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THE VOICE FOR HEALTH CARE CONSUMERS

October 4, 2016

Secretary Sylvia Matthews Burwell
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted electronically via Medicaid.gov

Dear Secretary Burwell,

Thank you for the opportunity to submit comments on Kentucky's 1115 waiver, Kentucky HEALTH. Families USA is a national organization representing the interests of health care consumers, with a particular focus on low-income consumers. We are extremely supportive of Kentucky's decision to extend Medicaid coverage under the Affordable Care Act (ACA). Kentucky's success in decreasing the uninsured and improved access to care- particularly preventative care- has been a national model. As we outlined in the comments submitted during the state comment period for this waiver[1], the Commonwealth's Medicaid expansion has laid the foundation for long-term health gains among Kentucky's low-income residents.

The waiver proposal that the Commonwealth has submitted raises serious concerns. Several of the proposed program changes would set back Kentucky's progress and make it harder for low-income residents to afford or keep coverage. By the Commonwealth's own estimates included in the waiver, enrollment in expanded Medicaid will drop by 214,000 member months the first year, rising to over 1 million less member months by 2021.[2] Additionally, some of the program changes requested in the waiver are beyond CMS's legal authority to approve.

Kentucky's low-income residents have benefited tremendously from the Commonwealth's Medicaid expansion. We hope that CMS and Kentucky can successfully negotiate a waiver agreement such that Kentuckians will continue to benefit from the Medicaid expansion. And, as in Ohio, we hope CMS remains committed to building on improvements in coverage, access to care and financial security for Medicaid recipients.

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[1] Families USA State Comments on Kentucky Health (July 22, 2016), *available online at* http://familiesusa.org/sites/default/files/documents/comments/Kentucky_Health_state_comments.pdf

[2] In the waiver request, the state readily admits that this reduction will be caused by "program non-compliance" including non-payment of premiums, failure to complete community engagement and employment activities, etc. (p.81)

Comments on our specific concerns are outlined below. Please don't hesitate to contact us with questions at dmahan@familiesusa.org and we thank you for your consideration.

Work and Community Service Requirement

The request to tie participation in work, work related activities, or community service to Medicaid expansion eligibility should be denied.

- ***Tying Medicaid benefits to work or related activities is not allowed under federal law.*** CMS has clearly stated that federal Medicaid funds cannot be used for promoting employment.[3] This decision is consistent with Medicaid's role as a health coverage entitlement program. To date, CMS has appropriately denied all other states' requests for work requirements and should do so here.

- ***A work requirement is contrary to the purpose of the Medicaid program.*** Medicaid is a medical assistance program that pays for health services or insurance coverage for low-income individuals in order to improve their access to affordable health care. A work requirement would fundamentally change the nature of the Medicaid program. Approving such a fundamental program change is outside the Secretary's authority under Section 1115 of the Social Security Act.

- ***Work requirements do not meet the purpose of 1115 demonstration projects, and the Secretary does not have the authority to approve them.*** Under the requirements of 42 U.S.C. 1315(a) 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.[4] As outlined in the bullet above, the objective of the Medicaid program is to provide medical assistance to low-income individuals by paying for health services or insurance coverage. A work/community service requirement is not only unrelated to providing medical assistance, but would make it more difficult for low-income individuals to qualify for or keep Medicaid coverage, in direct conflict with the requirements of an 1115 demonstration project.[5]

- ***Requiring individuals to provide community service in order to receive health care coverage is bad policy and may violate federal labor laws.*** In most cases, Medicaid pays health care providers for services provided to Medicaid enrollees or purchases

[3] Centers for Medicare and Medicaid Services, CMS and Indiana Agree on Medicaid Expansion. January 2015, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-01-27.html

[4] 42 U.S.C. 1315(a).

[5] While most individuals who gain coverage through the Medicaid expansion are working, not all are working. It is not the purpose of Medicaid to penalize individuals who are not working by withholding health coverage from them.

insurance coverage for enrollees, enrollees do not receive any payments from the program.[6] Enrollees may go many months without receiving any direct benefit from Medicaid (i.e., people do not use health services all the time, the need is often unpredictable, hence the rationale for insurance to protect one from unpredictable costs). Given the way Medicaid operates, the state's proposed community service requirement amounts to requiring those without paying jobs to engage in unpaid work in exchange for health coverage.

