FLORIDA HEALTH JUSTICE PROJECT

October 19, 2021

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9906-P, P.O. Box 8016
Baltimore, MD 21244-8016

Submitted via Electronic Submission

Re: 1115 Research and Demonstration Waiver, Project Number 11-W-00206/4

Dear Administrator Brooks-LaSure:

Florida Health Justice Project submits these comments in response to the Agency for Health Care Administration's (AHCA's) request to amend the 1115 Managed Medical Assistance (MMA) waiver.

Florida Health Justice Project is a nonprofit engaged in comprehensive advocacy aimed at expanding health care access and promoting health equity for vulnerable and marginalized Floridians.

In addition to reiterating the comments we filed with the state during its public comment period regarding extension of post-partum coverage, we are now including additional comments related to the waiver's Low Income Pool (LIP) and sharing an example of how the repeal of retroactive Medicaid impacted an FHJP client.

We also want to cite agreement with the comments submitted by the National Health Law Program (NHeLP) regarding serious legal questions raised under section 1115 of the Social Security Act. These concerns relate particularly to LIP, retroactive coverage waiver and the shocking and inappropriate length of the waiver. (*See* attached NHeLP comments.)

**Low Income Pool (LIP)**

Florida's LIP program provides a supplemental funding to help reimburse providers for their costs in providing services to uninsured individuals. As a state that has not expanded Medicaid, over 830,000 low-income uninsured Floridians who would benefit from Medicaid expansion.[1]

And while we applaud that the Florida LIP program now includes local health centers providing primary care (FQHCs) and the recent waiver request proposes including non-profit licensed behavioral health providers who participate in county indigent care programs, the vast majority of LIP dollars go to hospitals to reimburse for uninsured patients and emergency department costs. Refer to SFY 2020-21 LIP Model Summary.

It is the position of FHJP, other consumer advocates and health policy experts that a superior plan for supporting providers, lowering costs and improving health care would be providing actual coverage through Medicaid expansion. (*See* NHeLP comments at 4-5). If Medicaid were expanded, the number of uninsured individuals would decrease, and all types of providers, including primary and preventive care providers would receive reimbursement for providing care to low-income uninsured adults.

In addition, Medicaid expansion would be less administratively wasteful and subject to abuse. Reviews over the last 10 years have flagged problems with Florida's LIP program. For example, in 2008 the Secretary of DHHS was informed that the supplemental funding scheme was "problematic." U.S. Government Accountability Office, Medicaid Demonstration Waivers: Recent HHS Approvals Continue to Raise Cost and Oversight Concerns 28 (Jan. 2008) (GAO-08-87) (finding federal spending under the Florida LIP "problematic" and that DHHS had not ensured the "fiscal integrity" of the Medicaid program); *see also* GAO, Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lacks Transparency 14-17 (June 2013) (GAO-13-384) (raising similar concerns with similar pooling arrangements in Texas); Navigant Healthcare, Study of Hospital Funding and Payment Methodologies for Florida Medicaid, Prepared for: Florida Agency for Health Care Administration, at 24-25, 142, 181 (Feb. 27, 2015) (noting the lack of monitoring) [hereinafter the Navigant Report][2]. In 2019, the HHS Office of Inspector General found that Florida paid hundreds of millions of dollars to a Miami safety net hospital "that were not in accordance with the waiver and applicable federal regulations." As a result, OIG recommended that Florida refund $412 million to the federal government.[3] (*See also* NHeLP comments at 6, citing further concerns with LIP, including the fact that "LIP undermines the administration's efforts to advance racial equity.")

Finally, while Florida is eligible for a total LIP allotment of $1,508,385,7734[4], Florida, which relies entirely on local counties for the state match, has been unable to raise the required matching funds from local entities. Thus, the actual funds available are far less than $1.5 billion. *See* SFY 2018-19 LIP Model Summary which had a total LIP program of $857,693,3165[5] and the SFY 2020-21 model which proposes a total of just over $1 billion in total LIP funding.

**Waiver of Retroactive Medicaid Coverage**

The state's proposed amendment on retroactive Medicaid coverage essentially requests permission to continue this benefit cut through June 2030 with no further federal oversight.

We continue to be deeply concerned about the harmful impact of this waiver on beneficiaries and intend to ask the Secretary of the U.S. Department of Health & Human Services (HHS) to withdraw its authorization for Florida to continue this experiment. HHS is authorized to take this action when it finds that the experiment is not likely to achieve the statutory purposes of Medicaid.[6] That purpose is to *promote coverage*, not take it away.

"George's" story is a perfect example of how this policy change is hurting low-income Floridians and safety net providers. In late January 2020, George suffered a heart attack and was rushed to the hospital. The paperwork for his Medicaid coverage was filed in February. Because his application was not submitted during the month of his hospitalization, he received a bill for $62,000. This is creating significant stress for George and his family that would have been preventable before the elimination of

retroactive coverage. And, given his minimal income (only $1100/month), he will never be able to pay the hospital bill, and a critical safety net provider will be further stressed.

