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December 27, 2019

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

VIA ELECTRONIC SUBMISSION

RE: TennCare Demonstration, Amendment 42

Dear Secretary Azar:

The Medicare Rights Center (Medicare Rights) welcomes this opportunity to comment on the TennCare Demonstration Waiver Amendment 42. Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Medicare Rights provides services and resources to three million people with Medicare, family caregivers, and professionals each year. Through our National Helpline, we hear daily from people who are dually eligible for Medicare and Medicaid who are experiencing enrollment issues and barriers in access to care, including bureaucratic hurdles. Given this focus, we have a particular interest in how this waiver would affect Tennesseans with disabilities and who are older.

The Medicaid program, now in its 54th year, is a success story. Through Medicaid, millions of low-income Americans have built well-being and gained greater economic security via access to health insurance coverage. This coverage has guaranteed health care to older adults and people with disabilities who need access to care with less financial burden than Medicare alone can provide. In addition, Medicaid helps millions of children and their families and, in states that have chosen the life-saving and cost-effective option of Medicaid expansion, those who are unable to find work, whose employers or job types do not grant access to health insurance, or who are caregivers, students, or who have conditions that interfere with regular work.

General Comments

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The Medicaid program is jointly funded by the federal government and the states with a great deal of flexibility afforded to states to choose how to arrange their Medicaid coverage. Many states also have chosen to go beyond the standard coverage and benefits through various waivers. Because of this flexibility, and the existence of such varied waivers, the current Medicaid program differs widely between states, but still offers protections for people who need Medicaid coverage in order to age in place with dignity and to preserve their health and well-being.

With this amendment, Tennessee is attempting to alter its existing 1115 waiver in ways that would upend the Medicaid program and destroy many of the safeguards on which Tennesseans rely to keep their care accessible and safe. In part, the state is requesting to receive some of its federal Medicaid funding in the form of a "modified block grant" and to retain half of any federal "savings" achieved under the demonstration.[1] Tennessee is also seeking additional administrative flexibilities, such as the authority to implement a closed formulary and a waiver from all federal managed care oversight rules.

If advanced, this proposal would cap federal Medicaid spending for low-income children and adults, children and adults with disabilities, and older adults in the state, as well as eliminate critical program functionalities and beneficiary protections.

Among the program elements at risk is Medicaid's core federal-state partnership. Today, federal support automatically changes to match a state's spending and needs—increasing in near real-time if a state's costs go up. Tennessee's amendment would effectively sever this relationship. This would leave the state fully responsible for all costs in excess of the annual federal allocation and jeopardize Tennesseans access to Medicaid.

Tennessee's plan would allow the caps to adjust somewhat over time to reflect annual growth estimates. Under this approach, the federal allocation would increase if enrollment were to exceed prior estimates but would not decrease if rates were to decline. However, there would be no additional adjustment if per enrollee costs were to rise faster than anticipated. This would insufficiently protect the state from variabilities in the health care system, such as public health crises (e.g., the opioid epidemic) or advances in treatment (e.g., new drug therapies). In the event of such occurrences, Tennessee would face impossible funding choices.

Moreover, the eventually negotiated inflation rate used to calculate the base and subsequent year spending levels is likely to be inadequate to fully cover the cost of providing care. Together with other structural changes being proposed, this could perversely incentivize the state to reduce enrollment and services in order to keep spending below the capped block grant amount.

The pressures of capped federal Medicaid financing would uniquely threaten access to care for high cost enrollees, like older adults and people with disabilities. Though the block grant would initially exclude people who are dually eligible for both Medicare and Medicaid, services for approximately 138,300 non-dual seniors and persons with disabilities would still be at risk.[2] For example, in an effort to control costs, Tennessee could seek to roll back critical but non-mandatory benefits that are often among the services most utilized by these groups, like Home- and Community-Based Services (HCBS). The state says it does not intend to restrict eligibility or benefits,

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[1] "TennCare Demonstration, Proposed Amendment 42," p. iii (November 20, 2019), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn/tn-tenncare-ii-pa10.pdf.