That is not only bad public policy—essentially requiring work in exchange for a non-monetary benefit—there is also the potential for labor market disruption. In communities with weak labor markets, "free labor" provided through community service work could displace paying jobs and have the effect of increasing the ranks of the unemployed and the poor.

Additionally, it may be that laws not related to the Medicaid program would be violated by this proposed scheme. While Families USA is not an expert in this area, we urge CMS to solicit input from the Department of Labor regarding this aspect of Kentucky's proposal. In addition to being contrary to Medicaid law, the community service requirement in the request may be in violation of the Fair Labor Standards Act.

- ***Adding a work or community service requirement would increase administrative costs shouldered by the state and federal government.*** In TANF, the work requirement has increased administrative costs as extensive resources must be devoted to tracking work hours and determining whether enrollees have met the required hours.[7] In its waiver request, the Commonwealth states it is having trouble paying the administrative costs of the program. Increased administrative complexity will not address this issue.

- ***There are less punitive, and more cost-effective, ways to connect Medicaid enrollees with employment.*** Work requirements in other safety net programs have not been shown to result in long term employment gains, despite significant administrative costs to operate them.[8] Alternatively, Kentucky can use its own funds to promote employment in voluntary programs and connect Medicaid enrollees to employment referral services. New Hampshire and Indiana have programs like these in place.

Tying Premiums to Time on Program

[6] Medicaid may pay enrollees directly for some long-term services and supports.
[7] Pavetti, Ladonna, "Work Requirements Don't Cut Poverty, Evidence Shows" June 7, 2016 available at http://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows
[8] *Ibid.*

CMS should deny the request to increase enrollees' premiums based on their time on Medicaid.

- ***The request to increase premiums based on time on program is punitive, inconsistent with the goals of the Medicaid program and outside the Secretary's authority.*** Aside from its determination on the proposed premium structure (see our comments related to premiums, below), in its determination on this waiver, CMS should make it clear that there is no provision in Medicaid law allowing cost-sharing or any other program aspect to be linked to time that an individual needs Medicaid insurance. Medicaid is a health insurance program for individuals who meet program eligibility criteria. It is designed to advance public health and the health of the individuals it serves. There are many reasons individuals may need Medicaid coverage for three years or more, including: working in a low-wage job that does not provide health insurance; being unable to work because of health conditions or injuries; living in a community where jobs simply are not available. The proposal is punitive, essentially punishing individuals for being poor, inconsistent with the goals and objectives of the Medicaid program, and outside the Secretary's authority.

Premiums

Charging enforceable/collectable premiums to enrollees at any income level is incompatible with the goals of the Medicaid program, serves no demonstration purpose, and should not be approved.

- ***The imposition of premiums serves no demonstration purpose and is not in keeping with the goals of the Medicaid program.*** As we have noted in our comments on 1115 expansion waiver proposals from Arizona[9], Arkansas[10], Indiana[11], Iowa[12], Michigan, Montana, Ohio, and Pennsylvania[13], premiums in Medicaid do not serve a demonstration purpose. Adding premiums, particularly with a disenrollment penalty,

[9] Families USA comments on Arizona's Section 1115 waiver (Dec. 4, 2015) *available online at* http://familiesusa.org/sites/default/files/documents/AZ%20comments%20FUSA_FINAL.pdf;
[10] Families USA comments on Arkansas' Section 1115 waiver (Sept. 7, 2013) *available online at* (http://familiesusa.org/sites/default/files/documents/Families%20USA%20AR%201115%20Comments%209-7-13.pdf ; Families USA comments on Arkansas' Section 1115 Waiver Amendment (Oct. 17, 2014) *available online at* (http://familiesusa.org/sites/default/files/documents/Families%20USA%20Comments%20on%20Arkansas%20Medicaid%20Expansion%201115%20Waiver%20AMendment.pdf
[11] Families USA comments on Indiana's Section 1115 waiver (Sept. 19, 2014) *available online at* http://familiesusa.org/sites/default/files/documents/Families%20USA%20Comments%20HIP%202%200%201115%20waiver.pdf
[12]Families USA comments on Iowa's 1115 waiver request (Sept. 26, 2013) *available online at* http://familiesusa.org/sites/default/files/documents/Families%20USA%20Iowa%201115%20Comments%209-26-13.pdf
[13]Families USA comments on Pennsylvania's 1115 Waiver Request (April 10, 2014) *available online at* http://familiesusa.org/sites/default/files/documents/Families%20USA%20Comments%20Healthy%20Pennsylvania%201115%20waiver%20request.pdf