FHJP's comments submitted to HHS at the time the state initially sought this waiver in 2018 are equally relevant today. Moreover, this experiment should also be considered in the context of newly released research[7] showing crushing medical debt across the country, but highest in states like Florida that have not expanded their Medicaid programs. Taking away retroactive coverage exposes thousands of Floridians, primarily seniors and people with disabilities, to even more medical debt.

And continuing this waiver during this unprecedented pandemic and economic downturn is particularly cruel given massive job and insurance coverage losses. Uninsured people face even greater risks of facing substantial medical debt due to high treatment costs for COVID-19. The resulting health and economic suffering could be greatly mitigated through reinstatement of retroactive Medicaid coverage. [8]

The State claims that this experiment will encourage people to enroll in Medicaid quickly instead of waiting until they are very sick. But those in the coverage gap -- people without a severe disability or with income above the Medicaid limits, who do not make enough money for a subsidized Marketplace plan -- are facing a double whammy merely by accident of geography. Because they live in Florida, a state that has not expanded Medicaid, they have no ability to enroll in ongoing coverage when they are healthy and, when they become sick enough to qualify for Medicaid, Florida denies them the lifeline of retroactive coverage for medical bills incurred due to the illness or accident that led to their qualifying disability. Simply put, Florida's elimination of retroactive Medicaid coverage results in devastating medical debt for individuals who are unexpectedly rendered disabled. *That result does not, as this experiment requires, promote Medicaid coverage*.

**10-Year Waiver Extension**

Finally, we are respectfully requesting HHS to withdraw the 10-year extension of Florida's MMA 1115 waiver that was covertly granted in January 2021 at the eleventh hour of a transition to the new federal administration. Such authorization is unprecedented and in violation of federal law.

Thank you for your consideration of these written comments and please let us know if you have questions or need additional information.

Sincerely,

*s/Miriam Harmatz*

Miriam Harmatz
Advocacy Director & Founder

[1] https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/

[2] Navigant Report at https://ahca.myflorida.com/medicaid/Finance/finance/LIP-DSH/LIP/docs/FL_Medicaid_Funding_and_Payment_Study_2015-02-27.pdf

[3] Office of the Inspector General available at https://oig.hhs.gov/oas/reports/region4/41704058.pdf

[4] Florida Managed Medical Assistance Demonstration available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-mma-ca.pdf

[5] SFY 2018-2018 LIP Model Summary available at https://ahca.myflorida.com/Medicaid/Finance/finance/LIP-DSH/LIP/pdfs/18-19_LIP_Model_1_Pct_Minimum.pdf

[6] 42 U.S.C. § 1315

[7] S. Kliff, M. Sanger-Katz, "Americans Medical Debts Are Bigger Than Was Known Totaling $140 Billion," New York Times, July 20,2021, https://www.nytimes.com/2021/07/20/upshot/medical-debt-americans-medicaid.html

[8] P. Shafer, et al., "Medicaid Retroactive Eligibility Waiver Will Leave Thousands Responsible for Coronavirus Treatment Costs, " May 8, 2020, Health Affairs, https://www.healthaffairs.org/do/10.1377/hblog20200506.111318/full/

October 15, 2021

The Honorable Xavier Becerra, Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

Re: Florida Managed Medical Assistance Waiver Amendment Request

Dear Secretary Becerra:

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 underserved people. We appreciate the opportunity to comment on the proposed Florida Managed Medical Assistance Waiver Amendment request (Florida Request). As discussed below, the Florida Request seeks to amend an approval raising serious legal questions under section 1115 of the Social Security Act, particularly as it involves use of a Low-Income Pool (LIP), waiver of retroactive coverage, and a whopping 10-year period of approval. We are also concerned that the Florida Request maintains existing racial health disparities in the State.

## I. HHS Authority Under Section 1115

For the Secretary to approve a project pursuant to section 1115, the project must:

- be an "experimental, pilot or demonstration" project;
- be likely to promote the objectives of the Medicaid Act;

- waive compliance only with requirements in 42 U.S.C. § 1396a; and
- be approved only to the extent and for the period necessary to carry out the experiment.

Discussing each of these limitations a bit further:

*First*, the Secretary can only approve a state proposal to conduct an "experimental, pilot, or demonstration" project. This demands a "novel approach" to program administration.[1] To evaluate whether a proposed project is a valid experiment, the Secretary needs to know what will be tested and how, at the point in time when the project is being approved.

