[NOT SCHEDULED FOR ORAL ARGUMENT]

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

CHARLES GRESHAM, et al., Plaintiffs-Appellees, v. ALEX M. AZAR II, et al., Defendants-Appellants,	Nos. 19-5094 & 19-5096
RONNIE MAURICE STEWART, et al.,, Plaintiffs-Appellees v. ALEX M. AZAR II, et al., Defendants-Appellants.	Nos. 19-5095 & 19-5097

MOTION TO EXPEDITE RELATED APPEALS

INTRODUCTION

The federal government respectfully requests that the Court establish an expedited schedule for briefing and argument in the above-captioned related appeals. The district court invalidated Medicaid demonstration projects proposed by Kentucky and Arkansas and approved by the Department of Health & Human Services (HHS). The Arkansas project has been in effect for more than ten months. The Kentucky project was scheduled to commence this month. Other States have similar approved projects, the implementation of which requires advance planning and a commitment of resources. The district court's orders have caused and will continue to cause

significant disruption to the detriment of the States and the federal government, which looks to the results of demonstration projects to determine fruitful courses of action in administering the Medicaid program.

We therefore propose the following briefing schedule:

5/14	opening briefs for the federal and state appellants
5/21	amici for reversal
6/18	appellees' briefs
6/25	amici for affirmance
7/16	reply briefs for the federal and state appellants
7/23	joint appendices
7/30	final briefs with joint appendix cites

We further request that the Court hear argument during the first week after the summer recess. We request that the Court issue its decision at the earliest possible time so that the projects can go forward and so that, after this Court's decision, the losing party would be afforded an opportunity to decide whether to ask the Supreme Court to consider the cases before the end of the next Term.

Although the federal government agreed to expedite briefing in district court, plaintiffs oppose expedition on appeal and intend to file a brief opposition.

STATEMENT

A. Background

Section 1115 of the Social Security Act authorizes HHS to approve "any experimental, pilot, or demonstration project" proposed by a State that, "in the judgment of the Secretary, is likely to assist in promoting the objectives" of the particular Social Security Act program. 42 U.S.C. § 1315(a). Congress enacted

Section 1115 to ensure that federal requirements would not "stand in the way of experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients." S. Rep. No. 87-1589, at 19 (1962).

The cases at issue here involve Medicaid demonstration projects proposed by Kentucky and Arkansas and approved by HHS. The demonstration projects establish "community engagement" requirements that are similar to the requirements in the Temporary Assistance for Needy Families program, 42 U.S.C. § 607(d). The projects provide that, to remain eligible for Medicaid, certain adults must spend at least 80 hours per month performing activities that include working, looking for work, job-skills training, education, and community service. The adults who are subject to the community-engagement requirements are overwhelmingly members of the expansion population created by the Patient Protection and Affordable Care Act (ACA), which expanded Medicaid coverage to include low-income adults who are not elderly, disabled, or pregnant and who do not necessarily have dependent children. *See Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 575 (2012) (*NFIB*) (contrasting the adult expansion population with the populations served under the traditional Medicaid program).[1] The demonstration projects provide additional exemptions for, *inter alia*, persons identified as medically frail, persons experiencing an acute medical condition, and full-time students.

[1] The Kentucky community-engagement requirement applies to parents of dependent children, but only if the adult is not the primary caregiver for a dependent child.

Similar demonstration projects have been requested and approved for Arizona, Indiana, Michigan, New Hampshire, Ohio, Utah, and Wisconsin, with varying implementation dates that require advance planning and a commitment of resources. For example, in Indiana, community engagement will become a condition of Medicaid eligibility beginning June 1, 2019, although no beneficiaries will have their eligibility suspended for noncompliance before January 1, 2020.[2] Wisconsin intends to implement its community-engagement requirement this fall.[3] Michigan, Utah, and Arizona have approval to implement their community-engagement requirements beginning January 1, 2020.[4] New Hampshire is scheduled to require beneficiaries to begin reporting qualifying hours starting June 1, 2019,[5] but counsel for the plaintiffs here recently filed suit to block the implementation of the New Hampshire project. *See Philbrick v. Azar*, No. 1:19-cv-773 (D.D.C.) (Boasberg, J.).

Other States have pending applications for approval of similar demonstration

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[2] *See* https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=25478.

[3] *See* https://madison.com/wsj/news/local/govt-and-politics/state-will-implement-medicaid-work-requirements-until-told-otherwise/article_2201e541-9a8b-5626-8f0e-f4f732bd0987.html; *see also* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wi/wi-badgercare-reform-ca.pdf.

[4] *See* https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8517 (Michigan); https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8404 (Utah); https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8142 (Arizona).

[5] *See* https://www.dhhs.nh.gov/ombp/medicaid/documents/cmcs-traylor-wce-notice.pdf.

projects. In Virginia, for example, the November 2018 legislation that authorized the Commonwealth to participate in the ACA's adult eligibility expansion also directed the Commonwealth to seek HHS approval to establish a community-engagement requirement for the newly eligible adults through a demonstration project. The Commonwealth has submitted that application to HHS.[6]

B. District Court Proceedings

In a suit brought by fifteen Medicaid recipients, the district court vacated the approval of the Kentucky demonstration project in June 2018, on the ground that HHS had not adequately considered whether the demonstration project would further the Medicaid program's objective of furnishing medical assistance to its citizens. *Stewart v. Azar*, 313 F. Supp. 3d 237, 243 (D.D.C. 2018) (*Stewart I*). After an additional period of public comment, HHS issued a new approval letter that explained why Kentucky's demonstration project is likely to help the Commonwealth furnish medical assistance to its citizens. KY AR 6718.[7]

The approval letter explained that the community-engagement provision requires able-bodied adults to work, look for work, or engage in other activities that

[6] Letter from Jennifer S. Lee, M.D., Dir., Va. Dep't of Med. Assistance Servs., to Mary Mayhew, Deputy Adm'r & Dir., Ctr. for Medicaid & CHIP Servs. (Nov. 20, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/va/va-gov-access-plan-gap-pa4.pdf.

[7] "KY AR" refers to the administrative record for the second approval of Kentucky's demonstration project. That approval letter is reproduced in the addendum to this motion, along with an earlier letter approving the Arkansas project.

enhance their employability such as job-skills training, education, and community service—potentially enabling them to transition from Medicaid to financial independence and thus free up resources to provide medical assistance to others. KY AR 6724-25. The approval letter emphasized that requirements that help adults transition from Medicaid "may enable states to stretch their resources further and enhance their ability to provide medical assistance to a broader range of persons in need, including by expanding the services and populations they cover" and preserving their "ability to continue to provide the optional services and coverage they already have in place," such as the coverage for the adult expansion group that was made optional as a result of the Supreme Court's decision in *NFIB*. KY AR 6719-20.

On March 27, the district court issued a decision that again vacated the approval of the Kentucky demonstration project. *See Stewart v. Azar*, __ F. Supp. 3d __, 2019 WL 1375496 (D.D.C. 2019) (*Stewart II*). The court did not dispute that the Medicaid program's objectives would be served by requirements that help adults transition to financial independence and commercial coverage, and thus enhance the fiscal sustainability of Medicaid. *See id.* at *15. However, the court concluded that HHS could not rely on that rationale for approving the demonstration project without "concrete estimates of how many beneficiaries might make that transition." *Id.* at *10. The court expressed doubt that such transitions would occur, *id.*, and emphasized that HHS "made no finding, supported by substantial evidence, that [Kentucky's project] would improve the sustainability of Kentucky's Medicaid

program." *Id.* at *16. The court also concluded that HHS was required to "compare the benefit of savings to the consequences for coverage," analogizing Kentucky's experiment with the benefits cut at issue in *Beno v. Shalala*, 30 F.3d 1057 (9th Cir. 1994). *Stewart II*, 2019 WL 1375496, at *16.

Also on March 27, the district court vacated the approval of the Arkansas demonstration project, where the community-engagement requirement had been in effect for ten months, and which was not challenged until after the district court issued its *Stewart I* decision. *See Gresham v. Azar*, __ F. Supp. 3d __, 2019 WL 1375241 (D.D.C. 2019). The court acknowledged that halting the ongoing experiment would be disruptive, but ruled that the harm to Medicaid recipients outweighs the harm from that disruption. *Id.* at *13-14.

ARGUMENT

The federal government respectfully asks this Court to adopt the proposed expedited schedule, in light of the importance of these appeals and the harm that would be caused by delay. The ruling in *Gresham* disrupts the status quo in Arkansas, which has been ordered to halt an ongoing demonstration project that has been in effect for more than ten months and that HHS approved a year ago. The ruling in *Stewart II* is preventing Kentucky from conducting an approved demonstration project that was due to begin April 1. More broadly, the rulings create uncertainty with respect to whether other Medicaid recipients will seek to disrupt similar

demonstration projects by other States, where implementation requires advance planning and a significant commitment of resources. *See supra*, pp.4-5.

The district court's rulings rest on errors of law, including a basic misunderstanding of the nature of a demonstration project. Demonstration projects are experiments. The point of these experiments is to test hypotheses, and either validate a hypothesis that might lead to new innovations or else refute the hypothesis and help Congress and HHS avoid mistaken policies in the future. Section 1115's text asks only whether a project, "in the judgment of the Secretary, is likely to assist in promoting the objectives" of the Medicaid statute, 42 U.S.C. § 1315(a)—not whether it has been proven to promote those objectives by some evidentiary standard. The costs of trying out new approaches in State-level experiments are vastly lower than the alternative of testing out new provisions nationwide through statutory or regulatory amendments, and even unsuccessful experiments can provide useful information.

HHS acted well within its Section 1115 authority in determining that the Kentucky and Arkansas demonstration projects are likely to assist in enhancing the fiscal sustainability of the Medicaid program. The district court expressed doubt that activities such as "education, job skills training, job search activities, and community service" could lead to greater financial independence, and suggested that the affected adults are "unlikely to get coverage on [the] labor market." *Stewart II*, 2019 WL 1375496, at *10. But as HHS explained, community-engagement activities enhance a person's employability, KY AR 6724, and persons who transition out of Medicaid can

gain access not only to employment-based coverage but also to the subsidized coverage that is available through the ACA's Exchanges, KY AR 6725; *see also King v. Burwell*, 135 S. Ct. 2480, 2493 (2015) (noting that in 2014, approximately 87% of people who bought insurance on a federal Exchange did so with tax credits).