would reduce coverage and thus negatively impact the health outcomes of Kentuckians subject to such payments. The impact of premiums on low-income people is well documented and is in conflict with the goals of the Medicaid program. Furthermore, premiums are already being tested in several states, and the preliminary evidence from these premium programs does not suggest that they should be tried in other states. This preliminary evidence supports earlier findings that premiums in Medicaid pose a financial hardship on enrollees.[14] Until further evaluation of premiums in existing demonstrations, including an independent evaluation of Indiana's HIP 2.0 waiver, CMS should not approve premiums in additional Medicaid or Medicaid expansion programs.

- ***Premiums pose financial barriers for Medicaid expansion enrollees.***
  The difficulty that premium payments pose on low-income people, and associated losses in coverage, can be seen across Medicaid expansions that include premiums.

    - **Michigan's** demonstration requires premiums for enrollees above poverty, although there is no disenrollment penalty. Collection rates are generally below 50 percent, attesting to the difficulty even higher income enrollees have meeting premium payments. In an attempt to improve collections, program administration has been expanded to include reminder phone calls, increasing administrative costs.[15]

    - **In Iowa**, disenrollment for non-payment of premiums has been high. Expansion enrollees with incomes above poverty are placed in the Marketplace Choice program (also called Coverage Program 2). They must pay premiums and there is a non-payment disenrollment penalty after a 90-day grace period. In its 4th Quarter 2015 report to CMS, the state reported that roughly 40 percent of Marketplace Choice enrollees were dis-enrolled that quarter for failure to pay premiums.[16]

[14] Andrea Callow, "Charging Medicaid Premiums Hurts Patients and State Budgets," Families USA Blog, April 2016 http://familiesusa.org/product/charging-medicaid-premiums-hurts-patients-and-state-budgets.

[15] Michigan Department of Health and Human Services, July 2016 *Program Evaluation Report on Healthy Michigan*, submitted to the Center for Medicare and Medicaid Services, available online at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/Healthy-Michigan/mi-healthy-michigan-qtrly-rpt-jan-mar-2016.pdf.

[16] In October 2015, Iowa reported that there were over 9,000 individuals enrolled in its Marketplace Choice program and over 6,000 cases were sent to collections that month. In November, over 3,500 enrollees were dis-enrolled for failure to pay premiums within the state's 90-day grace period. CMS Quarterly Report, Iowa Wellness Plan, 4th Quarter 2015, Attachment 7, available online at https://dhs.iowa.gov/sites/default/files/IWP.Q4.2015_0.pdf

- **In Indiana**, November 2015 through January 2016, the state dis-enrolled 1,680 individuals from its Medicaid expansion HIP 2.0 program for failure to pay premiums (POWER account contributions).[17]

- ***Premiums reduce Medicaid enrollment and coverage retention.***
  The Kentucky HEALTH program would impose premiums on all non-disabled adult Medicaid enrollees, excluding pregnant women. One multi-state study found that premiums as low as 1 percent of income—a lower percentage than Kentucky is proposing—reduced Medicaid enrollment by up to 15 percent.[18] Premiums also make it difficult for Medicaid enrollees to retain coverage. Even among higher income Medicaid enrollees, premiums result in enrollees dropping coverage.[19]

- ***The premium structure envisioned will add administrative costs that will likely outweigh any payments collected and will be an added cost to the federal government and taxpayers.*** There is a significant administrative cost to collecting premiums, tracking payments, sending notices, and administering disenrollment and reenrollment. Evidence in other states, including Virginia[20] and Arizona[21], show that premium collection alone increases Medicaid program costs, and Kentucky's more complicated program would likely be even more costly.

