Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

Paul R. LePage, Governor Ricker Hamilton, Acting Commissioner

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August 1, 2017

Tom Price, US Secretary of Health and Human Services
Office for the Secretary of the Department of Health and Human Services
The Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

Re: MaineCare 1115 Demonstration Project Application

Dear Secretary Price:

Please accept this letter as official notice of the Maine Medicaid ("MaineCare") Agency's request for approval of the attached 1115 waiver application.

As Governor Paul LePage shared with you earlier this year, one of the hallmarks of the current administration has been fiscally responsible decision-making. Dedication to this principle has allowed the MaineCare program to recover from days of annual and semi-annual budget deficits and provide strategic investments to better meet the needs of our most vulnerable populations.

Maine is seeking approval to continue this work within traditional Medicaid populations, with a focus on transitioning working aged, able-bodied adults to employment and financial independence. The three main goals of this demonstration are:

- To preserve limited financial resources for the State's most needy individuals, ensuring long-term fiscal sustainability for the MaineCare program.
- To promote financial independence and transitions to employer sponsored or other commercial health insurance.
- To encourage individual responsibility for one's health and healthcare costs.

We thank CMS for their partnership and guidance in support of renewed state flexibility and we look forward to working with you to see the successful implementation of this demonstration project.

Sincerely,

Ricker Hamilton

Ricker Hamilton
Acting Commissioner

RH/klv

1115 Waiver Application
Department of Health and Human Services
State of Maine

August 2, 2017

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I. Introduction

The Maine Department of Health and Human Services (DHHS) is the single state agency that administers the Medicaid program (known as "MaineCare") for the State of Maine.

Under the current administration, DHHS is focused on managing the Medicaid program to meet not only MaineCare program objectives, but also to improve Maine's overall financial standing. At the same time, DHHS has embraced initiatives gaining momentum at the national level to address improvements in our healthcare delivery and payment system. This demonstration seeks to implement a number of critical changes which will allow Maine to continue pursuing these important goals simultaneously.

First and foremost, DHHS believes that Medicaid must provide a basic medical safety net to the neediest populations in our state. To achieve this, DHHS must be able to prioritize limited resources for children, elderly, and the disabled, instead of turning Medicaid into an entitlement program for working-age, able-bodied adults. In support of this goal, DHHS will use lessons learned from the successful implementation of Supplemental Nutrition Assistance Program (SNAP) work requirements to incentivize work and work-related activities for MaineCare members. DHHS knows that employment and education are key factors to moving individuals out of poverty, and must be treated as such by all social services.

Protecting Medicaid's critical services requires flexibility to implement cost sharing, benefit design, and eligibility requirements that foster personal responsibility and financial independence. Medicaid must embrace private market policies and principles such as premiums and differential cost sharing based on setting; these are common tools used by other payers to manage utilization and costs in their programs. DHHS believes federal regulations should not prohibit Medicaid programs from responsibly employing these standard methods.

Many of these initiatives have the added benefit of transitioning MaineCare members into active consumers of healthcare who are better prepared to transition to commercial health insurance. To assist in this transition, DHHS seeks to improve transparency and information sharing to members regarding the cost incurred to the State for their healthcare services – individuals must have access to this information if payers are to expect more engagement and cost-conscious consumption of healthcare resources.

DHHS seeks to improve coverage for low-income populations by focusing resources on populations that have no other options for gaining coverage. DHHS does not believe that Medicaid should crowd out private insurance due to rigid regulations which ignore individual assets and create a consumer environment that is vastly different from the experience of those in commercial markets. As we continue our work to maintain fiscal discipline and stability in our

Medicaid program, we must have greater flexibility at the state level to manage programmatic decisions.

The three main goals of this demonstration are:

- To preserve limited financial resources for the State's most needy individuals, ensuring long-term fiscal sustainability for the MaineCare program.
- To promote financial independence and transitions to employer sponsored or other commercial health insurance.
- To encourage individual responsibility for one's health and healthcare costs.

II. Program Description

A. Community Engagement and Work Requirements

Employment provides not only monetary compensation, but also daily structure and a sense of pride that no government program can replicate. For these reasons, and in alignment with other social service programs in our state, DHHS intends to institute a community engagement and work requirement for able-bodied adults in MaineCare similar to the requirements DHHS implemented in the SNAP program in 2014. When Maine implemented work requirements for able-bodied adults without dependents in SNAP, the earned income of those who left SNAP rose 114% in just one year. Similarly, the goal of this initiative is to increase employment and wage earnings of able-bodied adults, while subsequently focusing MaineCare funding on Maine's most needy individuals.

Maine people must receive consistent messaging on the importance of employment to Maine's economy and overall wellbeing. To achieve this, the demonstration seeks to add community engagement and work requirements for working-age, able-bodied adults in coordination with similar work requirements for Temporary Assistance for Needy Families (TANF) and SNAP. The determination of who is required to comply with these requirements has been tailored to the MaineCare population and the various types of valuable community engagement and work activities that may be pursued by MaineCare members. Each registrant who is referred shall be advised of the participation requirements, what constitutes noncompliance, and the consequences of noncompliance.

Members will be assessed at the point of application or reassessment to determine if they are required to meet the MaineCare work requirements. Members will be able to request exemptions, as described in the waiver, throughout their eligibility. Members who are required to meet these requirements, may receive up to three months of MaineCare coverage in a thirty-six month period (beginning on the implementation date as outlined in this waiver application and subject to adjustment based on the waiver approval date) without meeting the community engagement and work requirements. MaineCare may authorize an additional month of eligibility beyond the three months in exceptional circumstances.

Members will be notified of all applicable reporting requirements, and the MaineCare eligibility system will track countable months for members who are subject to MaineCare community engagement and work requirements. Members who fail to comply with the community engagement and work requirements and who have exhausted their three month allowance will be removed from MaineCare until compliance is achieved. The start date of the disenrollment shall be the first of the month after normal procedures for closing or removal of the individual have taken place. Should a fair hearing delay the disenrollment process, the period shall start

the first of the month following the decision upholding the agency's determination. The disqualification period shall continue until the disqualified member complies with all work registration requirements. Members will be afforded the usual due process rights and existing Medicaid protections.

Requirements

There are numerous ways in which individuals may fulfill the community engagement and work requirements. An able-bodied adult must show evidence of employment, job-training, enrollment as a student, job search activities, community service, receipt of unemployment benefits, or compliance with the work requirements of SNAP or TANF. More specifically, the following activities or combination of activities will constitute compliance with the MaineCare work requirements:

- Working in paid employment at least 20 hours per week (averaged monthly). If self-employed, the member must be employed for 20 hours or more per week and receive weekly earnings at least equal to state or federal minimum wage, whichever is higher, multiplied by 20 hours; or
- Participating in and complying with the requirements of a Department-approved work program for at least 20 hours per week (averaged monthly); or
- Workfare or volunteer community service 24 hours/month; or
- Individual or group job search and job readiness assistance; or
- Enrollment as a student at least half time, as evidenced by documentation from the academic institution. The goal of the education must be to gain employment. This is based on the requirement for 20 hours/week; or
- Completing a combination of employment and education, based on achieving the threshold of 20 hours/week; or
- Receiving unemployment benefits; or
- Complying with work requirements for SNAP or TANF.

These work requirements will apply to individuals between the ages of 19-64 in the eligibility groups described in Section IV. In addition to eligibility groups which are exempted, individuals within impacted populations may be exempted based on the criteria below.

Individual exemptions

The following individual circumstances will exempt an individual from the requirement to comply with the proposed MaineCare work requirements:

- Residing in an institutional residential facility (defined as a nursing facility, adult family care home, Intermediate Care Facility for the Intellectually Disabled, Private Non-Medical Institution, or Home and Community Based Services waiver home); or

- Residing in a residential substance abuse treatment and rehabilitation program; or
- Caring for a dependent child under age six; or
- Providing caregiver services for an incapacitated adult; or
- Being pregnant; or
- Being physically or mentally unable to work 20 or more hours per week. If not evident, medical certification is required. In lieu of a doctor's statement, statements from nurses, nurse practitioners, social workers, or medical personnel may be sufficient; or
- Receiving temporary or permanent disability benefits issued by governmental or private resources.

When a MaineCare member has failed to comply with the work requirements, a determination of whether or not good cause existed shall be made. All facts and circumstances shall be considered, including information submitted by the MaineCare member and the employer, when applicable.

B. Cost Sharing Initiatives

The purpose of the cost sharing mechanisms are to support a level of personal responsibility, increase member awareness of the cost of medical services, and introduce members to commercial market policies and tools. Individuals will continue to be subject to point-of-service cost sharing as described in the Maine State Plan. Member cost sharing will not exceed the Medicaid limits of five percent of monthly household income.

1. DHHS will require monthly premiums for able-bodied adults ages 19-64. This requirement does not impact existing premium requirements in the MaineCare program. This provision will be limited to populations who have the ability to earn as defined by the eligibility groups described in Table 3. The same individual exemptions apply to premiums as to the community engagement and work requirements, except that American Indians and Alaska Natives who are members of federally-recognized tribes are also exempt from the premium requirements.

   Premiums will be due for each month that a member has MaineCare eligibility, unless specifically excluded from this requirement. Premiums can be paid monthly, for multiple months, or they can be paid in advance for the twelve month enrollment period. DHHS will notify the member of failure to make the required payment and of termination from the program if the payment is not made. All monthly premium payments must be made by the

last day of the final enrollment month or the member will be disenrolled from MaineCare for a period of 90 days or until any unpaid premiums are paid.

The MaineCare premium schedule establishes four premium brackets, based on member income. With this design, members who move to the top of their income bracket are paying a lower percentage of their income toward their premium.

Monthly premium amounts are calculated using 2% of the lowest available income in each income bracket, for a family size of one person. The premium requirements will be as follows:

Table 1. Premium Requirements by Income

Income Range	Monthly Premium by Household
0-50% FPL	$0
51-100% FPL	$10
101 -150% FPL	$20
151-200% FPL	$30
201% FPL and above	$40

2. DHHS has implemented a number of operational and payment policies to address inappropriate use of the Emergency Department (ED), including: (1) the ED Collaborate which provides team-based care management to MaineCare's highest ED utilizers, and (2) reducing payment to hospitals for non-emergency ED visits. Currently, there is not a corresponding incentive on the members' side to encourage individuals to seek care through primary care and other non-emergency settings. This demonstration provides that final piece by extending cost sharing for non-emergency ED use. Co-payments will be required if the primary diagnosis on the ED claim for the member is contained in the table in Appendix A. This will be applied to all members, except for members dually eligible for Medicare and Medicaid who do not have full MaineCare, members residing in an institutional residential facility (defined as a nursing facility, adult family care home, Intermediate Care Facility for the Intellectually Disabled, Private Non-Medical Institution, or Home and Community Based Services waiver home), and American Indian and Alaska Natives who are members of federally-recognized tribes.

   DHHS proposes to set the non-emergency use of the ED copayment at $10.

DHHS will identify members who have an ED claim with one of the applicable primary diagnosis codes through periodic claims review. For each of these visits, DHHS will send a bill to the member for $10. For a statistically significant sample of affected members, their bill will include a breakdown of the costs (an "explanation of benefits") associated with their ED visit to provide information to members regarding the cost of their care to Maine taxpayers. DHHS will evaluate the impact of the explanation of benefits on future non-emergency ED use and on payment of ED co-payments.

DHHS will be responsible for collecting these payments, and this will not result in any decrease to provider payments.

C. Asset Limitations

DHHS seeks to require individuals to apply personal finances and assets to their own healthcare costs in order to preserve MaineCare funding for the neediest members.

1. DHHS does not believe that Modified Adjustment Gross Income (MAGI)-based methodology, with its disallowance for asset or resource tests, is aligned with MaineCare's program goals. Therefore, DHHS proposes to apply a reasonable asset test to Medicaid, similar to the asset test utilized in the SNAP program. The $5,000 asset test will be applied to all MAGI households and assets that are not excluded as part of the existing State Plan will be countable in the determination of MaineCare eligibility.

   This test would be applied to all populations who do not otherwise have an asset test as part of their eligibility determinations.

2. DHHS also seeks to waive the prohibition of imposing a transfer penalty for the purchase of Medicaid-compliant annuities for long-term care coverage determinations and institute reasonable minimum pay out periods for the annuitant.

   Transfer penalties are applied when an individual who has assets that exceed the spousal asset allocation (a set amount of money the law allows a non-institutionalized spouse to retain for community living) attempts to give away the excess in order to ensure Medicaid eligibility. Under Section 1917(c)(a)(F) of the Social Security Act, an individual can purchase, for any dollar amount, what is widely known as a Medicaid-compliant annuity to avoid this penalty. Purchasing this type of annuity can effectively shelter an unlimited amount of money for a person (or the spouse of a person) applying for Medicaid long-term care coverage. For the annuity to be considered Medicaid-compliant, the state in which the individual is applying for assistance must be named as the beneficiary for the total amount

of Medicaid benefits paid on behalf of the institutionalized individual. The annuity must also meet three other requirements:

- It must be actuarially sound (meaning that the annuity is expected to pay out in full within the lifetime of the annuitant);
- It must be irrevocable and non-assignable; and
- It must provide for payments in equal amounts throughout the life of the annuity (no balloon payments are allowed).

As long as an annuity meets these conditions, the purchase of the annuity is not subject to a transfer penalty. In addition, the value of the annuity is not counted toward the applicant's (and spouse's, if applicable) asset limit.

Since 2011, twelve individuals have purchased annuities valued at $400,000 or more within two months of their spouse applying for long-term coverage in Maine. Given the requirements and the cost of a Medicaid-compliant annuity, the only reasonable explanation for purchasing one is to shelter assets and qualify for Medicaid.

In addition to the request to apply a transfer penalty to these types of annuities, DHHS seeks to amend policies around the actuarial soundness criteria for these annuities. Specifically, DHHS would like to require that the minimum length of the payout of a Medicaid-compliant annuity equal 80% of the life expectancy of the annuitant, regardless of whether the annuitant is the institutionalized spouse or the non-institutionalized spouse.

Under current Medicaid long-term care post-eligibility rules, the non-institutionalized spouse's income and assets are not considered when determining *ongoing* eligibility for the long-term care client. As long as the annuity pays out in full sometime within the life expectancy of the annuitant, the annuity is actuarially sound within the meaning of the rule. According to the actuarial life table published by the Social Security Administration, all men and women under the age of 100 have life expectancies of over 25 months.

The shorter the length of the payout period, the more advantageous a Medicaid-compliant annuity is to a non-institutionalized spouse. As the length of the payout period grows, the probability that the State may be able to recoup some of the Medicaid costs expended on behalf of the institutionalized spouse increases.

According to records DHHS has maintained since 2011 in regard to this type of annuity, the average annuity is paid out in full after 25 months from the date of purchase. In addition to how this annuity is used by couples, single individuals routinely use this type of annuity to privately pay for long-term care during a period of ineligibility for Medicaid coverage due to

a transfer of assets (i.e., an individual intentionally transfers assets knowing a transfer penalty will be imposed and purchases this type of annuity to pay for long-term care while the penalty is being served). Appendix B contains additional information collected by DHHS regarding use of annuities since 2011.

