic conditions, visits to specialists or other treatments and services related to their conditions. The undersigned organizations oppose the requirement to enroll in ESI without wraparound services and full financial protections for patients.

Georgia already operates a program to enroll current Medicaid beneficiaries in ESI, and the website for the Medicaid program states that it "does not pay coinsurance and deductibles".[10] However, Section 1906(a) of the Social Security Act requires that all participants in an ESI program receive all benefits and cost-sharing protections available under Medicaid coverage, including "all deductibles, coinsurance and other cost-sharing obligations."[11] While outside the scope of this waiver, we urge CMS to review this matter and ensure that the state complies with federal law.

Georgia has also requested to waive non-emergency transportation (NEMT) for the waiver demonstration population. NEMT helps low-income patients overcome barriers to care due to

transportation and allows patients to keep appointments with doctors and other healthcare providers. For example, one study found patients with asthma, hypertension or heart disease who needed multiple visits to a medical professional to maintain their health were more likely to keep their appointments if they had NEMT.[12] Our organizations oppose a waiver of NEMT.

Our organizations believe that this proposal withholds access to quality and affordable healthcare coverage for thousands of patients with serious and chronic health conditions. We urge CMS to reject this waiver. Thank you for the opportunity to provide comments.

Sincerely,

American Heart Association
American Kidney Fund
American Lung Association
Arthritis Foundation
Chronic Disease Coalition
Crohn's & Colitis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Leukemia & Lymphoma Society
Lutheran Services in America
NAMI National Alliance on Mental Illness
National Hemophilia Foundation
National Multiple Sclerosis Foundation
National Organization for Rare Disorders
National Patient Advocate Foundation
National Psoriasis Foundation
Pulmonary Hypertension Association
Susan G. Komen

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[1] Georgia Department of Audits and Accounts, Fiscal Note Analysis for LC 46 0015 – Medicaid Expansion – HB37, Jan. 18, 2019. Available at: https://opb.georgia.gov/document/fiscal-notes-2019-health-and-human-services/lc-46-0015-medicaid-expansion-hb-37/download.

[2] Robin Rudowitz, MaryBeth Musumeci, and Cornelia Hall, "A Look at February State Data for Medicaid Work Requirements in Arkansas," Kaiser Family Foundation, December 18, 2018. Available at: https://www.kff.org/medicaid/issue-brief/a-look-at-february-state-data-for-medicaid-work-requirements-in-arkansas/; Arkansas Department of Health and Human Services, Arkansas Works Program, December 2018. Available at: http://d31hzlhk6di2h5.cloudfront.net/20190115/88/f6/04/2d/3480592f7fbd6c891d9bacb6/011519_AWReport.pdf

[3] Ohio Department of Medicaid, 2018 Ohio Medicaid Group VII Assessment: Follow-Up to the 2016 Ohio Medicaid Group VIII Assessment, August 2018. Accessed at: http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Final-Report.pdf.

[4] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017. Available at: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

[5] Id.

[6] Friedman, A.S., Schpero, W. L., Busch, S.H. Evidence Suggests That The ACA's Tobacco Surcharges Reduced Insurance Take-Up and Did Not Increase Smoking Cessation. Health Aff 2016; 35:1176-1183. doi: 10.1377/hlthaff.2015.1540 accessed at: http://content.healthaffairs.org/content/35/7/1176.abstract

[7]Monti, D., Kusemchak, M., Politi, M., Policy Brief: The Effects of Smoking on Health Insurance Decisions Under the Affordable Care Act. Center for Health and Economics Policy Institute for Public Health at Washington University. July 2016. Accessed at: https://publichealth.wustl.edu/wp-content/uploads/2016/07/The-Effects-of-Smoking-on-Health-Insurance-Decisions-under-the-ACA.pdf

[8] See for example: Chernew M, Gibson TB, Yu-Isenberg K, Sokol MC, Rosen AB, Fendrick AM. Effects of increased patient cost sharing on socioeconomic disparities in health care. J Gen Intern Med. 2008. Aug; 23(8):1131-6. Ku, L and Wachino, V. "The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings." Center on Budget and Policy Priorities (July 2005), available at http://www.cbpp.org/5-31-05health2.htm.

[9] Wallace NT, McConnell KJ, et al. How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan. Health Serv Res. 2008 April; 43(2): 515–530.

[10] Georgia Medicaid Health Insurance Premium Payment Program, Georgia Medicaid, Accessed on Febraru 7, 2020 at https://medicaid.georgia.gov/third-party-liability/health-insurance-premium-payment-program-hipp Accessed on January 23, 2020.

[11] See §1906(a)(3). Accessed at https://www.ssa.gov/OP_Home/ssact/title19/1906.htm

[12] Michael Adelberg, Marsha Simon, "Non-emergency Medical Transportation: Will Reshaping Medicaid Sacrifice An Important Benefit? Health Affairs. September 20, 2017. Accessed at: https://www.healthaffairs.org/do/10.1377/hblog20170920.062063/full/