[2] Elizabeth Hinton, MaryBeth Musumeci, & Robin Rudowitz, "Why it Matters: Tennessee's Medicaid Block Grant Waiver Proposal," Kaiser Family Foundation (December 2019), http://files.kff.org/attachment/Issue-Brief-Why-it-Matters-Tennessees-Medicaid-Block-Grant-Waiver-Proposal.

but the proposal does not require Tennessee to maintain current levels. And the shared savings provision—which would allow Tennessee to retain and reallocate a portion of any unspent federal block grant dollars—could create an incentive for the state to make such cuts.

Over time, coverage and eligibility restrictions would become inevitable. The initial funding caps would likely be tied to inflation rates that are too low to fully cover the cost of providing care, leaving Tennessee to make up the difference. Each year, the gap between the amount the state gets and the amount the state needs would grow, exposing Tennessee to higher and higher costs. Facing an ever-increasing funding shortfall, Tennessee would have no choice but to cut services, eligibility, or both in order to curtail spending.

Further, because the proposed financing changes are coupled with removing or loosening federal standards about coverage, managed care, and eligibility, dual-eligibles would nevertheless be immediately harmed by this waiver amendment. The state explicitly acknowledges that its proposals to eliminate these beneficiary protections and deregulate managed care organizations are intended to apply to the entire TennCare population, including people eligible for both Medicare and Medicaid.[3] Accordingly, this amendment could allow managed care plans to make changes—like limiting provider networks or imposing stringent prior authorization requirements—that would make it difficult or impossible for duals to accesses or afford needed care.

We are also troubled by the proposal's lack of specificity and analysis. It is so vague that it fails to disclose information that is essential for providing an effective opportunity for public comment. The application and proposed structure of the block grant raise serious concerns that the state has not thought through the impact on its Medicaid population, including on those who are dually eligible. The state intends to exclude all expenditures on behalf of dually eligible beneficiaries—regardless of their age or type of Medicaid coverage—from the block grant, while subjecting them to the deregulation of the managed care organizations that are supposed to deliver their care.

Finally, this proposal goes against the goals and purpose of the Medicaid program. It would cause immense harm and jeopardize coverage for Tennesseans, including older adults and people with disabilities.

For these and the reasons outlined in more detail below, we strongly oppose Tennessee's waiver amendment. It would fundamentally alter Medicaid's federal-state partnership, threatening TennCare and the integrity of the Medicaid program nationwide. Changes of that magnitude must be done through congressional action, not administrative fiat. We respectfully urge you not to advance this harmful proposal.

Disproportionately impacts people with high health care needs

Block grants save money by cutting into benefits, eligibility, standards, or all of the above. This puts beneficiaries with the greatest needs—often those who are older, frail, or who have significant disabilities—at the greatest risk of having their access to care impeded. At times, these access barriers are in the name of "savings," but savings found by slashing needed programs and putting the health and well-being of those who rely on them are often illusory. Where states curtail necessary care at earlier, less acute stages, they may create a scenario where they are on the hook for more costly emergency or institutional care later. For example, HCBS is generally only available to Medicaid beneficiaries who would otherwise be institutionalized in a nursing facility. HCBS is usually

[3] "TennCare Demonstration, Proposed Amendment 42," pp. 39-40 (November 20, 2019), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn/tn-tenncare-ii-pa10.pdf.

less expensive than nursing facility care but states may perceive it as costly and, more importantly, it is optional for states. This means that a state experiencing massive shortfalls in funding or with huge incentives to cut costs might seek to cut HCBS or institute draconian waiting lists or caps. This in turn could lead to more beneficiaries being forced to leave their homes and communities for institutions which could, paradoxically, put more strain on state budgets. Despite Tennessee's protestations that it has no current plans to reduce coverage or cut benefits, the amendment would give the state that freedom.