Requiring the length of the payout equal 80% of the life expectancy of the annuitant would make Medicaid-compliant annuities less attractive for at least two reasons:

- Although the non-institutionalized spouse could still receive 100% of his/her investment back in full, this could take several years (depending on the age of the individual at the time of purchase);
- The potential for the non-institutionalized spouse to receive his/her entire investment prior to his/her passing would decrease; and
- The payments received by the institutionalized spouse after the penalty period has expired would either be applied to his/her cost of care (if determined eligible for assistance) or would result in an ineligibility decision due to excess income.

D. Retroactive Eligibility

Initial MaineCare coverage for an individual should begin on the first day of the month that an application for assistance is filed. Consistent with private insurance coverage, it is not the State's responsibility to pay for medical bills incurred during a time when an individual is not enrolled. Providers should determine whether or not they wish to deliver a service based on the insurance status of the individual at the time of the service and not based on potential for future retroactive insurance coverage by MaineCare. Individuals applying for long-term care coverage will still be eligible for retroactive eligibility determinations.

This initiative also encourages individuals to seek coverage when they are healthy instead of waiting for medical expenses to incur. This is a mindset necessary for commercial insurance coverage when enrollment is often limited to an open enrollment period. DHHS believes this will contribute positively to health outcomes, as individuals may begin receiving preventive care and establish a relationship with a primary care provider before a health crisis.

Retroactive eligibility may be granted, as appropriate, for individuals whose existing MaineCare coverage lapses.

E. Presumptive Eligibility Determinations by Qualified Hospitals

In combination with the waiver of providing retroactive coverage to MaineCare members, DHHS seeks to eliminate the option for qualified hospitals to make presumptive eligibility determinations. The focus of MaineCare eligibility will be on comprehensive assessments to best determine MaineCare coverage and to set clear parameters around coverage periods.

These processes will help ensure that State dollars are used only for appropriate healthcare coverage and they will encourage members to complete applications in a timely manner. Presumptive eligibility determinations for pregnant women will remain, in accordance with 42 CFR §435.1103.

III. Delivery System

All MaineCare members will continue to receive services through the current delivery system. Members will be afforded all required due process rights and members may appeal any adverse determinations.

IV. Demonstration Eligibility

DHHS proposes to implement the following initiatives across all eligibility groups (with individual exemptions as described in Section II. Program Description):

- Charging enhanced cost sharing for non-emergency use of the Emergency Department
- Using asset tests in eligibility determinations
- Applying a transfer penalty on "Medicaid-compliant annuities"
- Ceasing to provide initial non-long-term care retroactive eligibility
- Ceasing the hospital presumptive eligibility policy option

Table 2 describes the eligibility groups impacted by the proposed work requirements and premiums. Only members aged 19-64 are included in the initiatives below. Certain income levels within these groups are not subject to premiums (please see Section II. Program Description).

Table 2. Demonstration Eligibility

Eligibility Group Name	Social Security Act and CFR Citations	Work Requirements	Premiums
Mandatory Categorically Needy			
Low Income Families Parents/Caretaker Relatives	1931 42 CFR 435.110	X	X
Transitional Medical Assistance	408(a)(11)(A) 42 CFR 435.112 1931(c)(2) 1925 1902(a)(52)	X	X (first six months)
Former Foster Care Children	42 CFR 435.150 1902(a)(10)(A)(i)(IX)	X	X
Optional Categorically Needy			

Individuals Eligible for Family Planning Services	1902(a)(10)(A)(ii)(XXI) 1902(ii) Clause (XVI) of 1902(a)(10)(G) 42 CFR 435.214	X	X
Reasonable classifications of individuals under age 21	1902(a)(10)(A)(ii)(I) and (IV) 42 CFR 435.222	X	X
Medically Needy Individuals Age 18 through 20	42 CFR 435.308 1902(a)(10)(C)	X	X
Medically Needy Parents and Other Caretaker Relatives	1902(a)(10)(C) 42 CFR 435.310	X	X
Special Benefits Waiver (HIV Waiver)		X	-

V. Types of Waivers Requested

A. Amount, Duration, Scope and Comparability **Section 1902(a)(10)(B)**
Section 1902(a)(17)

To the extent necessary to enable DHHS to vary the premiums, work requirements as described in this waiver application.

B. Reasonable Promptness and Eligibility **Section 1902(a)(10)(A) and 1902(a)(8)**

To the extent necessary to enable DHHS to make compliance with the MaineCare community engagement and work requirements and timely premium payments, a condition of eligibility for able-bodied adults.

C. Retroactive Eligibility **Section 1902(a)(34)**

To the extent necessary to enable DHHS to not provide medical coverage to MaineCare members for any time prior to the first day of the month in which the individual's initial application for coverage is received.

D. Cost Sharing **Section 1902(a)(14) insofar as it incorporates Sections 1916 and 1916A**

To the extent necessary to enable DHHS to impose mandatory cost sharing for non-emergency use of the Emergency Department and for premium payments.

E. Asset Tests **1902(e)(14)**

To waive the restriction on the use of asset test for Medicaid eligibility determinations as described in this waiver application.

F. Transfer Penalties **Section 1917(c)(a)(F)**
Section 1902(a)(18)

To the extent necessary to waive specific requirements of which prohibits the State from imposing a transfer penalty for the purchase of Medicaid-compliant annuities.

To the extent necessary to allow DHHS to require that the minimum length of the payout of the Medicaid-compliant annuity equals eighty percent of the life expectancy of the annuitant, regardless of whether the annuitant is the institutionalized spouse or the non-institutionalized spouse.

G. Presumptive Eligibility Determinations by Hospitals **Section 1902(a)(47)**
42 CFR 435.1110

To the extent necessary to waive the requirement to allow hospitals to serve as entities able to determine presumptive eligibility.

VI. Demonstration Area and Timeframe

DHHS seeks a five-year waiver approval period for this demonstration. This demonstration will operate statewide.

VII. Implementation Schedule

All initiatives, except for the premium requirements, will be implemented within six months of demonstration approval (estimated at January 1, 2018). Premium requirements will begin July 1, 2018.

VIII. Hypotheses and Evaluation

Through this demonstration, DHHS intends to evaluate a number of hypotheses. Table 3 describes these hypotheses and how DHHS will evaluate the impact of this demonstration.

Table 3. Evaluation Plan

#	Hypothesis	Methodology	Data Sources and Metrics
Goal 1: To preserve limited financial resources for the State's most needy individuals, ensuring long-term fiscal sustainability for the MaineCare program.			
1.1	The elimination of asset tests has resulted in MaineCare eligibility for individuals who have personal assets that could be used to purchase health insurance coverage or pay for medical bills.	Examine impact on eligibility for individuals reassessed for MaineCare coverage after asset tests are reintroduced.	Eligibility files
1.2	The inability to impose restrictions and transfer penalties on Medicaid-compliant annuities has resulted in MaineCare eligibility for individuals who have personal assets that could be used to purchase health insurance coverage or pay for medical bills.	Record the number of transfer penalties applied to applicants and data on annuity use pre- and post – demonstration implementation.	Eligibility files
Goal 2: To promote financial independence and transitions to employer sponsored or other commercial health insurance.			
2.1	Earned income of those who leave MaineCare will increase after community and engagement requirements are implemented.	Maine will conduct an analysis of the wage and employment experiences of the impacted population.	Administrative data from DHHS Wage and employment records available at the Maine Department of Labor.
2.2	Members will become accustomed to paying monthly premiums.	MaineCare will track timely payments of premiums.	Administrative data from DHHS
Goal 3: To encourage individual responsibility for one's health and healthcare costs.			
3.1	Non-emergency utilization of the Emergency Department (ED) will decrease as members are held responsible for an enhanced copayment.	DHHS will conduct a pre- and post-utilization analysis of ED use and will measure the impact of receiving information regarding the cost of ED services on payment of co-payments and subsequent ED use.	Claims data Control and intervention group analysis

IX. Demonstration Financing

The Centers for Medicare and Medicaid Services (CMS) requires that all 1115 waivers demonstrate budget neutrality. This application presents information on projected

expenditures with and without the implementation of this waiver. Projections on eligible member months are provided to illustrate any potential changes to eligibility. Per Member Per Month (PMPM) estimates provide the expected expenditure per MaineCare eligible member.

Projections in Table 7 (implementation of the waiver) represent all changes except ED co-payments and premiums. Premium payments and ED cost sharing are expected to result in approximately $1.4 million in State revenue annually. This revenue is not counted as a reduction in expenditures in the Table 7. Administrative costs are also not included in this estimate.

DHHS estimates that the current trend in eligibility decline will continue regardless of this waiver implementation; however, the decline may slightly increase over the short-term with this waiver as a result of the newly proposed eligibility criteria. The impact on eligibility as a result of the waiver is expected to include able-bodied adults, which tend to have a smaller PMPM than other members. For this reason, the average PMPM is expected to increase slightly under the waiver.

These estimates are highly dependent upon assumptions utilized in the analysis including the assumed approval and implementation dates, medical trend estimates, and eligibility assumptions. As part of this demonstration, DHHS will look to evaluate these assumptions.

Note: This section reflects what was prepared and submitted for public input assuming a January 1, 2018 demonstration start date (except for premium collections, which would begin on July 1, 2018).

Table 4. Demonstration Period

Demonstration Year	DY1	DY2	DY3	DY4	DY5
Time Period	1/1/2018-12/31/2018	1/1/2019-12/31/2019	1/1/2020-12/31/2020	1/1/2021-12/31/2021	1/1/2022-12/31/2022

Table 5. Historical Data

	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
Total Expenditures	$2,323,453,881	$2,256,222,980	$2,243,704,171	$2,296,672,691	$2,288,058,837
Eligible member months	3,542,635	3,403,333	3,265,058	3,104,659	2,983,647
Average PMPM	$656	$663	$687	$740	$767

Table 6. Projections (Without Waiver)

	DY1	DY2	DY3	DY4	DY5
Total Expenditures	$2,219,874,683	$2,208,775,310	$2,197,731,433	$2,197,731,433	$2,197,731,433
Eligible member months	2,807,015	2,778,945	2,751,155	2,751,155	2,751,155
Average PMPM	$791	$795	$799	$799	$799

Table 7. Projections (With Waiver)

	DY1	DY2	DY3	DY4	DY5
Total Expenditures	$2,219,743,528	$2,208,646,777	$2,197,604,186	$2,197,605,459	$2,197,605,459
Eligible member months	$2,807,015	$2,750,875	$2,723,366	$2,696,132	$2,696,132
Average PMPM	$791	$803	$807	$815	$815

X. Public Notice

DHHS conducted public hearings and public notice in accordance with the requirements in 42 CFR 431.408. The following describes the actions taken by DHHS to ensure the public was informed and had the opportunity to provide input on the proposed waiver amendment.

On April 25, 2017, DHHS published a press release and posted a full public notice seeking input on the draft waiver application in major newspapers around the state. The 30-day public comment period thus began on April 25, 2017 and ended on May 25, 2017.

DHHS created a public webpage that includes the public notice, the public input process, scheduled public hearings, the draft amendment application, and a link to the Medicaid webpage on Section 1115 demonstrations. The webpage, which will be updated as the amendment process moves forward, can be found at http://www.maine.gov/dhhs/oms/rules/demonstration-waivers.shtml .

The webpage and public notice stated clearly that a copy of the waiver amendment documents, including the final waiver amendment application once complete, could be obtained from DHHS at no charge by downloading the documents from the website or by visiting any DHHS office. The webpage and public notice further explained that public comments were welcome and

were accepted for 30 days (from April 25, 2017 to May 25, 2017). Written comments on the changes could be sent by email, or regular mail.

DHHS conducted two public hearings in geographically distinct areas of the state and included teleconference capabilities for both hearings.

Hearing 1:	**Portland Public Hearing**
Date:	May 17, 2017
Time:	9:00AM
Location:	Cross Insurance Arena 45 Spring Street Portland, Maine 04101

Hearing 2:	**Augusta Public Hearing**
Date:	May 18, 2017
Time:	9:00 AM
Location:	Augusta Civic Center 76 Community Drive Augusta, Maine 04330

DHHS also held a MaineCare Advisory Meeting to discuss the waiver on May 23, 2017, which had in-person and telephone capabilities, and consulted with representatives of the federally recognized tribes located in Maine, in accordance with the Maine State Plan tribal consultation process. Please see Appendix C for the full report on comments received and how the Department considered comments in waiver development.

XI. Demonstration Administration

Ricker Hamilton
Acting Commissioner
Maine Department of Health & Human Services
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Appendix A: Emergency Department Co-payment Diagnosis List

Table 8. Non-emergent Emergency Department Diagnosis Criteria

Summary	ICD-10 Code	ICD-10 Code Description
Strep	J02.0	Streptococcal pharyngitis
	J03.00	Acute streptococcal tonsillitis, unspecified
	J03.01	Acute recurrent streptococcal tonsillitis
Enterovirus due to other classified disease	B97.10	Unspecified enterovirus as the cause of diseases classified elsewhere
Other viral agents caused by classified disease	B97.89	Other viral agents as the cause of diseases classified elsewhere
Anxiety	F41.9	Anxiety disorder, unspecified
	F41.1	Generalized anxiety disorder
Conjunctivitis	H10.30	Unspecified acute conjunctivitis, unspecified eye
	H10.31	Unspecified acute conjunctivitis, right eye
	H10.32	Unspecified acute conjunctivitis, left eye
	H10.33	Unspecified acute conjunctivitis, bilateral
	H10.9	Unspecified conjunctivitis
Abscess of ear	H60.00	Abscess of external ear, unspecified ear
	H60.01	Abscess of right external ear
	H60.02	Abscess of left external ear
	H60.03	Abscess of external ear, bilateral
Cellulitis of ear	H60.10	Cellulitis of external ear, unspecified ear
	H60.11	Cellulitis of right external ear
	H60.12	Cellulitis of left external ear
	H60.13	Cellulitis of external ear, bilateral
Pain and swelling of the ear canal	H60.311	Diffuse otitis externa, right ear
	H60.312	Diffuse otitis externa, left ear
	H60.313	Diffuse otitis externa, bilateral
	H60.319	Diffuse otitis externa, unspecified ear
	H60.391	Other infective otitis externa, right ear
	H60.392	Other infective otitis externa, left ear
	H60.393	Other infective otitis externa, bilateral
	H60.399	Other infective otitis externa, unspecified ear
Middle ear inflammation or fluid buildup, no infection	H65.00	Acute serous otitis media, unspecified ear
	H65.02	Acute serous otitis media, left ear
	H65.03	Acute serous otitis media, bilateral
	H65.04	Acute serous otitis media recurrent, right ear
	H65.05	Acute serous otitis media recurrent, left ear
Middle ear inflammation or fluid buildup, no infection	H65.06	Acute serous otitis media, recurrent, bilateral
	H65.07	Acute serous otitis media , recurrent, unspecified ear

cont.	H65.90	Unspecified nonsuppurative otitis media, unspecified ear
	H65.91	Unspecified nonsuppurative otitis media, right ear
	H65.92	Unspecified nonsuppurative otitis media, left ear
	H65.93	Unspecified nonsuppurative otitis media, bilateral
	H66.001	Acute suppurative otitis media without spontaneous rupture of the ear drum, right ear
	H66.002	Acute suppurative otitis media without spontaneous rupture of the ear drum , left ear
	H66.003	Acute suppurative otitis media without spontaneous rupture of the ear drum , bilateral
	H66.004	Acute suppurative otitis media without spontaneous rupture of the ear drum, recurrent, right ear
	H66.005	Acute suppurative otitis media without spontaneous rupture of the ear drum, recurrent, left ear
	H66.006	Acute suppurative otitis media without spontaneous rupture of the ear drum, recurrent, bilateral
	H66.007	Acute suppurative otitis media without spontaneous rupture of the ear drum, , recurrent, unspecified ear
	H66.009	Acute suppurative otitis media without spontaneous rupture of the ear drum, unspecified ear
Middle ear infection	H66.90	Otitis media, unspecified, unspecified ear
	H66.91	Otitis media, unspecified. right ear
	H66.92	Otitis media, unspecified, left ear
	H66.93	Otitis media, unspecified, bilateral
Sinusitis/Sinus Infection	J01.90	Acute sinusitis, unspecified
	J01.91	Acute recurrent sinusitis, unspecified
	J32.9	Chronic sinusitis, unspecified
Pharyngitis	J02.8	Acute pharyngitis due to other specified organisms
	J02.9	Acute pharyngitis, unspecified
Upper respiratory infection	J06.9	Acute upper respiratory infection, unspecified
Bronchitis	J20.0	Acute bronchitis due to Mycoplasma pneumoniae
	J20.1	Acute bronchitis due to Hemophilus influenzae
	J20.2	Acute bronchitis due to streptococcus
	J20.3	Acute bronchitis due to coxsackievirus
	J20.4	Acute bronchitis due to parainfluenza virus
	J20.6	Acute bronchitis due to rhinovirus
	J20.7	Acute bronchitis due to echovirus
	J20.8	Acute bronchitis due to other specified organisms
	J20.9	Acute bronchitis, unspecified
	J40	Bronchitis, not specified as acute or chronic
Exercise induced bronchospasm	J45.990	Exercise induced bronchospasm
Asthma	J45.20	Mild intermittent asthma, uncomplicated
	J45.30	Mild persistent asthma, uncomplicated
	J45.40	Moderate persistent asthma, uncomplicated
	J45.50	Severe persistent asthma, uncomplicated

