

# JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

January 6, 2019

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

## **Re: Virginia COMPASS Section 1115 Demonstration Waiver Extension**

Justice in Aging appreciates the opportunity to comment on Virginia's Creating Opportunities for Medicaid Participants to Achieve Self-Sufficiency (COMPASS) proposal to amend and extend its current demonstration project under section 1115 of the Social Security Act.

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries and populations that have traditionally lacked legal protection such as women, people of color, LGBT individuals, and people with limited English proficiency. Justice in Aging conducts trainings and engages in advocacy regarding Medicare and Medicaid, provides technical assistance to attorneys and others from across the country on how to address problems that arise under these programs, and advocates for strong consumer protections at both the state and federal level.

We urge the Department of Health and Human Services (HHS) to reject Virginia's proposals to take away Medicaid coverage by requiring low-income adults to perform "work and community engagement" activities and pay premiums and cost-sharing. These proposals will greatly harm older adults and cause thousands of low-income Virginians to lose Medicaid coverage.

We have cited research demonstrating the harms of these proposals and we respectfully request that HHS review each of the sources cited and made available to the agency through active hyperlinks. We further request that the full text of each of the sources cited, along with the full text of our comments, be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act.

### **A. Work Requirements Will Cause Many Older Adults, People with Serious Health Conditions & Family Caregivers to Lose Coverage**

Virginia's proposal to take Medicaid coverage away from people who fail to meet "work or community engagement" requirements would greatly harm older adults under age 65 with serious health conditions who are not eligible for Medicare. Although taking away coverage for failure to meet a work requirement will harm many Medicaid enrollees across demographic groups, this policy will be particularly harmful to older adults and people with serious health conditions and functional

#### **WASHINGTON**

1444 Eye Street, NW, Suite 1100  
Washington, DC 20005  
202-289-6976

#### **LOS ANGELES**

3660 Wilshire Boulevard, Suite 718  
Los Angeles, CA 90010  
213-639-0930

#### **OAKLAND**

1330 Broadway, Suite 525  
Oakland, CA 94612  
510-663-1055

limitations because they face additional challenges in meeting such requirements, and the health consequences of losing Medicaid coverage are likely to be especially severe.

### **1. Older Adults and People with Serious Health Conditions will Lose Coverage**

Although Virginia proposes to exempt individuals who have a disability and “medically frail” individuals from the work requirements, many individuals who have chronic illnesses or health-related limitations will still be required to work. Medicaid eligibility rules classify a person as “disabled” or “not disabled,” but in real life, disability is a continuum. A Medicaid beneficiary may not be formally “disabled” under Medicaid law but nonetheless face significant health-related challenges. Data from the National Center for Health Statistics shows that approximately 40% of working-age Medicaid beneficiaries “have broadly defined disabilities, most of whom are not readily identified as such through administrative records.”<sup>1</sup> Similarly, data from the March 2017 Current Population Survey (reflecting 2016 health insurance coverage) show that, among Virginia’s non-elderly Medicaid population not receiving Supplemental Security Income due to disability, 46% cited being ill or disabled as the reason for not being employed.<sup>2</sup>

Likewise, Medicaid law classifies a beneficiary as either “aged”—age 65 or older—or not aged. But in reality some beneficiaries in their 50s or early 60s face many of the same health-related challenges that confront beneficiaries who are formally classified as “aged.”

### **2. Family Caregivers will Lose Coverage**

Work requirements would also greatly harm the health of many Medicaid beneficiaries who care for family members or other individuals who cannot live independently. Many family caregivers leave the workforce or reduce their hours to provide informal care to seniors and others who need it. Therefore, these caregivers are likely to be low-income and unlikely to have access to health insurance through a job or spouse.<sup>3</sup>

Virginia’s proposal would count hours spent providing “Caregiver services for a non-dependent relative or other person with a chronic, disabling health condition” towards the work requirement and provides and exemption for the “[p]rimary caregiver for an adult dependent with a disability or a non-

---

<sup>1</sup> H. Stephen Kaye, Community Living Policy Ctr., How Do Disability and Poor Health Impact Proposed Medicaid Work Requirements? 2 (Feb. 2018), available at

<https://clpc.ucsf.edu/sites/clpc.ucsf.edu/files/reports/Disability%20%26%20Medicaid%20Work%20Requirements.pdf>.

