

February 7, 2020

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

**Re: Comments on Pending “Georgia Pathways to Coverage” Waiver Application**

**Submitted electronically via [Medicaid.gov](https://www.Medicaid.gov)**

Dear Secretary Azar:

Families USA appreciates the opportunity to provide comments on Georgia’s proposed Pathways to Coverage Section 1115 Demonstration Waiver. Families USA is a national, non-partisan health care policy and advocacy organization that supports policies and programs at the state and federal levels to ensure the best health and health care are equally accessible and affordable to all, with a particular focus on actions that affect lower-income individuals. Please note that in addition to my current role at Families USA, I was formerly the Health Division Director at the bipartisan National Governors Association’s Center for Best Practices, where I worked with governors of both parties to improve their Medicaid programs.

This proposed 1115 waiver includes multiple elements that are both legally problematic and poor policy choices for the state. We support state decisions to accept federal funds to expand Medicaid coverage; however, to receive those added funds, states must comply with the requirements of the Medicaid program and Medicaid law. Much of Georgia’s request fails to meet that test. Therefore, we encourage the Centers for Medicare and Medicaid Services (CMS) to deny the state’s request in its entirety and instead work with the state to expand its Medicaid program in a way that does not violate Medicaid statute and maximizes federal funding. The elements of the waiver request that fail to meet federal requirements are discussed in greater detail below.

**Comments on Specific Provisions in the Amendment Request**

***Context of the analysis***

The Supreme Court’s decision in *National Federation of Independent Business v. Sebelius* (NFIB) made the Affordable Care Act’s (ACA’s) Medicaid expansion an option for states.<sup>1</sup> However, that same decision also made clear that when a state accepts the option to expand Medicaid, the requirements related to

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<sup>1</sup> *NFIB –v- Sebelius*, 567 U.S. 519 (2012).

the ACA's Medicaid expansion still apply.<sup>2</sup> In writing for the majority, Justice Roberts explicitly stated that the opinion did not rewrite Medicaid law. He made it clear that the opinion was indeed quite narrow, only reversing the requirement that states expand Medicaid. The remainder of the law was unaffected by that decision.<sup>3</sup> Once a state accepts the expansion, all Medicaid laws and regulations apply.

In its consideration of Georgia's new waiver application, CMS must apply all Medicaid laws in its review. Under the statutory requirement that Medicaid waivers be reviewed in light of whether they will promote the core objective of Medicaid—provision of medical assistance—many elements in the state's request, including but not limited to the request for enhanced federal match for less than a full expansion and the request to implement a work reporting requirement, must be denied.

### **1. Enhanced Match for Partial Expansion**

Georgia is requesting the enhanced 90/10 federal match for its partial expansion of Medicaid for adults up to 100 percent of the federal poverty level (FPL). Families USA believes this is bad policy and illegal. To date, CMS has not approved states' requests to partially expand Medicaid with the enhanced federal match rate and Administrator Verma has made this position clear. Most recently, in an August 2019 correspondence with Utah Governor Herbert, Verma informed the state that it would not grant its request to "cover only a portion of the adult expansion group and still access the enhanced federal funding available under section 1905(y)(1) of the Social Security Act."<sup>4</sup>

This rejection is the correct decision, but not necessarily based on the right reasoning. Federal law clearly stipulates that states are eligible for the 90/10 match rate only if they expand Medicaid up to 133 percent FPL. CMS does not have the authority to approve an enhanced federal match for an expansion that does not extend coverage to 133 percent FPL, as specified in section 1905 of the Social Security Act.<sup>5,6</sup> Additionally, the enhanced match for the Medicaid expansion is codified in section 1905 of the Social Security Act. That section of the Act cannot be waived under section 1115 authority. **This request**

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<sup>2</sup> *Ibid.* Noting that the law allows the Secretary to withhold all Medicaid funds from a state if it is not in compliance with Medicaid requirements, including those applying to the expansion.

<sup>3</sup> *Ibid.*

<sup>4</sup> <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/per-capita-cap/ut-per-capita-cap-correspondence-ltr-20190816.pdf>

<sup>5</sup> Section 1905(y) of the Social Security Act [42 USC sec. 1396d(y)]. Income calculations in these comments do not include the 5 percent income disregard.

