Harold P. Wimmer
National President and
CEO

August 3, 2018

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

Re: 1115 Primary Care Network Demonstration Waiver: Adult Expansion Amendment Request

Dear Secretary Azar:

The American Lung Association appreciates the opportunity to submit comments on the proposed 1115 Primary Care Network Demonstration Waiver: Adult Expansion Amendment Request.

The American Lung Association believes all Americans and all Utah residents must have affordable, quality healthcare. This is especially important for low-income Utah residents that depend on Primary Care Network (PCN) and Medicaid. In March of 2017 the Lung Association committed to a set of healthcare principles (see Appendix A). The principles state that any changes to the healthcare system must achieve healthcare that is affordable, accessible and adequate for patients. Unfortunately, as currently written, the proposed waiver does not meet this standard.

Expanding Access to Medicaid

The Primary Care Network and the Utah Medicaid program provide vital care to the poorest residents of Utah. Families rely on these programs for lifesaving treatments. The state's proposal to expand Medicaid to 100 percent of the Federal Poverty Level ($20,708 for a family of three[1]) is a positive development for Utah residents; however, the Lung Association believes Utah's proposal is short-sighted. Alternatively, by expanding Medicaid to 138 percent of the federal poverty level ($28,577 for a family of three), in accordance with the Affordable Care Act, the state would be eligible for the enhanced federal matching funds of over 90 percent, rather than the current match rate of 69.71 percent This would cover more people than an expansion at 100 percent FPL.

Expanding Medicaid to 138 percent of the federal poverty level (FPL) is not only in the economic best interest of the state, but will also improve the health of Utah residents. A 2016 JAMA study[2] found residents in Medicaid expansion had better use of preventive services and reduced emergency

department use. For patients with lung disease or at risk for lung disease, access to preventive services like lung cancer screenings or quit smoking treatments can improve health outcomes, including saving lives. For example, Medicaid enrollees smoke at higher rates than the general population (25.3 vs. 15.5)[3] and helping Medicaid enrollees quit can prevent tobacco-caused diseases. Additionally, every year approximately 900 Utahans are newly diagnosed with lung cancer and over 450 Utahans will die from lung cancer, but early detection through low-dose CT screening can decrease lung cancer mortality by 14 to 20 percent among high-risk populations.[4] The Lung Association encourages CMS to reject the proposed limited expansion of the Medicaid program and work with the state to create a new proposal to expand Medicaid to 138 percent of FPL.

Enrollment Limits

The amendment proposes to set an enrollment limit for this expansion population. The Lung Association strongly opposes enrollment limits.

Enrollment limits will harm patients and is short-sighted. These hard enrollment limits do not account for economic recessions when an increased number of individuals qualify for Medicaid. Limiting enrollment will also harm lung disease patients as it will limit patients from getting treatment to manage chronic diseases such as asthma and COPD. The policy will reduce access to preventive services, regular visits with health care providers, daily medications that patients need to manage their chronic conditions, and life-saving treatments for lung cancer and other life-threatening illnesses. This is not consistent with the statutory objectives and purpose of the Medicaid program and will harm patients and therefore must be rejected by the Centers for Medicare and Medicaid Services (CMS).

Community Engagement through a Work Requirement

Utah's waiver amendment would limit access to healthcare coverage for patients at 100 percent of the federal poverty level if they do not work at least 30 hours per week, unless they qualify for certain exemptions that are not fully defined in the application.

A major consequence of this requirement will be to increase the administrative burden on all enrollees. Increasing administrative requirements will likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt or not. For example, 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.[5] In Utah, the process of having to document exemptions from or compliance with the new requirements has not yet been developed, but is similarly likely to create substantial administrative barriers to accessing or maintaining coverage. 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. When the demonstration begins, individuals will have 90 days to comply with the new requirements or their Medicaid coverage will be terminated. Thereafter, if the state finds that individuals have failed to comply with the new requirements, their health coverage will be terminated after 30 days. People who are in the middle of treatment for a life-threatening disease rely on regular visits with health care providers or must take daily medications to manage their chronic conditions cannot afford a sudden gap in their care.

Since Utah's application does not provide sufficient detail on who will qualify for exemptions, specifically related to physical or mental illness, or how they will be identified, the American Lung Association is 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. Regardless, it appears that even exempt enrollees will have to provide documentation of their medical condition validated by a medical professional, creating opportunities for administrative error that could jeopardize their coverage. No exemption criteria can circumvent this problem and the serious risk to the health of the people with lung disease.

Administering these requirements will also be expensive for the state of Utah. While Utah does not estimate these costs in its application, states such as Kentucky, Tennessee and Virginia have estimated that setting up the administrative systems to track and verify exemptions and work activities will cost tens of millions of dollars.[6] This would divert federal resources from Medicaid's core goal – providing health coverage to those without access to care.

Ultimately, the requirements outlined by Utah do not further the goals of the Medicaid program or help low-income families improve their circumstances without needlessly compromising their access to care. Most people on Medicaid who can work already do so.[7] A recent 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. The Lung Association urges CMS to reject this requested proposal.

The American Lung Association is also deeply worried about the evaluation measures that Utah is proposing to collect to test their hypothesis, "The work requirement will not negatively impact an individual's health." While Utah added new measures in its application to the federal government, they have failed to include the proportion of the population that will lose coverage because they were unable to file the correct paperwork or were unable to meet the work requirement. The Lung Association encourage s CMS to work with the state of Utah to develop an evaluation measure that tracks the health status for the entire Medicaid-eligible population.