<sup>2</sup> Rachel Garfield *et al.*, Kaiser Family Foundation, Understanding the Intersection of Medicaid and Work 10 (Appendix Table 2) (Jan. 2018), available at <http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work>.

<sup>3</sup> Justice in Aging, MEDICAID WORK REQUIREMENTS: The Impact on Family Caregivers and Older Adults (Nov. 2018), available at <http://www.justiceinaging.org/wp-content/uploads/2018/11/JusticeInAging-Medicaid-IssueBrief-November19-11am-2018.pdf>.

dependent relative with a disability.”<sup>4</sup> However, it is not clear what caregiving responsibilities would qualify either as “work” or for the exemption. As discussed above, many people who have health-related challenges requiring the assistance of a family caregiver may not meet strict definitions of “disability.” Moreover, these narrow categories fail to recognize the realities of family caregiving. Most family caregivers are not providing care because a doctor told them it was necessary. Even if a medical professional did consider the care necessary, most people would not have documentation to show that. In addition, limiting the exemption for caregivers to a dependent or relative ignores that many individuals do not have family to care for them or may need help from multiple caregivers, some of whom may not be related.<sup>5</sup> Finally, imposing a work requirement puts an enormous and unnecessary burden on family caregivers to track their hours, obtain documentation, and understand and comply with reporting requirements in the midst of their caregiving and other responsibilities.<sup>6</sup> Given these realities, many caregivers would be forced to choose between providing care for their loved ones and maintaining their own health.<sup>7</sup>

### **3. Burdensome Reporting Requirements Will Cause Medicaid Eligible Individuals to Lose Coverage**

Finally, Virginia residents who are eligible for Medicaid are at risk of losing coverage because they do not or cannot complete the necessary documentation to show they met the work requirement. Requiring beneficiaries to complete paperwork and submit documentation has been shown to reduce Medicaid enrollment across populations.<sup>8</sup> And Arkansas’ experience with implementing work requirements is further proving this to be true. Less than 15% of the beneficiaries whom Arkansas required to report work activities had successfully done so, indicating the vast majority were either unaware of this reporting requirement or unable to navigate it.<sup>9</sup>

Furthermore, research on the Temporary Assistance for Needy Families (TANF) program found that beneficiaries with disabilities and poor health are more likely to lose benefits due to an inability to navigate the system.<sup>10</sup> This research indicates that the existence of exemptions does not necessarily ameliorate problems, since a beneficiary may likely have difficulty understanding and obtaining the

---

<sup>4</sup> Commonwealth of Virginia, Virginia Department of Medical Assistance Services 1115 Demonstration Extension Application (Nov. 20, 2018) 6-8, *available at* [www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/va/va-gov-access-plan-gap-pa4.pdf](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/va/va-gov-access-plan-gap-pa4.pdf).

<sup>5</sup> See Justice in Aging, *supra* note 3; AARP New Hampshire, Testimony on SB 313 (Feb. 20, 2018), *available at* <https://states.aarp.org/aarp-testifies-new-hampshire-granite-advantage-program/>.

<sup>6</sup> Paperwork requirements have been shown to reduce Medicaid enrollment across populations. See Margot Sanger-Katz, “Hate Paperwork? Medicaid Recipients Will Be Drowning in It,” *The New York Times*, January 18, 2018, [www.nytimes.com/2018/01/18/upshot/medicaid-enrollment-obstacles-kentucky-work-requirement.html](http://www.nytimes.com/2018/01/18/upshot/medicaid-enrollment-obstacles-kentucky-work-requirement.html).

<sup>7</sup> See Justice in Aging, *supra* note 3.

<sup>8</sup> Sanger-Katz, *supra* note 5.

