October 19, 2018

Jennifer Lee, MD
Secretary
Virginia Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219

Re: Virginia Department of Medical Assistance Services 1115 Demonstration Extension Application – Virginia COMPASS: Creating Opportunities for Medicaid Participants to Achieve Self-Sufficiency

Dear Dr. Lee:

The Epilepsy Foundation and Epilepsy Foundation of Virginia appreciate the opportunity to submit comments on the Virginia Department of Medical Assistance Services 1115 Demonstration Extension Application – Virginia COMPASS: Creating Opportunities for Medicaid Participants to Achieve Self-Sufficiency.

The Epilepsy Foundation is the leading national voluntary health organization that speaks on behalf of the at least 3.4 million Americans with epilepsy and seizures. We foster the wellbeing of children and adults affected by seizures through research programs, educational activities, advocacy, and direct services. Epilepsy is a medical condition that produces seizures affecting a variety of mental and physical functions. Approximately 1 in 26 Americans will develop epilepsy at some point in their lifetime. According to the CDC figures there are 84,800 people living with epilepsy in Virginia. For people living with epilepsy, timely access to appropriate, physician-directed care, including epilepsy medications, is a critical concern.

The Epilepsy Foundation and Epilepsy Foundation of Virginia believe everyone, including Medicaid enrollees, should have access to quality and affordable health coverage. Unfortunately, this waiver creates administrative and financial barriers that will jeopardize patients' access to quality and affordable health coverage, and Epilepsy Foundation and Epilepsy Foundation of Virginia therefore oppose the proposed waiver.

<u>Work and Community Engagement Requirements</u>
The Virginia Department of Medical Assistance Services 1115 Demonstration Extension Waiver seeks to add a work and community engagement requirement for some Medicaid enrollees. This would increase the administrative burden on all Medicaid patients. Individuals will need to either attest that they meet certain exemptions or the number of hours they have worked.

Increasing administrative requirements will likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt or not. Arkansas is currently implementing a similar policy requiring Medicaid enrollees to report their hours worked or their exemption. As of October 1, four months into implementation, the state has terminated coverage for 8,462 individuals and locked them out of coverage until January 2019.[i] An additional 12,589 individuals had one or two months of noncompliance and are at risk for losing coverage in the coming months.[ii] In another case, after Washington state changed its renewal process from every twelve months to every six months and

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instituted new documentation requirements in 2003, approximately 35,000 fewer children were enrolled in the program by the end of 2004.[iii] 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. If the state finds that individuals have failed to comply with the new requirements for three months within a 12-month period, they will be locked out of coverage until they demonstrate their compliance. People who are in the middle of treatment for a life-threatening disease, rely on regular visits with healthcare providers or must take daily medications to manage their chronic conditions cannot afford a sudden gap in their care.

The Epilepsy Foundation and Epilepsy Foundation of Virginia are also 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. Additionally, Virginia's "good cause" exemption that includes circumstances like hospitalizations or serious illnesses is still not sufficient to protect patients. In Arkansas, many individuals were unaware of the new requirements and therefore unaware that they needed to apply for such an exemption,[iv] and in August the state granted just 45 good cause exemptions while terminating coverage for 4,353 individuals at the end of that month.[v] No exemption criteria can circumvent this problem and the serious risk to the health of the people we represent.

Administering these requirements will be expensive for Virginia. States such as Michigan, Pennsylvania, Kentucky and Tennessee have estimated that setting up the administrative systems to track and verify exemptions and work activities will cost tens of millions of dollars.[vi] Virginia's fiscal impact statement estimated that the changes to the IT system would cost approximately $8 million.[vii] These costs would divert resources from Medicaid's core goal – providing health coverage to those without access to care.

Ultimately, the requirements outlined in this waiver do not further the goals of the Medicaid program or help low-income individuals improve their circumstances without needlessly compromising their access to care. Most people on Medicaid who can work already do so.[viii] A study published in *JAMA Internal Medicine*, looked at the employment status and characteristics of Michigan's Medicaid enrollees.[ix] 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. In another report looking at the impact of Medicaid expansion in Ohio, the majority of enrollees reported that that being enrolled in Medicaid made it easier to work or look for work (83.5 percent and 60 percent, respectively).[x] Terminating individuals' Medicaid coverage for non-compliance with these requirements will therefore hurt rather than help people search for and obtain employment. The Epilepsy Foundation and Epilepsy Foundation of Virginia oppose the work and community engagement.

<u>Premiums and Cost-Sharing</u>

One feature of the Virginia COMPASS program is to charge premiums to some Medicaid expansion enrollees. Premiums will range from $5 - $10 per month. If an enrollee fails to pay a month's premium, following a three-month grace period, coverage will be suspended until the enrollee is able to pay the premium. Additionally, enrollees above 100 percent of the federal poverty level will be required to contribute, through the monthly premiums, either $50 or $100 depending on income level and

participate in a healthy behavior activity to access a premium account to pay for non-covered medical or health-related services. This program is unnecessarily confusing and will not promote coverage.