TennCare's waiver also strikes hardest at care for patients with the high needs through its proposed changes to prescription drug coverage. Older adults would be particularly at risk because they are more likely than their younger counterparts to take prescription drugs and to take multiple prescriptions.[4] By limiting prescription drug access, the state is likely to reduce compliance with needed medications, forcing beneficiaries to jump through administrative hoops to get the drugs they need to support their diagnoses. Lack of access to medications can lead to health risks and increased costs for the health care system. Several studies have shown how medication non-adherence leads to death, hospitalization, and cost increases in the tens or hundreds of billions of dollars.[5]

In the waiver application, the state notes that it would "maintain an exceptions process to cover drugs that are not on the formulary when medically necessary… [that] will be similar to the existing authorization process used for situations such as determining coverage of non-preferred products or off-label indications."[6] But exceptions and authorization processes are cumbersome and create hurdles for beneficiaries. At Medicare Rights, we see every day the challenges beneficiaries experience when attempting to access needed medications. The creation of a closed formulary in Medicaid would increase these risks and burdens.

The proposal would also waive compliance with federal Medicaid rules that prohibit discrimination on the basis of a diagnosis or medical condition and eliminate other rules that guarantee parity between medical and mental health conditions, thereby enabling TennCare to cherry pick beneficiaries for enhanced spending at will and provide less treatment to patients with certain conditions, including mental illness or addiction. Each of these acts can reduce accessibility of necessary care and can also increase the need for acute care later, as conditions progress and patient health deteriorates.

As the prevalence of chronic and pre-existing conditions, including both physical and mental health conditions, increases significantly with age, these risks are especially worrying among the older adult population. According to the Office of the Assistant Secretary for Planning and Evaluation, "[U]p to 84 percent of those ages 55 to 64—31 million individuals—have at least one pre-existing condition".[7] Based on health care expense data, the Agency for Healthcare Research and Quality found that over 75% of people ages 55 through 64 have at least one chronic

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[4] Ashley Kirzinger, Tricia Neuman, Juliette Cubanski, & Mollyann Brodie, "Data Note: Prescription Drugs and Older Adults," Kaiser Family Foundation (August 09, 2019), https://www.kff.org/health-reform/issue-brief/data-note-prescription-drugs-and-older-adults/.

[5] Meera Viswanathan, Carol E. Golin, Christine D. Jones, Mahima Ashok, Susan J. Blalock, Roberta C.M. Wines, Emmanuel J.L. Coker-Schwimmer, David L. Rosen, Priyanka Sista, Kathleen N. Lohr, "Interventions to Improve Adherence to Self-administered Medications for Chronic Diseases in the United States: A Systematic Review," Ann Intern Med. 2012;157(11):785-795, https://annals.org/aim/fullarticle/1357338/interventions-improve-adherence-self-administered-medications-chronic-diseases-united-states.

[6] TennCare Demonstration, Proposed Amendment 42, p. 15 (November 20, 2019), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn/tn-tenncare-ii-pa10.pdf.

[7] Office of the Assistant Secretary for Planning and Evaluation, "Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act," DEPARTMENT OF HEALTH AND HUMAN SERVICES (January 5, 2017), https://aspe.hhs.gov/pdf-report/health-insurance-coverage-americans-pre-existing-conditions-impact-affordable-care-act.

condition, with the majority (57%) having two or more.[8] AARP came to similar conclusions in an analysis of data for the age 50–64 population, finding that 72.5% have at least one chronic condition, and almost 20% suffer from some sort of mental illness.[9]

Elimination of federal managed care protections

All Tennessee Medicaid beneficiaries in all coverage groups are required to access care through TennCare's mandatory managed care program.[10] State Medicaid managed care must conform to federal standards currently, but this TennCare proposal would exempt the state from holding its Managed Care Organization to those national standards and allow it to "[o]perate a managed care program that does not comply with the requirements of 42 CFR Part 438."[11] This could allow for networks that are too narrow to ensure access to care; permit reduced capitation payments that fail to cover the cost of patient care; and provide few protections for beneficiaries who run into hurdles with their access to care. This runs counter to the needs of Medicaid beneficiaries and the goals of the program. We need higher standards for states and Managed Care Organizations, not lower.

Elimination of federal checks and balances

Acceptance of the TennCare proposal would allow the state to "[m]odify enrollment processes, service delivery system, and comparable program elements without the need for a demonstration amendment." This appears to mean no federal checks or oversight of new proposals would be required. If so, it would free the state to erect barriers to enrollment, create new hurdles for maintaining coverage, or limit access to medical services.