<sup>9</sup> See Jennifer Wagner, “Eligible Arkansas Medicaid Beneficiaries Still Struggling to Meet Rigid Work Requirements,” Center on Budget and Policy Priorities, August 21, 2018, [www.cbpp.org/blog/eligible-arkansas-medicaid-beneficiaries-still-struggling-to-meet-rigid-work-requirements](http://www.cbpp.org/blog/eligible-arkansas-medicaid-beneficiaries-still-struggling-to-meet-rigid-work-requirements)

<sup>10</sup> Yeheskel Hasenfeld, *et al.*, Social Service Review, *The Logic of Sanctioning Welfare Recipients: An Empirical Assessment* 304, 306–07 (June 2004), *available at* [https://repository.upenn.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1028&context=spp\\_papers](https://repository.upenn.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1028&context=spp_papers).

exemption. In a similar vein, a recent nationwide report from the U.S. Department of Agriculture found that implementing work requirements for the Supplemental Nutrition Assistance Program (SNAP) was an “administrative nightmare” that was “error prone” in multiple states.<sup>11</sup> In several instances, the Department found that the state was terminating beneficiaries’ SNAP benefits even though the beneficiary qualified for an exemption.<sup>12</sup> Likewise, the Virginia Medicaid program is likely to take improper actions, and beneficiaries with chronic conditions or functional limitations have less ability to contest those improper actions or apply for an exemption to keep their coverage.

#### 4. Work Requirements Do Not Promote the Objectives of the Medicaid Program

Section 1115 of the Social Security Act requires an “experimental, pilot, or demonstration project ... [that] is likely to assist in promoting the objectives” of the Medicaid program.<sup>13</sup> As confirmed by the court in *Stewart v. Azar*,<sup>14</sup> Medicaid’s primary objective is to furnish medical assistance to low-income persons.<sup>15</sup> Virginia’s proposal to take away Medicaid coverage by requiring low-income adults to meet work requirements does not promote that objective. In fact, it would terminate or reduce coverage for thousands of low-income Virginians.

Virginia states that the goal is to promote “health, wellness, and greater financial stability and self-sufficiency for Medicaid enrollees who are subject to TEEOP”<sup>16</sup> Not only is there is no evidence that requiring beneficiaries to work would achieve Virginia’s stated goals, these objectives of improving health, wellness, and increasing financial stability and self-sufficiency do not assist in providing Medicaid coverage. As demonstrated above, work requirements would end coverage for thousands of Medicaid eligible adults and increase the number of uninsured Virginians. Virginia’s own estimate is that more than 21,000 low-income Virginians will be unable to meet the work requirements and lose coverage.<sup>17</sup> It is clear from Arkansas’ experience that imposing work requirements will cause thousands of more eligible individuals to lose coverage.<sup>18</sup>

---

<sup>11</sup> U.S. Dep’t of Agric., Office of the Inspector Gen., FNS Controls Over SNAP Benefits for Able-Bodied Adults Without Dependents 5 (Sept. 29, 2016), available at [www.usda.gov/oig/webdocs/27601-0002-31.pdf](http://www.usda.gov/oig/webdocs/27601-0002-31.pdf).

<sup>12</sup> *Id.*

<sup>13</sup> 42 U.S.C. § 1315(a).

<sup>14</sup> Memorandum Opinion, *Stewart v. Azar*, Civil Action No. 1:18-cv-152 (JEB), filed June 29, 2018.

<sup>15</sup> See 42 U.S.C. § 1396-1.

<sup>16</sup> Virginia, *supra* note 4 at 6.

<sup>17</sup> Virginia, *supra* note 4 at 22.

<sup>18</sup> See Judith Solomon, Center on Budget & Policy Priorities, “Commentary: Administration Can’t Justify Re-Approving Waiver Taking Coverage Away from Kentuckians,” (Aug. 23, 2018), available at [www.cbpp.org/health/commentary-administration-cant-justify-re-approving-waiver-taking-coverage-away-from](http://www.cbpp.org/health/commentary-administration-cant-justify-re-approving-waiver-taking-coverage-away-from); Sara Rosenbaum *et al.*, The Commonwealth Fund, “State 1115 Proposals to Reduce Medicaid Eligibility: Assessing Their Scope and Projected Impact,” (Jan. 11, 2018), available at [www.commonwealthfund.org/blog/2018/state-1115-proposals-reduce-medicaid-eligibility-assessing-their-scope-and-projected?redirect\\_source=/publications/blog/2018/jan/state-1115-proposals-to-reduce-medicaid-eligibility](http://www.commonwealthfund.org/blog/2018/state-1115-proposals-reduce-medicaid-eligibility-assessing-their-scope-and-projected?redirect_source=/publications/blog/2018/jan/state-1115-proposals-to-reduce-medicaid-eligibility); Jennifer Wagner, “Eligible Arkansas Medicaid Beneficiaries Still Struggling to Meet Rigid Work Requirements,” Center on Budget and Policy Priorities” (Aug. 21, 2018), available at [www.cbpp.org/blog/eligible-arkansas-medicaid-beneficiaries-still-struggling-to-meet-rigid-work-requirements](http://www.cbpp.org/blog/eligible-arkansas-medicaid-beneficiaries-still-struggling-to-meet-rigid-work-requirements).