The district court was thus wrong to analogize the community-engagement requirements to the benefits cut at issue in *Beno v. Shalala*, 30 F.3d 1057 (9th Cir. 1994). Although the stated objective of that benefits cut was to give welfare recipients an incentive to find work, the cut applied to disabled persons and children, prompting the Ninth Circuit to describe the purported work-incentive as "absurd." *Id.* at 1072. By contrast, the community-engagement requirements are tailored to allow covered adults to succeed. The requirements apply only to non-elderly adults who are not eligible for Medicaid on the basis of disability, and there are additional exemptions for (among others) persons who are medically frail. And unlike in *Beno*, everyone who complies with the community-engagement requirement will continue to receive Medicaid benefits. The design of these experiments is sound, and the Secretary had authority to approve them.

The district court compounded its errors by invalidating provisions that did not cause any plaintiff Article III injury. *See Stewart II*, 2019 WL 1375496, at *5. Contrary to the district court's premise, the fact that *the Secretary* considers a demonstration project as a whole in determining which (if any) parts to approve is not license for *a court* to conclude that components that could not otherwise be challenged

are invalid because they do not advance the objectives of Medicaid. The Secretary, in consultation with the affected State, should retain the authority to determine whether a partial demonstration, including provisions that plaintiffs lacked standing to challenge, advances the objectives of Medicaid.

In sum, the orders below rest on error and are resulting in ongoing harm, and they warrant the requested expedition.

CONCLUSION

The expedition motion should be granted.

Respectfully submitted,

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APRIL 2019

CERTIFICATE OF COMPLIANCE

I certify that this motion complies with the word limit of Fed. R. App. P. 27(d)(2)(A) because, excluding the parts of the document exempted by Fed. R. App. P. 32(f), it contains 1933 words.

s/ Alisa B. Klein
Alisa B. Klein

CERTIFICATE OF SERVICE

I hereby certify that on April 11, 2019, I electronically filed the foregoing motion with the Clerk of the Court by using the appellate CM/ECF system. I certify that the participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

s/ Alisa B. Klein
Alisa B. Klein

ADDENDUM

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services

Office of the Administrator
Washington, DC 20201

NOV 20 2018

Carol H. Steckel
Commissioner, Department for Medicaid Services
Commonwealth of Kentucky
Cabinet for Health and Family Services
275 East Main Street, 6 West A
Frankfort, KY 40621

Dear Ms. Steckel:

Under Section 1115 of the Social Security Act (the Act), the Secretary of Health and Human Services may approve any experimental, pilot, or demonstration project that, in the judgment of the Secretary, is likely to assist in promoting the objectives of certain Act programs including Medicaid. Congress enacted section 1115 of the Act to ensure that federal requirements did not "stand in the way of experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients." S. Rep. No. 87-1589, at 19 (1962), *as reprinted in* 1962 U.S.C.C.A.N. 1943, 1961. As relevant here, section 1115(a)(1) of the Act allows the Secretary to waive compliance with the Medicaid program requirements of section 1902 of the Act, to the extent and for the period he finds necessary to carry out the demonstration project. In addition, section 1115(a)(2) of the Act allows the Secretary to provide federal financial participation for demonstration costs that would not otherwise be considered as federally matchable expenditures under section 1903 of the Act, to the extent and for the period prescribed by the Secretary.

On January 12, 2018, the Centers for Medicare & Medicaid Services (CMS) approved the Commonwealth of Kentucky's request for a new section 1115 demonstration project, entitled "Kentucky Helping to Engage and Achieve Long Term Health" (KY HEALTH) (Project Number 11-W-00306/4 and 21-W-00067/4). A district court subsequently vacated the approval of the demonstration project component known as Kentucky HEALTH, on the ground that CMS "never adequately considered whether Kentucky HEALTH would in fact help the state furnish medical assistance to its citizens, a central objective of Medicaid." *Stewart v. Azar*, 313 F. Supp. 3d 237, 243 (D.D.C. 2018). The district court remanded the matter to CMS for further review. On July 19, 2018, CMS opened a new 30-day comment period to give interested stakeholders an opportunity to comment on the issues raised in the litigation and in the court's decision.

For the reasons discussed below, CMS is approving Kentucky HEALTH as a component of the KY HEALTH demonstration, in accordance with section 1115(a) of the Act. Consistent with the Secretary's authority, the demonstration is being approved for a 5-year period, subject to the limitations specified in the attached expenditure authorities, waivers, and special terms and conditions (STCs). The state may deviate from Medicaid state plan requirements only to the

extent those requirements have been listed as waived, to the extent the state has been granted expenditure authority, or to the extent requirements are identified as not applicable to the expenditure authorities. This statewide demonstration component, Kentucky HEALTH, is approved effective April 1, 2019, through September 30, 2023.

Objectives of the Medicaid Program

As noted above, the Secretary may approve a demonstration project under section 1115 of the Act if, in his judgment, the project is likely to assist in promoting the objectives of title XIX. The purposes of Medicaid include an authorization of appropriation of funds to "enabl[e] each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." Act § 1901. This provision makes clear that an important objective of the Medicaid program is to furnish medical assistance and other services to vulnerable populations. But there is little intrinsic value in paying for services if those services are not advancing the health and wellness of the individual receiving them, or otherwise helping the individual attain independence. Therefore, we believe an objective of the Medicaid program, in addition to furnishing services, is to advance the health and wellness needs of its beneficiaries, and that it is appropriate for the state to structure its demonstration project in a manner that prioritizes meeting those needs.

Section 1115 demonstration projects present an opportunity for states to experiment with reforms that go beyond just routine medical care and focus on evidence-based interventions that drive better health outcomes and quality of life improvements, and that may increase beneficiaries' financial independence. Such policies may include those designed to address certain health determinants and those that encourage beneficiaries to engage in health-promoting behaviors and to strengthen engagement by beneficiaries in their personal health care plans. These tests will necessarily mean a change to the status quo. They may have associated administrative costs, particularly at the initial stage, and section 1115 acknowledges that demonstrations may "result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing." Act § 1115(d)(1). But in the long term they may create incentives and opportunities that help enable many beneficiaries to enjoy the numerous personal benefits that come with improved health and financial independence.

Section 1115 demonstration projects also provide an opportunity for states to test policies that ensure the fiscal sustainability of the Medicaid program, better "enabling each [s]tate, as far as practicable under the conditions in such [s]tate" to furnish medical assistance, Act § 1901, while making it more practicable for states to furnish medical assistance to a broader range of persons in need. For instance, measures designed to improve health and wellness may reduce the volume of services consumed, as healthier, more engaged beneficiaries tend to consume fewer medical services and are generally less costly to cover. Further, measures that have the effect of helping individuals secure employer-sponsored or other commercial coverage or otherwise transition from Medicaid eligibility may decrease the number of individuals who need financial assistance from the state. Such measures may enable states to stretch their resources further and enhance

their ability to provide medical assistance to a broader range of persons in need, including by expanding the services and populations they cover.[1] By the same token, such measures may also preserve states' ability to continue to provide the optional services and coverage they already have in place.

Our demonstration authority under section 1115 of the Act allows us to offer states more flexibility to experiment with different ways of improving health outcomes and strengthening the financial independence of beneficiaries. Demonstration projects that seek to improve beneficiary health and financial independence improve the well-being of Medicaid beneficiaries and, at the same time, allow states to maintain the long-term fiscal sustainability of their Medicaid programs and to provide more medical services to more Medicaid beneficiaries. Accordingly, such demonstration projects advance the objectives of the Medicaid program.

Background on Medicaid Coverage in Kentucky

Effective January 1, 2014, Kentucky amended its state plan to include coverage of the ACA expansion population. As of September 2018, more than 454,000 individuals received medical assistance under the Kentucky state plan as a result of Kentucky's decision to participate in that expansion. Kentucky's ACA expansion population includes not only childless adults but also many parents of dependent children, who otherwise were not eligible for coverage under the Kentucky state plan unless their household income was equal to or less than 24 percent of the federal poverty level.

In addition to providing non-mandatory coverage for the adult expansion population, Kentucky's state plan provides coverage for other non-mandatory populations, such as the medically needy and lawfully residing immigrant children under age 19. In addition, the Kentucky plan currently covers an array of non-mandatory benefits, including over-the-counter drugs, vision benefits, and dental benefits.

Extent and Scope of Demonstration

The KY HEALTH demonstration encompasses several initiatives, including the program called Kentucky HEALTH, into which Kentucky will enroll certain non-elderly adult beneficiaries who

[1] States have considerable flexibility in the design of their Medicaid programs, within federal guidelines. Certain benefits are mandatory under federal law, but many benefits may be provided at state option, such as prescription drug benefits, vision benefits, and dental benefits. Similarly, states have considerable latitude to determine whom their Medicaid programs will cover. Certain eligibility groups must be covered under a state's program, but many states opt to cover additional eligibility groups that are optional under the Medicaid statute. The optional groups include a new, non-elderly adult population (ACA expansion population) that was added to the Act at section 1902(a)(10)(A)(i)(VIII) by the Patient Protection and Affordable Care Act (ACA). Coverage of the ACA expansion population became optional as a result of the Supreme Court's decision in *NFIB v. Sebelius*, 567 U.S. 519 (2012). Accordingly, several months after the *NFIB* decision was issued, CMS informed the states that they "have flexibility to start or stop the expansion." CMS, *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid* at 11 (Dec. 10, 2012). In addition to expanding Medicaid coverage by covering optional eligibility groups and benefits beyond what the Medicaid statute requires, many states also choose to cover benefits beyond what is authorized by statute by using expenditure authority under section 1115(a)(2) of the Act. For example, recently, many states have been relying on this authority to expand the scope of services they offer to address substance use disorders beyond what the statute explicitly authorizes.

do not qualify for Medicaid on the basis of a disability. Groups in the Kentucky HEALTH program primarily include the ACA expansion population and two groups of low-income parents and caretaker relatives: those described in section 1931(b) and (d) of the Act, and those described in sections 1925 and 1931(c)(2) of the Act who are transitioning off of Medicaid due to increases in their income.[2] Central elements of the demonstration are described below.

Kentucky will implement a community engagement requirement (described in STCs 42-47) as a condition of eligibility for adult beneficiaries ages 19 to 64 in the Kentucky HEALTH program, with exemptions for various groups, including: former foster care youth, pregnant women, survivors of domestic violence, primary caregivers of a dependent (limited to one caregiver per household), beneficiaries considered medically frail, beneficiaries diagnosed with an acute medical condition that would prevent them from complying with the requirements, and full-time students. To remain eligible for coverage, non-exempt beneficiaries must complete and report 80 hours per month of community engagement activities, such as employment, education, job skills training, job search activities, and community service. Beneficiaries will have their eligibility suspended for failure to report compliance with the community engagement requirement and will be able to reactivate their eligibility on the first day of the month after they complete 80 hours of community engagement in a 30-day period or a state-approved health literacy or financial literacy course. The option to take a course to re-enter from suspension is available one time per 12-month benefit period. Beneficiaries who are in an eligibility suspension for failure to meet the requirement on their redetermination date will have their enrollment terminated and will be required to submit a new application. Kentucky will provide procedural protections for affected beneficiaries, and will also provide opportunities for beneficiaries to demonstrate good cause in certain circumstances for failing to meet the requirement. Additionally, beneficiaries can re-activate Medicaid coverage if, during a suspension, they become eligible for an exemption from the community engagement requirement, or become eligible under a Medicaid eligibility category not subject to the requirement.

