September 29, 2017

VIA ELECTRONIC SUBMISSION

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

Re: Amendments to Utah's Primary Care Network demonstration project

Dear Sir/Madam:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and under-served people. We appreciate the opportunity to provide these comments on the proposed amendments to Utah's Primary Care Network (PCN) project.

We support Utah's decision to accept federal funds to cover low-income adults through Medicaid. However, NHeLP recommends that the Department of Health & Human Services (HHS) not approve the amendments. These amendments do not comply with the requirements of § 1115 of the Social Security Act and will harm Medicaid enrollees' access to vital health care services.

Procedural Issues

Utah's current application seeks to amend the State's 2016 extension application.[1] The proposed amendments make substantial changes to the renewal application. With these changes incorporated, the extension application does not meet the federal requirements for a complete § 1115 application.[2] In particular, with respect to the amendments, the application lacks both "a narrative of the changes being requested along with the

[1] Utah Dep't of Health, *Utah 1115 PCN Demonstration Waiver Amendment #20* 1 (2017) (hereinafter "Application").
[2] 42 C.F.R. § 431.412(c)(2).

objective of the change and desired outcomes" and "a list and programmatic description of the waivers and expenditure authorities that are being requested for the extension period."[3]

These components are crucial to helping the public understand the goals and justifications for the changes and, thus, to giving the public a chance to provide meaningful input on the amendments. Because Utah's application did not include these elements, it should not have been deemed complete. We ask CMS to require the State to submit an application that adheres to the content requirements and to allow the public the opportunity to comment on that proposal.

HHS Authority and § 1115

To be approved pursuant to § 1115, Utah's amendments must:

- propose an "experiment[], pilot or demonstration;"
- waive compliance only with requirements in 42 U.S.C. § 1396a;
- be likely to promote the objectives of the Medicaid Act; and
- be approved only "to the extent and for the period necessary" to carry out the experiment.[4]

The purpose of Medicaid is to enable states to furnish medical assistance to individuals who are unable to meet the costs of necessary medical care and to furnish such assistance and services to help these individuals attain or retain the capacity for independence and self-care.[5] As explained below, Utah's proposals to impose work requirements, place time limits on Medicaid coverage, cap enrollment in certain population groups, charge heightened copayments for non-emergency use of the emergency room, eliminate hospital presumptive eligibility, and eliminate EPSDT for individuals ages 19 and 20 cannot be approved because, separately and together, they are inconsistent with the provisions of § 1115.

Work Requirements

Utah is seeking to impose a work requirement on individuals enrolled in PCN and to extend the requirement to the Targeted Adults Without Dependent Children population at a later time at its own discretion. Enrollees will be required to participate in online job search or job training for three consecutive months during every twelve-month eligibility period. Enrollees who do not comply will lose PCN eligibility and can only re-enroll if they complete the requirement or meet an exemption from the requirement.

Under § 1115 and other relevant law, HHS has no authority to approve any waiver permitting Utah to condition Medicaid eligibility on compliance with work activities (and, thus, has never done so). Work requirements are an illegal condition of eligibility beyond the Medicaid eligibility criteria clearly enumerated in federal law. Medicaid is a medical assistance program, and although states have flexibility in designing and administering

[3] *Id*. § 431.412(c)(2)(ii), (iii).
[4] 42 U.S.C. § 1315(a).
[5] *See* 42 U.S.C. § 1396-1.

their Medicaid programs, the Medicaid Act requires that they provide medical assistance to all individuals who qualify under federal law. As courts have held, additional eligibility requirements are illegal.[6]

