FamiliesUSA
The Voice for Health Care Consumers

September 26, 2013

The Honorable Kathleen Sebelius
United States Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

By E-Mail to: Kathleen.Sebelius@hhs.gov

Re: Comments on Iowa Marketplace Choice Plan and Iowa Wellness Plan Section 1115 Waiver submissions

Dear Secretary Sebelius:

Families USA is grateful for the opportunity to comment on the 1115 waiver requests submitted by the state of Iowa: the Marketplace Choice Plan and the Wellness Plan. In this letter, we are commenting on both.

We are a national healthcare advocacy organization with the mission of supporting policy changes that will expand access to affordable healthcare for all Americans. We are committed to seeing Iowa expand Medicaid eligibility and we support Iowa's decision to accept federal funding to extend Medicaid coverage to low-income parents and adults.

However, we have serious concerns with several components of both of Iowa's waiver requests. Both waiver applications include components that set dangerous precedents for the Medicaid program and for future Medicaid expansions. These include the imposition of premiums on very low-income beneficiaries; linking exemption from premium payments to beneficiaries' completion of wellness activities; omitting wrap-around coverage; and, a failure to provide a full cost comparability analysis. These concerns, and others, are addressed more fully below.

Premiums

Premium payments are a component of both waiver applications. We are extremely concerned by Iowa's proposal to impose monthly premiums on individuals with incomes between 51 and 100 percent of poverty in the Wellness Plan and between 101 and 138 percent of poverty in the Marketplace Choice Plan. The effect of premium requirements on Medicaid enrollees is well known. Past demonstrations have clearly shown that premium payments pose a financial

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hardship for Medicaid beneficiaries, negatively affecting enrollment rates and coverage retention.

The purpose of an 1115 demonstration project is to give the Secretary authority to approve pilot, experimental or demonstration projects that promote the objectives of the Medicaid program.[1] Because there is ample evidence of the effect of premium payments on Medicaid enrollees and their continued access to care, as outlined below, there is little demonstration value in including premium payments in the Iowa program, particularly for those with incomes below the poverty level.

Past demonstrations imposing premium in Medicaid have shown that they limit enrollment and result in program drop-out. There is little demonstration value in adding premium payments to the Iowa programs.

Past Medicaid demonstrations have examined the effect of premiums on access to care and found that premiums limit enrollment. Additionally, demonstrations have also shown that many in Medicaid are unable to maintain premium payments and lose coverage when premiums are imposed. Monthly premiums proposed for the Iowa programs will almost certainly cause enrollees to lose coverage, and cause newly eligible individuals to not enroll at all.

- Premiums negatively affect coverage retention even among higher income Medicaid enrollees. In July 2012, Wisconsin added or increased premiums for some adults enrolled in its Medicaid program, BadgerCare. Enrollees with incomes between 133 and 150 of poverty who had previously had no premium costs were required to pay three percent of their income in premiums. Preliminary analysis showed that premium payments had a negative effect on the ability of these low-income enrollees to maintain coverage. From July through September 2012, there was a 24 percent enrollment reduction due to non-payment of premiums for those in the 133 to 150 percent of poverty income group.[2] Wisconsin's premium payment was a comparable percent of income to that proposed in the Iowa applications. However, Iowa is proposing to impose those premiums on a much lower income population (51 to 138 percent of poverty). The Iowa premiums would therefore impose an even greater financial burden relative to income, inevitably resulting in a higher drop-out than experienced in Wisconsin.

- Premiums negatively affect enrollment. A study of multiple Medicaid programs in which premiums were imposed found that for low-income families, premiums as low as one

[1] 42 U.S.C. 1315(a).