Kentucky HEALTH also includes two consumer-driven tools, the *My Rewards Account* (described in STC 29) and the *Deductible Account* (described in STC 28). Beneficiaries will receive incentives that have a dollar value equivalent (but have no actual monetary value) for healthy behavior and community engagement in their *My Rewards Account* that can be used to obtain additional benefits: vision benefits, dental benefits, over-the-counter medications, and limited fitness-related services such as a gym membership. Pregnant women, former foster care youth, beneficiaries who are medically frail, survivors of domestic violence, and adults in Kentucky HEALTH who are not in the ACA expansion population (i.e., the groups described in sections 1925 and 1931(b), (c)(2), and (d)) will continue to receive vision, dental, and over-the-counter medications pursuant to the state plan, but will have the choice to opt-in to the *My Rewards Account* to access the limited fitness-related services.

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[2] In addition to these groups, pregnant women and former foster care youth are included in Kentucky HEALTH, but they are generally exempt from many of the Kentucky HEALTH program's requirements, as described below and in the STCs. They are included in the demonstration in part because Kentucky needs section 1115(a)(1) waiver authority to limit coverage of former foster care youth to persons who were the responsibility of another state or a tribe on the date they turned 18. Their inclusion also, in part, is anticipated to smooth transition into all features of the Kentucky HEALTH program for a pregnant woman after the 60-day postpartum period, or when a former foster care youth reaches age 26. Additionally, including pregnant women and former foster care youth in the Kentucky HEALTH program gives them the option of accessing limited fitness services through the *My Rewards Account*.

The *Deductible Account* is an educational tool to inform beneficiaries about the cost of healthcare and encourage appropriate healthcare utilization. All Kentucky HEALTH program beneficiaries (except pregnant women and beneficiaries receiving premium assistance) will have a deductible account. At the beginning of each benefit year, the deductible account will reflect an initial dollar value equivalent of $1,000, which is available to cover a $1,000 value plan deductible that is applicable to all non-preventive healthcare services. If funds in the deductible account are exhausted before the end of a beneficiary's 12-month benefit period, the beneficiary still will be able to receive covered services just as services would be covered after satisfaction of a deductible under commercial coverage. Beneficiaries with funds remaining in their deductible account after the end of the 12-month benefit period may transfer up to 50 percent of the prorated balance to their *My Rewards Account*.

CMS is also authorizing additional waivers and expenditure authorities for the Kentucky HEALTH program, including:

- Premiums (described in STCs 30-41), in lieu of the copayments required under the state plan, of not less than one dollar per month and not to exceed 4 percent of household income, for Kentucky HEALTH beneficiaries in the ACA expansion and low-income parent and caretaker groups (with exceptions for pregnant women, survivors of domestic violence, former foster care youth, beneficiaries who are eligible for transitional medical assistance as described in sections 1925 and 1931(c)(2) of the Act, and those determined medically frail), with specified consequences for beneficiaries who do not pay premiums after a 60-day payment period (including a six-month non-eligibility period for beneficiaries with household income over 100 percent of the federal poverty level) and procedural protections for affected beneficiaries, as well as opportunities to demonstrate good cause for failure to meet the requirements;

- A six month non-eligibility period (described in STCs 21-22) for beneficiaries who fail to provide the necessary information or documentation to complete the annual redetermination process, with exceptions for pregnant women, survivors of domestic violence, former foster care youth, and individuals determined to be medically frail, and procedural protections for affected beneficiaries, as well as opportunities to demonstrate good cause for failure to meet the requirements;

- Disenrollment and a six-month non-eligibility period (described in STCs 23-24) for beneficiaries who fail to report a change in circumstance that resulted in Medicaid ineligibility, with exceptions from the six-month non-eligibility period for pregnant women, survivors of domestic violence, former foster care youth, and beneficiaries who are medically frail, and with procedural protections for affected beneficiaries, as well as opportunities to demonstrate good cause for failure to meet the requirements;

- A waiver of retroactive eligibility (described in STC 19) for beneficiaries enrolled in Kentucky HEALTH, with exceptions for pregnant women and former foster care youth (the eligibility effective date for beneficiaries who become eligible for transitional

medical assistance as described in sections 1925 and 1931(c)(2) of the Act will be governed through the state plan); and

- A waiver of the requirement to provide non-emergency medical transportation (NEMT) (described in STC 26) for beneficiaries enrolled in the new adult group, with exceptions for beneficiaries who are medically frail, 19- or 20-year-old beneficiaries entitled to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, former foster care youth, survivors of domestic violence, and pregnant women.

The broader KY HEALTH demonstration also includes other provisions, including a substance use disorder (SUD) program (described in STCs 92-100) available to all Kentucky Medicaid beneficiaries to ensure that a broad continuum of care is available to Kentuckians with a substance use disorder, including an opioid use disorder. CMS approved this program on January 12, 2018, and that approval remains in effect.

As noted above, the STCs for this approval are similar to those approved on January 12, 2018. However, CMS and Kentucky have made some changes, which include:

- The January 12, 2018, approval authorized a waiver of retroactive eligibility that would otherwise be required under section 1902(a)(34) of the Act, and CMS and the Commonwealth are now, in an abundance of caution, also adding a waiver of section 1902(a)(10) of the Act to the extent that it imposes an analogous requirement of retroactive eligibility;

- Revision of the premium requirement for beneficiaries who are eligible for transitional medical assistance;

- Updated monitoring and evaluation STCs; and

- A requirement for Kentucky to submit a demonstration implementation plan and a demonstration monitoring protocol, both of which must address community engagement and other key demonstration policies, consistent with CMS requirements in other community engagement demonstrations.

Determination that the demonstration project is likely to assist in promoting Medicaid's objectives

For reasons discussed below, the Secretary has determined that Kentucky HEALTH, working within the larger KY HEALTH demonstration program, is likely to assist in promoting the objectives of the Medicaid program.

The demonstration promotes beneficiary health and financial independence.

With approval of the demonstration, Kentucky and CMS will be able to evaluate the effectiveness of various policies that are designed to improve the health of Medicaid beneficiaries, encourage them to make responsible decisions about their health and accessing

health care, and promote beneficiary financial independence. Promoting beneficiary health and independence advances the objectives of the Medicaid program. Indeed, in 2012, HHS specifically encouraged states to develop demonstration projects "aimed at promoting healthy behaviors" and "individual ownership in health care decisions" as well as "accountability tied to improvement in health outcomes."[3]

Kentucky HEALTH's community engagement requirement is designed to encourage beneficiaries to obtain employment and/or undertake other community engagement activities that may lead to improved health and wellness.

Kentucky HEALTH is also designed to encourage more individuals to seek preventive care, which can help improve beneficiary health. During the first year of Kentucky's Medicaid expansion, fewer than 10 percent of beneficiaries in the ACA expansion population received an annual wellness or physical exam. The *My Rewards Account* incentives for healthy behaviors are intended to increase uptake of preventive services. The waiver of retroactive eligibility for the populations included in Kentucky HEALTH (with exceptions for pregnant women and former foster care youth) is also designed to encourage preventive care. It is designed to test whether these beneficiaries will be encouraged to obtain and maintain health coverage, even when healthy, and whether there will be a reduction in gaps in coverage when beneficiaries churn on and off Medicaid or sign up for Medicaid only when sick. Eligible individuals in these populations who wait until they are sick to enroll in Medicaid may be less likely to obtain preventive health services during periods when they are not enrolled due to out-of-pocket costs.

Kentucky will also evaluate whether the *My Rewards* and *Deductible* accounts, as well as redetermination and reporting requirements, will strengthen beneficiary engagement in their personal health and provide an incentive structure to support responsible consumer decision-making about maintaining health and accessing care and services. A prior evaluation of one demonstration project with beneficiary engagement components has shown some promise that these strategies can have a positive impact on beneficiary behavior.[4] Overall, the research findings on the effects of healthy behavior incentives in Medicaid have shown some promising results but require further study. Kentucky will include evaluation of the outcomes associated with these requirements in its evaluation design to further enrich the evidence regarding beneficiary engagement strategies.

Kentucky HEALTH, working in coordination with KY HEALTH, is also likely to promote the objective of helping beneficiaries attain or retain financial independence. The community engagement provisions generally require Kentucky HEALTH beneficiaries to work, look for work, or engage in activities that enhance their employability, such as job-skills training, education, and community service. Substance-use disorder treatment also qualifies as a community engagement activity, which not only supports beneficiaries' health needs, but may also lead to healthier beneficiaries who therefore may better be able to attain and sustain employment, which is incentivized through this demonstration. The demonstration will help the

[3] CMS, *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid* at 15 (Dec. 10, 2012) (noting also that "states have considerable flexibility under … [existing] law to design benefits for the new adult group and to impose cost-sharing, particularly for those individuals above 100 percent of the federal poverty level").
[4] https://www.in.gov/fssa/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.pdf

Commonwealth and CMS evaluate whether the community engagement requirement helps adults in Kentucky HEALTH transition from Medicaid to financial independence, thus reducing dependency on public assistance.

Because the demonstration is intended to encourage beneficiaries to attain greater levels of financial independence, it contains policies designed to prepare people for the commercial health insurance market, including to prepare them for the federally subsidized insurance that is available through the Exchanges. Kentucky's application noted the significant number of individuals in the Kentucky HEALTH program who are estimated to move between Medicaid eligibility and Exchange coverage. Kentucky HEALTH seeks to provide beneficiaries the tools to utilize commercial market health insurance successfully, thereby removing potential obstacles to a successful transition from Medicaid to commercial coverage.

Coverage for most individuals enrolled in Kentucky HEALTH is designed to work more like insurance products sold on the commercial market. Kentucky HEALTH includes premium payment requirements (with a non-eligibility period for certain beneficiaries for non-payment), deductibles, and limited enrollment windows, all of which beneficiaries are likely to encounter should they transition from Medicaid to commercial coverage. Further, Kentucky HEALTH provides participants with an opportunity to use the *My Rewards Account*, which can be used to access certain additional benefits in a manner similar to a Health Savings Account available through many commercial plans. The *Deductible Account* is also likely to prepare beneficiaries to manage their coverage in the commercial market, where plans often impose deductibles. And, the waiver of NEMT is also aligned with the commercial insurance market, where this benefit is not typically available.