Section 1115 cannot be used to short circuit these Medicaid protections because there is no basis for finding that work requirements are likely to assist in promoting the objectives of the Medicaid Act.[7] The purpose of Medicaid is to enable states to furnish medical assistance to low-income individuals who cannot afford the costs of medically necessary services and to furnish rehabilitation and other services to help such individuals attain or retain capability for independence or self-care.[8] Conditioning Medicaid eligibility on completion of work activities gets it exactly backwards by blocking access to care and services that help individuals attain and retain independence or self-care and, as a result, be able to work. Research confirms that *Medicaid coverage allows individuals to obtain and maintain employment*. For example, more than half of individuals enrolled in the Medicaid expansion in Ohio reported that Medicaid coverage has made it easier to continue working. Among enrollees who did not have a job, three-quarters reported that Medicaid coverage made it easier for them to look for one.[9]

Moreover, the vast majority of individuals enrolled in Medicaid already work or have good reason for not working.[10] A recent study by the Kaiser Family Foundation found that adult Medicaid enrollees who were not receiving disability benefits and did not have a job were not working because they were: going to school (18%); taking care of their home or family (28%); retired (8%); unable to find work (8%); or dealing with illness or disability (35%).[11]

While Utah's application indicates that the work requirement will not apply to individuals who are "physically or mentally unfit for employment,"[12] evidence from other programs with similar exemptions shows that, in practice, individuals with disabilities are not exempted as they should be – often due to verification requirements – and are more likely than other individuals to lose benefits.[13] Numerous studies of state Temporary Assistance for Needy

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[6] *See, e.g.*, *Camacho v. Texas Workforce Comm'n,* 408 F.3d 229, 235 (5th Cir. 2005) (enjoining Texas regulation that terminated Medicaid coverage of TANF recipients who were substance abusers or whose children were not getting immunizations or check-ups or were missing school because regulation was inconsistent with Medicaid and TANF statutes).

[7] By contrast, as far back as the 1970s, states obtained section 1115 waivers to test work requirements in the AFDC program (which, unlike Medicaid, does have work promotion as a purpose of the program). These waivers required states to conduct "rigorous evaluations of the impact," typically requiring the random assignment of one group to a program operating under traditional rules and another to a program using the more restrictive waiver rules. United States Dep't of Health & Human Servs., *State Welfare Waivers: An Overview*, http://aspe.hhs.gov.hsp/isp/waiver2/waivers.htm.

[8] 42 U.S.C. § 1396-1.

[9] Ohio Dep't of Medicaid, *Ohio Medicaid Group VII Assessment: A Report to the Ohio General Assembly*, (2017), http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf.

[10] Rachel Garfield, Kaiser Family Found., *Understanding the Intersection of Medicaid and Work* (2017), http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work (finding that almost 80% of adults who are enrolled in Medicaid, but do not receive SSI, live in families with at least one worker, and almost 60% are working themselves).

[11] *Id*.

[12] Application at 2.

[13] *See, e.g.*, Andrew J. Cherlin et. al., *Operating within the Rules: Welfare Recipients' Experiences with Sanctions and Case Closings*, 76 Soc. Serv. Rev. 387, 398 (finding that individuals in "poor" or "fair" health

Families (TANF) programs have found that participants with physical and mental health issues are disproportionately likely to be sanctioned for not completing the work requirement.[14]

Evidence from the Supplemental Nutrition Assistance Program (SNAP) is also relevant, as the PCN work requirement will align with the SNAP requirement. Researchers have expressed concern that states might incorrectly determine that many of the nearly 20% of all SNAP participants who have a disability, but do not receive disability benefits, are subject to the work requirement.[15] One study from Franklin County, Ohio found that one-third of individuals referred to a SNAP employment and training program in order to keep their benefits reported a physical or mental limitation, and 25% of these individuals indicated that the condition limited their daily activities. Additionally, almost 20% of the individuals had filed for SSI or SSDI within the previous two years.[16] In another example, when Georgia reinstated the SNAP work requirement and time limits for "able-bodied adults without dependents" in 2016, the State found that 62% of nearly 12,000 individuals subject to the requirement were disenrolled after only three months.[17] State officials acknowledged that hundreds of enrollees had been wrongly classified as "able-bodied" when they were actually unable to work.[18]