## 5. Work Requirements Could Actually Impeded Individuals' Ability to Find or Maintain a Job

This policy would also be counterproductive as low-income Virginians who lose coverage for failure to comply with a work requirement could see their health deteriorate, which in turn will make it harder for them to become or remain employed.<sup>19</sup> Recent reports show that Medicaid can reduce health barriers to finding or holding a job for beneficiaries who are not working.<sup>20</sup> For example, in Michigan, 55% of those who were out of work said Medicaid coverage made them better able to look for a job while 69% of those who had jobs said they did better at work once they got coverage.<sup>21</sup> Ohio Medicaid enrollees reported similarly that Medicaid coverage made it easier to both seek employment and continue working.<sup>22</sup> For many individuals, access to health services could be the pathway to employment; if blocked from Medicaid coverage, they could find it much more difficult to find and hold a job.

As another example, a recent Urban Institute analysis estimates that among Kentucky Medicaid beneficiaries who are working and do not qualify for a student or caregiver exemption, 55,000 are at risk of losing Medicaid coverage at some point during the year because they do not work enough hours or may not work consistently enough to satisfy the work requirement each month.<sup>23</sup> The same is likely true for Virginia residents who are eligible for Medicaid and working, but not consistently enough to meet the 20-80 hour work requirement each month. Additionally, issues with finding and maintaining steady jobs in a volatile job market<sup>24</sup> are even more profound for older adults who also face employment discrimination based on their age.<sup>25</sup> This data demonstrates that adding work requirements is likely to provide little actual assistance and put an already burdened population in greater danger of losing health insurance and even their jobs.

---

<sup>19</sup> Coverage interruptions could lead to increased emergency room visits and hospitalizations, admissions to mental health facilities, and health care costs, research has shown. Leighton Ku and Erika Steinmetz, "Bridging the Gap: Continuity and Quality of Coverage in Medicaid," Association for Community Affiliated Plans, September 10, 2013, [www.communityplans.net/Portals/0/Policy/Medicaid/GW%20Continuity%20Report%209-10-13.pdf](http://www.communityplans.net/Portals/0/Policy/Medicaid/GW%20Continuity%20Report%209-10-13.pdf).

<sup>20</sup> Larisa Antonisse & Rachel Garfield, Kaiser Family Foundation, "The Relationship between Work and Health: Findings from a Literature Review" (Aug. 7, 2018), available at [www.kff.org/medicaid/issue-brief/the-relationship-between-work-and-health-findings-from-a-literature-review/](http://www.kff.org/medicaid/issue-brief/the-relationship-between-work-and-health-findings-from-a-literature-review/).

<sup>21</sup> Kara Gavin, "Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches," University of Michigan Health Lab, June 27, 2017, <http://labblog.uofmhealth.org/industry-dx/medicaid-expansion-helped-enrollees-do-better-at-work-or-job-searches>.

<sup>22</sup> Ohio Department of Medicaid, Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly (Jan. 2017), available at <http://medicaid.ohio.gov/portals/0/resources/reports/annual/group-viii-assessment.pdf>.

<sup>23</sup> Anuj Gangopadhyaya *et al.*, Urban Institute, Kentucky Medicaid Work Requirements: What Are the Coverage Risks for Working Enrollees? 3 (Aug. 2018), available at [www.urban.org/sites/default/files/publication/98893/2001948\\_kentucky-medicaid-work-requirements-what-are-the-coverage-risks-for-working-enrollees.pdf](http://www.urban.org/sites/default/files/publication/98893/2001948_kentucky-medicaid-work-requirements-what-are-the-coverage-risks-for-working-enrollees.pdf).

