MEMO TO CMS REGARDING THE EXECUTIVE ORDER REDUCING POVERTY IN AMERICA BY PROMOTING OPPORTUNITY AND ECONOMIC MOBILITY

On April 10, 2018, President Trump signed the Executive Order Reducing Poverty in America by Promoting Opportunity and Economic Mobility. This order directs federal officials to update rules, regulations, and guidance to better meet core objectives in various welfare programs. The new regulations should promote economic mobility, increase employment, improve economic independence, strengthen state flexibility, reduce wasteful spending, and preserve resources for the truly needy.

The Centers for Medicare and Medicaid Services should approve state requests to implement Medicaid work requirements, issue new guidance on how states can roll back failed ObamaCare expansions, and provide states with additional flexibility to improve program integrity.

The Trump administration should continue approving state waivers for Medicaid work requirements and begin allowing states to roll back ObamaCare expansion

Nearly 28 million able-bodied adults are now dependent on Medicaid, up from fewer than 7 million in 2000. This enrollment explosion is fueling a massive spending surge, with spending on able-bodied adults increasing a jaw-dropping 700 percent over that time. Much of this increase is the result of states expanding Medicaid to a new class of able-bodied, mostly childless adults under ObamaCare. As a result, millions of able-bodied adults are now dependent on a welfare program that discourages work. With no work requirements in place on a national scale, few able-bodied adults on Medicaid work full-time. In fact, most do not work at all. And ultimately, this explosion in enrollment and costs leaves fewer dollars available for truly vulnerable individuals who depend on the Medicaid program to survive, as every dollar spent on able-bodied adults is a dollar that cannot be spent on the truly needy.

In order to move more able-bodied adults into self-sufficiency, the Centers for Medicare and Medicaid Services should continue approving state waivers for Medicaid work requirements and begin allowing states to roll back ObamaCare expansion.

I. APPROVE PENDING MEDICAID WORK REQUIREMENT WAIVERS

In January 2018, the Centers for Medicare and Medicaid Services issued guidance that it would consider state waiver requests to require able-bodied adults to work, train, or volunteer at least part-time as a condition of Medicaid eligibility. These waivers further Medicaid's core statutory purpose of helping families and individuals attain or retain capability for independence. Since the guidance was issued, the agency has approved Medicaid work requirement waivers in Kentucky, Indiana, and Arkansas.

Additional waiver requests from Arizona, Kansas, Maine, Mississippi, New Hampshire, North Carolina, Utah, and Wisconsin are currently pending federal review. Requests from Alabama and Ohio are pending public comment before official submission to the Centers for Medicare and Medicaid Services. State officials in Oklahoma, South Carolina, South Dakota, West Virginia, and other states are also preparing waivers to be submitted in the near future.

Work requirements have been very successful in moving able-bodied adults out of dependency in other welfare programs. Research on work requirements for childless adults receiving food stamps and parents receiving cash assistance found able-bodied adults went back to work in more than 600 different industries and saw their incomes more than double on average. Higher incomes more than offset lost welfare benefits, leaving individuals better off financially than they were before.

The Centers for Medicare and Medicaid Services should continue to approve state waiver requests for Medicaid work requirements.

II. ALLOW STATES TO MAKE PROSPECTIVE PROGRAM CHANGES

ObamaCare's Medicaid expansion has created significant cost overruns in states that opted to expand the program to a new class of able-bodied adults. So far, more than twice as many able-bodied adults have already signed up for the program than states expected to ever enroll at any point in the future. In the first three years, the cost per-person was 76 percent higher than initial projections from actuaries at the Centers for Medicare and Medicaid Services. Overall, Medicaid expansion has cost taxpayers more than 2.5 times what was expected. These soaring costs and higher than anticipated enrollment have left states and the federal government with fewer resources for the truly needy, including seniors, poor children, and individuals with disabilities.

Past research also finds that expanding Medicaid to able-bodied adults discourages work—an outcome in direct conflict with Medicaid's core statutory objective of helping individuals attain or retain capability for independence, as work is the best way to attaining independence. The Congressional Budget Office has repeatedly concluded that ObamaCare's Medicaid expansion discourages work and reduces the number of people working at all and the number of hours worked.