	J45.991	Cough variant asthma
	J45.909	Unspecified asthma, uncomplicated
	J45.998	Other asthma
COPD	J44.9	Chronic obstructive pulmonary disease, unspecified
Eczema/dermatitis	L22	Diaper dermatitis
	L20.0	Besnier's prurigo
	L20.81	Atopic neurodermatitis
	L20.82	Flexural eczema
	L20.84	Intrinsic (allergic) eczema
	L20.89	Other atopic dermatitis
	L20.9	Atopic dermatitis, unspecified
	L23.7	Allergic contact dermatitis due to plants, except food
	L24.7	Irritant contact dermatitis due to plants, except food
	L25.5	Unspecified contact dermatitis due to plants, except food
	L23.9	Allergic contact dermatitis, unspecified cause
	L24.9	Irritant contact dermatitis, unspecified cause
	L25.9	Unspecified contact dermatitis, unspecified cause
	L30.0	Nummular dermatitis
	L30.2	Cutaneous autosensitization
	L30.8	Other specified dermatitis
	L30.9	Dermatitis, unspecified
Joint/extremity pain	M25.50	Pain in unspecified joint
	M25.512	Pain in left shoulder
	M25.519	Pain in unspecified shoulder
	M25.521	Pain in right elbow
	M25.522	Pain in left elbow
	M25.529	Pain in unspecified elbow
	M25.531	Pain in right wrist
	M25.532	Pain in left wrist
	M25.539	Pain in unspecified wrist
	M79.643	Pain in unspecified hand
	M79.646	Pain in unspecified finger(s)
	M25.551	Pain in right hip
	M25.552	Pain in left hip
	M25.559	Pain in unspecified hip
	M25.561	Pain in right knee
	M25.562	Pain in left knee
	M25.569	Pain in unspecified knee
	M25.571	Pain in right ankle and joints of right foot
	M25.572	Pain in left ankle and joints of left foot
	M25.579	Pain in unspecified ankle and joints of unspecified foot
	M25.50	Pain in unspecified joint

	M25.50	Pain in unspecified joint
Back pain	M54.5	Low back pain
	M54.6	Pain in thoracic spine
	M54.89	Other dorsalgia
	M54.9	Dorsalgia, unspecified
Muscle inflammation	M60.80	Other myositis, unspecified site
	M60.81	Other myositis shoulder
	M60.811	Other myositis, right shoulder
	M60.812	Other myositis, left shoulder
	M60.819	Other myositis, unspecified shoulder
	M60.82	Other myositis, upper arm
	M60.821	Other myositis, right upper arm
	M60.822	Other myositis, left upper arm
	M60.829	Other myositis, unspecified upper arm
	M60.83	Other myositis, forearm
	M60.831	Other myositis, right forearm
	M60.832	Other myositis, left forearm
	M60.839	Other myositis, unspecified forearm
	M60.84	Other myositis, hand
	M60.841	Other myositis, right hand
	M60.842	Other myositis, left hand
	M60.849	Other myositis, unspecified hand
	M60.85	Other myositis, thigh
	M60.851	Other myositis, right thigh
	M60.852	Other myositis, left thigh
	M60.859	Other myositis, unspecified thigh
	M60.86	Other myositis, lower leg
	M60.861	Other myositis, right lower leg
	M60.862	Other myositis, left lower leg
	M60.869	Other myositis, unspecified lower leg
	M60.87	Other myositis, ankle and foot
	M60.871	Other myositis, right ankle and foot
	M60.872	Other myositis, left ankle and foot
	M60.879	Other myositis, unspecified ankle and foot
	M60.88	Other myositis, other site
	M60.89	Other myositis, multiple sites
	M60.9	Myositis, unspecified
Muscle pain	M79.1	Myalgia
	M79.7	Fibromyalgia
Extremity pain	M79.601	Pain in right arm
	M79.602	Pain in left arm
	M79.603	Pain in arm, unspecified

	M79.604	Pain in right leg
	M79.605	Pain in left leg
	M79.606	Pain in leg, unspecified
	M79.609	Pain in unspecified limb
	M79.62	Pain in upper arm
	M79.621	Pain in right upper arm
	M79.622	Pain in left upper arm
	M79.629	Pain in unspecified upper arm
	M79.63	Pain in forearm
	M79.631	Pain in right forearm
	M79.632	Pain in left forearm
	M79.639	Pain in unspecified forearm
	M79.641	Pain in right hand
	M79.642	Pain in left hand
	M79.643	Pain in unspecified hand
	M79.644	Pain in right finger(s)
	M79.645	Pain in left finger(s)
	M79.646	Pain in unspecified finger(s)
	M79.65	Pain in thigh
	M79.651	Pain in right thigh
	M79.652	Pain in left thigh
	M79.659	Pain in unspecified thigh
	M79.66	Pain in lower leg
	M79.661	Pain in right lower leg
	M79.662	Pain in left lower leg
	M79.669	Pain in unspecified lower leg
	M79.671	Pain in right foot
	M79.672	Pain in left foot
	M79.673	Pain in unspecified foot
	M79.674	Pain in right toe(s)
	M79.675	Pain in left toe(s)
	M79.676	Pain in unspecified toe(s)
Fatigue	G93.3	Postviral fatigue syndrome
	R53.0	Neoplastic (malignant) related fatigue
	R58.83	Other fatigue
Weakness	R53.1	Weakness
Discomfort, illness or uneasiness via unknown cause	R53.81	Other malaise
Rash	R21	Rash and other nonspecific skin eruption
Headache	R51	Headache
Cough	R05	Cough

Appendix B: Record of Medicaid Compliant Annuities

Calendar Year	Number of Annuities Reviewed	Total Dollars Spent	Average Purchase Price	Avg Payback Period (in months)
2011	46	$5,847,488	$127,119	20.07
2012	33	$5,237,827	$158,722	24.42
2013	48	$6,911,607	$143,992	26.94
2014	51	$7,530,086	$147,649	23.51
2015	50	$7,329,468	$146,589	26.08
2016	59	$6,639,391	$112,532	28.07
Total	287	$39,495,867	$137,616	-

The Department currently uses $8,476 as the average monthly cost to live in a semi-private room in a nursing facility. This means that if the money used to pay for the average cost of these annuities had instead been used to pay for private care, the funds would have paid for an average of 16 months of care for each of these individuals.

Appendix C: Summary and Response to Comments

The Department received comments from 180 people including current and former MaineCare members, MaineCare providers, provider organizations, advocacy groups, non-profit organizations, research and policy organizations, religious organizations, attorney offices, tribal representatives, foundations, financial services and healthcare management businesses, and the general public. Over three-quarters of commenters expressed general opposition to the waiver. Approximately 35-50 people provided feedback regarding the work requirements, premiums, missed appointments, retroactive eligibility, and ED co-payments, while less than 20 people provided specific feedback related to Medicaid compliant annuities, asset tests and retroactive eligibility. All commenters were reviewed and considered in developing the final waiver proposal.

General Comments

1. Many commenters opposed the waiver in its entirety and asked that it be withdrawn. A few commenters shared the desire of the Department to move individuals struggling with poverty into situations in which work, social resources, and skills enable individuals to meet their full potential and achieve independence, but they did not agree that the expectations in the waiver proposal were realistic or would achieve the desired results. Commenters requested the Department engage stakeholders to achieve their goals and review available research and evidence-based approaches in developing proposals. Commenters provided various sources of evidence around the impacts of cost-sharing, work requirements, and asset tests on healthcare utilization and outcomes. Commenters felt that this waiver suggests that people are "taking advantage of the system" without recognizing the economic and public policies that contribute to structural poverty. Commenters also discussed the value of MaineCare to members and the healthcare economy. Commenters felt that people sometimes need safety net programs to live healthy productive lives and contribute to Maine's economy. Commenters felt the waiver would have harmful effects and is misaligned with the role of the Medicaid program.

   Response: *This waiver is one of many initiatives designed to ensure that MaineCare meets its core mission of providing a basic safety net to the neediest populations in Maine. The Department agrees that MaineCare can serve as a temporary support for eligible individuals; however, feels that the focus of this eligibility should be to assist transitions to private health insurance coverage and responsible use of taxpayer dollars. The Department feels that this waiver provides a reasonable balance of member requirements to support the provision of MaineCare services. The Department has made adjustments to the original proposal in response to specific comments, as described below.*

2. Commenters questioned the timing of this waiver, as it relates to Maine's recovering economy and the Administration's biennial budget which also sought reductions to MaineCare eligibility. Commenters felt that the time and effort spent on initiatives like this waiver request creates a burden on the people in the Department and the general public by investing time in thinking, worrying, and commenting on this initiative. They felt more time and energy should be spent on

building a system that encourages that linkage between people and their primary healthcare providers, addresses youth incarceration, homelessness, and the drug overdose epidemic. Commenters felt this would create the biggest savings to the system.

Response: *The Department appreciates the time that stakeholders spend in reviewing MaineCare proposals and attending public hearings; this feedback is valuable to the Department. This waiver is separate and distinct from any budget initiatives and is just one of many initiatives that the Department is pursuing to reform MaineCare. This initiative is intended to run concurrent with other strategic reforms designed to improve quality of care, improve population health, and increase the value of healthcare spending. No changes were made as a result of this comment.*

3. Commenters raised concerns about recent figures of childhood poverty, infant mortality rates, and other health indicators in Maine. Commenters felt the waiver would exacerbate these issues. Some commenters felt these are warning signs related to the impact of recent public policy changes.

   Response: *The Department will continue to monitor population health indicators. No changes were made as a result of this comment.*

4. Commenters raised concerns about various populations that would be impacted by the waiver. Some commenters felt that these changes would disproportionately affect children because children do better when their caregivers are healthy and not experiencing high levels of parental stress. Commenters talked about the effect of losing coverage on members with lung disease, diabetes, cancer, rare genetic diseases, HIV, and others who depend on regular access to maintenance medicine or specialty care. Commenters provided information on the impact of such diseases on health, medical costs, and other indirect costs. One commenter stated that the waiver will be especially harmful to women, 19 and 20 year olds who need to access substance use and mental health services, former foster care youth, youth LGBTQ populations, families of military members/veterans, and victims of human trafficking and exploitation. One commenter wrote, from personal experience, about the challenges faced when aging out of the foster care system at 21. The commenter felt that the Department takes over the role of parents when children became wards of the State and so they should protect these members. Another commenter asked that the Department ensure that these changes do not apply to those with Developmental Disabilities and Autism; the commenter felt that premiums, deductibles, work requirements, and co-payments would not be reasonable or appropriate for this population.

   Response: *As evidenced by the list above, commenters described circumstances and characteristics of various populations which elicited concern. The Department believes that the individual and group exclusions in the waiver provide the appropriate level of flexibility to account for circumstances that span these populations. The Department did make the decision to exempt additional populations from the work and premium requirements, including members enrolled under the Maine Breast and Cervical Health Program (MBCHP) eligibility category.*

5. One commenter said that by excluding pregnant women people could have a baby on a regular basis to keep benefits and that they should also have a chance for training and help finding jobs.

Response: *The Department does not believe that this risk outweighs the administrative and health benefits of providing an exemption to pregnant women. No changes were made as a result of this comment.*

6. The commenter was concerned that the proposed waiver would severely limit eligibility and access to care for women diagnosed with cancer through MBCHP. The commenter said that MaineCare remains critically important for Mainers who depend on the program for cancer prevention, early detection, diagnostic, and treatment services.

Response: *The Department reviewed the inclusion of this eligibility group and has decided to exclude members eligible for MaineCare through MBCHP from the work and premium requirements.*

7. Commenters were concerned about the impact on access to family planning services for low-income women and discussed the negative consequences of unplanned births, including more families being stuck in the cycle of poverty. The commenter felt that if increased work participation and reduced dependency on public assistance were a true goal, increasing access to family planning benefits would be a more appropriate way to achieve those ends. Another commenter discussed the positive outcomes associated with family planning services and that family planning services include breast and cervical cancer screenings that aid in the early detection of preventable and treatable cancers, thus reducing the costs that may be incurred through MBCHP.

Response: *This waiver does not target family planning services; it only requires that members who receive the Limited Family Planning Benefit pay premiums. The Limited Family Planning Benefit provides family planning services to individuals with incomes equal to or less than 209% of the Federal Poverty Level (FPL). Eligible individuals have the ability to retain coverage, and continue accessing all MaineCare services, through compliance with the premium and work requirements. No changes were made as a result of this comment.*

8. A few commenters felt that reducing the number of MaineCare members would result in less federal dollars coming to the State to care for the most vulnerable citizens. For example, if MaineCare doesn't pay for a prescription, then General Assistance may be used to cover it with State dollars.

Response: *The Department acknowledges the importance of federal dollars in sustaining many programs; however, this is not the only factor in determining strategic priorities. No changes were made as a result of this comment.*

9. Commenters discussed concerns regarding this waiver for rural Maine where there is increased poverty and unemployment. A few commenters discussed data regarding the financial stress that rural healthcare providers are experiencing, such as negative operating margins and increases in free care for hospitals. One commenter asked how DHHS will ensure that the rural hospital and Federally Qualified Health Center (FQHC) infrastructure is not in jeopardy for those individuals who remain covered by the MaineCare program, as well as other low income uninsured individuals and those with Medicare and private insurance who rely on these providers for care. The commenter noted that rural hospitals and FQHCs rely on MaineCare reimbursement to stay solvent.