Any new bureaucratic hurdles would affect a broad swath of adults with Medicaid. When states make the Medicaid program more complicated, either through eligibility rules or paperwork, fewer people can gain or keep coverage, despite their eligibility.[12]

If Tennessee chose to increase administrative hurdles and paperwork, the state could greatly increase "churn," where people lose coverage, often briefly, then re-enroll in the program after resolving documentation or mailing address issues. Currently, many Medicaid beneficiaries experience churn where they are forced out of the program because of administrative errors or paperwork burdens and then find themselves uninsured.[13] TennCare appears to be striving for an environment where even more paperwork barriers could go into effect without federal approval or oversight.

Paperwork barriers are extremely troublesome for people with limited incomes. The challenges—such as difficulty receiving mail, lack of a fixed address, and chronic or intermittent homelessness—can be emphasized when one's

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[8] Steven Machlin, Joel W. Cohen & Karen Beauregard, "Statistical Brief #203: Health Care Expenses for Adults with Chronic Conditions, 2005," Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality (May 2008), https://meps.ahrq.gov/data_files/publications/st203/stat203.pdf.

[9] AARP Public Policy Institute, "Chronic Care: A Call to Action for Health Reform" (2009), https://assets.aarp.org/rgcenter/health/beyond_50_hcr.pdf.

[10] Centers for Medicare & Medicaid Services, "Managed Care in Tennessee" (last accessed December 17, 2019), https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/tennessee-mcp.pdf.

[11] TennCare Demonstration, Proposed Amendment 42, p. 25 (November 20, 2019), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn/tn-tenncare-ii-pa10.pdf.

[12] Emmett Ruff & Eliot Fishman, "The Return of Churn: State Paperwork Barriers Caused More Than 1.5 Million Low-Income People to Lose Their Medicaid Coverage in 2018" (April 2019), https://familiesusa.org/wp-content/uploads/2019/09/Return_of_Churn_Analysis.pdf.

[13] Emmett Ruff & Eliot Fishman, "The Return of Churn: State Paperwork Barriers Caused More Than 1.5 Million Low-Income People to Lose Their Medicaid Coverage in 2018" (April 2019), https://familiesusa.org/wp-content/uploads/2019/09/Return_of_Churn_Analysis.pdf.

income is extremely low. Adding the stress of a risk of loss of coverage to an already complex or harrowing situation is a mistake. For example, a beneficiary may be suffering from an acute illness and unable to fill out paperwork to maintain coverage precisely when coverage is the most important. The risk of losing coverage is especially troubling for people currently being treated for chronic illness, mental illness, or substance use disorder.

Such paperwork barriers serve no other purpose than to cut people off Medicaid, making it even more difficult for them to get back on their feet. In the meantime, the lack of coverage would create disruptions in care, leading to poorer health outcomes and increased costs for Tennessee residents. The vast majority of Medicaid enrollees who lose coverage would likely become uninsured, because they do not have access to other affordable coverage. Multiple studies have found that regular and ongoing access to health care reduces preventable hospitalizations for people with chronic diseases such as diabetes and heart disease.[14] The direct, foreseeable consequence of any policy that increases churn will be worse health for Tennessee's lowest-income residents.

For these reasons, CMS should not approve a waiver that would increase administrative hurdles and churn. Such barriers would further harm Medicaid beneficiaries who are already negatively impacted by states failing to adhere to enrollment and eligibility standards. We need more oversight of Medicaid enrollment and eligibility adherence, not less. We need higher standards, not lower.

Incentivization of stinting on care

The TennCare amendment would also provide a strong incentive for Tennessee to cut care and benefits for Medicaid enrollees by allowing the state to divert any savings into other parts of the state budget. This risk is especially apparent given the proposal's claims that Tennessee already "operates one of the most cost-effective Medicaid programs in the nation."[15] This claim of programmatic leanness raises pressing questions about how any significant additional savings could be realized. It also raises questions about how the state would spend any such savings, since the only stated promise is that the savings would be reinvested "in the *health* [emphasis in the original] of TennCare members, not just their healthcare."[16] It is unclear how the state would define investing in the health of Tennesseans and whether redirecting Medicaid funds away from the primary purpose of the program would be legal.