If CMS does approve premiums for Kentucky's program, it should require significant modifications to the requested program. Such modifications are detailed below.

- ***CMS should not approve any premiums for enrollees below 50 percent of poverty.***
  If CMS does approve premiums for Kentucky's program, they should be limited to enrollees with incomes above 100 percent of poverty, but under no

[17] Healthy Indiana Plan Section 1115 Quarterly Report to CMS (submitted March 31, 2016), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-qtrly-rpt-nov-jan-2016-03312016.pdf

[18] Leighton Ku & Teresa Coughlin, *Sliding Scale Premium Health Insurance Programs: Four States' Experiences*, 36 Inquiry 471 (1999/2000).

[19] A study of Medicaid enrollees in Wisconsin found that increasing premiums from 0 to $10/month for higher income Medicaid enrollees (incomes 133-150 percent of poverty, higher incomes than Kentucky HEALTH covers), reduced the probability of individuals remaining enrolled for a full year by 12 percent. Laura Dague, "The effect of Medicaid premiums on enrollment: A regression discontinuity approach," *Journal of Health Economics,* May 2014, available online at http://ccf.georgetown.edu/wp-content/uploads/2012/03/Dague-Premiums.pdf.

[20] Tricia Brooks, *Handle with Care: How Premiums Are Administered in Medicaid, CHIP and the Marketplace Matters*, Georgetown Center for Children and Families, December 2013, http://www.healthreformgps.org/wp-content/uploads/Handle-with-Care-How-Premiums-Are-Administered.pdf

[21] Arizona Health Care Cost Containment System, *Fiscal Impact of Implementing Cost Sharing and Benchmark Benefit Provisions of the Federal Deficit Reduction Act of 2005*. December 2006. available online at: http://citeseerx.ist.psu.edu/viewdoc/download;jsessionid=6205E959C49B77AE4B63671D2B6EBE4B?doi=10.1.1.482.6057&rep=rep1&type=pdf

circumstances should enrollees below 50 percent of poverty be charged preiums. A recent ASPE report found that cost-sharing and premiums pose significant financial burden on individuals in deep poverty, defined as below 50 percent of poverty. The report found that low-income individuals facing premiums and cost sharing fees must decide whether to go to the doctor, fill prescriptions, or pay for other basic needs like child care and transportation. As a result of these daily tradeoffs, low-income individuals are especially sensitive to modest and even nominal increases in medical out-of-pocket costs.[22]

CMS has not approved premium payments for enrollees below 50 percent of poverty in any Medicaid expansion except Indiana's and should not do so in Kentucky. Notably, Indiana's program which requires enrollees below poverty to pay premiums to remain in a higher benefit program was based on an existing demonstration in the state.

That is not the case in Kentucky. For those less below 100 percent of poverty who do not pay their premiums, Kentucky would require them to pay copayments for all services, would suspend their My Rewards Account, and remove $25 from the account, leaving them unable to access certain benefits. To re-enroll before the end of a six month lockout period, enrollees would have to pay their past debt as well as the premium for the reinstatement month. This would be extremely difficult for the lowest income enrollees and presents a huge barrier to their access to care.

- ***CMS should not approve coverage lock-outs at any income level.***
  Locking individuals out of coverage is antithetical to Medicaid's goals and CMS should not approve them at any income level. CMS should stand by its comments in a recent letter to Indiana regarding the state's request to add lock-outs for individuals who do complete a redetermination process. In that letter, it was noted, "Exclusions from coverage, such as lockouts, are not permitted under Medicaid law."[23] CMS is correct in that interpretation and should not allow the proposed six month coverage lockout for enrollees with incomes above 100 percent of poverty in Kentucky.