    Response: *The Department already employs reimbursement methodologies that provide enhanced reimbursement for Critical Access Hospitals, FQHCs, Rural Health Clinics, and other rural providers. The Department will continue to monitor member access to care as required by Section 1902(a)(30)(A) of the Social Security Act. No changes were made as a result of this comment.*

10. Commenters discussed overall concerns regarding impact on hospital and other provider's financial viability due to changes in payer sources, current financial stress, and already low reimbursement from Medicaid. One commenter felt the proposed waiver would create more tension on the home and community-based services system and further push quality staff to seek alternative work.

    Response: *The Department does not believe the Medicaid program is responsible for ensuring the financial success of private institutions. However, the Department believes that the current reimbursement methodologies are sufficient to adequately compensate providers, including hospitals. The Department does not anticipate that the changes proposed in the waiver will have a significant impact on the ability of facilities to continue to operate. The Department will continue to monitor member access to care as required by Section 1902(a)(30)(A) of the Social Security Act. No changes were made as a result of this comment.*

11. Multiple commenters suggested DHHS set up an evaluation, monitoring, and remedy framework that takes into account the assumptions that this waiver is built on and provides a failsafe against adverse outcomes.

    Response: *The Department agrees with this comment and will be working with the Centers for Medicare and Medicaid Services (CMS) to establish an evaluation plan as required by federal law.*

12. Commenters were concerned about loss of healthcare coverage. Commenters discussed the importance of MaineCare to individuals, families, small businesses, communities, and the healthcare system. Some commenters felt this waiver was designed to remove individuals from MaineCare, using the same format as the changes to SNAP benefits several years ago. One commenter noted that Medicaid enrollees report less financial stress and depressions and greater financial security than individuals who are uninsured. Commenters provided personal stories about how MaineCare has been a vital resource in their lives.

Commenters felt this waiver would result in more people becoming uninsured or not having adequate or affordable healthcare. This was often discussed in relation to recent declines in Medicaid enrollment which one commenter felt left people uninsured. Commenters felt that loss of coverage could result in increasing poverty, unintended pregnancies, poor health outcomes, ill health, homelessness, suicidality, addiction, relapses, arrests, incarcerations, and hospitalizations. Commenters felt that overall this waiver would make it more difficult for people to take preventive health actions and receive necessary care. One commenter shared information which demonstrated that even short-term gaps in health insurance coverage have negative impacts and that when the person reenrolls in Medicaid/Medicare, after the lock-out period, they will be sicker and have higher healthcare needs. Another commenter warned that in the event of an epidemic or other health crisis, everyone in the state will be impacted by people not having access to care. This could result in missing an early warning sign of an impending crisis.

Response: *The Department appreciates these comments and will continue to monitor the health and wellbeing of Maine people across various areas. The Department will also be working with CMS to establish an evaluation plan as required by federal law. In regard to the potential impacts of the waiver, the Department feels that this waiver provides a reasonable balance of member requirements to support the provision of MaineCare services while simultaneously shifting the responsibility of maintaining MaineCare coverage for able-bodied adults. MaineCare members have the opportunity to retain coverage through compliance with the waiver requirements. No changes were made as a result of this comment.*

13. Commenters discussed the difficulties of climbing out of poverty. Some felt that any "extra" dollars can and should be invested in that which will help the poor to climb the ladder, not on co-pays or fees for a healthcare system that by design is supposed to be the ladder. One commenter said that poor Mainers have no money to pay copays, premiums, for ER visits, or missed appointment fees. One commenter discussed how, without solutions to child-care, which would allow primary caregiving parents to go to work, there is no route out of poverty.

    Response: *While there are undoubtedly a number of challenges to escaping poverty, the Department believes that employment and education are key factors to support this transition. To ensure an appropriate balance of member responsibilities and requirements, the Department has removed the provision allowing providers to charge for missed appointments, restricted and reduced proposed premium amounts (including eliminating the premium requirement for individual earning under 50% FPL), and restricted and reduced the proposed co-payments to non-emergency Emergency Department (ED) use. The Department will continue to offer child care subsidies through current programs*

14. Two commenters spoke about their research regarding MaineCare policy changes and the current mental health crisis in Maine's county jails. The commenters felt that the waiver would further

promote a state system in which we incarcerate individuals with mental illness, rather than provide them treatment. One commenter stated that the county jail or other correctional facility is not the appropriate place to address these individuals' problems and may worsen these illnesses. Additionally, Maine counties have to pay for the cost of incarceration instead of treating individuals in their homes and communities.

Response: *The Department agrees that individuals should be served in appropriate care settings, but does not feel that MaineCare policy changes are the source of this issue. The Department welcomes additional engagement from the researchers regarding their work. No changes were made as a result of this comment.*

15. Two commenters discussed how Maine has recognized the value of preventive care and early intervention through the Value-Based Purchasing (VBP) programs and that these initiatives correctly assume that getting early care in a primary care setting saves money. The commenter said that limiting access to MaineCare will ensure that sick residents will delay care until the underlying condition worsens and requires more costly care.

    Response: *The Department believes that this waiver can operate concurrently with the ongoing VBP initiatives. Through the VBP initiatives, MaineCare providers will be expected to continue to focus on delivering high-quality and high-value care on their MaineCare member panels. No changes were made as a result of this comment.*

16. In various ways, commenters felt that increasing bureaucracy is likely to discourage treatment and cost more to the State. Commenters provided examples of when Department errors, incorrect information, and delays have led to negative consequences for members and overall inefficiency. Commenters felt that this waiver would likely delay the processing of new MaineCare applications, which commenters were concerned was already too long, and this could also contribute to fewer member days being covered. Commenters described how the public already has difficulty reaching the Department (e.g. hold times, delays in responses) and this would likely worsen under the waiver. Another concern expressed was the Department's lack of understanding of their own rules. The commenters felt that when rules change there is collateral damage for years afterwards, as evidenced by eligibility specialists that still struggle with MAGI rules. One commenter discussed generally how adding requirements to the application process will also worsen the issue of patients "living" in hospitals as they await the processing of their MaineCare applications (because the post-acute care setting may require confirmation of MaineCare coverage prior to accepting the patients in transfer). Commenters raised the concern that according to studies done in other states which have similar requirements, the cost of investigating and enforcing the requirements cost the State way more than the monies that were brought in and do not contribute to smaller government. Commenters also asked the following questions:
    - Is there a plan for DHHS to hire more staff to implement all of these various things? How many staff would need to be hired?

- Has the Department estimated the additional administrative costs of overseeing work requirements, analyzing applicants' assets, collecting new premiums and co-pays, and managing the adverse consequences for individuals who fail to comply?
- Has the Department estimated the additional cost of educating enrollees and applicants about the proposed requirements?
- Has the Department estimated the additional staff necessary for the administration of the proposed requirements?

Response: *The Department is assessing operational needs to support the initiatives in this waiver and will develop proposals for how to avoid the challenges addressed above. At this time, the Department does not have estimates of administrative costs or staff needed to implement this waiver effectively; much of this discussion will occur throughout the review process with CMS. No changes were made as a result of this comment.*

17. In various ways, commenters felt that these changes would result in increased costs and would not be cost-effective or have economic savings in the long-run. A few commenters felt this would result in paying more for poorer outcomes as compared to what we would have traditionally paid for under MaineCare. Commenters discussed concerns that this was shifting costs to communities and providers, not reducing the cost or need for healthcare. Commenters also discussed research that demonstrates that increased access has shown to lower spending in the long-term (after initial spending on pent up demand).

    Response: *The Department will be working with CMS to establish an evaluation plan as required by federal law. The Department will also continue to track trends in expenditures and outcomes, as well as engage with stakeholders to elicit feedback on other impacts of the waiver on the external environment. No changes were made as a result of this comment.*

18. One commenter asked whether all the requirements will apply to the American Indians/Alaska Native populations. The commenter noted that currently Medicaid does not charge any type of co-pay for these populations.

    Response: *The Department has amended the waiver submission package to explicitly state that American Indian and Alaska Native populations are excluded from the cost-sharing provisions. These populations are not excluded from the other waiver provisions.*

19. One commenter wanted to know if the 1115 waiver includes members in long-term care.

    Response: *There are a few ways in which members in long-term care facilities are excluded from the waiver; some of these instances represent changes as a result of comments received: (1) for able-bodied adults, members residing in an institutional residential facility are not required to comply with work requirements, pay premiums, or pay ED co-payments, and (2) long-term care coverage*

determinations are not subject to the prohibition on retroactive MaineCare eligibility. Members seeking long-term care coverage will be impacted by the proposed reforms related to Medicaid-compliant annuities. Members in long-term care may or may not be impacted by other provisions of the waiver, dependent on their eligibility group. The Department advises the commenter to look at individual circumstances to determine how/if the waiver will interact with their MaineCare coverage.

20. Many commenters felt that the waiver was not aligned with the intent of the Medicaid law or Section 1115 demonstration waivers because it is not "likely to assist in promoting the objectives" of the Medicaid Act and is not a time-limited test exploring ideas that will expand access to healthcare for low-income people. Commenters noted that ways by which the federal government evaluates whether 1115 waiver applications further the objectives of the Medicaid Act. Commenters noted that waivers also must maintain budget neutrality to the Federal Government. Commenters felt this waiver application did none of these things; instead the proposal limits and erects barriers to healthcare. Commenters also noted that past waiver requests that have been submitted by other states to institute work requirements have been denied. Some commenters felt that even if the waiver was allowed, the waiver initiatives would do nothing to further the goals outlined in the waiver. Commenters stated that 1115 waivers cannot and should not be for the purpose of allowing states to continue to receive funding under a federal program with mandatory guidelines, but at the same time to pick and choose certain provisions that the State simply does not agree with or because the State wishes to save money. Commenters provided case law references in support of their arguments. Commenters also discussed how waivers must be limited to Medicaid provisions according to certain sections of the federal law and the Social Security Act (42 U.S.C. Section 1396A – Section 1902 of the SSA). They believe that certain provisions in the waiver cannot be waived. Commenters suggested that the Department review the Medicaid Act carefully and remove any request that is not allowable under federal law.

    A few commenters felt that the waiver was counter to federal and/or state laws and potentially the Bill of Rights and Constitution. A number of commenters felt that it was inappropriate for the Department to propose such substantive changes to MaineCare without the involvement of the Legislature and that doing so exceeds the authority of unelected bureaucrats. Another commenter requested that United States Senators Angus King and Susan Collins intervene. One commenter noted that Congress and the Maine Legislature have known about the possibility of work requirements and have not enacted them in the 50 years of Medicaid's existence and that the Department is attempting to circumvent those 50 years of policy. One commenter felt the Maine Legislature should appoint a DHHS oversight committee made up of healthcare professionals and business management personnel. The commenter also felt this committee should vet people who want to be the DHHS Commissioner to ensure the person has formal training in healthcare and direct healthcare experience.

    Response: *The Department believes it is within the authority of the Department, as established in the Maine Revised Statues, to seek a waiver from CMS regarding the rules and operations of the*

MaineCare program. The waiver application will be submitted to CMS, which will conduct an independent review of the appropriateness of waiver provisions.

21. Commenters provided suggestions of other ways to improve health, reduce costs, and engage members, as alternatives to the waiver; these spanned a broad range of topics (e.g. minimum wage, support services for individuals experience long-term homelessness, the National Diabetes Prevention Program, juvenile justice reform, cost control, investment in the Private Health Insurance Premium program, adopting new policies to address program integrity). Many commenters requested that Maine provide MaineCare to everyone or expand MaineCare. Many commenters felt healthcare is a right not a privilege. Commenters also felt that healthcare should not be something left to charity organizations to pay for or provide. One commenter said that many people turn to churches for money to pay for bills and while churches are happy to do it, many church communities are actually declining and struggling financially just to keep the doors open. The commenter said that churches and non-profits are not able to pick up the slack because the State has decided to put it aside. Commenters expressed concern and offered opinions on broader social and political issues. Commenters also compared the U.S. healthcare system to other countries and discussed current federal proposals for healthcare reform. Commenters also made comments regarding other State programs or news stories and speculated on the political motivation for the waiver.

    Response: *The Department appreciates these suggestions and is simultaneously considering some of these initiatives; however, a number of the proposals fall outside the purview of this 1115 waiver and cannot be adequately discussed or addressed through the 1115 waiver review process. No changes were made as a result of this comment.*

22. One commenter commented on the Non-Emergency Transportation (NET) services provision.

    Response: *While this provision was discussed in earlier iterations of the 1115 waiver, this was not included in the 1115 waiver proposal released for public comment. The waiver application does not include any reductions to the NET benefit.*

Work Requirements

23. Commenters discussed and provided evidence from national studies about how people on Medicaid may already be working. Commenters noted that people who are working still may not be paid enough to afford all their basic needs and/or their employer may not offer health insurance benefits, which means people may still rely on other assistance. Commenters did not think that Medicaid eligibility rules serve as a deterrent to work.

    Response: *The Department acknowledges that some MaineCare members may already be working and notes that these members may retain their MaineCare coverage by complying with the requirements in this waiver. The Department maintains the position that for able-bodied adults, MaineCare is not intended to serve as a long-term support and should instead be focused on transitioning individuals to the private market. No changes were made as a result of this comment.*

24. Commenters presented research findings and general discussion of reasons why people might not be working and the demographics of who would likely be subject to the work requirements. Commenters provided many reasons for why an individual may not be working, including disabilities, illnesses, caregiving activities, lack of available jobs, schooling, opioid addiction, lack of transportation, adverse child events, low-literacy rates, criminal histories, undiagnosed traumatic brain injury, victims of trafficking and violence, no phone, no housing, no food, and no affordable child care options. Commenters raised the concern of what would happen if people want to work/volunteer but are living in a part of the state where there are no opportunities. One commenter suggested the exemption for those caring for dependent children under six and for those caring for a disabled dependent be revised to include family caregivers who provide care to their adult loved ones with chronic, disabling, or serious health conditions. One commenter felt that the work requirements would disproportionately impact women, as women are more likely to provide informal and undervalued caregiving. Another commenter stated that most jobs in Maine pay less than it costs to put one child in daycare, making it impossible for both parents or a single parent to work. Also, subsidized child-care programs are extremely deficient and that commenter shared concerns about the process to apply for childcare assistance. Commenters asked how the Department proposes to provide childcare for pre-school or school-age children while that parent works, volunteers, or attends school. There were similar concerns for adult day care. The commenter asked if any benefit of employment would be offset by the cost to the State for such child or adult care.

    Response: *The Department has made some adjustments to the individual and group exemptions as a result of comments. The Department believes that in its current form, the waiver strikes the appropriate balance of allowing for exemptions, yet retaining the focus on employment and financial independence. The Department has established an individual exemption for a person "providing caregiver services for an incapacitated adult" in addition to the exemption for "caring for a child under the age of six." The Department notes that work requirements in other programs do not always make exceptions for rural beneficiaries, and because of the various methods by which a member can comply, the Department believes that it would not be appropriate to make that blanket exception for this population. To this point, the Department has added another method of compliance through "Individual or group job search and job readiness assistance." Lastly, the operations of the child care subsidy program are outside the purview of this waiver, but this program remains an option for eligible families. This waiver does not provide additional supports for child care or adult day care activities.*

25. One commenter felt that the exemption for individuals in residential substance abuse treatment programs will only help the limited number of people in these residential programs. The commenter felt that individuals who struggle with addiction may require time and support on an outpatient basis and adding work requirements only makes beginning steps toward recovery more challenging.