Failure to comport with the objectives of Medicaid

Tennessee's proposal contains all the core flaws of the off-target waiver approach as seen in other states, for example when they have pursued work requirements. In the Stewart v. Azar decision rejecting federal approval of Kentucky's work requirements waiver, the judge stated that the administration "never adequately considered whether Kentucky HEALTH would, in fact, help the state furnish medical assistance to its citizens, a central objective of Medicaid," with medical assistance (the statutory term for Medicaid) defined as "payment of part or

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[14] Andrew B. Bindman, et al., "Preventable Hospitalizations and Access to Health Care," JAMA, 274(4):305–311 (July 26, 1995), https://doi.org/10.1001/jama.1995.03530040033037; Xuanping Zhang, et al., "Diabetes Care," 35(7): 1566-1571 (July 2012), https://doi.org/10.2337/dc12-0081.

[15] TennCare Demonstration, Proposed Amendment 42, p. iii (November 20, 2019), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn/tn-tenncare-ii-pa10.pdf.

[16] TennCare Demonstration, Proposed Amendment 42, p iv (November 20, 2019), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn/tn-tenncare-ii-pa10.pdf.

all of the cost of medical care and services."[17] Giving the state license to cut benefits, erect new bureaucratic enrollment or redetermination hurdles, and discriminate against higher acuity patients—either immediately or in the future—does not furnish medical assistance to the people of Tennessee. Instead, it puts any assistance from Medicaid at risk and compromises the promise of the program to serve as a backstop.

The consequences of ignoring Medicaid's objective of furnishing medical assistance can be dire as the health of patients with unmet health needs is often compromised, and cuts to benefits or increases in churn would exacerbate this problem across a person's whole lifespan. A lack of quality coverage can lead to reduced well-being for entire families;[18] poorer health;[19] lack of access to care;[20] economic devastation;[21] and higher Medicare costs when they are ultimately eligible.[22]

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[17] Civil Action No. 18-152 (JEB), 2 (D.D.C. Apr. 10, 2018)

[18] Committee on the Consequences of Uninsurance, Board on Health Care Services, "Health Insurance is a Family Matter," INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, Chapter 5 (2002), https://www.nap.edu/catalog/10503/health-insurance-is-a-family-matter ("Davidoff and colleagues (2002) analyzed the NSAF 1999 data set and found that having an uninsured parent decreased the likelihood that a child would have any medical provider visit by 6.5 percentage points and the likelihood of a well-child visit by 6.7 percentage points, compared with having an insured parent. In addition, this analysis found that a parent without health insurance is less likely to have confidence in the family's ability to get medical care when needed. As would be expected, the effects of having uninsured parents are smaller than the effects of the children themselves being uninsured. Still, they add to the mounting body of evidence that links parents' well-being to that of their children"; "The weight of the studies just discussed suggest that neglecting financial access to care for adults may have the unintended effect of diminishing the impact of targeted health insurance programs for children").

[19] David W Baker, Joseph Feinglass, Ramon Durazo-Arvizu, Whitney P Witt, Joseph J Sudano, & Jason A Thompson, "Changes in Health for the Uninsured After Reaching Age-eligibility for Medicare," J Gen Intern Med. 2006 Nov; 21(11): 1144–1149 (2006), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1831646/ ("Adults in late middle age may be particularly vulnerable to adverse health consequences that result from lack of health insurance and impaired access to care because of their higher prevalence of chronic disease and higher chance of suffering major, debilitating illnesses such as heart attack and stroke. Previous studies have shown that adults age 51 to 61 years old who lack health insurance have higher risk-adjusted rates of decline in their overall health and physical functioning and higher risk-adjusted mortality…").

[20] Committee on the Consequences of Uninsurance, Board on Health Care Services, "Health Insurance is a Family Matter," INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, pp 91-106 (2002), https://www.nap.edu/catalog/10503/health-insurance-is-a-family-matter ("Uninsured adults in poor health are especially likely to encounter access problems in obtaining care for themselves; they are two to three times as likely to go without needed care and are twice as likely to lack a regular source of care as healthier uninsured adults (Schoen and Puleo, 1998; Duchon et al., 2001). Uninsured adults in fair or poor health are more likely to have experienced a time without needed care than are continuously insured adults of comparable health status. Schoen and Puleo (1998) find that the worse the health status, the greater is the likelihood of access problems when insurance status is controlled in the analysis.")