[2] For analyses of the BadgerCare results see: "State of Wisconsin Department of Health Services Wisconsin Medicaid Premium Reforms: Preliminary Price Impact Findings," available online at: http://www.dhs.wisconsin.gov/MAreform/report12.11.12.pdf Wisconsin Council on Children and Families, "Evaluation of Last Year's BadgerCare Changes Makes Strong Case Against New Waiver," September 4, 2013, available online at: http://wccf.org/pdf/BadgerCare_changes_evaluation.pdf.

percent of income are associated with decreased enrollment.[3]

- Premium payments have been shown to be a hardship for very low-income individuals. A decade ago, Oregon imposed premiums on adults with incomes below the poverty level. Premiums ranged from $6 per month for people with no income to $20 per month for people at the poverty line. In the nine months that followed the increase, nearly half of those that had been on the program were no longer enrolled and the majority of them were left without coverage.[4]

Allowing Iowa to impose premiums on people with incomes below 100 percent of the poverty line would set a new and dangerous precedent in the Medicaid program.
If approved, Iowa's plan would be the first Medicaid demonstration project approved since the creation of a mandatory group of low-income individuals (under Section 1902(a)(10)(A)(i)(VII) of the Social Security Act) that would require adults with incomes below 100 percent of the poverty line to pay premiums. As outlined above, premium payments for very low-income individuals have already been shown to result in lost coverage. Allowing Iowa to charge premiums to people with very low incomes will lead to a financial hardship for enrollees and coverage losses, results that are inconsistent with the objectives of the Medicaid program and not an appropriate use of demonstration authority. Moreover, it would be inconsistent with previous CMS policy positions. The March 2013 FAQs on premium assistance does not contemplate imposing premiums on individuals with incomes below 100 percent of poverty. And as noted in an April 23, 2013 letter to Iowa State Senator Pam Jochum, CMS has generally not permitted Medicaid programs to impose premiums on those with incomes below poverty.

Premiums are fundamentally different from cost sharing.
We recognize that Medicaid rules limit the imposition of premiums for individuals with incomes below 150 percent of poverty, whereas cost sharing can be applied at lower income levels.[5] Both premium and cost sharing can be barriers to care for very low-income individuals, and Families USA has serious concerns with both.[6] However, there is a policy rationale for allowing cost sharing at lower income levels than the income level at which premiums are allowed.

As a monthly payment requirement that must be made regardless of services used, premiums not only pose a recurring hardship on extremely low income individuals, but are more likely to cause individuals, particularly those who perceive that they are healthy, to drop coverage or

[3] Leighton Ku and Victoria Wachino, "The Effect of Increased Cost Sharing in Medicaid: A Summary of Research Findings," Center on Budget and Policy Priorities, July 2005, available online at http://www.cbpp.org/files/5-31-05health2.pdf.
[4] Leighton Ku and Victoria Wachino, "The Effect of Increased Cost Sharing in Medicaid: A Summary of Research Findings," Center on Budget and Policy Priorities, July 2005, available online at http://www.cbpp.org/files/5-31-05health2.pdf.
[5] 42 CFR 447. 55 and 42 CFR 447.52.
[6] Families USA, "Increasing Cost Sharing in Medicaid: A Bad Solution to Budget Issues," June 2012, available online at http://familiesusa2.org/assets/pdfs/Cost-Sharing-in-Medicaid.pdf.

not enroll. The result is that many low-income individuals end up with no coverage at all. They are then likely to forgo needed care, and when they do need medical services they will incur large medical bills, rather than incurring the more manageable cost-sharing permitted by Medicaid law.

Many enrolled in Iowa's Marketplace Choice or Wellness Plans will likely face premium charges.

We understand that enrollees can avoid premium charges if they engage in "healthy behaviors," which are not specified in the waiver application (see the discussion below under "Wellness Plans" where we address concerns that we have with that component of the application). As a general matter, we support programs designed to encourage Medicaid enrollees to engage in healthy behaviors. However, as currently proposed, these waivers penalize non-compliance, rather than encourage participation. As a result, extremely low-income individuals will face financial penalties in the form of premiums they can ill-afford.