Another commenter said that for members receiving Medication Assisted Treatment, the service alone can practically be a full-time job, especially if they're not able to get rides easily to these services. This was also brought up in relation to other day programs or other work-like activities.

Response: *The Department is actively engaged in addressing substance abuse issues in Maine. In alignment with the federal Substance Abuse and Mental Health services Agency, the Department believes that recovery requires a holistic approach, which includes establishing purpose and stability. The Department continues to believe that community engagement and/or employment provides this daily structure and a sense of pride. The Department does not believe that individuals with substance abuse should receive a blanket exclusion from this reform initiative because the initiative has value for these members. No changes were made as a result of this comment.*

26. Commenters asked the following questions:
    - How many MaineCare members are within each identified "able-bodied' eligibility group? And, what do they each constitute as a percentage of the total MaineCare population?

      Response: *The Department is not able to fully define from available data, the number of individuals that will be considered able-bodied for the purposes of compliance with the work requirements. This is because there are individual exemptions, such as being medically or physically unable to work, which will rely on clinical documentation from a healthcare provider. Without all available data, the Department estimates that approximately 15,000 - 20,000 members across all eligibility groups will be subject to work requirements. This represents approximately 7% of the MaineCare population.*

    - How many of those members are not currently meeting the proposed Community Engagement and Work Requirements?

      Response: *The Department is also not able to define the number of people that are currently in compliance, as this is not currently tracked. Please see the Department's response to the previous comment.*

    - What percentage is the Department assuming for non-compliance? In other words, how many MaineCare members are expected to be dropped from MaineCare coverage for non-compliance? How is this information currently collected, if at all? If it currently isn't collected, how will it be and by whom?

      Response: *Please see the Budget Neutrality section of the waiver for the Department's estimate of the number of individuals that will be disenrolled under the waiver as compared to the number of members the Department projects in the absence of the waiver. This information will be collected by the Department over the course of waiver implementation. Please note that it is the Department's aspiration that all members are in compliance with requirements.*

- The proposal references that MaineCare members will be assessed to determine whether or not they meet the work requirements. How will those assessments be conducted? Will assessments, medical hardship determinations, member reporting, evidence of employment, and appeals be required to happen in person, thereby potentially placing undue hardships on older Mainers, people with disabilities, or for anyone without access to transportation? Will member reporting and assessments be done electronically, without consideration for an individual's lack of computer or internet access?

  Response: *Applicants will be assessed by the Office of Family Independence (OFI) to determine whether or not they may be subject to work requirements through a similar set of questions used in determining work registrant requirements in SNAP. The Department does not have a comprehensive protocol regarding implementation to share publicly at this time.*

- If healthcare providers are going to be asked or expected to conduct the assessments, how will those services be reimbursed?

  Response: *Healthcare providers may be asked to complete a form/letter attesting to a member being physically or mentally unable to work 20 or more hours per week. The provider should determine whether or not a billable service has occurred in accordance with MaineCare rules.*

- How will members appeal a determination, or request a new assessment if their work situation changes? Although there is a reference to a fair hearing for members who fail to comply, there are no details on how a hearing may be requested, what the hearing will entail, and how and when the hearing will occur.

  Response: *These processes will follow the same protocols currently used for other eligibility determinations and members will have full appeal rights.*

- What happens if a person who loses eligibility through this process then obtains a job or engages in community activities? Will prospective or retroactive eligibility be granted?

  Response: *In general, retroactive eligibility will not be applied during periods of non-compliance, regardless of whether compliance is achieved in the future. However, once a member comes into compliance with work or community engagement requirements, he or she will be reinstated without a waiting period.*

27. A few commenters discussed the work requirements in terms of time limits on coverage. One commenter felt that even before members reach the time limit, they may opt to forego coverage in order to "bank" their months of eligibility against future need. Another commenter said that if

parents die because of the waiver, then they will create an orphan and taking care of orphan children is a lot more expensive that providing MaineCare on a reasonable basis.

Response: *The Department encourages members to comply with the community engagement and work requirements in order to avoid having their coverage terminated. No changes were made as a result of this comment.*

28. Commenters asked questions about, and were skeptical of, the implementation of the assessments regarding who is able-bodied and therefore subject to work requirements. One commenter asked how case managers will be assisting individuals in seeking exemptions to the work requirements. The commenter felt that this additional administrative burden would further limit the time case managers have available to attend to member needs. Several commenters noted that not everyone is capable of working even if they are not granted eligibility to MaineCare based on a disability category. Others stated that people may be unable to work because of mental health issues and felt that "able-bodied" was discriminatory. A few commenters did not feel that DHHS would adequately be able to make the determination of able-bodied and that this bore out in the recent implementation of a similar requirement under Section 17. Commenters were concerned that people with disabilities would be disproportionately impacted by this change and would lose eligibility because they are unable to comply with the requirements. Commenters provided data from Ohio and Wisconsin's SNAP programs and the demographics of individuals impacted by the work requirements in those states. One commenter raised concerns of discrimination against people with disabilities pursuant to the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act which makes it illegal for states to take actions that have discriminatory impact on people with disabilities. Two commenters reported that repeated studies of the TANF programs have found that clients with physical and mental health issues are disproportionally sanctioned for not completing the work requirements. Such clients may not understand what is required of them, or may find it difficult to complete paperwork or travel to appointments to be assessed for exemptions.

    Commenters discussed data from a TANF program analysis and an analysis of potential impacts of Medicaid work requirements which showed negative and disproportionate impacts on women and families, despite the extensions and exemptions in the program. One commenter asked that cystic fibrosis be considered a condition that would cause an individual to be considered physically unable to work and to be an acceptable cause for failure to comply with the work requirements. Commenters also discussed how during episodes of great medical need (such as depression), not only can you not necessarily work, but that you need healthcare the most and are least able to cope with DHHS bureaucracy. One commenter felt that losing coverage during these times would have dire consequences. Commenters were especially concerned about the impact on losing services for people with mental health or substance use disorder who are currently receiving treatment.

Response: *The term "able-bodied" is all encompassing and includes both mental and physical health. There is an individual exception for individuals who are physically or mentally unable to work 20 or more hours per week; this determination will be made by an independent medical professional and not based on a set list of allowable diagnoses. There is also an exemption for anyone receiving disability benefits. The Department will monitor the implementation of these exemptions and carefully consider any internal processes to avoid any unintended consequences. No changes were made as a result of this comment.*

29. Commenters discussed work support strategies for low-income people such as training, health coverage, nutrition benefits, child care subsidies, and reducing unnecessary steps in the application process. Commenters suggested DHHS add realistic and voluntary work training and placement programs or other evidence based models to help build skills, enhance educational competencies, and assist in sustained job placement. One commenter noted that the State may offer supportive employment services under Section 1915(i). One commenter discussed evaluations of work requirements that showed disappointing results.

    Response: *The Department and the State provide for work support strategies through various mechanisms. In response to comments, the Department has added the option for members to comply with work requirements through individual or group job search or job readiness activities, which are often components of support programs. Employment is a focus of the State as a whole and appreciates these suggestions; they will be considered for future efforts.*

30. A few commenters felt that the waiver ignored evidence that having access to healthcare is essential to work and that MaineCare is a support to work/becoming financially independent. Commenters felt that MaineCare allowed individuals to care for their families, stay healthy, remain productive in their communities, and meet financial obligations (e.g. property taxes, food, and heat). Commenters provided data from Ohio which showed that more than half of individuals who were newly-covered by that state's Medicaid program said getting Medicaid coverage made it easier for them to continue working, while three-quarters (75%) said Medicaid helped them find a job. Commenters also said that one study of individuals with disabilities found that those living in states that expanded Medicaid eligibility were more likely to be working than those in non-expansion states. Lastly, a commenter felt this proposal would exacerbate barriers to economic growth in Maine by creating more barriers to labor force participation.

    Response: *The Department believes that the waiver provides enough exemptions and options for compliance with the community engagement and work requirements to allow individuals to receive MaineCare benefits while simultaneously working toward full employment and financial independence. No changes were made as a result of these comments.*

31. Commenters felt that if implemented, it will be critical to maintain an individual's due process rights and existing Medicaid protections. A commenter also requested assurances that dispute situations

will be fairly and expeditiously resolved; that individuals will continue to receive adequate notice of State agency actions and a meaningful opportunity to have unfavorable administrative decisions reviewed with reasonable promptness; that coverage of care will continue pending resolution of the appeal; and that Medicaid applicants and beneficiaries will have the right to request a fair hearing on eligibility determinations and coverage issues. One commenter asked that the Department clarify when a member can appeal the "good cause" exemption determination as it relates to the work requirement. The commenter felt that a member should be able to request a Fair Hearing to appeal any adverse determination as that would be a termination, suspension, denial or reduction of MaineCare benefits and that this should be made explicit in the waiver.

Response: *The Department agrees and assures that all required due process rights will be maintained and that members may appeal any adverse determination. Language to this effect has been added to the waiver.*

32. Commenters stated that few volunteer opportunities have the capability to document these efforts to DHHS for the individual to maintain benefits on a monthly basis. Another commenter talked about how volunteering isn't free for the hosting organization.

Response: *The Department has experience with this provision through SNAP and will utilize any lessons learned and best practices. No changes were made as a result of these comments.*

33. Commenters questioned the legality of work requirements as a condition of Medicaid eligibility because it adds a requirement that is not otherwise in the Medicaid Act. The commenter provided the legal citations to support this assertion. Commenters felt that work requirements were not consistent with Medicaid's objectives, but working with individuals to find or develop work would be consistent with the program objectives. Commenters referenced the statutory language as to the purpose of Medicaid which is to furnish medical assistance, rehabilitation, and other services that will help individuals attain and retain independence and self-care. The commenter said that independence and self-care are the results of the goal and not outcomes in and of themselves. Commenters noted that other states' attempts to add work requirements to Medicaid through 1115 waivers have been denied and felt that Maine's program should also not be approved.

Response: *The waiver application will be submitted to CMS, which will conduct an independent review of the appropriateness of waiver provisions. No changes were made as a result of this comment.*

34. One commenter asked for clarification on the exemption from the work requirement for individuals residing in an institutional residential facility. They asked for a definition and whether it includes Private Non-Medical Institutions (PNMIs), assisted living facilities, and Section 21 waiver homes. The commenter thought these all should be considered institutional residential facilities.

Response: *This exemption includes nursing facilities, Adult Family Care Homes, Intermediate Care Facilities for the Intellectually Disabled, Private Non-Medical Institutions, and Home and Community Based Services waiver homes (this includes Section 21 waiver homes). This information has been added to the waiver.*

35. One commenter expressed concern that many cancer patients in active treatment may be unable to work or require significant work modifications due to multiple physical and cognitive impairments, such as fatigue, depression, and other side effects commonly experienced by cancer patients and those undergoing cancer treatments. The commenter appreciated the exemptions from the work requirements, however, was concerned that this doesn't go far enough because it doesn't exclude women diagnosed through MBCHP and other cancer patients and recent survivors who would not fit into the "physically or mentally unable to work" exemption. The commenter urged the Department to consider implementation of a "medically frail" designation that would exempt individuals with serious, complex medical conditions from the work requirements and associated eligibility time limits. The commenter suggested using the "medically frail" designation in 42 CFR §440.315(f) and requested it explicitly include individuals who are currently undergoing active cancer treatment- including chemotherapy, radiation, immunotherapy, and/or related surgical procedures- as well as new cancer survivors who may need additional time following treatment to transition back into the workplace. Another commenter felt that it was unconscionable to include women needing treatment for breast and cervical cancer as they are serious possibly fatal diseases that must be treated aggressively to have a chance at survival. The commenter noted that many low-income jobs do not offer sick leave during which women could receive treatments.

    Response: *As a result of various comments, the Department has removed the requirement that members eligible through MBCHP required to comply with work requirements. The Department does not feel that the additional exemption of "medically frail" is necessary given the flexibility in the "mentally or physically unable to work" exemption which is available for members with appropriate documentation for a medical provider.*

36. One commenter discussed their personal health situation which results in severe disease episodes in which they may need to stop working and therefore could lose employer health coverage. The commenter was concerned about the ability to get MaineCare coverage in a timely manner due to the proposed policies. Along with other commenters, there was concern about needing to find a doctor to sign off on the ability not to work (especially without insurance to pay for care during this time). The medical complications from the gap in coverage could contribute to a longer recovery time and lengthen the amount of time the commenter would have to be out of work.

    Response: *The waiver allows for three months in every thirty-six month period in which work requirements do not need to be met. The Department believes this provides some flexibility for the circumstance described above. No changes were made as a result of this comment.*

37. A few commenters felt that the study which reports success with the SNAP work requirements is flawed because the earnings and employment of all Mainers increased in the same period where the increase was seen for former SNAP recipients. Commenters provided other critiques of the report, the methodology, and the statistics included, such as not including information about how many recipients entered employment when the time limit was not in effect. One commenter also noted that even though much of the state was initially still eligible for a waiver from the time limit due to high unemployment rates, thousands of people lost benefits. Another commenter discussed the challenges they saw in the homeless shelter regarding people's eligibility for food stamps when the work requirements were instituted. The commenter felt that food stamp policy has nothing to do with working or not working. The commenter could not imagine this policy being implemented in even more complex situation with parents with children at home.

    Response: *The Department thanks you for your comments and will consider these critiques when developing the evaluation plan for this waiver. No changes were made as a result of this comment.*

38. One commenter said that the proposal's suggestion that "people must receive consistent messaging on the importance of employment to Maine's economy and overall wellbeing" is not supported by any evidence that shows that such messaging would promote any of the goals of Medicaid. Also, that the work requirements are not consistent with SNAP regarding populations or ages.

    Response: *The Department does not believe that statistics are necessary to support this assertion. The 1115 waiver work requirements are intended to coordinate with SNAP and TANF, but are not intended to be an exact match due to differences in populations and programs. The waiver does allow for MaineCare members to use compliance with SNAP or TANF work requirements to fulfill MaineCare requirements. No changes were made as a result of this comment.*

39. One commenter provided information about working age adults with and without disabilities. The commenter discussed how CMS recognizes that employment is a fundamental part of life for people with and without disabilities. The commenter discussed the benefits of employment including that it provides a sense of purpose, a way to contribute to communities, and is associated with positive physical and mental health benefits. The commenter expressed that all individuals, regardless of disability and age, can work and should have access to pre-vocational services, education and training opportunities. The commenter then discussed the Medicaid Buy-In Programs called MaineCare Option for Workers with Disabilities in Maine. The commenter stated that the way this program is administered is confusing and underutilized. The commenter also discussed how Maine is an Employment First state with the passing of the Employment First Act (EFA)(26 M.R.S. §3403(1)). The EFA requires DHHS and other State agencies to include integrated community-based employment or customized employment as a core component of its services and supports. Specifically, the EFA requires DHHS, when providing services or supports to a person with a disability, to offer the person, as the first and preferred service or support option, a choice of employment services that will support the acquisition by the person of integrated community-based

or customized employment. The commenter said the DHHS should work with people with disabilities and using existing tools, rather than penalizing MaineCare members for not working.