<sup>6</sup> Section 1905 of the Social Security Act defines the increased federal match for adults as applying when a state provides medical assistance to the group covered in 1902(a)(10)(A)(i)(VIII).<sup>6</sup> The statutory language clearly defines the expansion group as a whole, consisting of *all individuals* with incomes below 133 percent of poverty who are under 65, not enrolled in Medicare, and not entitled to Medicaid on any other mandatory coverage basis (emphasis added). The group is defined clearly without permissive language or flexibility. There is no language allowing states to cover some of the defined group and receive the enhanced federal match. The group for which states can receive enhanced funding is clearly defined as a whole; it is not divisible. A state's receipt of enhanced federal funding is predicated on it meeting all of the coverage requirements outlined in section 1902(a)(10)(A)(i)(VIII).

**for partial expansion should be rejected both on its merits as bad policy and because CMS does not have the authority to approve it.**

## **2. Work Reporting Requirements**

Following in the misguided footsteps of other states, the proposed waiver requires non-exempt beneficiaries to report their participation in “qualifying activities” related to employment.<sup>7</sup> As evidenced by other states, these work reporting requirements are confusing and onerous for patients and providers<sup>8</sup>, administratively burdensome and costly for the state<sup>9</sup>, and potentially illegal.<sup>10</sup>

The state emphasizes that its “approach is different than other states” because their work requirement begins before an individual can enroll in Medicaid.<sup>11</sup> While the state is unique in its proposal to create a new eligibility group for whom enrollment in Medicaid is contingent on a work reporting requirement, these newly eligible beneficiaries will face the same — if not stricter — reporting requirements as other states, and will be just as vulnerable to coverage losses. On top of that, the reporting requirements in the state’s so-called “work-first approach” will prevent Georgians who would otherwise be newly eligible for Medicaid from enrolling in the first place. Estimated coverage losses due to work reporting requirements have been provided in similar waiver requests from other states. But Georgia’s proposal, which lacks transparency on multiple fronts, fails to publicly provide an estimate of the number of beneficiaries who would lose Medicaid eligibility due to the proposed work reporting requirement.

### **A work reporting requirement is contrary to Medicaid law.**

Section 1115 of the Social Security Act gives the Secretary the authority to “waive compliance with any of the requirements of section [...] 1902” of the Social Security Act for any experimental, pilot, or demonstration project which, in the judgment of the Secretary, “is likely to assist in promoting the objectives of title [...] XIX.”<sup>12</sup>

Medicaid’s objectives are outlined in Section 1901 of the Social Security Act. It states that federal Medicaid dollars are for the purpose of enabling states “to furnish (1) medical assistance on behalf of [statutorily eligible individuals], and (2) rehabilitation and other services to help such [individuals] attain or retain capability for independence or self-care...”<sup>13</sup> In the context of the statute, it is absolutely clear that “independence or self-care” refers to federal funding enabling states to provide care that can help individuals attain or retain physical independence.

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<sup>7</sup> <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ga/ga-pathways-to-coverage-ca.pdf>, page 6.

<sup>8</sup> <https://familiesusa.org/resources/nebraskas-reporting-requirements-an-unnecessary-burden-on-patients-and-providers/>

<sup>9</sup> [https://familiesusa.org/wp-content/uploads/2020/01/MCD\\_Utah-WR-State-Burden-Analysis\\_v2-00000002.pdf](https://familiesusa.org/wp-content/uploads/2020/01/MCD_Utah-WR-State-Burden-Analysis_v2-00000002.pdf)

<sup>10</sup> <https://familiesusa.org/resources/for-nebraska-a-work-requirement-by-any-other-name-will-still-be-struck-down-in-court/>

<sup>11</sup> <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ga/ga-pathways-to-coverage-ca.pdf>, page 2.

<sup>12</sup> Social Security Act, section 1115 [42 U.S.C. 1315].

<sup>13</sup> Social Security Act Sec. 1901. [42 U.S.C. 1396].

While HHS has updated its Medicaid.gov website to redefine the objectives of the Medicaid program, that has no legal import. Statutory language has precedence over any website language, no matter how official the website.