Kentucky HEALTH will also require beneficiaries to complete the annual redetermination process (with a non-eligibility period for non-compliance for certain populations), which will help educate beneficiaries on the need to timely complete enrollment requirements because of limited opportunities to enroll in coverage. While CMS has, in the past, rejected another state's request for a similar non-eligibility period for failure to complete redetermination, CMS now believes that this policy should be evaluated, because it is likely to support the objectives of Medicaid to the extent that it prepares individuals for a smooth transition to commercial health insurance coverage.

Similar to how commercial coverage operates, coverage eligibility under Kentucky HEALTH will be affected for certain individuals by nonpayment of premiums, failure to report changes in circumstances that affect eligibility, or failure to complete redetermination. However, Kentucky has provided for "on-ramps" that enable these individuals to regain eligibility and successfully access all of the benefits, resources, and tools of the Kentucky HEALTH program, without waiting until the end of the non-eligibility period. One opportunity for early reactivation of coverage will be available per each 12-month benefit period, under each of these policies. That is, someone who loses coverage due to nonpayment of premiums can regain coverage early only once per 12-month benefit period, and if that person fails to pay premiums and loses coverage again during the 12-month benefit period, he or she will not be able to use the on-ramp again to regain coverage early. However, if that person uses an on-ramp to regain coverage early after nonpayment of premiums, and then loses coverage due to failure to report changes in

circumstances or failure to complete redetermination, he or she will have another opportunity within the same 12-month benefit period to use an on-ramp to regain coverage early. Kentucky has also taken steps to protect beneficiaries by exempting certain vulnerable populations, such as pregnant women, former foster care youth, survivors of domestic violence, and individuals who are medically frail, from these policies, as well as by allowing beneficiaries who cannot meet the applicable requirement to demonstrate good cause for failure to meet it.

The demonstration will furnish medical assistance in a manner that improves the sustainability of the safety net.

CMS has determined that KY HEALTH, including its component program, Kentucky HEALTH, is likely to promote the objective of furnishing medical assistance because it provides coverage beyond what Kentucky is required to provide. Kentucky expects that the reforms included in the demonstration will enable the Commonwealth to continue to offer Medicaid to the ACA expansion population. Kentucky has repeatedly stated that if it is unable to move forward with its Kentucky HEALTH demonstration project, it will discontinue coverage for the ACA expansion population, a choice it is entitled to make. Additionally, the over-the-counter medications, vision services, and dental services that can be accessed through the *My Rewards Account* are benefits that the Medicaid statute does not require states to cover. The limited fitness-related services accessible through the *My Rewards Account* would not ordinarily be covered under Medicaid at all, and are being covered by Kentucky only under section 1115(a)(2) of the Act expenditure authority, through the demonstration. The demonstration's SUD program also covers high-quality addiction services through expenditure authority under section 1115(a)(2) of the Act. This new, non-mandatory coverage for treatment of substance-use disorders is a matter of particular importance to Kentucky in light of the opioid crisis.

The demonstration includes policies, like the community engagement requirement and non-eligibility periods for certain beneficiaries for failure to comply with the requirements dealing with premiums, redetermination, or reporting a change in circumstances, that may impact overall coverage levels if the individuals subject to these demonstration provisions choose not to comply with them. However, the demonstration as a whole is expected to provide greater access to coverage for low-income individuals than would be available absent the demonstration. It furthers the Medicaid program's objectives to allow states to experiment with innovative means of deploying their limited state resources in ways that may allow them to provide services beyond the statutory minimum. Enhancing fiscal sustainability allows the state to provide services to Medicaid beneficiaries that it could not otherwise provide.

By incentivizing healthy behaviors and preventive care, as described above, KY HEALTH, including the Kentucky HEALTH program, is also designed to lead to higher quality care at a sustainable cost. Promoting improved health and wellness ultimately helps to keep health care costs at sustainable levels. To the extent that the policies discussed above, including the community engagement requirement, help individuals achieve improved health and financial independence, the demonstration may make these individuals less costly for Kentucky to care for, thus further advancing the objectives of the Medicaid program by helping Kentucky stretch its limited Medicaid resources, ensure the long-term fiscal sustainability of the program, and ensure that the health care safety net is available to those Kentucky residents who need it most.

And, to the extent the community engagement requirement helps individuals achieve financial independence and transition to commercial coverage, the demonstration may reduce dependency on public assistance, while still promoting Medicaid's purpose of helping states to furnish medical assistance.

The waivers of retroactive eligibility and NEMT for certain populations in Kentucky HEALTH are also expected to enable the Commonwealth to better contain Medicaid costs and more efficiently focus resources on providing accessible and high-quality health care, thereby promoting the sustainability of its Medicaid program.

Finally, the policies included in the demonstration are likely to improve the fiscal sustainability of Kentucky's Medicaid program because they are designed to improve program integrity while reasonably minimizing the impact of its negative effects on Kentucky's most vulnerable populations. For example, it is a longstanding requirement of the Medicaid program that a beneficiary report a change in circumstance that could affect eligibility. 42 CFR § 435.916. Under the demonstration, beneficiaries who fail to report a change that resulted in their ineligibility for Medicaid might, as a consequence, be subject to a six-month non-eligibility period. The ineligibility period creates an incentive for compliance. To mitigate the potential adverse impact of this incentive, the ineligibility period applies only when the change that the beneficiary failed to report was one that would affect his or her Medicaid eligibility under any group covered by Kentucky. Additionally, the ineligibility period does not apply to pregnant women, former foster care youth, survivors of domestic violence, and beneficiaries who are medically frail. The demonstration also includes procedural protections for beneficiaries who are not exempt, as well as opportunities to demonstrate good cause for failure to report as required.

Similarly, it is a longstanding requirement of the Medicaid program that beneficiaries undergo an annual process to redetermine their Medicaid eligibility. 42 CFR § 435.916. Beneficiaries who fail to submit required information during the redetermination process lose coverage. Kentucky has determined that the existing incentives do not go far enough to ensure compliance with the program's requirements. State data from 2017 indicated that, of those Medicaid beneficiaries from whom additional information was needed in order for the state to redetermine eligibility, only 37 percent submitted the necessary information. CMS is giving states flexibility to experiment with additional incentives to ensure compliance with the redetermination process. In this demonstration, Kentucky is testing a six month non-eligibility period for beneficiaries who fail to provide the necessary information or documentation to complete the annual redetermination process. However, there are exceptions for pregnant women, former foster care youth, survivors of domestic violence, and individuals determined to be medically frail, and procedural protections for affected beneficiaries, as well as opportunities to demonstrate good cause for failure to provide the required information or documentation.

While CMS and the Commonwealth are testing the effectiveness of incentive structures that attach penalties to failure to take certain measures, the program is designed to make compliance with its requirements achievable. Kentucky has taken steps to include adequate beneficiary protections to ensure that the demonstration's requirements apply only to those beneficiaries who can reasonably be expected to meet them, to notify beneficiaries of their responsibilities under

the demonstration, and to provide an opportunity to regain Medicaid coverage by coming back into compliance with the program. Any individual whose coverage is terminated for failure to meet the requirements, or who experiences any other adverse action, will have the right to appeal the state's decision as with other types of coverage terminations, consistent with all existing appeal and fair hearing protections. Furthermore, the incentives to meet the requirements, if effective, may result in individuals becoming ineligible because they have attained financial independence – a positive result for the individual.

As described in the STCs, if monitoring or evaluation data indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. Further, CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the beneficiaries' interest or promote the objectives of Medicaid.

Consideration of public comments

To increase the transparency of demonstration projects, section 1115(d)(1) and (2) of the Act direct the Secretary to issue regulations providing for two periods of public comment on a state's application for a section 1115 project that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing. The first comment period occurs at the state level before submission of the section 1115 application and the second occurs at the federal level after the application is received by the Secretary.

Section 1115(d)(2)(A) and (C) of the Act further specify that comment periods should be "sufficient to ensure a meaningful level of public input," but the statute imposes no additional requirement on the states or the Secretary to address those comments, as might otherwise be required under a general rulemaking. Accordingly, the implementing regulations issued in 2012 provide that CMS will review and consider all comments received by the deadline, but will not provide written responses to public comments.[5]

CMS received approximately 3,149 comments during the two initial federal comment periods[6] on KY HEALTH, and approximately 8,583 unique, substantive comments during the comment period that CMS provided after the district court's decision in *Stewart*.[7] Although CMS is not legally required to provide written responses to comments, CMS is addressing some of the central issues raised by the comments and summarizing CMS's analysis of those issues for the benefit of stakeholders. After carefully reviewing the public comments submitted during the

[5] 42 CFR § 431.416(d)(2); see also Medicaid Program; Review and Approval Process for Section 1115 Demonstrations; Application, Review, and Reporting Process for Waivers for State Innovation; Final Rules, 77 Fed. Reg. 11678, 11685 (Feb. 27, 2012) (final rule).

[6] CMS conducted a federal public-comment period on Kentucky's original application on September 8, 2016, and a combined state-federal public-comment period when Kentucky submitted its modified application on July 3, 2017. *See* https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=39258.

[7] There were 11,750 comments submitted during this public-comment period. Of those, 3167 comments were either duplicates, blank, non-responsive or unclear, or general testimonials about Medicaid that did not state a position on the demonstration.

most recent public comment period, CMS has concluded that KY HEALTH, including Kentucky HEALTH, advances the objectives of Medicaid.

General comments

The vast majority of the comments CMS received were from self-identified Kentucky citizens who opposed either the demonstration as a whole or certain features of it. Many of those comments expressed general concerns that the demonstration will result in many poor citizens losing Medicaid. CMS shares the commenters' concern that everyone who needs Medicaid and is eligible for it should have access to it. As previously stated, however, CMS believes the features of this demonstration are worth testing to determine whether there is a more effective way to furnish medical assistance to the extent practicable under the conditions in Kentucky. That is why CMS has carefully reviewed the demonstration as a whole to ensure it is likely to promote sometimes competing Medicaid objectives.