Because conditioning Medicaid eligibility on completion of the work requirement will disqualify individuals with chronic and disabling conditions, the requirement implicates the civil rights protections contained in the Americans with Disabilities Act (ADA) and § 504 of the Rehabilitation Act.[19] These laws make it illegal for states to take actions that have a discriminatory impact on people with disabilities, and they cannot be waived under § 1115 or under any other authority of the Secretary.[20]

In addition, extensive research reveals that a mandatory work requirement does not effectively increase self-sufficiency. Studies of cash assistance programs have already established that a work requirement does little to increase stable, long-term employment and does not decrease poverty.[21] In fact, work requirements have had the reverse effect,

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were more likely to lose TANF benefits than those in "good," "very good," or "excellent health"); Vicki Lens, *Welfare and Work Sanctions: Examining Discretion on the Front Lines*, 82 SOC. SERV. REVIEW 199 (2008).

[14] *See, e.g.*, Yeheskel Hasenfeld et al., *The Logic of Sanctioning Welfare Recipients: An Empirical Assessment* (June 2004) (Departmental Paper, University of Pennsylvania School of Social Policy and Practice), http://repository.upenn.edu/cgi/viewcontent.cgi?article=1028&context=spp_papers.

[15] *See* Michael Morris et al., Burton Blatt Inst. at Syracuse Univ., *Impact of the Work Requirement in Supplemental Nutrition Assistance (SNAP) on Low-Income Working-Age People with Disabilities,* 4, 14 (2014).

[16] Ohio Association of Foodbanks, *Comprehensive Report: Able-Bodied Adults Without Dependents* (2015), http://admin.ohiofoodbanks.org/uploads/news/ABAWD_Report_204-2015-v3.pdf.

[17] *Correction: Benefits Dropped Story*, U.S. NEWS & WORLD REPORT, (May 26, 2017), https://www.usnews.com/news/best-states/georgia/articles/2017-05-25/work-requirements-drop-thousands-in-georgia-from-food-stamps.

[18] *Id*.

[19] 42 U.S.C. § 12312; Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 (prohibiting recipients of federal funds from discriminating on the basis of disability).

[20] See *Burns-Vidlak v. Chandler*, 939 F. Supp. 765, 772 (D. Haw. 1996).

[21] LaDonna Pavetti, Ctr. on Budget & Pol'y Priorities, *Work Requirements Don't' Cut Poverty, Evidence Shows* (2016); Sandra K. Danziger et al., *From Welfare to a Work-Based Safety Net: An Incomplete Transition*, 35 J. Pol'y Analysis & Management 231, 234 (2016).

leading to an increase in extreme poverty in some areas of the country, as individuals who do not secure employment lose their eligibility for cash assistance.[22]

There is no reason to expect better employment outcomes in Utah, in particular given the poor economic conditions in some areas of the State. In fact, recognizing the lack of available jobs, the U.S. Department of Agriculture waived the work requirement and time limits for "able-bodied adults without dependents" enrolled in SNAP in 6 of the 29 counties in the State.

A far more productive approach would be to connect PCN enrollees to properly-resourced voluntary employment programs, an activity that does not need waiver approval from CMS. Studies show that these voluntary employment programs increase employment and income among low-income individuals. For example, a rigorous evaluation of Jobs Plus, a voluntary employment program for public housing residents, found that the program produced substantial and sustained gains in earnings when fully implemented.[23] The State also has the option to offer supportive employment services under § 1915(i) of the Social Security Act.

In summary, work requirements stand Medicaid's purpose on its head by creating barriers to coverage and the pathway to health that the coverage represents. The end result of this policy will be fewer people with Medicaid coverage and more uninsured people delaying treatment and later seeking uncompensated care in hospitals and federally qualified health centers. There will be more gaps in coverage, meaning more expensive treatment when eligibility is eventually regained. Hospitals and community health centers will suffer financially as they are expected to treat more people with chronic or acute illness with less funding. For these and other reasons, HHS has consistently denied states' requests to impose a work requirement on individuals who are seeking medical assistance through the Medicaid program.