- ***CMS should not approve premium non-payment penalties for enrollees below poverty.***
  We do not believe that premium nonpayment penalties have a place in the Medicaid program, particularly disenrollment. However, should CMS allow

[22] Office of the Assistant Secretary for Planning and Evaluation, "Financial Condition and Health Care Burdens of People in Deep Poverty," July 16, 2015, http://aspe.hhs.gov/basic-report/financial-condition-and-health-care-burdens-people-deep-poverty

[23] July 29, 2016 letter from Vikki Wachino, Center for Medicare and Medicaid Services, to Tyler Ann McGuffee, Insurance and Healthcare Policy Director, Office of Governor Michael Pence, Indiana.

enforceable premiums in Kentucky, they should not apply any kind of penalties to enrollees with incomes below poverty. While the Kentucky HEALTH plan would not dis-enroll enrollees under 100 percent of poverty who do not make premium payments, they would lose access to their My Rewards accounts and be subject to co-pays. This constitutes both a financial penalty and effectively bars these enrollees from important benefits including dental and vision. The proposed program serves no demonstration purpose and is in stark conflict with Medicaid's objective of providing affordable health coverage to low-income individuals.

- ***The non-payment grace period is too short.***
  Kentucky is requesting approval to dis-enroll individuals with incomes above poverty if they do not pay premiums for 60 days. This grace period is too short. If disenrollment is allowed, the grace period should be at least as long as the Marketplace grace period of 90 days.

- ***Coverage should begin upon an eligibility determination, not premium payment.***
  Delaying coverage until the first premium payment, particularly for those below poverty, will essentially put coverage out of reach for many. CMS has not approved any comparable coverage delays and should not approve Kentucky's request. The closest approval was for Indiana, where CMS has allowed coverage to be withheld for up to 60-days for enrollees below poverty, pending a first premium payment. However, after 60-days, individuals who have not paid premiums receive coverage in a lesser benefit program. While we do not believe that delaying coverage or effective waiting periods, such as that approved in Indiana, are appropriate in Medicaid, there should be a time limit on how long coverage can be withheld should this provision be approved.

Retroactive Coverage

- ***CMS should not approve the request to omit retroactive eligibility.***
  Retroactive eligibility is a fundamental part of the Medicaid program. Omitting this coverage from Kentucky's program would make it more difficult for eligible individuals who are not yet enrolled to receive care and would place them at risk for medical debt if they are able to obtain care. It would also increase health care providers' risk for bad debt. We urge that this request be denied. However, if CMS does approve this omission, it should ensure that Kentucky fully implements its proposed presumptive eligibility system and keeps it robust.

Medically Frail Determinations

- ***CMS should require Kentucky to clarify a definition and framework for the determination of those who are medically frail.***
  Medically frail enrollees are excluded from premium requirements under Kentucky's waiver, but the process for obtaining a medically frail determination should be objective, consistent and easy for enrollees to navigate and understand. The Kentucky HEALTH plan as submitted for determining who is medically frail is vague and could result in many people who are medically frail not receiving that determination, which could in turn result in the neediest enrollees being unable to access necessary care. If the determination process is lengthy and difficult, medically frail enrollees could have to pay all premiums during this time, posing a significant burden for this population. If medically frail enrollees do not pay their premiums, they would have their My Rewards Account suspended and be subject to additional cost sharing, barring them from important benefits and imposing another financial burden on this vulnerable population.

"My Rewards" and Deductible Accounts

CMS must ensure that the Deductible and My Rewards Accounts do not impact enrollees' access to benefits or use of care.

- ***CMS should vigilantly monitor the implementation of Deductible Accounts***
  We are pleased that individual accounts will be funded so that enrollees will receive the health services that they need. However, as we have said in our comments on previous Section 1115 waivers, we are concerned that this type of account structure (high deductible and health savings account) establishes a framework that could, in the future, lead to health savings accounts that do not include the assurance that all costs of care will be covered. We recognize that is not the case with this proposal. We wish, however, to place on record our concerns about the potential evolution of this approach, and to urge CMS to be vigilant in guarding against future proposals that would result in higher-out-of-pocket costs on low-income beneficiaries.