Specifically, this demonstration is designed to extend coverage. Kentucky has repeatedly made clear that its continued expansion of coverage to the ACA expansion population is conditioned on implementation of this demonstration. The demonstration is also designed to improve health outcomes and reduce dependency on public assistance by incentivizing healthy behaviors and giving beneficiaries the choice either to engage in those behaviors or to stop participating in Medicaid. CMS has worked together with Kentucky to include guardrails that will protect beneficiaries. These guardrails, which are contained in a series of assurances in the STCs (described in STC 22, 24, 32, and 47), include requirements that the state: provide opportunities for re-enrollment before the end of the six month non-eligibility period for beneficiaries who meet certain requirements, screen beneficiaries and determine eligibility for other categories of Medicaid eligibility prior to a non-eligibility period, review for eligibility for insurance affordability programs prior to a non-eligibility period, provide full appeal rights prior to disenrollment, and maintain a system that provides reasonable modifications related to meeting the community engagement requirements to beneficiaries with disabilities, among other assurances. The STCs include a provision granting CMS the authority to discontinue the demonstration if the agency determines that it is not promoting Medicaid's objectives. Moreover, CMS will regularly monitor Kentucky HEALTH and will work with the Commonwealth to resolve any issues that arise as Kentucky works to implement the demonstration.

Some comments argued that a demonstration cannot advance the Medicaid program's objectives if the project is expected to reduce Medicaid enrollment or Medicaid spending. We recognize that some individuals may choose not to comply with the conditions of eligibility imposed by the demonstration, and therefore may lose coverage, as may occur when individuals fail to comply with other requirements like participating in the redetermination process. But the goal of these policies is to incentivize compliance, not reduce coverage. Indeed, CMS has incorporated safeguards into the STCs intended to minimize coverage loss due to noncompliance, and CMS is committed to partnering with Kentucky to ensure that the demonstration advances the objectives of Medicaid. Furthermore, we anticipate that some beneficiaries may dis-enroll from Medicaid if they obtain employer-sponsored or other commercial coverage and no longer qualify for the program. Finally, we note that in some cases, reductions in Medicaid costs can further the

Medicaid program's objectives, such as when the reductions stem from reduced need for the safety net or reduced costs associated with healthier, more independent beneficiaries. These outcomes promote the best interests of the beneficiaries whose health and independence are improved, while also helping states stretch limited Medicaid resources and ensure the long-term fiscal sustainability of the states' Medicaid programs.

In a similar vein, some comments suggested that it is impermissible for a demonstration to rely on disenrollment and a non-eligibility period as incentives for compliance with the project's requirements. As noted above, section 1115 of the Act explicitly contemplates that demonstrations may "result in an impact on eligibility"; furthermore, the amended demonstration as a whole is expected to provide greater access to coverage for low-income individuals than would be available absent the demonstration. Other comments predicted that Kentucky HEALTH will fail to achieve its intended effects. For instance, some comments argued that beneficiaries subject to the community engagement requirement will be unable to comply. To some extent, these comments reflect a misunderstanding of the nature of the community engagement requirement, which the comments described as a work requirement. In fact, the community engagement requirement is designed to help beneficiaries achieve success, and CMS and Kentucky have made every effort to devise a requirement that beneficiaries should be able to meet. For example, the community engagement requirement may be satisfied through an array of activities, including education, job skills training, job search activities, and community service.

More generally, these comments reflect a misunderstanding of the nature of a demonstration project. It is not necessary for a state to show in advance that a proposed demonstration will in fact achieve particular outcomes; the purpose of a demonstration is to test hypotheses and develop data that may inform future decision-making. As HHS previously explained, demonstrations can "influence policy making at the [s]tate and Federal level, by testing new approaches that can be models for programmatic changes nationwide or in other [s]tates." 77 Fed. Reg. at 11680. For example, the Temporary Assistance for Needy Families (TANF) work requirements that Congress enacted in 1996 were informed by prior demonstration projects. *See, e.g.*, *Aguayo v. Richardson*, 473 F.2d 1090 (2d Cir. 1973) (upholding a section 1115 demonstration project that imposed employment requirements as conditions of AFDC eligibility). Regardless of the degree to which Kentucky's demonstration project succeeds in achieving the desired results, the information it yields will provide policymakers real-world data on the efficacy of such policies. That in itself promotes the objectives of the Medicaid statute.

Comments addressing coverage losses

Some comments argued that the demonstration will cause approximately 95,000 individuals to lose Medicaid coverage and, for that reason, the project cannot be consistent with the objectives of the Medicaid program. As an initial matter, these commenters appear to misunderstand the budget neutrality study and other materials from which they appear to have derived the 95,000 figure.[8] The cited projections are based on Kentucky's 2017 estimate of the change in "total

[8] Kentucky HEALTH § 1115 Demonstration Modification Request, Attachments A and B (July 3, 2017), *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-pa2.pdf.

member months" covered by Medicaid during the demonstration. One member month is equal to one member enrolled for one month. Kentucky's projections show that, over its five-year life, the demonstration project was expected to cover slightly less than 5 percent fewer total member months than would have been covered without the demonstration project. The cited enrollment projections do not, however, predict how many recipients will become uninsured under the demonstration project. Thus, it is not accurate to assume, as some commenters did, that this study reflects that 95,000 individuals will completely lose coverage and not regain it. The projected decrease in total member months is likely attributable to a number of factors, including beneficiaries transitioning to commercial coverage, as well as the elimination of retroactive eligibility and beneficiaries who are temporarily suspended or otherwise lose eligibility for part of the year due to their noncompliance with program requirements. In addition, the projections were made prior to the inclusion of changes made to the demonstration at approval, including additional beneficiary guardrails expected to help beneficiaries maintain enrollment. Additionally, it is important to acknowledge that otherwise potentially eligible Medicaid beneficiaries lose coverage today for many reasons where they have failed to comply with program requirements.

We also note that the demonstration provides coverage to individuals that the state is not required to cover. Any potential loss of coverage that may result from a demonstration is properly considered in the context of a state's substantial discretion to eliminate non-mandatory benefits or to eliminate coverage for existing (but non-mandatory) populations, such as (in light of the Supreme Court's ruling in *NFIB v. Sebelius*) the ACA adult expansion population. As of September 2018, more than 454,000 individuals received medical assistance under the Kentucky state plan as a result of Kentucky's decision to participate in the ACA adult eligibility expansion. Kentucky's ACA expansion population includes not only childless adults but also many parents of dependent children, who are not eligible for coverage under the Kentucky state plan unless their household income is equal to or less than 24 percent of the federal poverty level. The Governor has indicated, however, that Kentucky will reconsider the ACA adult eligibility expansion if the Commonwealth is unable to implement the demonstration project. As noted in our letter of January 12, 2018, "Kentucky leaders have expressed the importance of this demonstration as a means of preserving coverage for individuals." Moreover, conditioning eligibility for Medicaid coverage on compliance with certain measures is an important element of the state's efforts, through experimentation, to improve beneficiaries' health and independence and enhance programmatic sustainability. To create an effective incentive for beneficiaries to take measures that promote health and independence, it may be necessary for states to attach penalties to failure to take those measures, including with conditions designed to promote health and financial independence. This may mean that beneficiaries who fail to comply will lose Medicaid coverage, at least temporarily. However, the incentives included in this demonstration are not designed to encourage this result; rather, they are intended to incorporate achievable conditions of continued coverage. And any loss of coverage as the result of noncompliance must be weighed against the benefits Kentucky hopes to achieve through the demonstration project, including both the improved health and independence of the beneficiaries who comply and the Commonwealth's enhanced ability to stretch its Medicaid resources and maintain the fiscal sustainability of the program.

It would be counterproductive to deny states the flexibility they need to implement demonstration projects designed to examine innovative ways to incentivize beneficiaries to engage in desired behaviors that improve outcomes and lower healthcare costs, as well as innovative ways to stretch limited state resources, given that states have the prerogative to terminate coverage for non-mandatory services and populations. Because a demonstration project, by its nature, is designed to test innovations, it is not possible to know in advance the actual impact that its policies will have on enrollment. That is one of the metrics to be measured. But even assuming that Kentucky HEALTH would result in a 5 percent decrease in covered member months as compared to the number of member months covered without the demonstration, and even assuming that most of these individuals would not transition to commercial coverage, that figure is likely dwarfed by the 454,000 newly eligible adults who stand to lose coverage if Kentucky elects to terminate the non-mandatory ACA expansion.

Furthermore, the Kentucky state plan covers other non-mandatory populations such as the medically needy and lawfully residing immigrant children under age 19, as well as non-mandatory services such as prescription drug, dental, and vision benefits. As a matter of federal law, it is a state's prerogative to reduce or eliminate non-mandatory coverage. Such judgments are left to the policy preferences of the state government and its electorate, and states are to be given great latitude in making tradeoffs in how the state furnishes medical assistance "as far as practicable under the conditions" in the state. Act § 1901. In evaluating Kentucky's demonstration project, it is appropriate to consider the possibility of coverage loss against the benefits that may accrue to the populations included in Kentucky HEALTH, as well as benefits that may accrue to the Commonwealth's other Medicaid eligibility groups as a result of the populations in Kentucky HEALTH growing more independent, healthier, and less expensive to cover. Moreover, as noted above, the projected decrease in enrollment that some commenters attributed to this demonstration is simply a projection. Kentucky will measure actual effects on enrollment as part of the demonstration, and that information should be useful in informing future Medicaid policy.

Commenters also expressed concerns that the demonstration's reporting requirements will cause beneficiaries to lose Medicaid coverage because of failure to report their community engagement hours, failure to report changes in circumstances, failure to provide information necessary to complete the annual redetermination process, or because of clerical errors by Kentucky's Medicaid agency. In general, these concerns reflect coverage loss that would occur only if the individual chooses not to comply with these requirements. In those cases, we note that individuals always are able to re-apply for Medicaid and have eligibility determined for other Medicaid groups for which they can be immediately enrolled. CMS has worked closely with Kentucky to ensure there are substantial beneficiary protections in place. The STCs provide for Kentucky to educate and reach out to beneficiaries and contain assurances that Kentucky will seek data from other sources, including SNAP, TANF, and other existing systems to permit beneficiaries to efficiently report community engagement hours and process beneficiary redeterminations. Clerical errors can occur in any program and are not reason to deny approval at the outset. Moreover, CMS will monitor the demonstration, and the STCs provided that CMS can amend or withdraw waivers or expenditure authority if it determines that continuing the demonstration would no longer be in the public interest or promote Medicaid's objectives.

Comments addressing individual demonstration features

The community engagement requirement

Some comments suggest that a community engagement requirement that many people will fulfill by working one or multiple part-time, minimum-wage jobs or through unpaid means (volunteering), will not directly lead to financial independence. CMS disagrees with that conclusion. While some of the activities that meet the community engagement requirement may not immediately cause all beneficiaries to be financially independent, those activities are nonetheless positive steps for beneficiaries to take on their path to financial independence. In addition, participation in these activities may reduce social isolation, which multiple studies have linked to higher rates of mortality.[9] At the very least, whether Kentucky HEALTH's community-engagement requirement will lead to beneficiaries' financial independence is an open question, which is why this demonstration project is necessary to test whether the incentive structure will have the desired effect. That is also why CMS will regularly evaluate the effects of Kentucky HEALTH on affected beneficiaries and reserves the right to discontinue specific waiver and expenditure authorities if CMS determines that it would no longer be in the public interest or promote Medicaid's objectives to continue them. Moreover, even if those activities do not cause beneficiaries to become financially independent, they are nevertheless linked to improved health outcomes, which itself furthers Medicaid's objectives.