Response: *The Department agrees with the commenter on the value of work for individuals with and without disabilities. These specific requirements do not apply to individuals who have disabilities which result in disability benefits or in an individual being unable to work. The Department fully supports employment for all people and is reviewing options for improving employment supports for home and community-based waiver populations. The Department has added a provision to the waiver application that allows members to meet the community and work engagement requirement through job search and job readiness activities. The Department will consider the suggestions of the Medicaid Buy-In Program for future work.*

40. Commenters discussed the costs and staffing associated with implementing this requirement, including developing a reporting system, verifying accuracy of member reporting, and conducting fact finding hearings. One commenter thought this would drain resources away from other priority initiatives or from putting money toward healthcare costs. Commenters noted additional verifications not only increase administrative burden but also increase the likelihood that clients will lose benefits, sometimes resulting in additional applications. One organization found that reducing administrative redundancies and barriers used workers' time more efficiently and also helped with federal timeliness requirements. They provided quotes to this effect from other states.

    Response: *The Department will use lessons learned and technological resources from the implementation of SNAP and TANF work requirements. At this time, the Department does not have a full implementation plan, but will be developing this over the coming months. No changes were made as a result of this comment.*

41. One commenter asked how the 20 hours per week standard as it relates to education is going to be based and how DHHS is going to determine whether or not a class can lead to gainful employment. The commenter felt that 20 hours may be a difficult target for various reasons, but families may be able to do one or two classes. Additionally, the 20 work hours may be difficult to maintain if someone works variable and unpredictable hours, which is characteristic of low-wage jobs. These unpredictable hours provide no guarantee of work but prevent people from scheduling other work or activities. Individuals with variable hours may also lose coverage if they fail to keep up with the requirement to document their hours of employment.

    Response: *The Department will use lessons learned from the implementation of work requirements in SNAP and TANF to determine how education will be applied to the work requirements set forth in the waiver application. No changes were made as a result of this comment.*

42. Commenters noted that there's nothing in the waiver that would react to an economic downturn, and the proposal is being submitted in a time of essentially full employment when jobs are available.

Commenters noted that Medicaid enrollment fluctuates with the economy and enrollment increased during economic recessions.

Response: *The Department believes that the waiver provides enough options for compliance with the community engagement and work requirements to account for this possibility. In addition, the Department has added a provision to the waiver application that allows members to meet the community and work engagement requirement through job search and job readiness activities.*

43. One commenter provided statistics to argue that the limited family planning benefit should not be included in the work requirements because family planning access is critical to a person's ability to further their education, careers, and financial standing. Another commenter felt that by including the limited family planning group it was creating a perverse incentive to become pregnant.

Response: *The Department does not believe these reasons warrant this group being excluded from this initiative nor does the Department believe that this will result in a change of behavior around seeking pregnancy. No changes were made as a result of this comment.*

Monthly Premiums

44. Commenters felt that charging individuals premiums that exceeded 2% of their family's income was generally unaffordable due to low-paying jobs and other expenses. Commenters asked where the Department expected people to come up with money for the premium and other expenses, and if the Department would be providing assistance for these expenses. Another commenter noted opposition to allowing out-of-pocket costs over the allowable Medicaid limit of 5% of family income. There was particular opposition to charging people with zero reported income. Some commenters felt that taking away healthcare coverage because a person was too poor to afford a monthly premium isn't sound policy and is inconsistent with Maine values. Others felt that charging premiums would not allow for a person to pull themselves out of poverty. Commenters felt this would stop MaineCare patients from visiting healthcare providers for care, resulting in increased ED use, loss of revenue for FQHCS and other providers, and will lead to more serious illness due to lack of early detection and treatment. Commenters felt this would ultimately result in increased cost to the State, health declines, and/or making individuals less able to work. Commenters felt that this provision would guarantee members will be dropped from coverage or deter enrollment and cause disruptions in care or create other barriers. Commenters shared evidence that even modest premiums keep people from enrolling in coverage. Commenters also discussed research on how cost-sharing can lead to forgoing care due to cost concerns, which can lead to health concerns. Commenters provided examples from Indiana, Michigan, and Iowa regarding premium collections and subsequent losses of coverage. The analysis found that there were affordability concerns and confusion about the payment process. One commenter felt that simply the burden of understanding the premium requirements and submitting payments on a regular basis may be challenging to people struggling with an overload of demands on their time and executive functioning capabilities. The commenter provided data from Indiana to support this assertion. The commenter was also

concerned that the state may fail to process payments in a timely fashion, leading to benefit denials even for people who make the required payments.

Response: *The Department has revised the premium requirements in a number of ways while still maintaining that individuals with the ability to earn should contribute to their healthcare costs. The waiver no longer requires individuals below 50% of the FPL to pay premiums. The Department has also adjusted the remaining premium bands which are now based on 2% of a one person household for the lowest FPL level in each band. The adjusted premiums are:*

Monthly Household Premium (by FPL)				
0-50%	51-100 %	101-150 %	151-199%	200% +
$0	$10	$20	$30	$40

By establishing a flat dollar amount within each income band, the Department intends to avoid confusion and complexity for both the Department and members. This avoids the overly complex premium structures seen in other states. Premium collection has also been amended to allow an individual to pay required premiums until the end of their eligibility term. Members will also be able to either serve the 90-day penalty or pay past due premiums, which provides more options for individuals to regain eligibility. Premiums will also be charged in accordance with current Medicaid cost sharing limits.

45. Commenters questioned the ability to waive exclusions of cost sharing or bar people from coverage for failure to pay premiums under Section 1115 waivers, for specific populations and specific services (such as family planning services).

Response: *The waiver application will be submitted to CMS, which will conduct an independent review of the appropriateness of waiver provisions. No changes were made as a result of this comment.*

46. Commenters provided examples of how MaineCare members already do not pay their co-payments and therefore believe the State will not be able to collect the premiums and questions whether there was any evidence to suggest the contrary. Commenters asked what the Department's experience has been with the collection of other premiums and whether there is data on non-payment and reasons for non-payment.

Response: *The Department does have experience in successfully collecting premiums for specific MaineCare eligibility groups and programs. The Department will be evaluating the success of premium collection through the 1115 waiver.*

47. Commenters also asked the following questions:
    - How many MaineCare members does the Department expect will be removed for non-compliance?

      Response: *Please see the Budget Neutrality section of the waiver for the Department's estimate of the number of individuals that will be disenrolled under the waiver as compared to the number of members the Department projects in the absence of the waiver. This information will be collected by the Department over the course of waiver implementation. Please note that it is the Department's hope that all members will comply.*

    - The Department is projecting $8 million in revenue from premiums and ED cost-sharing, and notes that it is not included in the cost-neutrality. As such, will the Department please share how it plans to use those funds? And, does that represent the total impact (state and federal) or is that just the impact to the state?

      Response: *This number has been revised, but it represents total dollars that the Department anticipates it will collect. The State does not have this money earmarked for any specific use.*

    - How soon from the time a person does not pay his/her premium will he/she be disenrolled?

      Response: *The Department intends to follow a process very similar to the Cub Care premium collection process; however, the exact details of implementation are not yet finalized. If payments are not made by the last day of the final enrollment month, the member will be disenrolled.*

    - Is there an appeal or other due process?

      Response: *Yes, members will be afforded the opportunity to appeal any adverse determination.*

48. Although appreciative of the 60-day grace period, commenters were concerned about the proposed 90-day lock-out period for non-payment, particularly for enrollees below 100 percent of the FPL. The commenters felt that this would cause disruptions in care and substantial financial burden by incurring healthcare expenses and needing to pay past due premiums in order to reenroll. Commenters felt that during the lock-out period, low-income patients with serious conditions will likely have no access to healthcare coverage, making it difficult or impossible to continue treatment and seriously jeopardize their chance of survival. Commenters also thought that this would lead to added uncompensated care costs for providers. A commenter urged the State to add a hardship waiver for members who cannot afford their monthly premiums and consider exempting individuals who meet the medically frail definition and implementing a medical or hardship exemption that would exclude individuals managing complex medical conditions from any lock-out penalties. They also encourage the Department to allow enrollees and/or the healthcare providers to proactively attest to any change in health status that would qualify them for an exemption.

Response: *The Department has amended the waiver so that members will be able to either serve the 90-day penalty or pay past due premiums in order to regain eligibility. The Department has also removed premium requirements for those earning under 50% of the FPL. The Department does not feel additional individual exemptions are necessary and reminds commenters that the same individual exemptions for the work requirements apply to the requirement to pay premiums.*

49. One commenter shared information about the cost of implementing premium programs in other states and how this may not be cost-effective.

    Response: *The Department is reviewing multiple methods of administering this provision. No changes were made as a result of this comment.*

50. Commenters felt that the premiums should not be modeled after private coverage because Medicaid is different. Most people who have private insurance do not have to write checks on a monthly basis to purchase coverage because they have it deducted through their paychecks. Moreover, one-quarter of households with incomes under $15,000 reported being "unbanked," which may create additional barriers to making regular payments. A commenter provided research which found that many beneficiaries in Michigan used money orders to pay their premiums (because they didn't have bank accounts or credit cards), and the fees could equal or exceed the premium amount.

    Response: *The Department is reviewing multiple methods of administering this provision. No changes were made as a result of this comment.*

51. *C*ommenters felt that the assumption in the proposal that a premium structure will encourage employment by reducing the percentage of income paid toward premiums as income rises, did not seem like much of an incentive. Another commenter felt that this regressive design would hurt the lower end earners in each tier.

    Response: *The Department has revised the methodology used to set premium amounts in each band. The premium bands are now based on 2% of a one person household for the lowest FPL level in each band to avoid any adverse impact on those at the lower end of each band. The Department believes it is appropriate to incentivize earnings within each premium band.*

52. One commenter recommended the Department focus on incentivizing members and promoting alternatives to Medicaid such as enhanced premium assistance instead of provisions, such as the premiums, which will lead to mass reductions in Medicaid.

    Response: *The Department will consider promoting premium assistance programs in future efforts No changes were made as a result of this comment.*

Emergency Department Use

53. Commenters were opposed to charging members $20 for each ED visit that does not result in an inpatient admission, although some commenters were supportive of the concept of charging a co-payment for non-emergent ED use if it were designed differently. Numerous commenters felt that there are still cases where visits to the ED cannot or should not be avoided and are medically justified. The commenters felt that just because someone is not admitted, does not mean that the visit was unnecessary. A number of commenters provided examples of such instances including: when walk-in care is not available, to stabilize blood sugar or blood pressure, exacerbation of COPD, etc. Others felt that because patients were not medical experts, people should seek medical care quickly if they feel they are experiencing an emergency. Another commenter felt that it was a person's right to decide whether or not to go to the ED for help. Commenters sought other ways to define inappropriate use of the ED.

    Response: *The Department thanks the commenters for these comments. This provision has been revised to reflect a co-payment of $10 that is focused on non-emergency use of the ED. Rather than being charged for any ED visit that does not result in an inpatient admission, the proposal is now designed to only charge a co-payment for ED visits that have a primary diagnosis which the Department has deemed to be indicative of non-emergency utilization. A full list of these diagnoses is provided in the waiver application. The Department believes this will more appropriately target care that is not appropriate for the ED setting and allow members to use the ED for emergency conditions without incurring a co-payment.*

54. Commenters discussed people who are involuntarily taken to the ED, such as people who depend exclusively on their support provider to determine when and if emergency healthcare is needed due to developmental disabilities. One commenter felt that it is critical that support staff have the ability to respond to the needs of the individuals they support, recognizing that it takes an individualized assessment and a keen instinct for the smallest indication that emergency intervention is warranted. Adding an additional element of weighing pecuniary penalty against the individual supported could result in DSPs erring on less intervention, resulting in devastating consequences.

    Response: *The Department agrees that individuals who reside in institutional residential facilities (defined as a nursing facility, Adult Family Care Home, Intermediate Care Facility for the Intellectually Disabled, Private Non-Medical Institution, or Home and Community-Based Services waiver home) may not be making the decisions regarding when to seek care in the ED and has exempted these members from the ED co-payment provision.*

55. Numerous commenters, including provider organizations, did not feel this policy change would result in a reduction to inappropriate ED utilization. A number of commenters felt that while some patients may seek care in different settings, this policy may lead to negative consequences such as individuals not seeking lifesaving care or postponing care. Two commenters asked the Department

to track how many people are ultimately admitted to the hospital because they went without appropriate and timely care in the ED.

Response: *The Department has revised the scope of this provision; please see the response to comment 53.*

56. Commenters were concerned that the ED co-payment policy may result in potential legal challenges under Emergency Medical Treatment and Labor Act (EMTALA) and the prudent layperson standard if hospitals need to determine whether a visit was subject to a co-payment or not, at the time of the visit. One commenter felt this would be untenable in the context of busy trauma centers and community hospitals. Another commenter stated that hospitals are required to provide free care for people up to 150 percent of the poverty level. The commenter felt that in some cases charging a co-payment in the ED would need to be waived because of State law.

    Response: *The Department is unclear on how this would result in an EMTALA compliance issue. The Department will be assessing whether to send a bill for an ED co-payment through retrospective claims analysis; this will not be determined by providers at the point of care. No changes were made as a result of this comment.*

57. Two commenters felt that Maine should not replicate, or go further than, Indiana's proposal to charge ED co-pays for people who use the ED in non-emergency situations until the Indiana program has been formally evaluated. Other commenters discussed how cost sharing has been heavily studied within the Medicaid program and has produced redundant, consistent findings that co-payments actually harm low-income people by causing them to forgo medically necessary care. Commenters said that there have also been many studies in Medicaid and CHIP on ED co-payments consistently showing they are ineffective in reducing non-emergency ED use. One commenter stated that this program has been rescinded in Maryland. Another commenter stated that no other states currently enforce fees for people who went to the ED when medically necessary.

    Response: *The Department believes that it has important information to gather from this provision. Maine has administrative efforts and provider disincentives in place to target inappropriate ED use, and monitors the success of these programs. The Department feels that a corresponding member disincentive is integral to the continued success of these initiatives. The revised proposal mimics the provider reimbursement policy in regard to what is considered "non-emergency" ED use. The Department will evaluate the success of this provision throughout waiver implementation.*

58. Commenters questioned how the co-payment would be collected when providers already have difficulty collecting smaller co-payments from MaineCare patients. One commenter said that the cost of trying to recover copays is much more costly than the amount that can be recovered and that these co-payments may make private practitioners less willing to accept MaineCare patients. The Maine Hospital Association noted and was appreciative of the fact that the waiver application

said that these co-payments would not result in decreased provider payments and sought clarification on how the ED co-payment policy would work. Other commenters were concerned about the financial impact on hospitals. One commenter recommended the State collect co-payments retrospectively and if the co-payment is to be applied at the time of service, they recommended it be applied to the facility payment and not the provider payment because providers do not have the systems in place to collect such co-payments while evaluating and treating patients and it would disrupt the trust between patient and provider.