<sup>24</sup> See Brynne Keith-Jennings, Center on Budget & Policy Priorities, Policy Brief: Labor Market Facing SNAP and Medicaid Participants Offers Low-Paying, Volatile Jobs (July 24, 2018), available at <https://www.cbpp.org/research/poverty-and-inequality/policy-brief-labor-market-facing-snap-and-medicaid-participants>.

<sup>25</sup> See Julia Angwin, "Dozens of Companies Are Using Facebook to Exclude Older Workers from Job Ads," (Dec. 20, 2017), [www.propublica.org/article/facebook-ads-age-discrimination-targeting](http://www.propublica.org/article/facebook-ads-age-discrimination-targeting).

## **B. Imposing Premiums and Emergency Department Copayments Will Further Decrease Coverage and Access to Necessary Care**

We oppose Virginia’s proposals to charge sliding-scale premiums and a \$5 copayment for each “non-emergent or avoidable ED [emergency department] visit” to individuals with incomes between 100-138% of the federal poverty level who are not exempt from the work requirements. The state estimates that 42,000 low-income Virginians will be required to pay premiums and would be at risk of losing their coverage if they are not able to pay these premiums after a 3-month grace period.

The \$5 copayment for each “non-emergent or avoidable ED [emergency department] visit” will be based on ICD-10 codes billed for non-emergent conditions that do not require treatment in the ED. Not only are states prohibited from imposing cost-sharing on “emergency services,” the Medicaid Act’s copayment provisions are non-waivable.<sup>26</sup> “Emergency services” include services necessary to evaluate or stabilize any condition for which a “prudent layperson” would understand the need for immediate medical attention.<sup>27</sup> But Virginia’s proposed copayments would be imposed even if the person used the ED for an emergency. For instance, an older adult who is having difficulty breathing, who prudently reports to the emergency department, could be charged the copayment based on the ultimate, post hoc diagnosis if it is considered “non-emergent” under the ICD-10 codes.

These copayments would be especially punitive towards older Medicaid beneficiaries, since they are more likely to experience such health issues and often face greater barriers to accessing care. It would be entirely unfair to penalize a layperson for choosing emergency room care when he or she is experiencing breathing difficulty, weakness, or pain; this is particularly true in the case of an older adult who may have a cognitive impairment.

Finally, the proposed use of ED copayments and premiums, which have been extensively studied, are neither experimental nor likely to promote the objectives of Medicaid. Premiums and cost sharing have been heavily studied both prior to and after implementation of the Affordable Care Act and these studies have produced redundant, consistent findings: premiums significantly reduce low-income individuals’ participation in Medicaid and other health coverage and copayments harm low-income people by causing them to forego medically necessary care.<sup>28</sup> Moreover, studies of Medicaid and CHIP nonemergency ED copayments specifically, including peer-reviewed evaluations of nonemergency ED copayments, consistently show that: (1) Medicaid enrollees use the ED at comparable rates to private

---

<sup>26</sup> Section 1115 allows for waiver of provisions within 42 U.S.C. § 1396a, but copayment-related provisions are found outside of § 1396a. These provide limited authorization for copayments, along with beneficiary protections. See 42 U.S.C. §§ 1396o, 1396o-1.

<sup>27</sup> 42 CFR § 447.51.

<sup>28</sup> See David Machledt & Jane Perkins, National Health Law Program, Medicaid Premiums and Cost Sharing (March 2014) available at <http://www.healthlaw.org/publications/search-publications/Medicaid-Premiums-Cost-Sharing#.U5cW-ij3ljw>; Kaiser Family Foundation, The Effects of Premiums and Cost-Sharing on Low-Income Populations: Updated Review of Research Findings (June 2017), available at <https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/>

pay patients if you factor in their health status, and are no more likely to use the ED for non-urgent visits; and (2) copayments are ineffective at reducing nonemergency ED use.<sup>29</sup>

**C. Virginia’s Proposed Coverage Restrictions Will Roll-Back Recent Coverage Gains and Create Particular Risks for Older Adults and Others with Chronic Conditions or Functional Limitations.**

Similar to other states that have expanded, Virginia is expected to cut its uninsured rate in half through Medicaid expansion.<sup>30</sup> The coverage restrictions in Virginia’s waiver, however, would reverse these gains, with a significant burden falling on expansion population beneficiaries in their 50s and 60s or younger expansion population beneficiaries with chronic conditions or functional limitations. These persons are not eligible for Medicare because they are not 65 years of age and (in most cases) do not meet the strict Social Security definitions of “disabled,” but they are relatively more likely to be facing significant health problems.