Some commenters also suggest that suspending eligibility for beneficiaries who fail to comply with the community engagement requirement will make it harder for beneficiaries to find employment, and some cited research that shows a correlation between individuals' access to health coverage and their ability to find employment. CMS has reviewed and considered the research cited to by commenters and notes that other research also shows a positive link between community engagement and improved health outcomes.[10] None of the existing research, however, definitively shows whether a community-engagement requirement as a condition for continued Medicaid coverage will help beneficiaries attain financial independence and improve health outcomes. Thus, CMS has determined that it is appropriate to permit states to use section 1115 demonstration projects to determine whether they can achieve such an outcome using community engagement requirements.

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[9] Julianne Holt-Lunstad, et al., *Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review*, 10 Persp. on Psychol. Sci. 227 (2015).

[10] Waddell, G. and Burton, AK. Is Work Good For Your Health And Well-Being? (2006) EurErg Centre for Health and Social Care Research, University of Huddersfield, UK;
Van der Noordt, M, Jzelenberg, H, Droomers, M, and Proper,K. Health effects of employment: a systemic review of prospective studies. BMJournals. Occupational and Environmental Medicine. 2014: 71 (10).
Crabtree, S. In U.S., Depression Rates Higher for Long-Term Unemployed. (2014). Gallup. http://news.gallup.com/poll/171044/depression-rates-higher-among-long-term-unemployed.aspx.
United Health Group. Doing good is good for you. 2013 Health and Volunteering Study.
Jenkins, C. Dickens, A. Jones, K. Thompson-Coon, J. Taylor, R. and Rogers, M. Is volunteering a public health intervention? A systematic review and meta-analysis of the health and survival of volunteers BMC Public Health 2013. 13 (773).
Chetty R, Stepner M, Abraham S, et al. The association between income and life expectancy in the United States, 2001-2014. JAMA. 2016; 315(16):1750-1766.

Commenters also expressed concern regarding beneficiaries they believed to be subject to the community engagement requirement. Commenters opposed the requirement because they believed that it would negatively impact pregnant women, the elderly, caregivers to minor dependent children, beneficiaries who are medically frail, and beneficiaries with disabilities. CMS and Kentucky provide several protections for vulnerable beneficiaries who cannot meet the requirement or who may need assistance to meet the requirements. The Kentucky HEALTH program provides exemptions from the community engagement requirement for several populations including pregnant women, beneficiaries who are medically frail, primary caregivers of a dependent minor child, and beneficiaries over the age of 64. Kentucky also provides beneficiaries with the opportunity to avoid the consequences for failure to comply with the requirement by demonstrating that they had a good cause not to meet it, and provides reasonable modifications for beneficiaries with disabilities protected by the ADA, Section 504 of the Rehabilitation Act, and Section 1557 of the Patient Protection and Affordable Care Act. Therefore, CMS believes that the demonstration adequately protects beneficiaries with circumstances which could prevent them from meeting the community engagement requirement, as well as other Kentucky HEALTH program requirements. Where individuals among the Kentucky HEALTH groups are capable of satisfying the community engagement requirement, CMS believes that including these individuals advances the purposes of Medicaid by improving beneficiary health and financial independence and enhancing the program's fiscal sustainability.

Premiums

Of the comments received on premiums, the majority of commenters were opposed to this requirement. Commenters were concerned that a monthly premium obligation creates a financial burden on beneficiaries, and creates a potential negative impact on health coverage and health outcomes. Kentucky designed the premium requirement in a way that minimizes potential impacts on beneficiaries. The premiums requirement is designed to align with requirements in the commercial insurance market, but also provides opportunities for beneficiaries to avoid the consequences of nonpayment if they can demonstrate they had a good cause for not meeting their premium obligation. Also, premiums are optional for several populations as an opportunity to access additional services not offered through the standard benefit package. For beneficiaries with a mandatory premium obligation, only beneficiaries with income above 100 percent of the federal poverty level are subject to a non-eligibility period for failure to meet the requirement. However, these beneficiaries will have a one-time opportunity, per year, to re-enter the program before the end of the non-eligibility period if they attend an early re-enrollment course and pay the premium required for the first month of re-entry.

Commenters also argued that premiums are inconsistent with the objectives of the Medicaid program, and do not have research value. CMS disagrees with this assertion. CMS has implemented premium obligations in several states and is currently evaluating the requirement; there is not sufficient evidence to assert that premium requirements do not advance the objectives of Medicaid. On the contrary, interim evaluation findings regarding premiums in one state found that beneficiaries who paid premiums are more likely to obtain primary care and preventive care, have better drug adherence, and rely less on the emergency room for treatment compared to

those who do not.[11] Additionally, premiums, when viewed as a component of the broader Kentucky HEALTH program, merit additional research and evaluation when viewed in conjunction with other demonstration features which together, seek to encourage beneficiaries to engage in health-promoting behaviors and to strengthen engagement by beneficiaries in their personal health care plans. Kentucky will evaluate the premium requirement, and CMS reserves the right to withdraw its authority if it is determined that premiums negatively impact health coverage or health outcomes.

The My Rewards Account; vision and dental benefits

Some comments expressed concern that under the demonstration, certain beneficiaries will not receive prescription drug, vision, and dental benefits under the state plan, and instead will be given the opportunity to obtain these benefits through the *My Rewards Account*. As an initial matter, Kentucky never proposed to stop offering prescription drugs under the state plan. Over-the-counter medications will be accessible for certain adults through the *My Rewards Account*. Moreover, Kentucky is not required to offer these medications or any of the other benefits available through the *My Rewards Account*; in fact, the fitness services available through the account are covered only *because* of CMS approval of the demonstration.

It furthers Medicaid's objectives to permit Kentucky to test incentives designed to promote healthy activities such as the *My Rewards Account*, which enables Kentucky to offer, or to continue to offer, the vision, dental, and over-the-counter medications available through the *My Rewards Account*, even if some beneficiaries may not earn them. As discussed above, it furthers the Medicaid program's objectives to allow states to experiment with innovative means of deploying their limited state resources in ways that may allow them to provide non-mandatory services. Providing non-mandatory services unquestionably advances the purposes of the Medicaid program.

Waiver of NEMT

Some commenters expressed concerns that the NEMT waiver for the new adult group will negatively impact Medicaid recipients in rural areas who lack consistent transportation options. Other commenters suggested that this waiver of NEMT will harm vulnerable beneficiaries, will undermine Kentucky's goal of improving beneficiaries' health, and is an impermissible benefits cut. To limit the impact on vulnerable beneficiaries, Kentucky chose to apply this waiver of NEMT to only the new adult group, and exempt pregnant women, survivors of domestic violence, beneficiaries who are medically frail, former foster care youth, and 19 and 20 year old beneficiaries entitled to early and periodic screening, diagnostic and treatment (EPSDT) services. CMS believes this approach adequately addresses commenters' concern, as it minimizes the impact on vulnerable beneficiaries while also achieving the state's goal of recreating the experience of the commercial insurance market, which does not offer the NEMT benefit. This component of Kentucky HEALTH is expected to improve the fiscal sustainability of the state's safety net and contribute to the provision of additional services offered through Kentucky HEALTH and KY HEALTH. Therefore, CMS believes that the benefit of offering NEMT to the

[11] The Lewin Group, Indiana Healthy Indiana Plan 2.0 Interim Evaluation Report (2016), available at: https://www.in.gov/fssa/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.pdf.

new adult group is outweighed by enhancements to programmatic sustainability and the value of the optional services that Kentucky will offer.

Waiver of Retroactive Eligibility

Some commenters expressed concerns that the waiver of retroactive eligibility will reduce coverage and therefore cannot promote Medicaid's objectives. The waiver of retroactive eligibility is likely to help promote Medicaid's objectives in at least two ways: (1) it may improve uptake of preventive services and thus improve beneficiary health; (2) it improves the fiscal sustainability of the Medicaid program, which helps to permit Kentucky to continue to provide Medicaid to the ACA expansion population, and to continue to cover non-mandatory benefits and eligibility groups.

Non-eligibility periods for failure to report a change in circumstances, failure to pay premiums, or failure to complete redetermination requirements

Some comments suggested that non-eligibility periods do not further Medicaid's objectives because they will cause beneficiaries to lose Medicaid coverage. These features of the demonstration are designed to incentivize program compliance and familiarize beneficiaries with the functioning of commercial insurance. These goals also further Medicaid's objectives by improving the financial sustainability of Kentucky's Medicaid program. CMS considered these provisions in the context of the whole demonstration and determined that the demonstration appropriately balances the Medicaid objectives of ensuring coverage and permitting states to furnish Medicaid "to the extent practicable under the conditions of each state."

Non-emergency use of the emergency room

A few commenters opposed Kentucky's *My Rewards Account* penalty for non-emergent use of the emergency room, citing concern that this penalty constitutes cost sharing that requires additional waiver authority. CMS seeks to clarify that the *My Rewards Account* penalty is not cost sharing because the *My Rewards Account* is an incentive tool that does not require monetary contributions from beneficiaries. The funds in the *My Rewards Account* are non-monetary credits. Beneficiaries are *never* required to pay out of pocket for *My Rewards Account* penalties or services, and to the extent a deduction is imposed in this context as a result of non-emergent use of the emergency room, a beneficiary would have only virtual credits reduced from his or her account. There would be no actual charges to the beneficiary. This penalty will not be imposed on beneficiaries who visit the emergency department for an emergency.

Other Information

CMS's approval of this demonstration is conditioned upon compliance with the enclosed list of waiver and expenditure authorities and the STCs defining the nature, character and extent of anticipated federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

Your project officer for this demonstration is Ms. Valisha Andrus. She is available to answer any questions concerning your section 1115 demonstration. Ms. Andrus's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Email: Valisha.Andrus@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to your project officer and Ms. Davida Kimble, Associate Regional Administrator in our Atlanta Regional Office. Ms. Kimble's contact information is as follows:

Ms. Davida Kimble
Associate Regional Administrator
Centers for Medicare & Medicaid Services
Division of Medicaid and Children Health Operations
61 Forsyth Street, South West, Suite 4T20
Atlanta, GA 30303-8909
Email: Davida.Kimble@cms.hhs.gov

If you have questions regarding this approval, please contact Ms. Judith Cash, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Sincerely,

[redacted]

Paul Mango
Chief Principal Deputy Administrator
and Chief of Staff

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

March 5, 2018

The Honorable Asa Hutchinson
Governor
State of Arkansas
500 Woodlane Street
Little Rock, Arkansas 72201

Dear Governor Hutchinson:

I am pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) is approving Arkansas's request for an amendment to its section 1115 demonstration project, entitled "Arkansas Works." The details of this approval will be transmitted to Cindy Gillespie, Director of the Arkansas Department of Human Services.