Response: *The Department will be assessing whether to send a bill for an ED co-payment through retrospective claims analysis; this will not be determined by providers at the point of care. Additionally, the Department has amended this provision to evaluate the impact of sending members a breakdown of costs to the State in conjunction with their $10 bill. The Department will share any lessons learned related to co-payment collection with stakeholders.*

59. One commenter discussed how reducing ED usage should not necessarily be the responsibility of individual patients; they thought it was the responsibility of the healthcare system as well, especially with vulnerable populations. The Maine Primary Care Association and one of their member organizations noted that they have made significant strides over the years to inform and educate patients about the importance of using the Health/Medical Home as a first option for non-emergent needs and most of the FQHCs have weekend and/or evening hours or walk-in care, as well as 24-hour on-call service to answer patient questions when the office is closed. The commenter felt these strategies are the ideal way to address this issue, not charging for the ED visit. One commenter suggested the Department look at examples from Camden, New Jersey where they have done educational outreach programs to people who are high ED users. One commenter felt that building trust and care management in primary care and ensuring stable housing are two proven means of decreasing ED use, which are jeopardized by this rule. Commenters discussed the current ED High Utilizers Program run by the Department, and how the Department has talked about program success in giving people the supports they need at the time that they are thinking about going to the ED. Commenters supported the current program, but not the proposal for co-payments. One commenter discussed a study done by the Muskie School of the reasons why there was some overuse in the ED and suggested greater collaboration and connection between MaineCare recipients and healthcare providers.

Response: *The Department agrees that there are multiple ways to approach this issue and believes the revised policy will complement these other approaches. The Department also agrees that it is both the responsibility of the member and the healthcare system to ensure care is delivered in the appropriate setting. No changes were made as a result of this comment.*

60. One commenter discussed patients who have dementia or a developmental disability who may not consistently seek care in the appropriate settings or cases when it is difficult to make a diagnosis, resulting in multiple ED visits. Another commenter stated that people use the ED when they are

scared, in pain, panicked, or without other reasonable options. Commenters provided examples of when people encounter law enforcement or have treatment plans that require they be transported to the ED for a mental health status exam. One commenter referenced a recent report from DHHS about the intersection of crisis workers, mental health consumers, and the hospital ED. The commenter felt that these individuals did not choose to go to the ED and instead crisis workers told them to go. One commenter discussed how Maine's EDs are filling the gaps left by an under-funded crisis response system and that families, law enforcement, and individuals have limited resources to turn to in times of crisis. The commenter said that these visits rarely result in an inpatient admission, not due to a lack of need, but rather due to a continuous" log jam" in Maine's mental health system. Commenters also noted that sometimes a doctor or urgent care clinic recommends that a person go to the ED, but they aren't then admitted. The commenter felt that people should not be charged when they are following a treatment plan, law enforcement protocol, or doctor's orders. One commenter also suggested the State track the frequency at which members attempt to access the healthcare system in an ambulatory care setting, yet are redirected to an ED as a more appropriate setting for evaluation and treatment.

Response: *With the revised set of diagnoses that trigger the ED co-payment, the Department believes that it is unlikely that someone in the situations described above would be subject to the $10 fee. Please see the full list of diagnoses in the waiver application.*

61. Commenters raised concerns about lack of primary care and urgent care services. Commenters described situations where there is a lack of primary care or urgent care facilities available either because of health professional shortage areas, providers who do not accept MaineCare, facilities that are not open 24/7 or are closed on weekends and holidays, or facilities that don't have reasonable access to a quick appointment. The commenter noted that some primary care offices book three or four months out and certain health issues cannot wait. Commenters felt that unless there's going to be a primary care place open 24/7, it did not seem like a reasonable expectation for members to use primary care instead of the ED. Commenters suggested Maine consider applying appropriate exemptions to the increased co-payment for certain individuals, as other states have done, such as for anyone who is greater than 20 miles from a community health center or urgent care or enrollees who call a triage line by a managed care organization or get a referral from their primary care provider before visiting the ED. This would mean the triage nurse or the PCP can decide whether it is an emergency or not. Another commenter suggested that in the event of an emergency, the member should call the PCP's office within one business day for approval/referral. The commenter suggested that clear definitions and examples of emergencies and non-emergencies need to be sent to both patients and providers so that care is received in the appropriate place without concern of financial burdens. Other commenters suggested the criteria for charges be revisited to look at things such as triage level or time of day (to see if alternative services could have been used). Commenters raised other instances such as inclement weather and holidays for why individuals may need to seek care in the ED. Commenters felt that the lack of reliable, affordable, and publicly available transportation is a significant barrier to accessing care. Commenters felt

improvements in this area could also potentially result in a decrease to missed primary care appointments, as well as fewer non-emergency ED visits.

Response: *The Department declines to add this exemption at this point in time, but will monitor the timing and geographic distribution of co-payment charges. As a reminder, the Department believes that it is both the responsibility of the member and the healthcare system to ensure care is delivered in the appropriate setting, regardless of any specific limitations faced by the members or providers. No changes were made as a result of this comment.*

62. Commenters stated that $20 was too much money for low-income people and would make care inaccessible, including specialty care, if people don't have access to care outside of the ED. This was raised as a specific concern for residents in nursing homes or other facilities who typically receive only $40-$70 per month in personal needs allowance. One commenter noted that this proposal creates an incentive for patients to choose inpatient over outpatient care when the diagnosis allows for either option and that this incentive is not in the best interest of the State.

    Response: *In addition to other changes, the Department has exempted individuals who reside in institutional residential facilities (defined as a nursing facility, Adult Family Care Home, Intermediate Care Facility for the Intellectually Disabled, Private Non-Medical Institution, or Home and Community-Based Services waiver home) from this provision. The Department has also reduced the co-payment to $10. The Department continues to stress the importance of members receiving care in appropriate settings, and does not believe the ED is appropriate for routine care.*

63. One commenter felt that MaineCare members should be afforded an opportunity to challenge the assessment in a fair hearing.

    Response: *The Department agrees; members will have this opportunity in accordance with MaineCare Benefits Manual, Chapter 1, General Administrative Policies and Procedures.*

64. Commenters requested clarification on what happens if people don't pay the $20. Would members be removed from MaineCare for nonpayment (resulting in more uncompensated care)?

    Response: *Members will not be removed from MaineCare for nonpayment of the ED co-payment.*

65. One commenter felt that even if the Department could seek a waiver on this, which they didn't believe the Department could, 42 C.F.R. 447.51 refers to the Secretary of the U.S. DHHS for the definition of emergency services. The regulation further defines emergency medical care as a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of medical attention to result in placing the health of the individual in serious jeopardy, serious impairment of body functions, or serious dysfunction of any bodily organ or part. Another commenter felt that this requires that the final determination of

coverage and payment must be made while taking into account the presenting symptoms rather than the final diagnosis. The commenter felt this definition was not able to be waived and that it is unlawful to charge a co-payment to a person who presents to the ED with an emergency medical condition. The commenter said that the only heightened co-payment that could theoretically be imposed would be under certain limited conditions not set forth in the waiver application. Another commenter felt that Maine should ensure that any co-payments required of Medicaid beneficiaries who seek care in the ED are in line with the requirements of 42 CFR §447.54, under which the maximum allowable cost-sharing for such use is limited to $8 for individuals with family income of less than 150 percent FPL.

Response: *The waiver application will be submitted to CMS, which will conduct an independent review of the appropriateness of waiver provisions. No changes were made as a result of this comment.*

Missed Appointments

66. Commenters understood and appreciated the Department intent to address provider's concerns related to the frequency of missed appointments, but felt there were additional factors to consider, such as steps the Department would take to ensure that physician offices would not take advantage of this provision, how the Department or provider will be able to prove that the member knowingly had an appointment to miss, the available process for dispute between the patient and provider regarding whether or not a patient gave proper notice, and how to resolve disputes in a manner that does not unfairly result in unaffordable charges to the patient.

    A few providers acknowledged that missed appointments are a problem for their practices. Some providers were open to the change but others did not believe that billing MaineCare members was necessarily the answer because they already have a difficult time collecting modest co-payments from patients. Some providers said there was too much gray area involved and they would not choose to exercise this option, even if they were permitted to do so. Those who were not open to this felt that pursuing this option may actually add costs or increase bad debt, in addition to being administratively burdensome.

    Generally, commenters felt there were various reasons why a member may miss an appointment through no fault of their own. Reasons included: sick family member, childcare issues, lack of awareness of dates and times, emergency admissions, mental health issues or substance use disorders, homelessness, potential theft or violence, side effects from cancer treatments, changing work schedules, a behavioral episode for an individual which makes them unable to be transported, weather, traffic delays, etc. One commenter was especially concerned about this policy in relation to former foster care youth.

Commenters requested the Department add a limitation that this applies when members miss appointments for no reasonable reason, and that MaineCare develop a clear and simple process for members to request an exemption.

Response: *The Department is not proceeding with this provision and has removed it from the waiver application.*

67. Many commenters shared opinions that MaineCare-provided transportation is often a barrier and felt members shouldn't be charged for lack of reliable transportation. One commenter provided data for two transportation regions regarding late or failed transports. One commenter felt these issues were especially apparent in the greater Lewiston area and that, due to lack of reliable transportation, some people may even call for an ambulance to provide at least one way "free" transportation. One commenter said that instead of penalizing MaineCare members for missed appointments, the Department should assist with childcare or elder care and fill gaps in transportation when NET services are late or don't show up.

    Response: *The Department is not proceeding with this provision and has removed it from the waiver application.*

68. Two commenters stated that the majority of Maine's FQHCs have "no call no show" (NCNS) policies which include notifying patients upon each instance of a NCNS, and discharging the patient from the practice after three successive instances. Commenters noted that providers can simply adopt a policy that bars recipients from receiving services in the future if they have violated the provider's policy on missed appointments for all patients. Other FQHCs have a policy to call the patient to find out why they missed their appointment and, if it is transportation related, to identify ways to assist them in making it to their next visit.

    Two commenters shared that CMS did approve a similar proposal in Arizona, but when the waiver was renewed, no physician wanted to charge for the missed appointments, so the provision was dropped.

    Response: *The Department is not proceeding with this provision and has removed it from the waiver application.*

69. One commenter felt that providers don't charge their other patients for missed appointments and therefore they shouldn't be allowed to charge MaineCare members. The commenter felt this was encouraging exploitation. Commenters felt that asking low-income individuals to cover what could be large bills is counterproductive to health and sanity. Additionally, the commenters stated that hospitals can be ferocious in using collection agencies.

Response: *The Department is not proceeding with this provision, but would like to clarify that the original proposal would only have allowed missed appointment fees to be charged in accordance with standard office policy.*

70. One commenter felt that this would result in people skipping going to the doctor in fear of missing an appointment and getting charged.

Response: *The Department is not proceeding with this provision and has removed it from the waiver application.*

71. One commenter stated that this is not within the purview of a Section 1115 waiver. One commenter felt that a missed appointment fee is contrary to longstanding Medicaid policy in that: (1) Medicaid sets a reimbursement rate for a service and a missed appointment cost is part of a provider's overall cost of doing business and is not a distinct reimbursable services; (2) Medicaid regulation 42 CFR §447.15 provides that as part of participating in the Medicaid program, providers agree to accept as payment in full the amounts paid by the state agency; and, (3) a policy allowing missed appointment fees would hinder recipients from seeking needed medical care and would not be in the recipients best interests.

Response: *The Department is not proceeding with this provision and has removed it from the waiver application.*

Asset tests

72. Commenters questioned the legality of this provision under both federal and state law. Commenters discussed the legislative history and research regarding the use of asset tests. One commenter noted that Maine is one of only 16 states with an asset test in SNAP. Other commenters felt there was nothing new to be learned about asset tests to make this an innovation or evaluation.

Response: *The waiver application will be submitted to CMS, which will conduct an independent review of the appropriateness of waiver provisions. As far as State law, the Department believes the commenter's citation refers to what may be considered a countable asset and the Department will comply with this law, as appropriate. No changes were made as a result of this comment.*

73. Some commenters were concerned about small business owners, such as farmers, and the impact of requiring people to sell their businesses to pay for medical care. Commenters felt that requiring people to sell all their assets would not help people escape poverty or gain independence later. Another commenter felt that this would force individuals to invest any funds they might have saved which then requires penalties for early withdrawals and taxes for any deferred income. Further, commenters said that asset limits send the message that people should spend rather than save and that raising or eliminating asset limits promotes long-term savings and economic independence. One commenter provided citations to support that accumulating even a small amount of savings

and assets may reduce the length of time families need public assistance. Additional commenters felt the asset limit was too low and may only represent a month's worth of expenses for someone with medical needs. They suggested that at least with an $8,000 asset limit. Commenters discussed how assets such as cars, houses, and businesses can be very expensive to maintain, leaving people unable to afford other expenses. One commenter said that even the non-poor are saving at rates that are too low to cover the expected costs in retirement. Another commenter discussed how it is challenging for household who are homeless to obtain and maintain documents to prove assets, a situation further exacerbated by having lost housing through natural disaster or eviction because moving from place to place often results in losing essential documentation. One commenter stated that current eligibility doesn't take into account medical debts already incurred, so there may be other expenses which make affording medical care not possible.

Response: *The Department believes that asset tests are a reasonable tool to ensure that taxpayer money is not used to support individuals who have certain personal assets that can be applied to medical care. No changes were made as a result of this comment.*

74. Commenters asked for more information on what would be considered in the asset test, such as cars. One commenter felt that for rural communities, the one car provision could be detrimental to health centers because people may miss more appointments with only one car. Commenters felt people would need to rely on the MaineCare NET program, which they said does not work well. Commenters raised concerns about members missing appointments, health centers losing revenue, members being dropped from MaineCare, and poor health outcomes.

    Response: *This provision will be similar to the asset test utilized in the SNAP program. Households are allowed one vehicle; however, other vehicles may also be excluded from the asset limit if they are for specific allowable uses. Otherwise, partial, up to full fair market value on vehicles not otherwise excluded will be counted. No changes were made as a result of this comment.*

75. Several commenters discussed the administrative burden of implementing asset testing, stating that it could cause delays in application processing and eligibility determinations. Other concerns were that it could deter members from applying and could keep otherwise eligible individuals from receiving benefits. Commenters provided evidence from other states that eliminated asset tests, showing it costs more in administrative costs to try and keep out the few "bad actors" than could ever be saved in program costs.

    Response: *The Department understands that there will be an additional administrative burden, but believes it is the Department's responsibility to ensure taxpayer funds are spent appropriately and to promote private insurance over public healthcare coverage. No changes were made as a result of this comment.*

76. One commenter questioned if the asset test will be applied to waiver beneficiaries already receiving services or people who may be on the wait list for services. Another commenter asked how the asset tests would impact an individual living at home under Section 29.