*Second*, the project must promote the Medicaid Act's objectives. According to Congress, the purpose of Medicaid is to enable states "to furnish[] medical assistance" to individuals "whose income and resources are insufficient to meet the costs of necessary medical services" and to provide "rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care."[2] Thus, the "central objective" of the Medicaid Act is "to provide medical assistance," that is to provide health coverage.[3] That coverage should be provided "as far as practicable," that coverage should be maximized to the extent possible under the conditions in the state.[4]

*Third*, the Secretary can only waive provisions set forth in section 1396a of the Medicaid Act. The Secretary cannot waive requirements contained in sections 1396b through 1396w-5.[5] Once the Secretary has acted under section 1115(a)(1) to waive compliance with designated provisions in section 1396a, section 1115(a)(2) provides that the costs of "such project" are "regarded as expenditures under the State plan" and, thus, paid for under the same statutory formula that applies for a state's expenditures under its State plan.[6] Section 1115(a)(2) does *not* create an independent "expenditure authority" for the Secretary to allow a state to ignore provisions of the Medicaid Act outside of section 1396a or to rewrite the provisions in section 1396a or any other provision outside of section 1396a. To the contrary, it is a clean-up

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[1] *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994).
[2] 42 U.S.C. § 1396-1; 1396d(a) (defining "medical assistance" as provision of, or payment for, specified health care and services).
[3] *Stewart v. Azar*, 366 F. Supp. 3d 125, 138 (D.D.C. 2019); *id.* at 144 (rejecting "promoting health" as an independent objective because the Medicaid Act is "designed … to address not health generally but the provision of care to needy populations" through a health insurance program).
[4] 42 U.S.C. § 1396-1.
[5] *See* 42 U.S.C. § 1315(a)(1).
[6] *Id.* § 1315(a)(2).

provision that merely provides the authorization necessary for federal reimbursement of expenditures for a project that has been approved under section 1115(a)(1).

*Fourth*, section 1115 allows approvals only "to the extent and for the period . . . necessary" to carry out the experiment.[7] The Secretary cannot use section 1115 to permit states to make long-term policy changes.

To sum up, HHS's use of section 1115 is limited to authorizing states to test out novel, time-limited experiments. As one court put it: "As a matter of principle, it is clear that the Secretary would abuse his discretion if he were to approve a project . . . which subject[ed] an unreasonably large population to the experiment or continu[ed] it for an unreasonably long period."[8] Courts have also noted that section 1115 "was not enacted to enable states to save money or to evade federal requirements but to test out new ideas and ways of dealing with the problems" of program enrollees.[9] Other courts have reminded HHS that experiments must reflect the objectives of the Medicaid Act—which, according to the Act itself, center on enabling states "to furnish medical assistance," to the greatest extent practicable, to individuals "whose income and resources are insufficient to meet the costs of necessary medical services."[10] As discussed below, the Florida Request conflicts with section 1115.

## I. LIP

Florida received permission to establish a temporary LIP in 2006, as part of a section 1115 project. The overarching purpose of that project was to allow the State to ignore certain, otherwise mandatory provisions of the Medicaid Act as it shifted enrollees into a managed care delivery system. The approval allowed Florida to provide supplemental payments to selected health care providers during the transition to help them offset the cost of caring for Medicaid beneficiaries and uninsured individuals. *See* Ctrs. for Medicare & Medicaid Servs., *Medicaid Reform Section 1115 Demonstration – Special Terms and Conditions,* 7-8, 24 (2006). The

[7] *Id*. § 1315(a); *see also id*. §§ 1315(e)(2), (f)(6) (limiting CMS's authority to extend "state-wide, comprehensive demonstration projects"). In 2017, CMS stated the intent to "[w]here possible, . . . approve the extension of *routine, successful, non-complex*" section 1115(a) waivers for a period up to 10 years." Ctr. for Medicaid & CHIP Servs., CMCS Informational Bulletin 3 (Nov. 6, 2017) (emphasis added). This Bulletin should be disregarded because it conflicts with, among other things, section 1115's limitation of approvals to experimental, pilot, or demonstration projects.

[8] *Cal. Welf. Rts. Org. v. Richardson*, 348 Fed. Supp. 491, 498 (N.D. Cal. 1972).

[9] *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994) (internal quotations and citation omitted).

[10] 42 U.S.C. § 1396-1; *see*, *e.g.*, *Stewart v. Azar*, 366 F. Supp. 3d 125, 138-40 (D.D.C. 2019) (discussing objectives of the Medicaid Act).

approval listed "research" questions for the project, such as: How many individuals receive services through the LIP? How do the individuals who receive services through the LIP vary according to their age, gender, ethnicity, and other characteristics? How much reimbursement is received by each provider? It is now 15 years later, long beyond the period needed to answer these straightforward questions. The project should have wrapped up a long time ago.