Premiums both increase the number of enrollees who lose Medicaid coverage and discourage eligible people from enrolling in the program.[xi] When Oregon implemented a premium in its Medicaid program, with a maximum premium of $20 per month, almost half of enrollees lost coverage.[xii] For individuals with epilepsy, maintaining access to comprehensive coverage is vital because those who have their medications switched or who experience a delay in access to their treatment options are at a higher risk of breakthrough seizures, injury, accident, and early death. Limits to physician-directed care can also significantly increase costs related to preventable seizures, along with lost wages and productivity – not just for the individual living with epilepsy, but for their families and communities as well.

Indiana implemented a similar payment structure in a previous waiver demonstration. The evaluation report[xiii] from the waiver demonstration found that over half of Medicaid enrollees failed to make at least one payment. The report also found that 29 percent of Medicaid eligible individuals either never enrolled because they did not make a payment or were disenrolled for failure to make payments. Coverage losses on this scale, especially for patients needing access to life-saving and life-sustaining treatment, would be dire.

Ultimately, all of these changes will create confusion and significant barriers for patients that will jeopardize their access to needed care. The Epilepsy Foundation and Epilepsy Foundation of Virginia oppose the addition of premiums and increased cost-sharing.

<u>Co-Payments for Non-Emergent Use of the ED</u>

The Virginia 1115 Demonstration Extension application includes a proposal to charge certain enrollees a five-dollar copayment for non-emergent use of the emergency department (ED) use. This policy could deter people from seeking necessary care during an emergency. Delays in care could have harmful impacts on the short- and long-term health of individuals with serious, acute and chronic diseases.

People should not be financially penalized for seeking lifesaving care for a breathing problem, a heart attack, hyperglycemia, complications from a cancer treatment, or any other critical health problem that requires immediate care. When people do experience severe symptoms, they should not try to self-diagnose their condition or worry that they can't afford to seek care. Instead, they must have access to quick diagnosis and treatment in the ED.

Evidence suggests cost-sharing may not result in the intended cost savings.[xiv] Research demonstrates that low-income individuals served by Medicaid are more price sensitive compared to others, more likely to go without needed care, and more likely to experience long-term adverse outcomes. A study of enrollees in Oregon's Medicaid program demonstrated that implementation of a copay on emergency services resulted in decreased utilization of such services but did not result in cost savings because of subsequent use of more intensive and expensive services.[xv] This provides further evidence that copays may lead to inappropriate delays in needed care. The Epilepsy Foundation and Epilepsy Foundation of Virginia oppose the punitive cost-sharing for non-emergent use of the emergency department.

EPILEPSY FOUNDATION

The Epilepsy Foundation and Epilepsy Foundation of Virginia believe healthcare should affordable, accessible, and adequate. The Virginia COMPASS program does not meet that standard. Thank you for the opportunity to provide comments.

Sincerely,

Suzanne Bischoff
Executive Director
Epilepsy Foundation of Virginia

Philip M. Gattone, M.Ed.
President & CEO
Epilepsy Foundation

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[i] Arkansas Department of Health and Human Services, Arkansas Works Program, August 2018. Accessed at: https://ccf.georgetown.edu/wp-content/uploads/2018/09/091218_AWReport_Final.pdf.

[ii] Arkansas Department of Health and Human Services, Arkansas Works Program, August 2018. Accessed at: https://ccf.georgetown.edu/wp-content/uploads/2018/09/091218_AWReport_Final.pdf.; Arkansas Department of Health and Human Services, Arkansas Works Program, September 2018

[iii] 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.

[iv] Jessica Greene, "Medicaid Recipients' Early Experience With the Arkansas Medicaid Work Requirement," Health Affairs, Sept. 5, 2018. Accessed at: https://www.healthaffairs.org/do/10.1377/hblog20180904.979085/full/.

[v] Arkansas Department of Health and Human Services, Arkansas Works Program, August 2018. Accessed at: https://ccf.georgetown.edu/wp-content/uploads/2018/09/091218_AWReport_Final.pdf.

[vi] Michigan House Fiscal Agency, Legislative Analysis of Healthy Michigan Plan Work Requirements and Premium Payment Requirements, June 6, 2018, http://www.legislature.mi.gov/documents/2017-2018/billanalysis/House/pdf/2017-HLA-0897-5CEEF80A.pdf; House Committee on Appropriations, Fiscal Note for HB 2138, April 16, 2018, http://www.legis.state.pa.us/WU01/LI/BI/FN/2017/0/HB2138P3328.pdf; Misty Williams, "Medicaid Changes Require Tens of Millions in Upfront Costs," Roll Call, February 26, 2018, https://www.rollcall.com/news/politics/medicaid-kentucky.

[vii] Joint Legislative Audit and Review Commission. Fiscal Impact Review. Bill number: HB 338 (Committee Substitute) Medicaid work requirement. Accessed at: http://lis.virginia.gov/cgi-bin/legp604.exe?181+oth+HB338JH1110+PDF

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

[ix] 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

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

[xi] Artiga, Samantha, Petry Ubri and Julia Zur. The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings. Kaiser Family Foundation. June 1, 2017. Accessed at: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/

[xii] Artiga, Samantha, Petry Ubri and Julia Zur. The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings. Kaiser Family Foundation. June 1, 2017. Accessed at: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/

[xiii] The Lewin Group, Health Indiana Plan 2.0: POWER Account Contribution Assessment (March 31, 2017). Accessed at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf

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

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