The proposed structure of the program demonstrates a lack of understanding of the challenges facing a medically under-served and low-income population. The majority of the expansion population does not currently have a regular source of health care. Most are employed at low-wage jobs that make it difficult to schedule doctors' visits. [7] They are likely to have low health care literacy, and in Iowa, many are likely to live in rural areas that are medically underserved. The expansion of Medicaid coverage should help address these problems, but solving them will take time. It is likely that many of those eligible will fail to meet the wellness requirements the program imposes during the first year, and will therefore face premium charges for the next 12 months. As outlined above, there is ample data showing that premium payments will lead to disenrollment and lost coverage.

The premiums proposed are too high as a percent of income.

While we believe that the imposition of premiums is poor policy and inappropriate for a demonstration, if premiums were imposed, the amount proposed (3 percent of income) is excessive.

In its Marketplace Choice application, Iowa states that out-of-pocket costs will be in line with what individuals would pay if they were enrolled in QHPs, because premiums will be the only cost sharing. In making this calculation, the state is considering both premium payments (2 percent of income) and potential cost sharing that an individual at 101 percent of poverty might pay in the exchange. However, if these individuals were in the exchange, it is not guaranteed that all would have cost sharing charges. Therefore, if premiums are allowed, they should be no more than premiums individuals would pay if they were in the exchange.

[7] Kaiser Commission on Medicaid and the Uninsured, *Characteristics of Uninsured Low-Income Adults* (Washington: Kaiser Commission on Medicaid and the Uninsured, August 2012), available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8350.pdf.

Furthermore, imposing the same premium charge, 3 percent of income, on individuals with incomes at 50 to 100 percent of poverty is unconscionable. The Affordable Care Act anticipated that these very low-income individuals would have Medicaid coverage with zero premiums. Therefore, there is not an analogous exchange premium payment at this income level. However, one can make assumptions about the premium levels Congress might have imposed on this very low income population by looking at the structure of the advance premium tax credits. The tax credits are proportionately more generous for lower income people, with higher income people paying a larger share of their income towards premiums. Therefore, had Congress imposed premiums on individuals with incomes below poverty, it is safe to assume that those premiums would have been a significantly lower percent of income than the amount imposed on individuals with incomes between 101 and 138 percent of poverty, if not waived entirely. If the unfortunate decision were made to allow premium payments on this low-income population, they should at least be considerably lower as a percent of income than the premiums imposed on the 101 to 138 percent of poverty group.

The legislation for Iowa's Health and Wellness Plan does not require a specific premium amount. Rather, it states "(T)otal member cost-sharing, annually, shall align with the cost sharing limitation requirements for the American health benefit exchange under the Affordable Care Act."[8] This language clearly leaves room to reduce the proposed premium requirements for the 101 to 138 percent of poverty population.

The grace period is less generous than that for individuals in the exchange.

The 60-day grace period for failure to pay premiums is less generous than that in exchange plans, where there is a 90 day grace period for individuals receiving premium tax credits.[9] While we strenuously object to premium payments for this population, at the least, the grace period should be at least as generous as it is for premium tax credit recipients in exchange plans.

Beneficiaries should be rewarded for compliance.

If premiums are nevertheless imposed, the premiums should be structured to end as soon as beneficiaries comply with their wellness requirements, rather than requiring beneficiaries to pay premiums for an entire 12 month period (for example, someone who completes her risk assessment and wellness exam in February of year 2 should be relieved of premiums for the rest of that calendar year and year 3, rather than having to wait until year 3). This is advisable for at least three reasons: 1) primary care providers will likely be very busy the first year of the program, making it hard to obtain all necessary wellness appointments; 2) low-income beneficiaries should have opportunity and incentive to obtain immediate relief from burdensome premiums; and 3) behavioral economics research suggests that people at all income levels are more likely to act if they can obtain an immediate benefit, rather than be promised a benefit at a later date.

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[8] Iowa Senate File 446, *An Act Relating to Appropriations for Health and Human Services and Including Other Related Provisions and Appropriations, Providing Penalties, and Including Effective, Retroactive, and Applicability Date Provisions,* Section 172(1), "Member financial participation," page 155-156. Available online at http://coolice.legis.iowa.gov/linc/85/external/SF446_Enrolled.html/.