Time Limit on Coverage

Utah requests permission to limit lifetime enrollment in PCN or the Targeted Adults Without Dependent Children group to 60 months. Every month that an individual is enrolled in the Targeted Adults Without Dependent Children group will count towards the lifetime limit. Every month that an individual is enrolled in PCN and is subject to the work requirement will also count towards the lifetime limit.

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[22] *Id*. Two recent reports from Kansas and Maine purport to indicate that the SNAP work requirements increase employment and earnings among enrollees. However, these reports reach flawed and misleading conclusions; they incorrectly "attribute rising work rates and earnings to the work requirements," when "most, if not all, of the changes would have happened without it." Dorothy Rosenbaum & Ed Bolen, Ctr. On Budget & Policy Priorities, *SNAP Reports Present Misleading Findings on Impact of Three-Month Time Limit (*2016), https://www.cbpp.org/sites/default/files/atoms/files/12-14-16fa.pdf.

[23] Howard Bloom et al., MDRC, *Promoting Work in Public Housing: The Effectiveness of Jobs-Plus* (2005), https://www.doleta.gov/research/pdf/jobs_plus_3.pdf; James A. Riccio, MDRC, *Sustained Earnings Gains for Residents in a Public Housing Jobs Program: Seven-Year Findings from the Jobs-Plus Demonstration* (2010), http://files.eric.ed.gov/fulltext/ED514703.pdf.

Placing a time limit on Medicaid coverage is inconsistent with the objectives of the Medicaid Act. CMS acknowledged as much in 2016, rejecting Arizona's request to impose a lifetime limit because it "could undermine access to care" and does "not support the objectives of the program."[24] According to Utah, the purpose of the time limit is to "frame[] public healthcare coverage for adults as temporary assistance (similar to Temporary Assistance for Needy Families (TANF)), with the expectation that they do everything they can to help themselves before they lose coverage."[25] However, Medicaid and TANF do not share the same objectives.[26] Congress did not intend for Medicaid to provide only temporary health care coverage. Instead, Congress designed the program to provide medical assistance to low-income individuals who cannot afford the costs of necessary medical care for as long as they need such assistance. Indeed, in stark contrast to private insurance and Medicare, Medicaid covers long term care services – services that become more and more critical as people age or if they have a disability. The Secretary may not now use § 1115 to allow Utah to transform the basic purpose of its Medicaid program in a way that will restrict access to coverage and services.

Notably, the arbitrary time limit that Utah proposes will disproportionately impact older individuals who might have hit the limit earlier in their lives. The policy will also disproportionately harm individuals who have serious or chronic health challenges that impede their ability to work. Medicaid offers dependable and affordable coverage that supports their ability to generate income (full-time or part-time) and may prevent them from otherwise becoming fully destitute. Because conditioning eligibility on an arbitrary time limit would likely disproportionately impact such individuals, the policy may violate the Americans with Disabilities Act and § 504 of the Rehabilitation Act – provisions that the Secretary is not authorized to waive under § 1115.

The State claims that the time limit will not affect individuals with chronic health conditions because months during which PCN enrollees are exempt from the work requirement will not count towards the lifetime limit. However, as explained above, not all individuals who meet the criteria for an exemption from the work requirement will be exempted. In addition, Utah's response does nothing to address the effect of the time limit on individuals who are enrolled in the Targeted Adults Without Dependent Children group and have ongoing, serious health challenges.

Moreover, there is no experiment here. The outcome is predictable – individuals will lose access to affordable health insurance coverage and as a result, to medically necessary services. The time limit will also harm Utah's provider infrastructure, as providers will continue to treat uninsured patients and suffer financial losses.

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[24] *See* Letter from Andrew M. Slavitt, Acting Admin., Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs. to Mr. Thomas Betlach, Dir. Az. Health Care Cost Containment Sys. 3 (Sept. 30, 2016).
[25] Application at 1.
[26] *Cf* 42 U.S.C. 1396-1 *with* 42 U.S.C. 601 (indicating that TANF is designed to, among other things, "end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage").