- ***Deductible Account statements may negatively affect appropriate service use****.*
  Monthly statements will include information on "the cost of each service utilized during the month and the overall account balance" (waiver application page 30). The presentation of the "overall account balance" might lead some enrollees to believe that they are responsible for managing their health care spending within that amount and that they will be financially responsible for costs exceeding account amounts.
  While moving toward price transparency may help to reduce overall health care spending, individuals will not be the ones to use this information in a way that will truly reduce spending or costs. Individuals without medical training- particularly those with low health literacy- do not have the knowledge to appropriately manage their medical care and health care costs, nor should they be expected to. For most consumers, the

majority of health care decisions, particularly those involving use of high-cost procedures, are driven by choices of referring or treating physicians. We are skeptical that the proposed account structure will result in consumers using health care services more wisely. We are concerned that the proposed quarterly account statements could create anxiety and confusion among enrollees that might cause them to delay or avoid necessary care. Such decisions could ultimately increase, rather than decrease, the cost of care. We therefore propose some mitigation strategies below.

- ***Incorporate enrollee education and require evaluation of the impact of the accounts****.* We urge CMS to work with the state to develop statements designed to minimize enrollee confusion and ensure that enrollees understand that they will not be responsible for costs of care in excess of account amounts. Statements should include a clear and conspicuous statement (bold, larger font, boxed/colored text) indicating that individuals will not be financially responsible for costs of care that is in excess of the account amounts. The state should also make available and prominently displayed a toll free number for enrollees to call if they have questions about their account statement.

  We also urge CMS to require the state to include a strong education component as part of the enrollment process to help ensure that enrollees understand their monthly statements, use that information appropriately, and understand that needed health care will be covered. Education for providers, who will likely be enrollees' first point of contact for questions about the program, should be furnished as well. As part of program evaluation, we recommend that the state be required to evaluate the impact of the health accounts. Such an evaluation should include an assessment of enrollees' understanding of the account information and the effect of the accounts on enrollees' health care use.

- ***CMS should not approve the envisioned structure for My Rewards Accounts, which would effectively reduce beneficiaries' benefits.***
  The request to shift vision and dental benefits into the My Rewards Account will make these services inaccessible for many low income enrollees. It will be extremely difficult if not impossible to accrue enough funds in the My Rewards Account to cover necessary vision and dental care.

- ***This reduction of benefits will work against other goals Kentucky has stated for its waiver including improved preventative care and chronic disease management, as well as increased employment among the state's low income population.***
  Untreated dental disease can have a negative impact on overall health. Difficulty eating, sleeping, and chronic pain due to untreated dental disease all have significant health implications beyond oral health. Poor oral health is also linked to complications for

people with diabetes, heart and lung disease, and to poor birth outcomes.[24] Access to dental services can improve health and employment prospects. Twenty-nine percent of low-income adults – nearly twice the rate of those with higher incomes—report that the state of their mouth negatively affects their ability to interview for a job.[25] If the Commonwealth truly wants to improve employment prospects among this population and improve chronic disease management, it should not implement policies like reducing access to dental benefits that would impede those goals.

If CMS approves the My Rewards Account and its associated benefit changes, it should require Kentucky to make changes to the program to mitigate its negative impact.

- ***Kentucky should increase the amount of money that enrollees can earn for their My Rewards Account so that enrollees are able to build up enough funds to cover vision and dental services.*** Vison and particularly dental care, especially for a low-income population that has high dental care needs, can be prohibitively expensive. Thus, enrollees should be able to earn higher amounts through health promotion activities. If their need and the cost of care exceeds the amount available in the My Rewards Account, enrollees should be able to get an exemption and have their care covered by the Medicaid program. Much like in a private insurance policy when an individual meets a catastrophic cap their cost sharing drops to nothing, so too should the state cover any dental or vision expenses that exceed the My Rewards Account balance.

- ***Kentucky needs to devise more options for earning dollars for the My Rewards Account, outside of activities associated with a work requirement.*** Since work requirements are not allowable under Medicaid law and cannot be approved, if the My Rewards account is to be implemented, the state must create alternative ways for enrollees to accrue My Rewards dollars. Under Medicaid law, health benefits cannot be conditioned to participation in work or community service activities. Therefore, many of the current activities that Kentucky has attached My Rewards dollars to must be eliminated from this program.