[9] 48 CFR 150.270(d).

The legislation for Iowa's Health and Wellness Plan does not require that premium payments for failure to complete wellness requirements must apply for an entire year. The relevant section of the legislation states, "If a member completes all required preventive care services and wellness activities as specified by rule of the department during the initial year of membership contributions shall be waived during the subsequent year of membership…." [10] "During" a year is not synonymous with an entire year. If premiums are imposed, payment requirements should end during the current year, at the point in time when wellness activities are completed.

Requirements for hardship waivers are not defined.
The waiver application does not specify the requirements for or provide examples of what defines a hardship for purposes of waiving premiums. This is a serious omission, because a person with income below the poverty level is by definition experiencing hardship. The hardship application and approval process should be clearly outlined to ensure that it is easy for applicants to apply and that the requirements for demonstrating a hardship are not onerous.

Wellness Incentives

Wellness requirements are inappropriate and ill-defined.
The proposal is inappropriately vague about what requirements will be imposed on beneficiaries. It suggests in year 1 that beneficiaries will be required to complete a health risk assessment and obtain a wellness exam from their PCP, and that Iowa plans to further refine these requirements in the future.[11] Although we support encouraging all beneficiaries to have a health risk assessment and wellness exam, obtaining these services depends on beneficiaries having access to providers. As noted above, low-income beneficiaries generally have inflexible work schedules and limited access to transportation. If the request to waive non-emergency transportation and limit access to some community health centers is approved (see below), beneficiaries will face further barriers to obtaining care. They should not be penalized for these barriers.

In addition, there is no indication of what sort of additional requirements will be imposed in the future. We strongly urge that if the waiver goes forward, CMS should review the wellness criteria the state seeks to impose. We are particularly concerned that Iowa not impose outcome measures, such as successful weight loss (as opposed to participating in a weight-loss program) or successfully stopping tobacco use (as opposed to participating in smoking cessation counseling). Using outcome measures as part of wellness programs, especially for low-income

[10] Iowa Senate File 446, *An Act Relating to Appropriations for Health and Human Services and Including Other Related Provisions and Appropriations, Providing Penalties, and Including Effective, Retroactive, and Applicability Date Provisions,* Section 172(2), "Member financial participation," page 155-156. Available online at http://coolice.legis.iowa.gov/linc/85/external/SF446_Enrolled.html/
[11] Iowa Wellness Application, p. 27.

people, is unwise, in part because it increases barriers to care for the very people who struggle most with health issues and therefore need health care services most.

There are alternatives to the Iowa wellness approach.

While we commend the waiver proposal's focus on promoting wellness, we believe that there are approaches other than the imposition of premiums that can encourage individuals to engage in behaviors that will benefit their health. These approaches tend to reward individuals with specific health risks for engaging in specific behaviors that should improve their health, rather than penalize a general population for non-compliance with generic obligations. Promising examples include those under development through the Medicaid Incentives for the Prevention of Chronic Disease Grant Program. For example, Minnesota Medicaid's *Medicaid Incentives for Diabetes Prevention Program* offers Medicaid patients diagnosed with pre-diabetes or with a history of gestational diabetes the opportunity to participate in an evidence-based Diabetes Prevention Program offered in a community based setting. Child care and transportation are provided. Participants can earn incentives like cash uploaded onto a debit card or membership to the YMCA for attending classes and meeting weight loss goals.[12] Connecticut Medicaid's *Incentives to Quit Smoking* program provides cash incentives to encourage enrollees to use tobacco cessation services and quit smoking.[13]

The analysis of compliance and non-compliance could be structured to better assess effectiveness.

If the waiver is approved, we recommend including two additional survey questions to better assess the effectiveness or lack thereof of the wellness incentives: 1) Members who do complete the wellness requirements should be surveyed to determine if the possibility of paying premiums was a factor to encourage them to complete the requirements. 2) Members who do not complete the wellness requirements should be surveyed to determine why they did not or could not complete the requirements.