Enrollment Caps

Utah proposes to limit enrollment in the Targeted Adults Without Dependent Children group to 25,000 individuals. The State requests permission to use its administrative rulemaking process to establish sub-caps for each of the three sub-population groups, with the sub-caps based on average annual enrollment.

Capping enrollment for this population group runs counter to the objectives of the Medicaid Act. Congress designed Medicaid as an entitlement program. With very few exceptions, every person who meets the eligibility criteria outlined in the Medicaid Act receives medical assistance. As a result of the Affordable Care Act, individuals who fall within the Targeted Adults Without Dependent Children population are described in the Medicaid Act.[27] There is no way to construe restricting enrollment to 25,000 of these individuals as likely to promote the goals of the program. Moreover, the cap undermines Utah's own goals in creating the Targeted Adults Without Dependent Children group. According to its 2016 renewal application, the State endeavored to: (1) reduce the number of uninsured individuals; (2) improve access to care and health outcomes among particular populations of adults with significant health care needs; (3) reduce non-emergency use of the emergency room among these populations; and (4) reduce hospitals' uncompensated care costs.[28] Restricting enrollment in Medicaid will only limit Utah's ability to achieve these goals.

In addition, capping enrollment in the Targeted Adults Without Dependent Children group will demonstrate nothing. Utah made clear that it is imposing the cap "due to available appropriations."[29] Obviously, the idea that restricting enrollment in Medicaid will reduce money spent on the program is hardly novel.

Cost Sharing for Non-emergency Use of the Emergency Room

Utah proposes to charge certain enrollees – parents and caretakers – $25 for non-emergency use of the emergency room. The policy conflicts with provisions of the Medicaid Act that cannot be waived under § 1115. In provisions located outside of § 1396a, the Medicaid Act provides states with flexibility to establish copayments, but it also includes beneficiary protections.[30] With respect to non-emergency use of the emergency room, §§ 1396o and 1396o-1 allow states to impose copayments on individuals with income under 150% of the federal poverty level (FPL), but only: (1) if certain conditions are met; and then (2) up to twice the "nominal" amount.[31] By regulation, the Secretary set the maximum charge at $8.[32] Thus, Utah seeks to charge more than three times the maximum amount allowable under the Medicaid Act.

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[27] *See* 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).
[28] *See* Utah Dep't of Health, *Utah 1115 Demonstration Waiver Renewal Application*, *Attachment 9* (2016), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/ut-primary-care-network-pa.pdf.
[29] Application at 20.
[30] *See* 42 U.S.C. §§ 1396o, 1396o-1.
[31] *Id*. §§ 1396o-1(e), 1396o(a)(3).
[32] 42 C.F.R. § 447.54.

Moreover, Utah's proposal fails to meet the five conditions set forth in § 1396o(f) for approval of cost sharing that exceeds the limits established in the Medicaid Act. In particular: (1) The use of emergency room copayments has been extensively studied (as described below) and, therefore, does not "test a unique and previously untested use of copayments." 42 U.S.C. § 1396o(f)(1); (2) Utah seeks to impose the copayments for five years – well beyond the two year limit imposed by statute, *id.* § 1396o(f)(2); (3) The proposed copayments offer no benefits to Medicaid enrollees in Utah, but rather only deter appropriate use of the emergency room, contrary to the requirements of 42 U.S.C. § 1396o(f)(3); (4) The copayments apply to all parents/caretakers, without "the use of control groups of similar recipients of medical assistance in the area," *id.* § 1396o(f)(4); and (5) The copayments are not voluntary and provide no "provision for assumption of liability for preventable damage to the health of recipients . . . resulting from involuntary participation." *Id.* at § 1396o(f)(5). As a result, the Secretary may not authorize the copayments.