- A work reporting requirement is unrelated to Medicaid’s objectives as defined in statute. The language in the statute is clear. Federal Medicaid dollars are to be used to *furnish* medical, rehabilitation, and long-term services. Requiring work or community service as a condition of coverage is not in any way related to the *state furnishing* medical services or to the *state furnishing* rehabilitative or other services—indeed it achieves the opposite goal by withdrawing medical services from otherwise eligible low-income people if they do not meet the work reporting requirement. It is therefore outside of CMS’s authority to approve under section 1115 authority.

In his recent ruling to vacate the approval of Arkansas’ work reporting requirement, Judge Boasberg affirmed that a work reporting requirement is unrelated to Medicaid’s objectives. Boasberg ruled that, “the Secretary’s approval of the Arkansas Works Amendments is arbitrary and capricious because it did not address – despite receiving substantial comments on the matter—whether and how the project would implicate the “core” objective of Medicaid: the provision of medical coverage to the needy.”<sup>14</sup>

Similarly, Judge Boasberg ruled in his decision to vacate the approval of New Hampshire’s work reporting requirement, “Medicaid, both as enacted and as later expanded by the ACA, reflects Congress’s desire to “mak[e] healthcare more affordable” for “needy populations.” [...] Congress therefore designed a scheme “to address not health generally but the provision of care to needy populations.”<sup>15</sup>

- Adding a work reporting requirement is beyond the Secretary’s authority to “waive” requirements in section 1902. Section 1115 gives HHS the authority to waive requirements in Section 1902. It does not allow states to add new program requirements that are not mentioned in 1902 and that are unrelated to the program’s statutory purpose of furnishing medical or rehabilitative services.<sup>16</sup> Section 1902 does not mention engaging in work or community service. States do not have the authority to add new requirements unrelated to the program’s objective of *furnishing* medical care.
- A mere nexus between an activity and health is not a sufficient basis for the Secretary to use 1115 authority to make Medicaid eligibility conditional upon participation in that activity. In its proposal, Georgia states the goal of the work reporting requirement is to improve the health of low income Georgians by encouraging work and other employment-related activities.<sup>17</sup> However, the mere connection between an activity and health status is not a basis for making receipt of Medicaid

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<sup>14</sup> [https://ecf.dcd.uscourts.gov/cgi-bin/show\\_public\\_doc?2018cv1900-58](https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv1900-58), page 26.

<sup>15</sup> [https://ecf.dcd.uscourts.gov/cgi-bin/show\\_public\\_doc?2019cv0773-47](https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2019cv0773-47), page 24.

<sup>16</sup> Social Security Act, section 1115 [42 U.S.C. 1315].

<sup>17</sup> <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ga/ga-pathways-to-coverage-ca.pdf>, page 3.

benefits conditional upon an individual's participation in that activity. There are numerous activities that have been shown to improve physical and mental health. Diet<sup>18</sup>, exercise<sup>19</sup>, marital status<sup>20</sup>, and social engagement<sup>21</sup> are only a few of the nearly endless activities that can impact individual health. It is gross regulatory overreach and a misuse of federal and state funds to add extra-statutory conditions that are not within the program's objectives simply because one or more of those activities have been shown to be related to individual health.

Medicaid is a program to furnish medical assistance: it is a health *insurance* program. Health insurance protects people from financial loss associated with medical costs. That is not synonymous with health. That distinction holds true for Medicaid, Medicare, employer sponsored coverage, and any health insurance program. Following a path of adding reporting requirements to Medicaid simply because they arguably promote health is far beyond the program's objectives and could turn the program into a virtual a la carte menu of extra-statutory requirements approved at any administration's whim. It sets up a dynamic that could lead to near unending government micromanagement of the lives of Medicaid enrollees.

Judge Boasberg affirmed that promoting health is not a freestanding objective of Medicaid in his ruling to vacate the approval of Kentucky's work reporting requirement waiver. In his decision, Boasberg notes that, were health to be considered a freestanding objective of Medicaid, "nothing would prevent the Secretary from conditioning coverage on a special diet or certain exercise regime."<sup>22</sup> He also notes that, "Even if health were such an objective, approving Kentucky HEALTH on this basis would still be arbitrary and capricious."<sup>23</sup> If approved, the same could be said for Georgia's proposal to add a work reporting requirement.