Wrap Around Services

In both waiver applications, Iowa asks to have the requirement to provide wrap around services waived. However, it does not offer any compelling patient care justification for such a waiver. Allowing Iowa to waive the requirement to provide wrap around services sets a bad precedent for future expansions.

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[12] Minnesota Department of Human Services, *RFP for Qualified Grantees to Offer Diabetes Prevention Program to Eligible Medicaid Recipents as part of the Minnesota Medicaid Incentives for Diabetes Prevention Program.* (August 6, 2012). Available online at: http://www.dhs.state.mn.us/main/groups/business_partners/documents/pub/dhs16_170774.pdf
Minnesota Department of Human Services, *Appendix 4a (Reading Level 6.9) We Can Prevent Diabetes in Minnesota Consent Form.* Available online at: http://www.dhs.state.mn.us/main/groups/business_partners/documents/pub/dhs16_171439.pdf.

[13] Center for Medicare and Medicaid Innovation, *MIPCD State Summary: Connecticut*. Available online at: http://innovation.cms.gov/Files/x/MIPCD-CT.pdf.

HHS has stated that premium assistance program demonstrations should provide wrap around services.

In its March guidance, HHS stated that it will only consider premium assistance proposals that, "(M)ake arrangements with the QHPs to provide any necessary wrap around benefits…."[14] Granting Iowa's request to waive wrap around services would undermine HHS's own very recent guidance and would set a very bad precedent for future expansions. The Medicaid package of benefits is designed to meet the needs of a low-income population. Congress intended for this population to receive this comprehensive set of benefits.

Non-emergency transportation should be a required service.

In both waiver applications, Iowa requests a waiver of the requirement to provide non-emergency transportation wrap around services yet fails to offer any rationale for this request that would further the objectives of the Medicaid program.[15] These services are necessary for the reasons outlined below and should not be waived.

The state's own study commission recommended increased support for non-emergency medical transportation.[16] While that study found that transportation was not a substantial barrier for non-disabled, non-elderly Iowa adults covered by Medicaid in 2008, the expansion represents coverage of a new population. Their transportation needs and barriers to care are not completely known. For this larger group of adults, many of whom will undoubtedly live in rural areas, transportation may well be a substantial issue.

Furthermore, given the structure of the program Iowa is asking to have approved, where beneficiaries will be subject to premiums if they do not complete certain wellness activities, it is critical to mitigate as many barriers to care as possible. Covering non-emergency transportation will lessen one barrier to care, making it easier for individuals to meet their wellness requirement.

EPSDT for 19 and 20 year olds should be required, or 19 and 20 year olds should be excluded from the program.

Iowa is requesting a waiver so that 19 and 20 year- olds who are entitled to receive Early Periodic Screening Diagnosis and Treatment (EPSDT) benefits can be enrolled in the wellness program or a qualified health plan in the health insurance marketplace where EPSDT services are not included in the benefit package. As a result, 19 and 20 year olds would not receive vision, dental or other EPSDT services they might need. HHS's March guidance states that only "individuals whose benefits are closely aligned with the benefits available on the Marketplace" should be included in premium assistance demonstrations. The lack of alignment between

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[14] HHS, Medicaid and the Affordable Care Act: Premium Assistance at Question 3 (March 2013) available at http://medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-Implementation/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-ACA-Implementation.html.

[15] 42 CFR 440.390 outlines the requirement to provide non-emergency transportation in Alternative Benefit Plans.

[16] University of Iowa, Public Policy Center, *Iowa Medicaid Non-Emergency Medical Transportation System Review and Options for Improvements*, September 30, 2008.

EPSDT and the wellness and marketplace plans suggests 19 and 20-year olds should not be included in the demonstration at this time.

Coverage requirements for federally qualified community health centers (FQHCs) and rural health centers (RHCs) should not be waived.