In addition, even if these affordability protections could be waived under § 1115, the proposed copayments are not experimental and not likely to promote the objectives of the Medicaid Act. For more than 35 years, cost sharing has been one of the most heavily studied aspects of the Medicaid program. These studies have produced redundant, consistent findings: copayments harm low-income people by causing them to forego medically necessary care.[33] Moreover, studies focusing on Medicaid and CHIP non-emergency ED copayments, including peer-reviewed evaluations of non-emergency ED copayments, consistently show that: (1) Medicaid enrollees use the emergency room at comparable rates to private pay patients if you factor in their health status, and are no more likely to use the emergency room for non-urgent visits; and (2) copayments are ineffective at reducing non-emergency use of the emergency room.[34]

Eliminating Hospital Presumptive Eligibility

Utah asks to eliminate the option for hospitals to make presumptive eligibility determinations for parents/caretakers and the Targeted Adults Without Dependent Children group.

By its own terms, this provision is not waivable.[35] Moreover, eliminating hospital presumptive eligibility will demonstrate nothing. The Affordable Care Act amended the Medicaid Act to require states to allow hospitals to make presumptive eligibility determinations, effective January 1, 2014.[36] The state cannot possibly demonstrate something new by returning to the eligibility system that was in place before that date.

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[33] *See* David Machledt & Jane Perkins, National Health Law Program, *Medicaid Premiums and Cost Sharing* (March 2014), http://www.healthlaw.org/publications/search-publications/Medicaid-Premiums-Cost-Sharing#.U5cW-ij3Ijw.

[34] *Id.*; Mona Siddiqui et al., *The Effect of Emergency Department Copayments for Medicaid Beneficiaries Following the Deficit Reduction Act of 2005*, 175 JAMA INTERNAL MED. 393 (2015); Karoline Mortensen, *Copayments Did Not Reduce Medicaid Enrollees' Nonemergency Use of Emergency Departments*, 29 HEALTH AFFAIRS 1643 (2010); David J. Becker et al., *Co-payments and the Use of Emergency Department Services in the Children's Health Insurance Program*, 70 MED. CARE RES. REV. 514 (2013).

[35] *See* 42 U.S.C. § 1396a(a)(47)(B).

[36] Pub. L. 111-148, 124 Stat. 119, 291, § 2202 (2010) (codified at 42 U.S.C. § 1396a(a)(47)(B)).

Finally, precluding hospitals from making presumptive eligibility determinations will harm low-income individuals in Utah. The purpose of hospital presumptive eligibility is to give individuals immediate Medicaid coverage and access to care until a final eligibility determination can be made. Presumptive eligibility also promotes permanent coverage by providing individuals with an additional way to apply for Medicaid.[37] Utah claims that eliminating presumptive eligibility will have little effect on parents/caretakers because half of the individuals who receive coverage through presumptive eligibility do not ultimately enroll in Medicaid.[38] This ignores: (1) that half the people who receive the coverage *do* ultimately enroll in Medicaid, meaning that presumptive eligibility does act as an avenue to permanent Medicaid coverage for many individuals; (2) the importance of temporary, immediate coverage for both individuals and providers, who are guaranteed reimbursement for services rendered during the presumptive eligibility period. There is simply no basis for permitting Utah to foreclose presumptive eligibility as a path to Medicaid coverage.

Eliminating EPSDT

The State proposes to waive the requirement to cover Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for individuals in the Adults Without Dependent Children group who are ages 19 and 20. The State also seeks to rescind its 2016 request to terminate the EPSDT waiver for parents/caretakers ages 19 and 20.

The Secretary does not have authority to waive EPSDT. Since adding EPSDT to the Medicaid Act in 1967, Congress has amended the EPSDT provisions on numerous occasions, each time adding more detail as to how it expects EPSDT to be covered by the states and consistently requiring EPSDT coverage for all individuals under age 21. Most recently, in 2010, Congress provided that adult coverage would consist of the coverage listed in 42 U.S.C. § 1396u-7. Notably, 42 U.S.C. § 1396u-7(a)(1)(A)(ii)—a provision outside of § 1396a—requires this coverage to consist of EPSDT for any individual described in § 1396d(a)(4)(B), which requires that EPSDT be provided to individuals "under the age of 21." Thus, the Secretary lacks authority to waive EPSDT, both because Congress' intent with respect to EPSDT coverage is abundantly clear and because the coverage requirement is located outside of § 1396a.