<u>Early and Periodic Screening, Diagnostic, and Treatment (ESPDT)</u>
The American Lung Association is troubled that the waiver is proposing to waiver EPSDT requirements for individuals aged 19 and 20. EPSDT requirements provide access to critical services and treatments for kids and young adults. This is a group of people who have been born into poverty. As these young adults transition to higher education or jobs, it is important that they receive the same medical care for any illness or chronic disease they might have. Disruption in medical treatment could have negative consequences for their long-term health and economic security. For example, patients with well-managed asthma need to continue their treatment to be successful at work or in school. Unnecessarily changing treatment will hinder their success. The Lung Association encourages CMS to reject this request.

Employer Sponsored Insurance (ESI) Reimbursement

The Lung Association is interested in the health outcomes of the previously Medicaid–eligible people that are enrolled in ESI with wrap-around benefits. The state estimates that up to 10,000 individuals will be covered through ESI as opposed to Medicaid. The Lung Association strongly encourages CMS to work with Utah to monitor the health outcomes of these enrollees to compare to that of the Medicaid enrollees.

The American Lung Association is deeply troubled by a number of proposals in the waiver amendment, including adding enrollment limits, conditioning healthcare coverage on employment and removing EPSDT requirements. They would create artificial and unnecessary barriers for people to get needed care, harming patients, including those with lung disease. The Lung Association requests CMS reject these proposals. Additionally, the Lung Association urges CMS to work with Utah to fully expand the Medicaid program to 138 percent of FPL to cover more residents.

Thank you for the opportunity to submit comments on the proposed waiver amendment.

Sincerely,

Harold Wimmer
National President and CEO

CC: The Honorable Seema Verma, Administrator,
The Centers for Medicare and Medicaid Services

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[1] https://aspe.hhs.gov/poverty-guidelines

[2] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2542420

[3] Jamal A, Phillips E, Gentzke AS, et al. Current Cigarette Smoking Among Adults — United States, 2016. MMWR Morb Mortal Wkly Rep 2018;67:53–59. DOI: http://dx.doi.org/10.15585/mmwr.mm6702a1

[4] De Koning HJ et al. Benefits and Harms of CT Lung Cancer Screening Strategies. A Comparative Modeling Study for the U.S. Preventive Services Task Force. *Annals of Internal Medicine*, 2014;160(5):311-20; The National Lung Cancer Screening Trial Team. Reduced Lung-Cancer Mortality with Low-Dose Computed Tomographic Screening. *New England Journal of Medicine*, August 2011; 365(5):395-409.

[5] 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.

[6] Misty Williams, "Medicaid Changes Require Tens of Millions in Upfront Costs," Roll Call, February 26, 2018. Available at https://www.rollcall.com/news/politics/medicaid-kentucky.

[7] Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, February 2017. Available at http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.

[8] Renuka Tipirneni, Susan D. Goold, John Z. Ayanian. Employment Status and Health Characteristics of Adults With Expanded Medicaid Coverage in Michigan. *JAMA Intern Med.* Published online December 11, 2017. doi:10.1001/jamainternmed.2017.7055

Appendix A

Consensus Healthcare Reform Principles

Today, millions of individuals, including many with preexisting health conditions, can obtain affordable health care coverage. Any changes to current law should preserve coverage for these individuals, extend coverage to those who remain uninsured, and lower costs and improve quality for all.

In addition, any reform measure must support a health care system that provides affordable, accessible and adequate health care coverage and preserves the coverage provided to millions through Medicare and Medicaid. The basic elements of meaningful coverage are described below.

Health Insurance Must be Affordable – Affordable plans ensure patients are able to access needed care in a timely manner from an experienced provider without undue financial burden. Affordable coverage includes reasonable premiums and cost sharing (such as deductibles, copays and coinsurance) and limits on out-of-pocket expenses. Adequate financial assistance must be available for low-income Americans and individuals with preexisting conditions should not be subject to increased premium costs based on their disease or health status.

Health Insurance Must be Accessible – All people, regardless of employment status or geographic location, should be able to gain coverage without waiting periods through adequate open and special enrollment periods. Patient protections in current law should be retained, including prohibitions on preexisting condition exclusions, annual and lifetime limits, insurance policy rescissions, gender pricing and excessive premiums for older adults. Children should be allowed to remain on their parents' health plans until age 26 and coverage through Medicare and Medicaid should not be jeopardized through excessive cost-shifting, funding cuts, or per capita caps or block granting.

Health Insurance Must be Adequate and Understandable – All plans should be required to cover a full range of needed health benefits with a comprehensive and stable network of providers and plan features. Guaranteed access to and prioritization of preventive services without cost-sharing should be preserved. Information regarding costs and coverage must be available, transparent, and understandable to the consumer prior to purchasing the plan.

ALS Association
American Cancer Society Cancer Action Network
American Diabetes Association
American Heart Association
American Liver Foundation
American Lung Association
Arthritis Foundation
Autism Speaks
Consumers Union
COPD Foundation
Crohn's & Colitis Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation
Family Voices
Futures Without Violence
Juvenile Diabetes Research Foundation
Leukemia & Lymphoma Society
Lutheran Services in America
March of Dimes
Mended Little Hearts
Muscular Dystrophy Association
National Alliance on Mental Illness
National Down Syndrome Society
National Health Council
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
National Psoriasis Foundation
United Way Worldwide
Volunteers of America
Women Heart the National Coalition for Women with Heart Disease