Moreover, almost from the start, the Secretary has been on notice that the LIP was "problematic."[11] By 2014, CMS had decided that the LIP would end.[12] Along with the one-year extension, CMS required Florida to commission an independent report that would "recommend reforms to the Florida Medicaid financing system that can allow the state, beginning in state fiscal year 2015-2016, to move toward Medicaid managed care and fee-for-service payments that ensure access for Medicaid beneficiaries to providers throughout the state through such payments rather than through over reliance on supplemental payments."[13] This report was produced by Navigant Healthcare. The Navigant report found numerous problems, including: "audits are not performed for the LIP program," "few if any standard reports," "very little review," and insufficient monitoring manpower.[14] And in 2019, the Office of Inspector General documented that hundreds of millions of dollars in unallowable payments were made under the LIP project.[15] Information about the LIP project has been repeatedly reported, and it is not favorable.

The LIP produces an uneven patchwork of funding for the chosen health care providers, often those seeing patients with previously undiagnosed and untreated problems that have become serious or acute. Low-income, uninsured Floridians would benefit to a greater degree if the options Congress has established for Medicaid are used, particularly the health coverage available through 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (section VIII). Florida is one of only

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[11] U.S. Gov't Accountability Office, *Medicaid Demonstration Waivers: Recent HHS Approvals Continue to Raise Cost and Oversight Concerns* 28 (Jan. 2008) (GAO-08-87) (finding Secretary had not adequately ensured the "fiscal integrity" of the Medicaid program).

[12] *See* Letter from Cindy Mann, Dir. of CMS to Justin Senior, Deputy Sec'y for Medicaid, Fla. Ag. for Health Care Admin. at 2 (July 31, 2014) ("This extension is approved for three years . . . *except for the Low Income Pool (LIP) supplemental payment authority which will be extended through June 20, 2015.*") (emphasis added).

[13] *Id.*

[14] Navigant Healthcare, *Study of Hospital Funding and Payment Methodologies for Fla.* at 31-32, 149, 188 (Feb. 27, 2015).

[15] U.S. Dep't of Health & Hum. Servs., Office of Inspector Gen., *Florida Medicaid Paid Hundreds of Millions in Unallowable Payments to Jackson Memorial Hospital Under Its Low Income Pool Program* (Aug, 30, 2019) https://oig.hhs.gov/oas/reports/region4/41704058.asp (recommending that Florida refund $412 million to the federal government, including $64 million of hospital-reported net overpayments and $348 million of unallowable costs).

twelve states that have not taken up the Medicaid expansion. Numerous studies find this inaction by the State is not penny wise but it is pound foolish.

In a review of over 600 studies conducted between January 2014 and March 2021, the Kaiser Family Foundation found that Medicaid expansion is linked to gains in coverage, and consequently, to improvements in access to care—including preventive and behavioral care and prescriptions for chronic conditions.[16] For example, a 2019 study, updated in January 2021, concluded that near-elderly adults in expansion states experienced a substantial drop in mortality compared to near-elderly adults in non-expansion states. The authors estimated that in the four years following Medicaid expansion, approximately 15,600 deaths could have been averted if the Medicaid expansions were adopted nationwide as intended by Congress.[17]

Medicaid expansion would also help Floridians gain financial security. A 2017 study investigated in detail the effects of Medicaid expansion on households' financial health and found direct as well as substantial indirect financial benefits. In its first two years, expansion not only reduced unpaid medical bills sent to collection by $3.4 billion, it also reduced the likelihood of a person becoming delinquent on a debt obligation, improved credit scores, prevented about 50,000 bankruptcies among subprime borrowers, and led to better terms for available credit valued at $520 million per year. The study concluded that the financial benefits of Medicaid double when considering these indirect benefits in addition to the direct reduction in out-of-pocket expenditures.[18]

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[16] *See* Madeline Guth et al., Kaiser Family Found., *The Effects of Medicaid Expansion Under the ACA: Studies from January 2014 to January 2020* (2020), https://files.kff.org/attachment/Report-The-Effects-of-Medicaid-Expansion-under-the-ACA-Updated-Findings-from-a-Literature-Review.pdf; Madeline Guth & Meghana Ammula, Kaiser Family Found., *Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021* (2021), https://www.kff.org/medicaid/report/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021/. *See also* U.S. Dep't of Health & Human Servs., Office of the Assistant Sec'y for Planning & Evaluation, *Impacts of the Affordable Care Act's Medicaid Expansion on Insurance Coverage and Access to Care* (2017), https://aspe.hhs.gov/system/files/pdf/255516/medicaidexpansion.pdf; Benjamin D. Sommers et al., *Three-Year Impacts of the Affordable Care Act: Improved Medical Care and Health Among Low-Income Adults*, 36 Health Aff. 1119, 1124 (2017), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.0293 (finding that Medicaid expansion "was associated with significant improvements in access to primary care and medications, affordability of care, preventive visits, screening tests, and self-reported health").