- Like the work requirement waivers in other states, if approved, this waiver will be vulnerable to legal challenges. To date, five of the states (KY, AR, NH, and IN) that have implemented work reporting requirement waivers have had the approvals of these waivers challenged in court or have lawsuits

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<sup>18</sup> See the U.S. Dietary Guidelines, Office of Disease Prevention and Health Promotion, Department of Health and Human Services, for an overview of the near endless number of studies looking at the relationship between diet and health, at <https://health.gov/dietaryguidelines/2015/guidelines/introduction/nutrition-and-health-are-closelyrelated/>.

<sup>19</sup> See the U.S. Physical Activity Guidelines, Office of Disease Prevention and Health Promotion, Department of Health and Human Services, for an overview of the near endless number of studies looking at the relationship between physical activity and health, at <https://health.gov/paguidelines/>

<sup>20</sup> For a summary of the copious data on this topic, see the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, The Effects of Marriage on Health: A Synthesis of Recent Research Evidence. Research Brief, 7/01/2007 online at <https://aspe.hhs.gov/report/effects-marriagehealth-synthesis-recent-research-evidence-research-brief>.

<sup>21</sup> For a summary of the data on the connection between social relationships and health see Debora Umberson, et al., "Social Relationships and Health: A Flashpoint for Health Policy," Journal of Health and Social Behavior, 2010; 51 (Suppl): S55-S66, online at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3150158/>.

<sup>22</sup> [https://www.courtlistener.com/recap/gov.uscourts.dcd.192935/gov.uscourts.dcd.192935.132.0\\_2.pdf](https://www.courtlistener.com/recap/gov.uscourts.dcd.192935/gov.uscourts.dcd.192935.132.0_2.pdf), page 27.

<sup>23</sup> *Idem*, page 28.

pending. In three of those states (KY<sup>24</sup>, AR<sup>25</sup>, and NH<sup>26</sup>) the court has ruled to vacate their approval, and in the other two states (IN<sup>27</sup> and MI<sup>28</sup>), the cases have yet to be heard.

### **A work reporting requirement will cost millions of dollars to implement.**

In October 2019, the United States Government Accountability Office (GAO) released a report that included five states' estimates of the administrative costs associated with implementing their approved work reporting requirement waivers.<sup>29</sup> Estimated costs varied from \$6 million to \$271 million for IT systems changes, beneficiary outreach, contracting and other administrative costs.<sup>30</sup> Much of these costs do not appear to be allowable for enhanced federal match and would therefore require significant state spending.

Georgia's administrative costs will likely exceed those of the states the GAO analyzed, since the state is proposing to require reporting on compliance with the "allowable activities" both pre-enrollment as part of an eligibility determination and post-enrollment as a condition of continued eligibility. Determining compliance with these requirements will require coordination across a myriad of systems and entities.

Despite the astronomical costs associated with implementing these waivers, the GAO found that states were not required to provide projections of administrative costs when requesting approval of these waivers.<sup>31</sup> Therefore, in the interest of transparency with regards to state and federal spending, we request that CMS require the state to provide projections of administrative costs associated with implementing this waiver.

### **Historically, beneficiaries have had low awareness and understanding of work reporting requirements.**

In 2019, New Hampshire halted implementation of its work reporting requirement due to lack of awareness among thousands of beneficiaries. Despite extensive efforts to inform beneficiaries of the work reporting requirement, the state failed to obtain compliance information for nearly 17,000 beneficiaries who were subject to the work reporting requirement and are therefore at risk of losing coverage.<sup>32</sup> Other states like Indiana,<sup>33</sup> Arizona,<sup>34</sup> and Kentucky<sup>35</sup> have followed suit and halted

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<sup>24</sup> [https://ecf.dcd.uscourts.gov/cgi-bin/show\\_public\\_doc?2018cv0152-74](https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv0152-74)

<sup>25</sup> [https://ecf.dcd.uscourts.gov/cgi-bin/show\\_public\\_doc?2018cv1900-58](https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv1900-58)

<sup>26</sup> [https://ecf.dcd.uscourts.gov/cgi-bin/show\\_public\\_doc?2019cv0773-47](https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2019cv0773-47)