I want to express my appreciation for the hard work and commitment to innovation that your team has displayed during this process. At CMS, we are dedicated to empowering states to better serve their residents through state-led reforms that improve health and help lift individuals out of poverty. Your efforts through this demonstration help us to fulfill that promise.

Congratulations to the entire Arkansas team on reaching approval. We look forward to our continued work together through the implementation of these important reforms.

Sincerely,

[redacted]

Seema Verma

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

MAR - 5 2018

Cindy Gillespie
Director
Arkansas Department of Human Services
700 Main Street
Little Rock, Arkansas 72201

Dear Ms. Gillespie:

The Centers for Medicare & Medicaid Services (CMS) is approving Arkansas's request for an amendment to its section 1115 demonstration project, entitled "Arkansas Works" (Project Number 11-W-00287/6) in accordance with section 1115(a) of the Social Security Act (the Act).

This approval is effective March 5, 2018, through December 31, 2021, upon which date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire. CMS's approval is subject to the limitations specified in the attached expenditure authorities, waivers, and special terms and conditions (STCs). The state will begin implementation of the community engagement requirement no sooner than June 1, 2018. The state may deviate from Medicaid state plan requirements only to the extent those requirements have been listed as waived or as not applicable to expenditures.

Extent and Scope of Demonstration

The current Arkansas Works section 1115 demonstration project was implemented by the State of Arkansas ("state") in December 2016. The Arkansas Works program provides certain adult Medicaid beneficiaries with premium assistance to purchase qualified health plan (QHP) coverage through the Health Insurance Marketplace. As originally approved, Arkansas Works was designed to leverage the efficiencies and experience of the commercial market to test whether this premium assistance mode improves continuity, access, and quality for Arkansas Works beneficiaries and results in lowering the growth rate of premiums across population groups. The demonstration project also attempts to facilitate transitions between and among Arkansas Works, ESI, and the Marketplace for Arkansas Works enrollees. Approval of this demonstration amendment allows Arkansas, no sooner than June 1, 2018, to require all Arkansas Works beneficiaries ages 19 through 49, with certain exceptions, to participate in and timely document and report 80 hours per month of community engagement activities, such as employment, education, job skills training, or community service, as a condition of continued Medicaid eligibility. Community engagement requirements will not apply to Arkansas Works beneficiaries ages 50 and older so as to ensure alignment and consistency with the state's Supplemental Nutrition Assistance Program (SNAP) requirements. The alignment is appropriate and consistent with the ultimate objective of improving health and well-being for Medicaid beneficiaries.

CMS also is authorizing authorities for additional features, including:

- Removing the requirement to have an approved-hospital presumptive-eligibility state plan amendment (SPA) as a condition of enacting the state's waiver of retroactive eligibility;
- Clarifying the waiver of the requirement to provide new adult group beneficiaries[1] with retroactive eligibility to reflect the state's intent to not provide retroactive eligibility but for the 30 days prior to the date of application coverage; and
- Removing the waiver and expenditure authorities related to the state's mandatory employer-sponsored insurance (ESI) premium assistance program, as the state no longer intends to continue this program.

Under the new community engagement program, the state will test whether coupling the requirement for certain beneficiaries to engage in and report work or other community engagement activities with meaningful incentives to encourage compliance will lead to improved health outcomes and greater independence. CMS is approving the community engagement program based on our determination that it is likely to assist in promoting the objectives of the Medicaid program. The terms and conditions of Arkansas's community engagement requirement that accompany this approval are consistent with the guidance provided to states through State Medicaid Director's Letter (SMD 18-0002), Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries, issued on January 11, 2018. CMS is not at this time approving Arkansas's request to reduce income eligibility for Arkansas Works beneficiaries to 100 percent of the federal poverty level (FPL).

Determination that the demonstration project is likely to assist in promoting Medicaid's Objectives

Demonstration projects under section 1115 of the Act offer a way to give states more freedom to test and evaluate innovative solutions to improve quality, accessibility and health outcomes in a budget-neutral manner, provided that, in the judgment of the Secretary, the demonstrations are likely to assist in promoting the objectives of Medicaid.

While CMS believes that states are in the best position to design solutions that address the unique needs of their Medicaid-eligible populations, the agency has an obligation to ensure that proposed demonstration programs are likely to better enable states to serve their low-income populations, through measures designed to improve health and wellness, including measures to help individuals and families attain or retain capability for independence or self-care. Medicaid programs are complex and shaped by a diverse set of interconnected policies and components, including eligibility standards, benefit designs, reimbursement and payment policies, information technology (IT) systems, and more. Therefore, in making this determination, CMS considers the proposed demonstration as a whole.

[1] This group includes adults up to and including 133 percent of the FPL who meet the other criteria specified in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

In its consideration of the proposed changes to Arkansas Works, CMS examined whether the demonstration as amended was likely to assist in improving health outcomes; whether it would address behavioral and social factors that influence health outcomes; and whether it would incentivize beneficiaries to engage in their own health care and achieve better health outcomes. CMS has determined that the Arkansas Works demonstration as amended is likely to promote Medicaid objectives, and that the waivers sought are necessary and appropriate to carry out the demonstration.

1. **The demonstration is likely to assist in improving health outcomes through strategies that promote community engagement and address certain health determinants.**

Arkansas Works supports coordinated strategies to address certain health determinants, as well as promote health and wellness through increased upward mobility, greater independence, and improved quality of life. Specifically, Arkansas Works' community engagement requirement is designed to encourage beneficiaries to obtain and maintain employment or undertake other community engagement activities that research has shown to be correlated with improved health and wellness.[2,3] As noted in CMS' SMDL: 18-0002, these activities have been positively correlated with improvements in individuals' health. CMS has long supported policies that recognize meaningful work as essential to the economic self-sufficiency, self-esteem, well-being, and improved health of people with disabilities.

Given the potential benefits of work and community engagement, we believe that state Medicaid programs should be able to design and test incentives for beneficiary compliance. Under Arkansas's demonstration, the state will encourage compliance by making it a condition of continued coverage. Beneficiaries that successfully report compliance on a monthly basis will have no disruption in coverage. It is only when a beneficiary fails to report compliance for 3 months that the state will dis-enroll the beneficiary for the remainder of the calendar year. Beneficiaries that are disenrolled from their plan will be able to re-enroll through Arkansas Works upon the earlier of turning age 50, qualifying for another category of Medicaid eligibility, or the beginning of a new calendar year.

Arkansas' approach is informed by the state's experience with the voluntary work-referral program in its current demonstration, which the state has not found to be an effective incentive. Since January 2017, certain individuals enrolled in Arkansas Medicaid have been referred to the Arkansas Department of Workforce Services (DWS), which provides a variety of services to assist individuals in gaining employment. Through October 2017, only 4.7 percent of beneficiaries followed through with the referral and accessed DWS services. Of those who accessed DWS services, 23 percent have become employed. This result suggests that referrals alone, without any further incentive, may not be be sufficient to encourage the Arkansas Works

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[2] Waddell, G. and Burton, AK. Is Work Good For Your Health And Well-Being? (2006) EurErg Centre for Health and Social Care Research, University of Huddersfield, UK

[3] Van der Noordt, M, Jzelenberg, H, Droomers, M, and Proper,K. Health effects of employment: a systemic review of prospective studies. BMJournals. Occupational and Environmental Medicine. 2014: 71 (10).

population to participate in community engagement activities. CMS will therefore allow Arkansas to test whether the stronger incentive model is more effective in encouraging participation.

Arkansas has tailored the incentive structure to include beneficiary protections, such as an opportunity to maintain coverage for beneficiaries who report that they failed to meet the community engagement hours due to circumstances that give rise to a good cause exemption, as well as the opportunity to apply and reenroll in Arkansas Works in the beginning of the next plan year. Additionally, if Arkansas determines that a beneficiary's failure to comply or report compliance was the result of a catastrophic event or circumstances beyond the beneficiary's control, the beneficiary will receive retroactive coverage to the date coverage ended without need for a new application. The impact of this incentive, as well as other aspects of the demonstration, will be assessed through an evaluation designed to measure how the demonstration affects eligibility, and health outcomes over time for persons subject to the demonstration's policies.

2. **The demonstration is expected to strengthen beneficiary engagement in their personal health care.**

CMS believes that it is important for beneficiaries to engage in their personal health care, particularly while they are healthy to prevent illness. Accordingly, CMS supports state testing of policies designed to incentivize beneficiaries to obtain and maintain health coverage before they become sick so they can take an active role in engaging in their personal health care while healthy. Consistent with CMS's commitment to support states in their efforts to align Medicaid and private insurance policies for non-disabled adults to help them prepare for private coverage (stated in the letter to governors on March 14, 2017), this amendment removes the requirement that Arkansas provide hospitals with an opportunity to conduct presumptive eligibility (consistent with Section 1902(a)(47)(B)) as a condition of its waiver of retroactive eligibility. It further clarifies the waiver of the requirement to provide new adult group beneficiaries with retroactive eligibility but for the 30 days prior to the date of application coverage. With respect to the waiver of retroactive eligibility, through this approval, we are testing whether eliminating 2 of the 3 months of retroactive coverage will encourage beneficiaries to obtain and maintain health coverage, even when they are healthy. This feature of the amendment is intended to increase continuity of care by reducing gaps in coverage when beneficiaries churn on and off of Medicaid or sign up for Medicaid only when sick with the ultimate objective of improving beneficiary health.

Consideration of Public Comments

Both Arkansas and CMS received comments during the state and federal public comment periods. Consistent with federal transparency requirements, CMS reviewed all of the materials submitted by the state, as well as all the public comments it received, when evaluating whether the demonstration project as a whole was likely to assist in promoting the objectives of the Medicaid program, and whether the waiver authorities sought were necessary and appropriate to implement the demonstration. In addition, CMS took public comments submitted during the federal comment period into account as it worked with Arkansas to develop the STCs that

accompany this approval that will bolster beneficiary protections, including specific state assurances around these protections to further support beneficiaries.