[17] *See* Sarah Miller et al., *Medicaid and Mortality: New Evidence from Linked Survey and Administrative Data*, *NBER Working Paper Series No. 26081* at 3, 21 (2019), https://www.nber.org/system/files/working_papers/w26081/w26081.pdf.

[18] *See* Kenneth Brevoort, Daniel Grodzicki, & Martin B. Hackman, *Medicaid and Financial Health, NBER Working Paper No. 24002* at 3,4 (2017), https://www.nber.org/system/files/working_papers/w24002/w24002.pdf. *See also* Kyle J. Caswell & Timothy A. Waidmann, *The Affordable Care Act Medicaid Expansions and Personal Finance*, 76 Med. Care Res. & Rev. 538, 562 (2019),

Research also shows that Medicaid expansion does not financially harm states. Studies examining the fiscal impact of Medicaid expansion on specific states or the effects across all states consistently find that expansion leads to significant budget savings and revenue increases without imposing additional taxes.[19] This is particularly true after March 11, 2021, when President Biden signed the American Rescue Plan Act into law and included section 9814, which offers non-expansion states bonus federal payments to expand.

Finally, the LIP undermines the administration's efforts to advance racial equity.[20] Due to the ongoing effects of structural racism and inequality, the poverty rate among Black and Hispanic Floridians is about twice as high as the poverty rate among white Floridians.[21] As a result, nonwhite individuals are more likely than white individuals to rely on Medicaid for their health care. By restricting access to Medicaid coverage and services to only the selected LIP providers (mostly hospitals), Florida may disproportionately harm people of color. A June 2021 study found that Black patients admitted with COVID-19 had a higher mortality rate than White patients and that this difference was attributable to the different hospitals to which Black and White patients were admitted.[22] Instead of perpetuating waivers that promote racial health disparities and inequities, CMS should be working with states to develop state plan amendments that reduce the gaps through Medicaid expansion.[23]

**II. Retroactive Coverage**

The Florida Request would allow Florida to stop complying with two STCs that require the State to submit annual information about its waiver of retroactive coverage. The request is

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https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6716207/pdf/10.1177_1077558717725164.pdf (finding that Medicaid expansion "significantly reduced the likelihood of new medical collections and, more generally, the flow of new and large derogatory debt balances").

[19] *See* Bryce Ward, The Commonwealth Fund, *The Impact of Medicaid Expansion on States' Budgets* (2020), https://www.commonwealthfund.org/publications/issue-briefs/2020/may/impact-medicaid-expansion-states-budgets.

[20] *See, e.g.*, Exec. Order No. 13985, 86 C.F.R. § 7009 (2021).

[21] *State Health Facts, Poverty Rate by Race/Ethnicity, 2019,* KAISER FAMILY FOUND., https://www.kff.org/other/state-indicator/poverty-rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[22] David A. Asch et al., *Patient and Hospital Factors Associated With Differences in Mortality Rates Among Black and White US Medicare Beneficiaries Hospitalized With COVID-19 Infection* (June 17, 2021), 4(6) *JAMA Netw. Open.* e2112842 (June 17, 2021), http://jamanetwork.com/journals/jamanetworkopen/fullarticle/2781182.

[23] *Id.* at 8-9.

made "since both of these provisions were extended indefinitely [presumably, by the state legislature]."[24] CMS should not grant this Request and, instead, should revoke this waiver because it violates section 1115.

To begin with, a state cannot extend a waiver "indefinitely," as that would be a facial violation of section 1115. Equally important, Florida did not request the waiver for an experiment; rather, the objective was "to enhance fiscal predictability."[25] Continuation of this waiver would simply be giving Florida permission to evade a federal requirement so that it can better predict spending. Multiple courts have said it is improper to use section 1115 to evade the requirements that Congress has placed in the Medicaid Act.[26]

Numerous states have been granted retroactive coverage waivers since at least the 1990s.[27] There is nothing novel about this waiver. By now, it is abundantly clear that retroactive coverage subverts the objectives of the Medicaid Act because it "by definition, *reduce[s*] coverage" for people not currently enrolled in Medicaid.[28] Florida's waiver acknowledges these harmful effects because it is a partial waiver that exempts some populations—those under age 21 and pregnant women. Such a waiver also breathes new life into tired concepts of worthy and unworthy poor, allowing HHS and willing states to pick and choose which populations are not worthy. It also raises serious legal questions: A partial waiver modifies, or changes, the wording of 42 U.S.C. § 1396a(a)(34), which on its face extends retroactive coverage to all Medicaid enrollees. While some other waiver authorities authorize HHS to "waive or modify" Medicaid Act provisions, section 1115 only authorizes the Secretary to waive them.[29]