In its Marketplace Choice waiver application, Iowa is requesting a waiver from the requirement to include all FQHCs/RHCs in the plan networks. The primary reason for this request seems to be that one of the two plans in the premium assistance program does not include all FQHCs/RHCs. HHS should not waive federal program requirements for the convenience of participating private plans. If participating plans cannot make the effort to align their networks and services with the needs of enrollees, perhaps they are not appropriate plans for the Medicaid expansion population.

Furthermore, as outlined in our discussion of non-emergency medical transportation, given the structure of the program that Iowa proposes, it is critical that every effort is made to lessen access barriers. FQHCs/RHCs are sites where individuals who will be in premium assistance may be accustomed to receiving care. Allowing participating plans to exclude those providers may make it more difficult for Medicaid enrollees to access care and fulfill the wellness requirements. If Iowa is allowed to link premiums and wellness requirements, it is essential that all FQHCs/RHCs be included in the plan networks.

Coverage requirements for family planning providers should not be waived.

The Iowa Marketplace Choice Plan does not list family planning services as a covered benefit. Additionally, the state requests a waiver of the beneficiary free choice of family planning providers.[17] As the waiver application is written, it appears that Iowa residents enrolled in the Marketplace Choice Plan will not have family planning services nor a free choice of family planning providers. Regulations require that Alternative Benefit Plans include family planning services.[18] Neither these services nor the free choice of providers should be waived.

Offering the essential health benefits to the expansion population is not a justification for not offering required Medicaid services.

In its Market Place Choice application, Iowa states that "(W)rap around benefits are not necessary for the Marketplace Choice Plan due to the Marketplace Choice Plan QHPs providing the required EHBs to members."

All QHPs are required to provide the essential health benefits. Alternative benefit plans for the Medicaid expansion population are required to provide the essential health benefits *plus* specified Medicaid wrap around services.[19] Providing the essential health benefits is not sufficient.

[17] Social Security Act section 1902(a)(10)(A).

[18] 42 CFR 440.335.

[19] Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medicaid Program: States Flexibility for Medicaid Benefit Packages, Final Rule, 75 *Federal Register*, 23068 (April 30, 2010).

Allowing states to legislate away federal Medicaid requirements sets a bad precedent.
In both applications, Iowa asserts that it should not be required to provide wrap around services because they are not specified benefits in the enabling legislation. Allowing states to legislate away federal program requirements for the Medicaid expansion sets a bad precedent.

Emergency Room Cost Sharing

There is no justification for cost sharing that exceeds what is allowed under the Medicaid program. We support strategies to discourage inappropriate use of emergency room services, provided there are adequate consumer protections in place. Those include providing a complete medical assessment to confirm no emergency exists and making arrangements for individuals to receive needed medical care quickly. We do not have issues with Iowa's decision to apply cost-sharing to non-emergency use of emergency departments, provided those consumer protections are in place. However, recent regulations set cost sharing for non-emergency use of emergency room services at $8 for the populations covered by these waiver requests.[20] There is no justification for the request to set cost sharing higher.

Budget Neutrality

The budget neutrality analysis is incomplete. A full analysis with opportunity for public comment should be required prior to approval.
In its March guidance, HHS stated, "As with all demonstration proposals, the actuarial, economic, and budget justification (including budget neutrality) would need to be reviewed and, if approved, the program and budgetary impact would need to be carefully monitored and evaluated."

In its Marketplace Choice application, in the column "Without Waiver Expansion," there is the notation "N/A." The reason given for this notation is that "projected without waiver costs are not available nor applicable for this population…." However, projected costs without a waiver are extremely relevant. CMS should not consider the application complete until such costs have been provided and there has been an opportunity for the public to comment on a complete budget neutrality analysis.

- <u>The budget neutrality analysis is both relevant and extremely important.</u> For the Medicaid expansion to be sustainable, the federal government must be carefully monitor program costs and HHS must understand how costs for premium assistance programs compare to costs projected for service delivery through Medicaid. Therefore, projected costs without a waiver are extremely relevant. Actuaries routinely estimate costs for new health care programs based on assumptions about the health of the population being covered and their service use. The consultants that Iowa contracted with for this analysis could certainly provide a "without waiver" baseline. They would simply need to estimate expansion costs for a comparable program structure delivered through Medicaid rather than private plans.