Opposing commenters expressed general disagreement with efforts to modify Arkansas Works. Some offered more specific feedback regarding individual elements of the demonstration or the impact of certain provisions on distinct populations. Some commenters expressed the desire to see greater detail regarding how the program would be operationalized, particularly with respect to provisions like the community engagement requirements. Other comments expressed concerns that these requirements would be burdensome on families or create barriers to coverage. The state has pledged to do beneficiary outreach and education on how to comply with the new community engagement requirements, and intends to use an online reporting system to make reporting easy for enrollees. Further, CMS intends to monitor state-reported data on how the new requirements are impacting enrollment.

Many commenters indicated that many beneficiaries not qualifying for Medicaid on the basis of disability may still have issues gaining and maintaining employment due to their medical or behavioral health conditions. To mitigate these concerns, Arkansas assures that it will provide these beneficiaries reasonable modifications, which could include the reduction of or exemption from community engagement hours. This is a condition of approval, as provided in the STCs.

Some commenters expressed concern that Arkansas's proposal "lacked sufficient detail to permit informed public comments." To ensure meaningful public input at the Federal level, and to facilitate the demonstration application process for States, CMS utilizes standardized demonstration application requirements so that the public, including those with disabilities, and CMS can meaningfully assess states' applications. Upon receipt of Arkansas' proposal, CMS followed its standard protocols for evaluating the completeness of the application and determined that Arkansas application was complete. We continue to believe that Arkansas submitted sufficient detail to permit meaningful public input.

Many commenters who opposed the community engagement requirement emphasized that the community engagement requirements would be burdensome for individuals and families or create barriers to coverage for non-exempt people who might have trouble accessing care. We believe that the community engagement requirements create appropriate incentives for beneficiaries to gain employment. Given that employment is positively correlated with health outcomes, it furthers the purposes of the Medicaid statute to test and evaluate these requirements as a means to improve beneficiaries' health and to promote beneficiary independence. However, CMS has included provisions in these STCs to ensure that CMS may withdraw waivers or expenditure authorities at any time if federal monitoring of data indicates that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX and Title XXI, including if data indicates that the community engagement features of this demonstration may not adequately incentivize beneficiary participation or are unlikely to result in improved health outcomes, or that other demonstration features are not operating as intended. In efforts to support beneficiaries, CMS will require Arkansas to provide written notices to beneficiaries that include information such as how to ensure that they are in compliance with the community engagement requirements, how to appeal an eligibility denial, and how to access primary and preventive care during the non-eligibility

period. The state will also implement an outreach strategy to inform beneficiaries how to report compliance with the community engagement requirements.

Additional comments characterized the provisions to terminate coverage for failure to participate in the community engagement process as "causing disruptions in care." CMS and Arkansas acknowledged these concerns and Arkansas will be exempting from the requirement those individuals who are medically frail, as well as those whom a medical professional has determined are unable to work due to illness or injury. The state will implement an outreach strategy to inform beneficiaries about how to report compliance with the community engagement requirements. In addition, monthly notices will provide information on resources available to beneficiaries who may require assistance reporting community engagement activities.

Several commenters expressed concern about the potential 9-month length of the non-eligibility period. This would only occur where (i) an individual fails to fulfill his or her community engagement obligations in the first month of a calendar year and then after receiving a notice from the State in the second month, fails to respond to that notice by rectifying the situation or seeking an exemption, (ii) the same individual fails to fulfill his or her community engagement obligations in the second month of a calendar year and then after receiving a notice from the State in the third month, fails to respond to that notice by rectifying the situation or seeking an exemption, and (iii) the same individual fails to fulfill his or her community engagement obligations in the third month of a calendar year and then after receiving a notice from the State in the fourth month, fails to respond to that notice by rectifying the situation or seeking an exemption. The program provides the individual with three opportunities to rectify the situation or seek an exemption. Any system that requires individuals to fulfill certain requirements as a condition of receiving benefits necessarily places some degree of responsibility on these individuals. We believe that the overall health benefits to the effected population through community engagement outweigh the health-risks with respect to those who fail to respond and who fail to seek exemption from the programs limited requirements.

Some comments pointed out that the maximum non-eligibility period is longer than what has been proposed in other state demonstration applications, and does not offer any way to regain eligibility during the non-eligibility period. CMS acknowledges this and Arkansas will be required to monitor and report to CMS certain metrics on compliance rates and health outcomes. CMS will closely monitor this data, and retains the right to suspend, amend or terminate the demonstration if the agency determines that it is not meeting its stated objectives.

Other commenters expressed concern about Arkansas' current eligibility and application operations and their impact on beneficiaries who may reapply for eligibility after serving their disenrollment period for non-compliance with community engagement. To help mitigate these concerns, CMS has added additional assurances to the STCs and Arkansas will submit for CMS approval an eligibility and enrollment monitoring plan within 90 calendar days after approval of the community engagement amendment of this demonstration which will allow CMS to track Arkansas' compliance with the assurances described in the STCs, including several related to eligibility and application processing systems. The state may not take adverse action on a beneficiary for failing to complete community engagement requirements until CMS has reviewed the application processing monitoring plan for completeness and determined that the

state has addressed all of the required elements in a reasonable manner. As part of this requirement, CMS will require that Arkansas provide status updates on the implementation of the eligibility and enrollment monitoring plan in the state's quarterly reports.

Finally, many comments expressed concern over the waiver of retroactive eligibility, citing disruptions in care for beneficiaries and potential financial burdens for both providers and beneficiaries. Arkansas had previously received approval for a conditional waiver of retroactive coverage conditioned upon the state coming into compliance with statutory and regulatory requirements related to eligibility determinations. CMS has determined the state has met these requirements. CMS believes that a more limited period of retroactive eligibility will encourage beneficiaries to obtain and maintain health coverage, even when they are healthy. As such, with this amendment we are testing whether this limited retroactive eligibility period supports increased continuity of care by reducing gaps in coverage when beneficiaries churn on and off Medicaid or sign up for Medicaid only when sick and whether this feature will improve health outcomes.

Other Information

CMS's approval of this demonstration is conditioned upon compliance with the enclosed list of waiver and expenditure authorities and the STCs defining the nature, character and extent of anticipated federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

Your project officer for this demonstration is Ms. Tia Witherspoon. She is available to answer any questions concerning your section 1115 demonstration. Ms. Witherspoon's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-03-17
7500 Security Boulevard
Baltimore, MD 21244-1850
Email: Tia. Witherspoon@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Witherspoon and Mr. Bill Brooks, Associate Regional Administrator, in our Dallas Regional Office. Mr. Brooks' contact information is as follows:

Mr. Bill Brooks
Associate Regional Administrator
Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
1301 Young Street, Suite 833
Dallas, TX 75202

If you have questions regarding this approval, please contact Ms. Judith Cash, Acting Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Thank you for all your work with us, as well as stakeholders in Arkansas, over the past months to reach approval.

Sincerely,

[redacted]

Seema Verma

Enclosures

[NOT SCHEDULED FOR ORAL ARGUMENT]

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

CHARLES GRESHAM, et al., Plaintiffs-Appellees, v. ALEX M. AZAR II, et al., Defendants-Appellants,	Nos. 19-5094 & 19-5096
RONNIE MAURICE STEWART, et al.,, Plaintiffs-Appellees, v. ALEX M. AZAR II, et al., Defendants-Appellants.	Nos. 19-5095 & 19-5097

CERTIFICATE OF PARTIES, RULINGS, AND RELATED CASES

A. Parties and Amici

The plaintiffs-appellees in *Gresham* are Charles Gresham, Cesar Ardon, Marisol Ardon, Adrian McGonigal, Veronica Watson, Treda Robinson, Anna Book, Russell Cook, and Jamie Deyo. The plaintiffs-appellees in *Stewart* are Ronnie Maurice Stewart, Shawna Nicole McComas, David Roode, Sheila Marlene Penney, Hunter Malone, Sarah Martin, Althea Humber, Melissa Spears-Lojek, Linda Keith, Kimberly Kobersmith, Debra Wittig, Randall Yates, Rodney Lee, Teri Blanton, Robin Ritter, and Diika Nehi Segovia.

The federal defendants-appellants in *Gresham* are Alex M. Azar II, in his official capacity as Secretary of Health and Human Services; Seema Verma, in her official capacity as Administrator of the Centers for Medicare & Medicaid Services; the United States Department of Health and Human Services; and the Centers for Medicare & Medicaid Services. The federal defendants-appellants in *Stewart* are Alex M. Azar II, in his official capacity as Secretary of Health and Human Services; Seema Verma, in her official capacity as Administrator of the Centers for Medicare & Medicaid Services; Paul Mango, in his official capacity as Chief Principal Deputy Administrator of the Centers for Medicare & Medicaid Services; Demetrios L. Kouzoukas, in his official capacity as Principal Deputy Administrator of the Centers for Medicare & Medicaid Services; Christopher Traylor, in his official capacity as Director of the Center for Medicaid and Children's Health Insurance Program Services; United States Department of Health and Human Services; and the Centers for Medicare & Medicaid Services.

The State of Arkansas is intervenor-defendant-appellant in *Gresham*. The Commonwealth of Kentucky is intervenor-defendant-appellant in *Stewart*.

The following organizations participated as amici in *Gresham*: Deans, Chairs and Scholars; and National Alliance on Mental Illness.

The following organizations participated as amici in *Stewart*: Deans, Chairs and Scholars; AARP; AARP Foundation; Justice in Aging; National Academy of Elder

Law Attorneys; Disability Rights Education and Defense Fund; American Academy of Pediatrics; American College of Physicians; American Medical Association; American Psychiatric Association; Catholic Health Association of the United States; March of Dimes; and National Alliance on Mental Illness.

B. Rulings under Review

In *Gresham*, the rulings under review are the opinion and order entered on March 27, 2019 (Dkt. Nos. 57, 58); the order entering judgment pursuant to Rule 54(b) on April 4, 2019 (Dkt. No. 60); and all prior orders and decisions that merge into those. The rulings were issued by the Honorable James E. Boasberg in Case No. 1:18-cv-1900 (D.D.C.).

In *Stewart*, the rulings under review are the opinion and order entered on March 27, 2019 (Dkt. Nos. 131, 132); the order entering judgment pursuant to Rule 54(b) on April 4, 2019 (Dkt. No. 134); and all prior orders and decisions that merge into those. The rulings were issued by the Honorable James E. Boasberg in Case No. 1:18-cv-152 (D.D.C.).

C. Related Cases

These cases were not previously before this Court. Substantially the same issues are presented in *Philbrick v. Azar*, No. 1:19-cv-773 (D.D.C.) (Boasberg, J.), which is pending in district court.

s/ Alisa B. Klein
Alisa B. Klein