Prevalence of chronic conditions, including both physical and mental health conditions, increases significantly with age. Reviewing health care expense data, the Agency for Healthcare Research and Quality found that 57% of persons from ages 55 through 64 have at least two chronic conditions. An additional 20.3% of these persons have one chronic condition, and only 22.7% have no chronic condition.<sup>31</sup> AARP came to similar conclusions in an analysis of data for the age 50–64 population, finding that 72.5% have at least one chronic condition, and almost 20% suffer from some sort of mental illness.<sup>32</sup> The National Institute on Aging and National Institutes of Health reached similar results based on surveys of tens of thousands of respondents. Sixty percent of respondents from the age of 55 to 64 reported at least one health problem, with 25% reporting at least two problems (for the purposes of this study, a “problem” was defined as being related to one of six categories: hypertension, diabetes, cancer, bronchitis/emphysema, heart condition, and stroke).<sup>33</sup>

All these data demonstrate how low-income beneficiaries in their 50s and 60s—along with some younger low-income beneficiaries with chronic conditions or functional limitations — who depend upon the Virginia Medicaid program are threatened by the restrictions imposed by the waiver. Lost

---

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

<sup>30</sup> See Virginia, *supra* note 4.

<sup>31</sup> Steven Machlin et al., Agency for Healthcare Research and Quality, Statistical Brief #203: Health Care Expenses for Adults with Chronic Conditions, 2005, at 1–2, 5 (Figure 1) (May 2008), available at [www.meps.ahrq.gov/mepsweb/data\\_files/publications/st203/stat203.pdf](http://www.meps.ahrq.gov/mepsweb/data_files/publications/st203/stat203.pdf).

<sup>32</sup> AARP Public Policy Institute, Chronic Care: A Call to Action for Health Reform 11–12, 16 (March 2009), available at [www.aarp.org/health/medicare-insurance/info-03-2009/beyond\\_50\\_hcr.html](http://www.aarp.org/health/medicare-insurance/info-03-2009/beyond_50_hcr.html).

<sup>33</sup> Nat’l Institute on Aging and Nat’l Institutes of Health, Growing Older in America: The Health & Retirement Study 23 (March 2007), available at [www.nia.nih.gov/sites/default/files/2017-06/health\\_and\\_retirement\\_study\\_0.pdf](http://www.nia.nih.gov/sites/default/files/2017-06/health_and_retirement_study_0.pdf).

months of Medicaid coverage have a human cost: less preventive care, greater decline, and avoidable deterioration in physical and mental health.

**D. Housing & Employment Supports Should Be Expanded**

We support Virginia’s proposal to pay for housing-related and employment support services for high-need Medicaid enrollees. The poverty rate among older adults is rising, as is homelessness. Concerns about adequate housing become especially acute for older adults who are living on fixed incomes and have significant healthcare needs. As the Commonwealth’s application notes, it is challenging to stay healthy and effectively treat chronic and serious health conditions for individuals who lack adequate housing. Therefore, we agree with the proposals to provide additional supports to help people find housing that meets their healthcare needs as well as employment supports for those who can work through the Medicaid program.

As the Commonwealth recognizes, the housing and employment supports benefit includes Home and Community-Based Services (HCBS) that would otherwise be allowable under Section 1915(i) state plan amendment authority. However, we are concerned that instead of using 1915(i) authority, the Commonwealth is seeking 1115 demonstration authority to impose an enrollment cap for these services that will be based on available state funding which has not yet been appropriated. Allowing states to use 1115 authority to cap the number of Medicaid enrollees who can receive these services undermines Congressional intent that these services be available to all who meet the state’s needs-based criteria.

**E. Conclusion**

Thank you for consideration of our comments. Virginia’s proposals to take away Medicaid coverage by requiring low-income adults to perform “work and community engagement” activities and pay premiums and cost-sharing do not meet the statutory standards for waiver under Section 1115 and would cause great harm to low-income older adults and other Virginians. Therefore, we urge HHS to reject these proposals.

Sincerely,



Jennifer Goldberg  
Directing Attorney