[21] Rohan Khera, Jonathan C. Hong, Anshul Saxena, Alejandro Arrieta, Salim S. Virani, Ron Blankstein, James A. de Lemos, Harlan M. Krumholz, & Khurram Nasir, "Burden of Catastrophic Health Expenditures for Acute Myocardial Infarction and Stroke Among Uninsured in the United States," CIRCULATION, 2018;137:00–00 (2018), https://www.ahajournals.org/doi/full/10.1161/CIRCULATIONAHA.117.030128 ("In summary, before the Affordable Care Act, >1 in 8 AMI and stroke hospitalizations among nonelderly adults occurred among those without insurance. In this vulnerable group of patients, in-hospital expenditures alone would be expected to cross the threshold to define a catastrophic expense in the large majority. Because many of these patients will have additional hospitalizations and health expenditures, they may easily exceed their annual income while being deprived of work during the illness. The potentially devastating financial impact of these events on the uninsured is considerable.")

[22] David W Baker, Joseph Feinglass, Ramon Durazo-Arvizu, Whitney P Witt, Joseph J Sudano, & Jason A Thompson, "Changes in Health for the Uninsured After Reaching Age-eligibility for Medicare," J GEN INTERN MED, 2006 Nov; 21(11): 1144–1149 (2006), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1831646/ ("Because of their higher risk-adjusted rates of health decline, many uninsured adults who reach age 65 and enroll in Medicare enter the program in worse health than they would have if they had continuous health insurance coverage before gaining Medicare. As a result, lack of health insurance during the preretirement years could lead to higher Medicare costs."); Jack Hadley and Timothy Waidmann, "Health Insurance and Health at Age 65: Implications for Medical Care Spending on New Medicare Beneficiaries," HEALTH SERV RES, 2006 Apr; 41(2): 429–451 (2006), https://www.ncbi.nlm.nih.gov/pubmed/16584457 ("Continuous insurance coverage is associated with significantly fewer deaths prior to age 65 and, among those who survive, a significant upward shift in the distribution of health states from fair and poor health with disabilities to good to excellent health. Treating insurance coverage as endogenous increases the magnitude of the estimated effect of having insurance on improved health prior to age 65. The medical spending simulations suggest that if the near-elderly had continuous insurance coverage, average annual medical spending per capita for new Medicare beneficiaries in their first few years of coverage would be slightly lower because of the improvement in health status. In addition, total Medicare and Medicaid spending for new beneficiaries over their first few years of coverage would be about the same or slightly lower, even though more people survive to age 65.")

As these resources demonstrate, the stakes are very high for all Medicaid enrollees and entire families. We are concerned that this waiver would undermine their access to health care coverage and services and, in so doing, increase costs, increase burdens, reduce well-being, and fail to "assist in promoting the objectives" of the Medicaid program.[23] The TennCare proposal could reduce Medicaid coverage for many low-income Tennesseans, and the terms of the waiver put the Medicaid program as a whole at risk by setting a dangerous precedent for siphoning money out for other state budget wishes.

Conclusion

Thank you again for this opportunity to comment on the proposed Tennessee amendment to its demonstration waiver. This is an important moment to protect the Medicaid program's guarantee of coverage for low-income Tennesseans and, by extension, the populations of other states. This proposed waiver is an attack on the fundamental purposes of the Medicaid program, which is meant to provide medical assistance to low-income beneficiaries. We encourage all parties to come together for solutions that build up the security and nimbleness of the Medicaid program rather than weaken it through cuts and beneficiary burden. For additional information, please contact me at LCopeland@medicarerights.org or 202-637-0961 or Julie Carter, Senior Federal Policy Associate, at JCarter@medicarerights.org or 202-637-0962.

Sincerely,

Lindsey Copeland
Federal Policy Director
Medicare Rights Center

[23] *See* 42 U.S.C. § 1315(a).