In addition, eliminating EPSDT for 19 and 20 year-olds is inconsistent with the objectives of the Medicaid Act. As noted above, Congress has included EPSDT in the Medicaid Act as a detailed, comprehensive program to cover preventive and treatment services for children and youth under age 21. EPSDT entitles individuals ages 19 and 20 to receive comprehensive screening services, as well as any of the services listed in the Medicaid Act when necessary to "correct or ameliorate" illnesses and conditions discovered during a screening.[39] Since 1967, Congress has targeted the EPSDT coverage standards to meet the particular health care needs that face low-income individuals under age 21.

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[37] *See* Ctrs. For Medicare & Medicaid Servs., *Medicaid & CHIP FAQs: Implementing Hospital Presumptive Eligibility Programs* (2014), https://www.medicaid.gov/state-resource-center/faq-medicaid-and-chip-affordable-care-act-implementation/downloads/faqs-by-topic-hospital-pe-01-23-14.pdf.

[38] Application at 13. The State notes that of the individuals who do not ultimately enroll in Medicaid, 76% did not follow through with the application process. If Utah wishes to decrease this percentage, there are a number of policy options available. *See id*. Eliminating presumptive eligibility is not an appropriate response.

[39] 42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).

Research confirms that individuals ages 19 and 20 face unique and significant health challenges. For example, this population experiences high rates of mental illness and substance use disorder. Approximately 21% of 19 year-olds and 24% of 20 year-olds have had a diagnosable mental illness other than a developmental or substance use disorder in the past year.[40] In addition, approximately 15% of individuals ages 18 to 25 have met the criteria for illicit drug or alcohol dependence or abuse in the past year.[41]

This population also experiences high rates of sexually transmitted infections. According to the Centers for Disease Control and Prevention (CDC), individuals ages 15 to 24 face the highest risk of acquiring STIs "for a combination of behavioral, biological, and cultural reasons."[42] CDC data show that individuals ages 15 to 24 account for 25% of the sexually active population, but 50% of new STIs.[43] In 2015, young people ages 13 to 24 accounted for more than 1 in 5 new HIV diagnoses.[44] Young people with HIV are the least likely out of any age group to be linked to care (55%) and to have a suppressed viral load (44%).[45]

Eliminating EPSDT will make it less likely that these serious health conditions will be prevented or detected early through screening services, which should include screening for mental illness, substance use, and STIs for 19 and 20 year-olds.[46] Notably, research shows that early diagnosis and treatment of many of these conditions can dramatically improve health outcomes.[47] In addition, without EPSDT, individuals will simply not have access to certain medically necessary treatment services. For example, Utah limits coverage of some mental health services for adults enrolled in its § 1115 project.[48] Without EPSDT, limits such as these will likely prevent many 19 and 20 year-olds from receiving necessary care.

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[40] Substance Abuse and Mental Health Servs. Admin. (SAMHSA), *Results from the 2016 National Survey on Drug Use and Health: Mental Health Detailed Tables, Adult Mental Health Tables, Table 8.1B*, https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2016/NSDUH-DetTabs-2016.htm#lotsect9pe (last accessed Sept. 26, 2017).

[41] *Id* at *Table 8.24B*. The percentages are much lower for adults: 9.4% of individuals ages 26 to 49 and 4.1% of individuals 50 or older.

[42] Ctrs. for Disease Control and Prevention, Div. of STD Prevention, *Sexually Transmitted Disease Surveillance 2015* 62 (2016), https://www.cdc.gov/std/stats15/STD-Surveillance-2015-print.pdf.