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[24] Agency for Health Care Admin., *Florida Managed Medicaid Assistance Waiver Amendment Request* 3 (Sept. 3, 2021).
[25] Agency for Health Care Admin., *Florida Managed Medicaid Assistance Waiver* 6 (Apr. 27, 2018).
[26] *See, e.g.*, *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994).
[27] *See* Leonardo Cuello, Ctr, for Children & Fam., *Retroactive Coverage Waivers: Coverage Lost and Nothing Learned* (Oct. 4, 2021), https://ccf.georgetown.edu/2021/10/04/retroactive-coverage-waivers-coverage-lost-and-nothing-learned/ (listing 14 current retroactive coverage waivers); MACPAC, *Medicaid Retroactive Eligibility: Changes Under Section 1115 Waivers* (2019), https://www.macpac.gov/wp-content/uploads/2019/08/Medicaid-Retroactive-Eligibility-Changes-under-Section-1115-Waivers.pdf (listing the 30 demonstration projects with a waiver of retroactive coverage as of August 2019 and noting that none of the states "have conducted a formal evaluation of the effects of these policies"). *See also* Jane Perkins & Catherine McKee, *Nat'l Health Law Program, Medicaid Retroactive Coverage: Stop These Waivers!* 2-3 (2021), https://healthlaw.org/resource/medicaid-retroactive-coverage-stop-these-waivers/ (describing the history of retroactive waivers).
[28] *Stewart v. Azar*, 313 F. Supp. 3d 237, 265 (D.D.C. 2019).
[29] *Cf.* 42 U.S.C. § 1320b-5 (section 1135 "waive or modify" authority during a national emergency) *with id.* § 1315 (section 1115 "waiver" authority for a time-limited experiment).

Retroactive coverage is critical for Medicaid beneficiaries. Florida reported that tens of thousands of people needed retroactive coverage in just the SFY2015-2016 time period—approximately 39,000 non-pregnant adult recipients.[30] Iowa estimated that waiving retroactive coverage in its Medicaid program would decrease coverage by 3,344 people every month and over 40,000 people every year.[31] During one 16-month period in New Hampshire, 4,657 individuals in the Medicaid expansion population alone benefited from retroactive coverage, which paid for more than $5 million in medical expenses.[32] When Indiana received permission to waive retroactive coverage in 2015, CMS required the State to continue to provide some retroactive coverage to parents and caretaker relatives, and almost 14% of that population used the coverage, with the amount paid averaging $1,561 per person.[33] Low-income people cannot afford $1500 in unexpected medical expenses. They become saddled with medical debt—an outcome that is antithetical to the Biden administration's focus on shoring up and building up the middle class. That outcome also has a disproportionate impact on people of color. Black households are much more likely to have medical debt than white households (28% to 17%); Hispanic households are also more likely to have medical debt.[34]

Waiving retroactive coverage also raises uncompensated care costs for hospitals and other safety-net health care providers. When Ohio requested a waiver of retroactive coverage, one report estimated that the waiver would result in roughly $2.5 billion more in uncompensated costs for hospitals over five years.[35] Iowa's waiver was opposed on similar grounds, with the Iowa Hospital Association warning that the waiver would "place a significant financial burden on hospitals and safety-net providers and reduce their ability to serve Medicaid patients . . .

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[30] Agency for Health Care Admin., Florida Managed Medicaid Assistance Waiver at 6 (Apr. 27, 2018).
[31] *See* Iowa Dep't of Human Servs., *Section 1115 Demonstration Amendment, Iowa Wellness Plan*, at Attachment A (2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-wellness-plan-pa4.pdf.
[32] *See* N.H. Dep't of Health & Human Servs., *Retroactive Coverage Waiver Submission* (2015), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program/nh-health-protection-program-premium-assistance-retro-cov-waiver-submission-12212015.pdf.
[33] Letter from Vikki Wachino, Dir., Ctr. for Medicaid & CHIP Servs., to Tyler Ann McGuffee, Ins. & Healthcare Policy Dir., Office of Governor Michael R. Pence (July 29, 2016), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf.
[34] *See* Leonardo Cuello, Ctr, for Children & Fam., *Retroactive Coverage Waivers: Coverage Lost and Nothing Learned* (Oct. 4, 2021), CITE
[35] *See, e.g.*, Virgil Dickson, *Ohio Medicaid Waiver Could Cost Hospitals $2.5 Billion*, MODERN HEALTHCARE (April 22, 2016), http://www.modernhealthcare.com/article/20160422/NEWS/160429965.

translate into increased bad debt and charity care for Iowa's hospitals and . . . affect the financial stability of Iowa's hospitals, especially in rural communities."[36]

In connection with this point, the waiver of retroactive coverage and the LIP create an unusual, and possibly illegal, dynamic. As approved by CMS, providers can use LIP funds to defray the costs of services described in 1905(a)(1).[37] That section describes inpatient hospital services, including those covered on a retroactive basis.[38] Thus, a hospital could receive LIP funding for retroactive services, even though retroactive coverage is purportedly waived. This raises serious comparability concerns—a person who receives inpatient hospital care will get retroactive coverage *if* they go to a hospital that seeks that coverage through the LIP, while a person who goes to a hospital that does not, will not. The dynamic is arbitrary in another way: A person who is an inpatient in a facility other than a hospital will not get retroactive coverage.