Given the problems experienced as a result of expanding Medicaid, it should come as no surprise that several expansion states are now looking for ways to unwind the expansion and preserve resources for the truly needy. One option receiving significant attention involves prospectively changing eligibility for the program.

Under this approach, current enrollees would stay on the program until their incomes increase or they otherwise become ineligible, but no new individuals would be allowed to enroll in the expansion. States have used this process to successfully unwind past Medicaid expansions through Section 1115 waivers or through the Children's Health Insurance Program.

The Ohio General Assembly passed a bill in 2017 that would adopt this reform. The bill requires the Department of Medicaid to seek any and all state plan amendments and waivers necessary to implement it. Gov. John Kasich vetoed the provision, but the debate over how to roll back the expansion continues and a veto override remains pending. Similar bills have passed the Arkansas House of Representatives and are being considered in other Medicaid expansion states.

Allowing states to unwind ObamaCare expansion in this way would immediately free up resources for the truly needy, encourage able-bodied adults to return to the workforce, and gradually reverse past policy mistakes. The Centers for Medicare and Medicaid Services should issue sub-regulatory guidance on the issue, making clear that CMS can and will approve state requests to unwind expansions in this way.

The Trump administration should grant state flexibility to improve program integrity

Waste, fraud, and abuse costs taxpayers billions of dollars each year, robbing resources from the truly needy. According to federal data, most improper payments in the Medicaid program relate to eligibility errors. Every dollar spent on individuals ineligible for Medicaid is a dollar that is unavailable to fund services for the truly needy, including poor children, seniors, and individuals with disabilities.

In order to preserve resources for the truly needy, the Centers for Medicare and Medicaid Services should provide states with additional flexibility to improve program integrity.

I. ALLOW STATES TO REDETERMINE MEDICAID ELIGIBILITY MORE OFTEN THAN ONCE PER YEAR

Federal regulations previously required states to redetermine Medicaid eligibility "at least every 12 months," with state flexibility to redetermine eligibility more frequently. Many states used that flexibility to redetermine eligibility for Medicaid on a more frequent basis to ensure those receiving benefits were truly eligible.

But beginning in 2014, states lost existing flexibility to check eligibility more frequently, as the regulation was rewritten to require states to check eligibility "no more frequently than once every 12 months." Although this regulatory change was adopted with other changes related to ObamaCare, it had no basis in statute.

Unfortunately, changes in employment, income, residency, and other factors affecting eligibility happen more frequently than once per year. In fact, the average person in poverty remains there for just six to seven months. Roughly 44 percent will exit poverty within four months, while just one in four will stay for 12 months or longer. The revised regulation made it increasingly more difficult for states to capture these changed circumstances.

The regulation does permit the state to check eligibility in between annual redeterminations if it receives information that suggests a change in circumstances. However, that process is limited in scope and relies heavily on self-reported changes. States must also significantly limit requests for additional information from individuals when redetermining eligibility under this provision.

Ultimately, the current regulation facilitates the crowding out of resources for the truly needy as states spend funds on individuals who may no longer be eligible for the program. States report that changing from a 6-month redetermination period to a 12-month redetermination period increased costs by lengthening the time individuals remained on Medicaid.

When the current regulation was implemented in 2014, it overturned longstanding policy, removed state flexibility, and created gaps in program integrity. The Centers for Medicare and Medicaid Services should revise the regulation to allow states to redetermine eligibility more frequently than once per year.

II. ELIMINATE PASSIVE ELIGIBILITY RENEWAL REQUIREMENTS

At the same time the Centers for Medicare and Medicaid Services limited state flexibility to check eligibility from frequently, it also limited how much information states could request to verify individuals were eligible. The revised regulations mandated that states rely upon existing information and passively renew eligibility in many cases, requiring no further information from enrollees.

State experiences with passive redetermination processes have uncovered significant program integrity risks. In Illinois, for example, an audit by the Office of Inspector General found that 34 percent of reviewed case files

contained eligibility errors—93 percent of them related to enrollees failing to provide accurate information—leading auditors to recommend that "the passive redetermination process be discontinued."

The Centers for Medicare and Medicaid Services should revise the regulation to provide states with the flexibility to seek additional information on applicants and enrollees in order to protect program integrity, eliminating passive renewal requirements and allowing for more active redetermination processes.