[20] 42 CFR 447.54.

In fact, the same consultants did provide a comparative baseline in Iowa's Wellness Plan application. They can do the same for the Marketplace Choice application.

- Iowa's application underscores problems found in the GAO June 2013 report. In June 2013, the Government Accountability Office issued a report expressing concern about the waiver approval and monitoring process, particularly with respect to enforcing budget neutrality.[21] The report noted concern with the lack of transparency in the basis for setting spending limits. If Iowa's application moves forward absent a full budget neutrality analysis that is publicly available and the basis for public comment, the process will be repeating some of the same problems noted in the GAO report.

Retroactive Eligibility

The requirement to provide retroactive eligibility should not be waived. In its Marketplace Choice and Wellness Plan applications, Iowa requests a waiver of retroactive eligibility. For the Marketplace Choice Plan, the rationale given is that the QHPs do not provide retroactive eligibility. The rationale given in the Wellness Plan application is to align the benefits with the QHP benefit structure. There is nothing precluding the state from providing retroactive eligibility through its traditional Medicaid program for both Marketplace Choice and Wellness Plan enrollees. In this way, Iowa will be able to continue Medicaid's retroactive eligibility provisions. This will keep low-income enrollees from incurring medical bills they cannot pay and will assist Iowa's safety-net providers. Waiving retroactive eligibility is a hardship on some Medicaid beneficiaries as well as on providers and should not be waived.

Delivery System Changes and Payment Reforms

In its Wellness Plan waiver request, Iowa proposes several delivery system changes and payment reforms. We have some concerns about the proposed changes, particularly the lack of detail included in the application.

Delivery and payment system reforms will require extensive outreach and education.
We support Iowa's efforts to re-shape its health care delivery system in an innovative way, through the promotion of ACOs and other care coordination. However, it appears that the Wellness Plan contemplates several different payment and delivery models operating simultaneously. If that is the case, it will be very difficult for beneficiaries to make an informed choice about how to receive their care. The proposal acknowledges the need to provide beneficiary education, but it does not provide any specifics about how this education will be done.

More detail is needed about payment reforms.

[21] United States Government Accountability Office, *Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lacks Transparency* (Washington: GAO, June 2013), available online at http://www.gao.gov/assets/660/655483.pdf.

The waiver states that Iowa will use the Wellmark ACO model as a design. It does not, however, explain how the "value index score (VIS)" will be used. If it is used to calculate quality bonuses, the measure needs to be appropriately adjusted to reflect the population that providers are serving.

More detail is needed about quality measures.
The discussion of quality focuses almost entirely on ACOs and other PCPs. Only one sentence notes that managed care plans will also be responsible for quality metrics (p. 34). Because managed care plans will play a role in delivering care, the quality metrics applied to them should be public and appropriate. We suggest making the measures available for public comment and that plan performance be available as well.

Finally, the waiver does not address in any detail how quality measures will be comparable across different forms of payment systems. Ideally, it should be possible to compare the quality performance of ACOs, managed care plans, and independent PCPs. This would help consumers make an informed choice about the delivery system they select, and help policymakers assess which models hold the most promise. While complete measure alignment may not be possible immediately, the waiver should include a plan for reaching this goal.

Iowa's waiver request is extremely important. As one of the early states requesting a demonstration waiver for a premium assistance program for its Medicaid expansion, and the first state requesting a waiver for the Medicaid expansion population not covered through premium assistance, what is approved will be a precedent for other states. It is critical that CMS adhere to recent guidelines for premium assistance programs. It is also critical that any waivers approved are structured so that they serve the purposes of the Medicaid program.

We have very serious concerns with some of the program requirements that Iowa is asking to have waived.

Thank you for the opportunity to submit these comments. If you have any questions, please

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Very truly yours,

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