Congress required retroactive coverage in order to "protect persons who are eligible for Medicaid but do not apply for assistance until after they have received care, either because they did not know about the Medicaid eligibility requirements or because the sudden nature of their illness prevented their applying."[39] There are no grounds for ignoring this congressional intent.

*First*, retroactive coverage is not needed to make managed care work. In the 1990s, the Clinton administration used section 1115 to test novel Medicaid managed care delivery systems in more than a dozen states, and as part of those projects, waived retroactive coverage because managed care companies did not want to be held financially responsible for managing care retroactively. But managed care has long since ceased to be novel, with nearly 70 percent of the Medicaid population nationwide is enrolled in a comprehensive managed care plan.[40] In 1997, Congress amended the Medicaid Act to allow states to implement

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[36] Virgil Dickson, *Hospitals Balk at Iowa's Proposed $37 Million Medicaid Cuts*, MODERN HEALTHCARE (Aug. 8, 2017), http://www.modernhealthcare.com/article/20170808/NEWS/170809906.
[37] Letter from Lisa Marunycz, U.S. Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Div. of System Reform Demos., to Beth Kidder, Dep. Sec. for Medicaid, Fla. Ag. for Health Care Admin. 44 (Jan. 19, 2021) (STC 65).
[38] *See* 42 U.S.C. § 1396d(a)(1).
[39] Staff of S. Comm. on Finance, 92d Cong., Rep. to Accompany H.R. 1 to Amend the Social Security Act, and for other purposes, at 209, H. Rep. No. 92-231, 92d Cong., 2d Sess., reprinted in [1972] U.S. Code Cong. & Ad. News 4989, 5099, https://bit.ly/2TtPPch.
[40] Elizabeth Hinton et al., Kaiser Fam. Found., *10 Things to Know about Medicaid Managed Care* (Oct 29, 2020), https://bit.ly/3xVUlin.

managed care for most enrollees as a state plan option (so a waiver is not needed).[41] Congress *did not* eliminate the retroactive coverage requirement, thus recognizing no incompatibility between the two policies (*e.g.,* the state Medicaid agency can remain responsible for these costs). Today, a number of states administer comprehensive managed care programs without a waiver of retroactive coverage (*e.g*., CA, IL, NY, OR).

*Second*, CMS has previously suggested that waiver of retroactive coverage could incentivize people to enroll in Medicaid earlier, when they are healthy.[42] This rationale is nonsensical in a non-expansion state like Florida, where most low-income adults cannot enroll in Medicaid until they become sick or injured and qualify for the program due to a disability. Moreover, there is no evidence suggesting that low-income individuals decide not to enroll in Medicaid because they are healthy and do not need care. To the contrary, evidence suggests that individuals do not know about Medicaid coverage or how to enroll.[43] Since the 1990s, when many of the retroactive coverage waivers were initially approved, Congress has taken a very different approach to incentivizing early enrollment and preventive care. Leaving the retroactive coverage requirement alone, Congress has enacted a variety of measures to encourage prompt Medicaid enrollment—*e.g.*, streamlining eligibility and enrollment and providing additional funding for outreach and enrollment assistance. Congress has it right here, and states should be required to adhere to the Medicaid requirements.

In short, waiving retroactive coverage is not experimental, and more than three decades of experience confirms that it reduces coverage, harming low-income people.[44] The waiver not only fails to advance the objectives of the Medicaid program, but it actively undermines the key goals of providing coverage, care, and related financial protection to low-income individuals.

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[41] 42 U.S.C. § 1396u-2.
[42] *See* Letter from Seema Verma, Admin., Ctrs. for Medicare & Medicaid Servs., to Justin Senior, Sec., Fla. Agency for Health Care Admin. at 2 (Nov. 30, 2018).
[43] *See*, *e.g.*, Jennifer M. Haley & Erik Wengle, Urban Inst., *Many Uninsured Adults Have Not Tried to Enroll in Medicaid or Marketplace Coverage* (Jan. 2021), https://urbn.is/3yYuAQ0 (noting problems with lack of awareness or understanding of public programs); Julie L. Judson & Asako S. Moriya, *Medicaid Expansion for Adults had Measurable 'Welcome Mat' Effects for Their Children*, Health Aff., Sept. 2017, https://bit.ly/37SadYG (noting significant increases in Medicaid coverage for previously eligible but not enrolled children). Alexia Fernandez Campbell, *These 2 Medicaid provisions prevent medical debts from ruining people's lives*, Vox (July 19, 2017), https://www.vox.com/policy-and-politics/2017/7/19/15949250/medicaid-medical-bankruptcy (highlighting the story of a man who did not realize he was eligible for Medicaid until after he faced $500,000 in medical bills and a family friend informed him that Medicaid may be able to help).
[44] *See* Harris Meyer, *New Medicaid Barrier: Waivers Ending Retrospective Eligibility Shift Costs to Providers, Patients*, MODERN HEALTHCARE (Feb. 11, 2019).