<sup>27</sup> [https://9kqpw4dcaw91s37koz5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2019/09/Complaint\\_Rose-v-Azar-REDACTED.pdf](https://9kqpw4dcaw91s37koz5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2019/09/Complaint_Rose-v-Azar-REDACTED.pdf)

<sup>28</sup> <https://healthlaw.org/wp-content/uploads/2019/11/Michigan-1115-Complaint-Redacted.pdf>

<sup>29</sup> <https://www.gao.gov/assets/710/701885.pdf>

<sup>30</sup> *Id.*

<sup>31</sup> *Id.*

<sup>32</sup> <https://www.dhhs.nh.gov/medicaid/granite/documents/ga-ce-findings.pdf>

<sup>33</sup> [https://www.in.gov/fssa/files/Gateway\\_to\\_Work\\_suspension\\_announcement.pdf](https://www.in.gov/fssa/files/Gateway_to_Work_suspension_announcement.pdf)

<sup>34</sup> <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/Health-Care-Cost-Containment-System/az-hccc-postponement-ltr-ahcccs-works-10172019.pdf>

<sup>35</sup> <https://kentucky.gov/Pages/Activity-stream.aspx?n=GovernorBeshear&prId=7>

implementation of their work reporting requirements. Georgia will likely face these same challenges, resulting in thousands of beneficiaries losing coverage.

### **3. *Mandatory Enrollment in Employer-Sponsored Insurance***

Georgia is also requesting authority to require beneficiaries who are eligible for employer-sponsored insurance (ESI) to purchase that coverage instead of enrolling in Medicaid. This provision further limits coverage. If ESI-eligible beneficiaries fail to enroll in ESI, they will lose Medicaid coverage. If they disenroll from ESI, they will not be eligible for Medicaid coverage. In addition to the negative impact on coverage, we are concerned with the potential administrative costs and burdens associated with determining who is eligible for ESI coverage and tracking enrollment in that coverage, especially since ESI falls outside the Medicaid program. Implementation of this provision will require substantial data matching and interagency collaboration. Failure to properly implement this provision could have devastating consequences for beneficiaries. If the state erroneously determines that an individual qualifies for ESI and terminates their Medicaid eligibility, that individual will lose access to health insurance coverage.”

### **4. *Premiums and Copayments***

In a purported attempt to prepare beneficiaries to “transition from Medicaid to a commercial health insurance plan,” the state is also proposing to require beneficiaries between 50% and 100% FPL to pay monthly premiums on a sliding scale based on income. Failure to pay one month’s premium will result in a suspension of coverage, and failure to pay three month’s premiums will result in disenrollment.

Medicaid beneficiaries are financially strained already.<sup>36</sup> Forcing them to spend what little money they have left on premiums can make their health care unaffordable.

In addition to premiums, the state is also proposing to assess copayments for a variety of standard services, including inpatient and outpatient hospitalizations, specialist care, durable medical equipment, and pharmacy costs. The state will also require a \$30 copayment per non-emergent ED visit. Similar provisions have historically been difficult to implement compared to other less punitive strategies to divert unnecessary utilization of the ED. Additionally, high surcharges for non-emergent use of the ED could deter individuals from appropriate use of emergency services, in addition to inappropriate use. CMS should deny the state’s request to charge the aforementioned premiums and cost-sharing.

### **5. *Prospective eligibility***

The state is requesting multiple waiver authorities to make eligibility for Medicaid under this waiver prospective only. The state is proposing to delay the coverage effective date for newly eligible beneficiaries until the month following their eligibility determination or, for beneficiaries who are subject to premiums, the month following their first premium payment. This means that beneficiaries who are determined eligible for Medicaid at the beginning of the month must wait weeks before they can access care. Beneficiaries with chronic conditions as well as those who anticipate costly treatments

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<sup>36</sup> <https://aspe.hhs.gov/basic-report/financial-condition-and-health-care-burdens-people-deep-poverty>

cannot afford to wait weeks before they can access services. This delay will cause confusion among beneficiaries who could otherwise access services upon enrollment and increase uncompensated care costs for providers who could otherwise be reimbursed for treating Medicaid-eligible patients.