Response: *The asset test will be applied based on eligibility group, not by services received. All eligibility groups that do not currently have asset tests (the MAGI groups) will be subject to the proposed asset test. No changes were made as a result of this comment.*

Retroactive Eligibility

77. Commenters were opposed to changing the current retroactive eligibility policy which people feel is reasonable and appropriate. Commenters were concerned about the impact on both members and providers. Long-term care was an area of particular concern due to the lengthy application process and the high cost of services. Commenters described that many elderly individuals have Medicare, but do not have MaineCare and they do not know ahead of time that they will not recover the ability to return home. At this point, the nursing facility doesn't have the option to discharge them, so this provision would force providers to give free coverage. Once the individual is admitted to the facility, the MaineCare application can begin to be completed by the family with help from the nursing home. If approved, the application is covered retroactive back to the date of admission. Under the proposed waiver, the nursing home would not be paid for any of the time delays, leaving the nursing home unpaid and the elderly person and their family with thousands of dollars in nursing home bills that can result in discharge or bankruptcy. Commenters felt that this proposal would cause nursing homes to reject vulnerable patients because of fear of not being paid. If they do accept patients, and depending on the contractual obligations to the family caregiver, there could be increased litigation if the nursing facility could sue the family members and hold them personally liable, by claiming that they should have filed the Medicaid application more swiftly. This could also increase costly appeals, which could result in increases to overall costs. Additionally, the commenter said that the proposed waiver said that this specific proposal was to put MaineCare in "alignment with how health insurance operates in the private market," but long-term care providers are not paid by private health insurance.

Commenters felt that this proposal fails to recognize the purpose of the retroactive coverage benefit which gives a couple, which by definition meets the financial eligibility requirements of impoverishment, the ability to obtain that coverage retroactively for three months. The commenter said that this benefit is of unprecedented value to impoverished families that did not anticipate a need for coverage, do not have the funds to pay, and that are doing their best to comply with the complicated set of MaineCare rules and requirements. Commenters discussed how the need for retroactive coverage may come up as result of a crisis situation, where the family may not have the capacity in the moment to think through the complexities of payment options and they certainly don't feel that foregoing services is a viable option. Multiple commenters wrote that applications are routinely denied for failure to provide requested documentation within a short period of time (usually two weeks). Commenters asked that long-term care be excluded from this provision.

Response: *The Department agrees that long-term care determinations are unique in many ways and therefore has excluded these eligibility determinations from the prohibition on retroactive coverage.*

78. Commenters noted that the Medicaid eligibility is also different than commercial insurance in that MaineCare eligibility is determined monthly and in each month the person must both be in a coverable group and meet the financial requirements for that group. Therefore, sometimes it is not possible to seek eligibility ahead of time because there are specific eligibility options which only become available once a person belongs to a certain population or reaches a certain income level.

    Other commenters stated that patients will not get care if the doctor knows they won't have a chance of being paid and/or individuals could delay seeking care out of fear of incurring medical debt. They discussed how immediate access to comprehensive care is crucial for individuals released from correctional facilities to avoid negative outcomes. One commenter felt that retroactive eligibility ensures that these individuals can access life-saving care immediately upon release. Another commenter felt that as the payer of last resort, MaineCare should be flexible to relieve the burden of such circumstances and mitigate the combined effects of a financial crisis concurrent with a medical or mental health crisis.

    Commenters noted that timely access to care is particularly relevant in the context of family planning care, as only a few days without contraception can result in an unintended pregnancy, abortions, and sexually transmitted infections that if left untested and untreated can spread throughout communities and cause lifelong problems or higher treatment costs. The commenter said it is in the State's interest to reduce transmission of communicable diseases. The commenter felt this would erase any financial and public health benefit of the MaineCare family planning benefit. Another commenter said that if pregnant women can't get retroactive coverage, they could put off necessary medical care which could result in not discovering problems until it is too late to intervene. Individuals may not be eligible to apply to MaineCare until they discover they are pregnant and have proof of pregnancy. One commenter also discussed how, for women who are suffering with substance abuse issues, 80 to 90 percent of pregnancies are unintended, so there is a clear State interest in making sure that women can get access to family planning care as quickly as possible.

    Response: *The Department believes that individuals and providers have a responsibility to ensure that applications are received by the end of the month in which care is initiated to protect the individual's and provider's finances and wellbeing. Regarding pregnant women, the Department reminds commenters that this waiver does not alter options for presumptive eligibility for pregnant women. The Department also acknowledges that certain safety net providers (such as FQHCs) have a responsibility to deliver care to patients regardless of ability to pay. No changes were made as a result of this comment.*

79. There was also concern for the impact of this provision on gaps in care, health outcomes, and financial distress for members, particularly for individuals battling cancer or individuals with complex medical conditions that require frequent follow-up and maintenance visits to help control disease progression. Commenters said it is not uncommon for families to lose track of coverage and have lapses that are discovered by the provider. For high-intensity services, like residential treatment or behavioral day health treatment, discharge due to a lapse in coverage is not appropriate, yet families are not in a position to pay out of pocket. The commenter felt the 90-day coverage window is an appropriate mechanism to cover this period.

    Response: *The Department has clarified that the prohibition on retroactive eligibility determinations only applies to initial MaineCare applications and not to renewals of coverage.*

80. There was also concern for financial burden on other providers. There was special concern if a provider, such as a hospital, delivers a service toward the end of the month and the person isn't able to complete an application before the end of the month to secure a coverage start date. One commenter noted that current policy allows hospitals to get paid for legally required emergency services, and helps FQHCs to provide services to all persons, regardless of an individual's ability to pay or insurance status. Commenters were concerned that even though FQHCs may have "enrollment assisters" or community health workers to help uninsured people sign up for health insurance/continue coverage, there is sometimes a delay between when a member signs up for this assistance and when they get an appointment.

    On the member side, one commenter felt that adoption of this provision would also punish those undergoing nonmedical crises, such as the death of a family member through whom coverage was previously obtained. One commenter felt the waiver was inconsistent in wanting people to sign up for coverage when they are healthy because the time limits may make people wait to use months when they are sick. One commenter noted that it often takes incurring a large medical bill to prompt people to call for assistance and learn that they are eligible for MaineCare. Another commenter said that people do not purposefully delay seeking care or coverage.

    Response: *The Department believes this provision will not only protect State interests, but will also spur innovation and collaboration among providers and community organizations to ensure that all eligible individuals are proactively enrolled in MaineCare. No changes were made as a result of this comment.*

81. Commenter expressed concern about the administration of this change, and whether it would result in increased confusion, denials, lapses in coverage, etc. One commenter asked if the statement on the application would still remain that says if your application hasn't been processed within 45 days retroactive payments will be made. The commenter noted that it can take months for the MaineCare application to process and a person may have made an effort to apply in a timely manner but DHHS doesn't process it in a timely manner. The commenter felt this is not the fault of

the person but an issue with DHHS. The commenter thought the application should be retroactive to the date of the submission of the application and not date of approval and that is the only scenario when a retro payment should be made.

Response: *The statement regarding timely processing of applications will remain. Currently and also under this proposal, applicants are eligible for coverage on the first day of the month in which the application is received, rather than when the application is processed. This will not change. No changes were made as a result of this comment.*

82. One commenter thought that this would result in increased costs to MaineCare due to increased appeals, increased burden on the Free Care program, death, or disability that leaves loved ones reliant on state assistance. One commenter felt that this strategy (and hospital presumptive eligibility changes) would shift costs to other sources, especially to commercial insurance carriers who will raise premiums on individuals and businesses.

Response: *The Department believes that this is a reasonable expectation for Maine and that the system will adjust to this new standard as enrollment assistance and support becomes more standard practice. No changes were made as a result of this comment.*

83. One commenter felt this would impact provider participation in Medicaid and weaken MaineCare's ability to comply with federal law which requires Medicaid to maintain an adequate provider network. Commenters felt this could increase wait times and cause delays in care which could increase health disparities and disproportionately impact rural areas.

Response: *The Department will continue to comply with the requirements of network adequacy and monitor Maine health indicators. No changes were made as a result of this comment.*

Presumptive Eligibility Determinations by Qualified Hospitals

84. One commenter felt that this provision could jeopardize access to care because many low-income, uninsured or underinsured individuals, including cancer patients and survivors, go to the ED for their care. The Presumptive Eligibility (PE) option allows hospitals to assume patients are Medicaid eligible, preventing the patient from having to pay for services (which may be unaffordable), ensuring timely access to needed care, and allowing providers to be reimbursed. The commenter felt that regardless of whether DHHS is correct in the assertion that DHHS will do a better job of determining eligibility, the point of this law is to allow PE while leaving the ultimate eligibility decision to DHHS.

The commenter felt this provision would negatively impact enrollment. The commenter felt that PE allows the State to realize more cost-savings by detecting cancers through preventive screenings, when they are less costly and outcomes are better. One commenter felt that PE would become even more important if eligibility determinations take longer due to restrictive eligibility criteria.

A commenter noted that no hospitals in Maine currently provide PE determinations because of DHHS requirements which put the hospital at risk. The commenter felt that the Department failed to effectively implement the current PE law, so it is hard to see what will be learned from waiving this provision. Moreover, precluding PE use forecloses an opportunity to experiment with initiatives that would promote coverage and increase the efficiency of care, both criterions which CMS considers favorably in determining whether a Section 1115 waiver meets the purpose of the Medicaid Act.

Response: *The Department does not feel that removing this provision will jeopardize access to care because, as another commenter mentioned, no hospitals are currently participating in this option. Additionally, the Department reminds commenters that currently, and under the waiver proposal, individuals are eligible for care the first day of the month in which their MaineCare application is received. The waiver application will be submitted to CMS, which will conduct an independent review of the appropriateness of waiver provisions. No changes were made as a result of this comment.*

85. One commenter said that not all eligible low-income people proactively enroll in MaineCare due to stigma and challenges of enrolling. PE and enrollment at point of care evolved because of studies of how care is accessed by people with limited resources.

Response: *As was achieved with the enrollment of individuals in the marketplace, the Department believes that the broader community can change standards of practice and social norms around seeking MaineCare coverage. The Department believes this simple alignment with private insurance will be beneficial to various stakeholders. No changes were made as a result of this comment.*

Medicaid Compliant Annuities

86. Commenters felt that this provision would adversely impact individuals with long term care needs. Many commenters felt that the State should not disrupt the current system which balances the needs of ensuring that community spouses have enough income and assets to live independently, and the State's interest in being reimbursed with funds remaining. One commenter discussed what they felt were differences between different types of medical care and how they are approached by society and insurance (e.g. nursing home care is not covered by regular insurance). This means that annuities are one of the few tools to help families with this expense, which if it were cancer, would be covered by insurance. The commenter felt that the State should not seek a waiver of compliance with a single requirement that is part of an overall scheme because they don't agree with it. The commenter recommended the State seek a change to the law itself instead of a waiver from it.

Commenters discussed the legislative history surrounding the Medicaid look back period and the provisions enacted to provide a "safe harbor" for specific annuities. The commenter said that one of the requirements for these annuities is that the State is named as the beneficiary to the extent of payments made on behalf of the Medicaid recipient, and that this is allowed regardless of whether that annuity thereby allows an applicant or spouse to convert otherwise countable assets into non-countable assets.

Commenters stated that, for married couples, the use of spousal MaineCare compliant annuities allows the non-nursing home spouse to avoid complete and total impoverishment because their loved one needed to go in a nursing home. They stated that nursing home care can easily wipe out a couple's life savings within a year or two, and may lead a couple to seek divorce just to protect those life savings. Commenters provided research which reported that the median expenses for households age 64-74 was nearly $42,000 in 2015. Another commenter said that in some cases where the new actuarially sound test is applied, community spouses will be unable to receive enough monthly income from all sources to achieve their Monthly Maintenance Needs Allowance, causing impoverishment.

One commenter mentioned how annuities can also be important for single individuals as they allow people to annuitize their extra assets prior to applying for MaineCare. This can be used to privately pay for their care during a penalty period that would be imposed. This penalty period isn't imposed until the person already has less than $10,000 so the annuity allows them to quickly get their assets under $10,000.

Response: *The Department understands the rationale behind Medicaid compliant annuities; however, the Department does not feel it is the purpose of the Medicaid program or in the best interest of Maine taxpayers to allow individuals to shelter personal assets, without penalty, in order to receive government sponsored healthcare coverage. No changes were made as a result of this comment.*

87. Commenters felt that the proposal was a broad-brush proposal that does not distinguish between whether the annuity is purchased by the MaineCare applicant or their spouse, and whether it is purchased with retirement funds or other funds. Federal and state laws have always given special treatment to retirement accounts in recognition that, with the phasing out of employer-provided pensions, retirement savings are an essential part of keeping our elderly populations financially secure (these funds are protected in bankruptcy proceedings). Many states do not include retirement funds as countable assets under Medicaid rules, but Maine does count these assets. The commenter felt that this penalizes people for wise financial decisions. Commenters discussed how most middle class people, hopefully, are saving for retirement and it can be a huge blow to find out that retirement savings must be put toward long-term care. Commenters said that most people who use the annuity planning are not wealthy and have modest savings. The commenters also mentioned how this could impact younger couples who may need to lose their retirement nest eggs and convert those savings into an annuity. If DHHS removes the annuity option, the only remaining choice will be divorce. The commenter felt that having decided to treat retirement accounts as countable assets, DHHS should not include these retirement security funds with the same broad brush of requiring the 80% of life expectancy condition.

Response: *This waiver is not intending to change the way that Maine treats retirement funds or any annuities other than those considered "Medicaid compliant annuities." No changes were made as a result of this comment.*

88. The commenter felt that the rationale given on the number of annuities purchased results in an average of two annuities statewide per year and therefore is not an example of any sort of widespread practice. Further, the commenter said that the Department did not provide any context to these examples. Another commenter said they would be curious to see from the State how many people have annuities that are much less.

    One commenter suggested that if there is a problem with wealthy senior citizens misusing MaineCare, the Department should find another way to address it that didn't force honest tax-payers who are attempting to avoid poverty by having a retirement account. Another commenter felt that for the people who do shelter hundreds of thousands of dollars, that if they need long-term care in the future, they will have money to privately pay for a long time because once their spouse is gone, they have a $10,000 asset limit.

    Response: *The Department has provided additional data regarding the use of Medicaid compliant annuities in the waiver application. While not all applicants that have used this financial tool have sheltered large amounts of money, the State believes any use of this financial tool should result in a corresponding transfer penalty. This waiver is not intending to change the way that Maine treats retirement funds or any annuities other than those considered "Medicaid compliant annuities." No changes were made as a result of this comment.*

89. Two commenters provided examples of individuals who unintentionally run afoul of MaineCare transfer penalty rules, resulting in penalties on eligibility. The commenters said that annuities are a way to ensure that the nursing home facilities are paid and the individual gets the care they need. Annuities may be used to help privately pay for the cost in the facility during the penalty period.

    Response: *The Department does not believe that the transfer penalty period should result in an exemption to this rule. No changes were made as a result of this comment.*

90. The commenter felt that the broad requirement that all annuities must last for at least 80% of a spouse's live expectancy could seriously limit the spouse's ability to meet expenses. The commenter felt that this also put Maine at a disadvantage compared to other states because smart couples with modest or significant assets would either get divorced or move out of Maine.

    Another commenter felt that unless the minimum payout rule is also applied to intra-family promissory notes, elder law attorneys will use intra-family promissory notes exclusively. Since intra-family promissory notes do not have a guaranteed beneficiary payback in favor of the State, like Medicaid compliant annuities, the MaineCare program will suffer in the end. The commenter said

that the requested waiver should include a provision that eliminates intra-family promissory notes, or, alternatively, places the same restrictions on them.

Response: *The Department believes that this requirement provides the appropriate balance between the interest of the community spouse to retain assets and the interest of the State to recoup some of the Medicaid dollars expended on behalf of the institutionalized spouse. Additionally, the Department believes the current rules regarding the treatment of promissory notes precludes the need to propose any changes. No changes were made as a result of this comment.*