[43] Ctrs. for Disease Control and Prevention, *Fact Sheet: Incidence, Prevalence, and Cost of Sexually Transmitted Infections in the United States* (2013), http://www.cdc.gov/std/stats/sti-estimates-fact-sheet-feb-2013.pdf.

[44] Ctrs. for Disease Control and Prevention, *HIV Among Youth*, http://www.cdc.gov/hiv/risk/age/youth/index.html?s_cid=tw_drmermin-00186 (last updated Sept. 21, 2017).

[45] *Id*.

[46] Am. Acad. of Pediatrics & Bright Futures, *Recommendations for Preventive Pediatric Health Care* (2017), https://www.aap.org/en-us/Documents/periodicity_schedule.pdf.

[47] *See, e.g.*, Ctrs. For Disease Control and Prevention, *2015 STDs Treatment Guidelines, HIV Infection: Detection, Counseling, and Referral*, https://www.cdc.gov/std/tg2015/hiv.htm (last updated Jan. 4, 2017) ("Early diagnosis of HIV infection and linkage to care are essential not only for the patients' own health but also to reduce the risk for transmitting HIV to others. As of March 2012, U.S. guidelines recommend all persons with HIV infection diagnoses be offered effective antiretroviral therapy."); Nat'l Institute of Mental Health, *Recovery After an Initial Schizophrenia Episode*: *What is RAISE?* (2017), https://www.nimh.nih.gov/health/topics/schizophrenia/raise/what-is-raise.shtml (describing research findings that coordinated specialty care (CSC) is more effective than usual treatment approaches to schizophrenia and that CSC is most effective when received early).

[48] *See, e.g.*, Utah Div. of Medicaid and Health Fin., *Utah Medicaid Provider Manual, Rehabilitative Mental Health and Substance Use Disorder Services* (2017),

Finally, eliminating EPSDT has no valid experimental purpose. The policy is nothing more than a cut in benefits. The State will not test an innovative approach to health care delivery by preventing individuals ages 19 and 20 from receiving medically necessary services.

Changing Elements of the Demonstration Project Without CMS Approval

The State requests permission to make a number of changes to its project through the state administrative rulemaking process. For example, Utah is asking for authority to change the eligibility criteria for the Targeted Adults Without Dependent Children population and also to impose the work requirement on this population if it is "successful" for the PCN group. The Secretary should not approve Utah's request for a number of reasons.

When a state receives approval to implement a demonstration project under § 1115, HHS outlines the requirements of §1396a that have been waived and for what purpose. These waivers must be narrowly construed, and as the Secretary has consistently noted in waiver approvals, any requirements not explicitly waived remain in full force and effect. States do not have the authority to alter or expand the waivers without approval by the Secretary, and the Secretary cannot properly delegate his § 1115 authority to states.

Relatedly, allowing Utah to unilaterally alter its project would raise significant transparency concerns. HHS has previously emphasized the importance of giving the public an opportunity to weigh in on amendments to § 1115 projects, vowing to post and accept public comments on all amendments.[49] However, if HHS grants Utah's request, members of the public will lose the opportunity to bring their concerns about proposed amendments to HHS. This is all the more troubling given that Utah has provided little information about these potential amendments in its application.

Conclusion

In summary, while NHeLP supports the use of § 1115 to implement experiments that the provision authorizes, we strongly object to any efforts to use § 1115 to skirt essential provisions that Congress has placed in the Medicaid Act to protect Medicaid beneficiaries and ensure that the program operates in the best interests of the population groups described in the Act. As demonstrated above, Utah's application contains numerous provisions that are inconsistent with the standards of § 1115 and with other provisions of law. We appreciate your consideration of our comments. If you have questions about these comments, please contact Catherine McKee (mckee@healthlaw.org) or me.

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https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Rehabilitative%20Mental%20Health%20And%20Substance%20Use%20Disorder%20Services/RehabMentalHealthSubAbuse7-17.pdf (limiting outpatient treatment for a mental health disorder to 30 days every year).

[49] CMS, Dear State Medicaid Director Letter (April 27, 2012).

Respectfully submitted,

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