## III. Length of Approval

On January 19, 2021, CMS approved the State's request to extend the waiver for a whopping 10-year period. Section 1115 allows the Secretary to waive Medicaid Act requirements only for an experimental, pilot, or demonstration project, and only "to the extent and for the period . . . necessary" to enable the state to carry out its experiment.[45] Congress intended for projects to be time-limited – it did not enact section 1115 to permit states to make long-term policy changes.[46] As described in detail above, the Florida Request would not amend a valid section 1115 experiment. Even if it were, there is simply no reason that Florida would need 10 years to conduct its experiment. Florida offered no basis for such an extraordinarily long project, and the approval appears to have been intended to tie the hands of the Biden administration. That intention does not make it "necessary" for the project to go on for a decade.

We acknowledge that, in 2017, CMS issued an Informational Bulletin announcing its intent "[w]here possible, . . . [to] approve the extension of routine, successful, non-complex" section 1115(a) waivers for a period of up to 10 years. But section 1115 only allows projects that have ongoing "research or demonstration value."[47] It does not permit "routine" projects. Similarly, it does not permit extending a "successful" project for up to a decade. If a project has proven successful, then it is no longer experimental, and granting an extension of any length would be improper.[48] This policy should be withdrawn, but in any event, it does not permit approving Florida's Request for 10 years.

Finally, the approval runs counter to the requirements in section 1115 governing the extension of state-wide comprehensive demonstration projects, which limit a project to two extensions.[49]

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[45] *Id*. § 1315(a); *see also id*. § 1315 (d)(2), (f)(6) (limiting the extension of "state-wide, comprehensive demonstration projects" to one initial extension of up to 3 years (5 years, for a waiver involving dual eligible individuals) and one subsequent extension not to exceed 3 years (5 years, for Medicare-Medicaid waivers)).
[46] "*Cal. Welf. Rts. Org. v. Richardson*, 348 Fed. Supp. 491, 498 (N.D. Cal. 1972) ("[I]t is clear that the Secretary would abuse his discretion if he were to approve a project . . . which subject[ed] an unreasonably large population to the experiment or continu[ed] it for an unreasonably long period.").
[47] Ctr. for Medicaid & CHIP Servs., CMCS Informational Bulletin 3 (Nov. 6, 2017).
[48] *See Newton Nations v. Betlach*, 660 F.3d 370, 381 (9th Cir. 2011) (questioning whether the Secretary could have determined that a section 1115 project imposing heightened cost-sharing on Medicaid enrollees had any research or demonstration value given that the use of cost sharing had already been heavily studied).
[49] 42 U.S.C. § 1315(e), (f).

Section 1115(e) establishes the requirements for the initial extension of such a project.[50] It limits the first extension to a period of up to three years, or in the case of a waiver involving Medicare and Medicaid dual eligibles, five years.[51] Section (f) then establishes the requirements for a subsequent extension of that project.[52] The provision authorizes a subsequent extension for "a period not to exceed three years (five years, in the case of a waiver [involving dual eligibles])."[53] The statute does not permit the extension of a project operating under subsection (f), meaning the Secretary does not have the authority to extend a state-wide comprehensive project for a third time.

**Conclusion**

We have included numerous citations to supporting research, including direct links to the research. We direct CMS to each of the materials we have cited and made available through active links, and we request that the full text of each of the studies and articles cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act. If CMS is not planning to consider these materials part of the record as we have requested here, we ask that you notify us and provide us an opportunity to submit copies of the studies and articles into the record.

We appreciate the opportunity to submit comment. If you have questions, please contact me (perkins@healthlaw.org) or Catherine McKee (mckee@healthlaw.org).

Sincerely,

Jane Perkins
Legal Director

[50] *Id*. § 1315(e)(1) ("The provisions of this subsection shall apply to the extension of any State-wide comprehensive demonstration project . . . for which a waiver of compliance with requirements of subchapter XIX is granted under subsection (a)).
[51] *Id*. § 1315(e)(2).
[52] *Id*. § 1315(f) ("An application . . . for an extension of a waiver project the State is operating under an extension under subsection (e)…shall be submitted and approved or disapproved in accordance with the following….").
[53] *Id*. § 1315(f)(6).