To implement prospective eligibility, the state is proposing to waive retroactive eligibility. Waiving retroactive eligibility makes beneficiaries responsible for the entire cost of their care prior to enrollment, even if they could have been determined eligible during their care visit or retroactively after receiving care.<sup>37</sup> Retroactive coverage keeps individuals from incurring high medical bills and medical debt by covering the medical bills they incurred in the three months before being determined eligible for Medicaid. Retroactive coverage also encourages doctors and hospitals to treat uninsured Medicaid eligible patients, because they will be compensated for the services they provided once the individual is enrolled.

The state is also proposing to waive presumptive eligibility, which helps patients get health care as soon as they arrive at the hospital and ensures that doctors and hospitals are reimbursed for that care. By waiving presumptive eligibility, the state would create additional barriers for uninsured patients who receive care at hospitals and are eligible for Medicaid. A delayed coverage date with a waiver of both retroactive and presumptive eligibility eliminates a vital pathway for hospitals to be reimbursed after caring for low-income, uninsured patients and for uninsured patients to avoid crippling financial liabilities.

## **6. Waiver of Early and Periodic Screening, Diagnostic, and Treatment Benefits**

The narrative section of the state's waiver application does not explicitly propose to waive Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits, nor does it provide a rationale for doing so. However, the state does request authority to waive coverage of vision and dental services for 19 and 20 year olds who are statutorily required to receive these services as part of the EPSDT benefit package.<sup>38</sup>

EPSDT covers items such as vision and hearing screening and treatment (e.g., glasses or hearing aids), basic dental, medical, mental health, and developmental services for children and young adults. Congress designed Medicaid with the EPSDT requirement because low-income children and young adults have a distinct need for comprehensive care in order to lead healthy lives.

Extending EPSDT to age 21 is critical. The brain does not develop fully until children reach about age 25.<sup>39</sup> As a result, young adults benefit from frequent screenings and access to comprehensive treatment as their medical needs, particular mental health needs, continue to change. Furthermore, EPSDT is cost effective. EPSDT provides sweeping benefits for all Medicaid enrollees under age 21, but it is not a high-

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<sup>37</sup> <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ga/ga-pathways-to-coverage-ca.pdf>, page 10.

<sup>38</sup> <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ga/ga-pathways-to-coverage-ca.pdf>, page 23.

<sup>39</sup> Massachusetts Institute of Technology, Young Adult Development Project, online at <http://hrweb.mit.edu/worklife/youngadult/brain.html>.



cost service. Removing the EPSDT benefits for 19- and 20-year-olds would not produce large savings, and would make it more difficult for these young adults to receive the care they need.

### **7. Waiver of Non-Emergency Medical Transportation**

The state's proposal to waive non-emergency medical transportation (NEMT) will limit beneficiaries' access to care and does not further the objectives of the Medicaid program. Medicaid's purpose is to provide low-income individuals with access to health care. The program's benefits were designed to address the unique needs of the low-income population. Among those unique needs is a greater need for transportation assistance than among the privately insured population.<sup>40</sup> The NEMT benefit helps address that need, and helps Medicaid fulfill its purpose. By ignoring the unique transportation needs of the Medicaid population and omitting a standard benefit designed to address those needs, Georgia's proposed waiver does not further the objectives of the Medicaid program. Allowing the state to waive the NEMT benefit would limit access to care for the population that Medicaid is intended to serve.

### **Conclusion**

Overall, Georgia's waiver application lacks a coherent, data supported rationale showing how approval of the waiver will further the objectives of the Medicaid program. In addition to proposals that limit coverage and access to care for beneficiaries, the state's application includes several requests that are simply not approvable based on statute and regulation. Therefore, CMS should deny Georgia's waiver request and encourage the state to fully expand Medicaid.

Thank you for your consideration of these comments. If you have any questions, please contact Emmett Ruff at [ERuff@familiesusa.org](mailto:ERuff@familiesusa.org) or 202-628-3030.

Respectfully submitted,

Frederick Isasi  
Executive Director at Families USA

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<sup>40</sup> A study based on National Health Interview Survey data found that Medicaid enrollees were 10 times more likely to report that transportation was a barrier to accessing timely primary care than were people who were privately insured. P.T. Cheung, et al., "National Study of Barriers to Timely Primary Care and Emergency Department Utilization Among Medicaid Beneficiaries," *Annals of Emergency Medicine* 60, no. 1 (March 2012): 4-10.