[24] US Department of Health and Human Services, Oral Health in America: A Report of the Surgeon General (Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000), http://www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/Documents/hck1ocv.@www.surgeon.fullrpt.pdf

[25] US Department of Health and Human Services, Oral Health in America: A Report of the Surgeon General (Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000), http://www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/Documents/hck1ocv.@www.surgeon.fullrpt.pdf

If a rewards structure is necessary, we encourage a program that incentivizes enrollees to participate in certain health promotion activities (such as getting a health risk assessment, having a wellness exam, participating in smoking cessation courses, etc.) However, it is critical that enrollees have the support necessary to engage in such wellness activities, particularly transportation. Additional support, like child care and after-work-hours access to providers should likewise be considered if the Commonwealth is truly committed to enrollees participating in health promotion activities.

- ***We also urge CMS to require a strong education component for this program.*** Enrollees need to understand what these benefit changes mean for them and to have full knowledge of how their My Rewards Account work. They need complete, easy to understand information on how they can earn funds to build up their account and under what circumstances funds could be deducted. To incentivize enrollees to be invested in the program and to participate in activities that allow them to accrue funds, possible deductions should be minimized or eliminated.

  Likewise, providers and enrollment assisters must also be educated with regards to the program, as they are likely to be beneficiaries' most frequent point of contact with the health care system and the requirements of Kentucky HEALTH.

Non-emergency use of emergency room services and account deductions

Kentucky already have sufficient options to impose higher costs for non-emergency use of ER services. The proposal to take deductions from enrollees' My Rewards Accounts is does not meet statutory requirements for approval, is unreasonably burdensome, and should be denied.

- ***Kentucky's request to deduct money from My Rewards Accounts for non-emergency use of the ER is excessive and should be denied.*** The state already has the ability to charge up to an $8 copay for non-emergency use of the emergency room. The proposed $20, $50, and $75 account deductions for non-emergency use of the ER, depending on the number of visits an enrollee makes, is a significantly larger burden for low income individuals. These account deductions are essentially increased cost sharing, which has been rightfully denied in every state except Indiana, where the state is required to evaluate the impact of higher cost sharing under strict protocols. Indiana's copay is limited to a select test group of enrollees with incomes above 100 percent of the federal poverty line. Charging this level of cost sharing for all enrollees, especially those with extremely low incomes, would unduly burden this population. If Kentucky were to impose a penalty for non-emergent use of the

ER, through either traditional cost sharing mechanisms or My Rewards account deductions, the fee should be limited to the approved $8.

- ***This request for increased cost sharing does not meet the requirements of 42 USC 1396o (Section 1916f of the Social Security Act).***

  The proposed deductions should be treated as cost-sharing under Sec. 1916f of the Act despite being deductions from My Rewards Account. *1916f* states:

  "*No deduction*, cost sharing, or *similar charge* [emphasis added] may be imposed under any waiver authority of the Secretary…."

  In order to comply with Section 1916f and impose increased cost-sharing under a waiver, must meet several criteria. The increased cost sharing must (1) test a unique and previously un-tested use of co-payments, (2) be limited to two years (3) provide benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients (4) be based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area (5) be voluntary. The Commonwealth fails on all five requirements of 1916f

  Cost sharing for non-emergent use of the ER is far from unique, as it is already being tested in Indiana. The waiver request is for five years, not the required two. The Commonwealth provides no indication that benefits will be equal to the risk to recipients. There is real risk to Medicaid enrollees in penalizing someone for using the emergency room. Such account deductions could lead individuals who should seek care for an emergent condition not to do so for fear of financial penalties. This issue is not addressed in the Commonwealth's waiver. Furthermore, the account deductions are not structured as a hypothesis with the use of control groups, nor is participation in the account deductions voluntary. The requirements that must be met for the Secretary to grant cost-sharing changes under the applicable section of the Social Security Act are clearly not met. The Commonwealth's state request should be denied for failure to meet the requirements of the relevant statutory authority or, at the least, restructured, if possible, to meet those requirements.

- ***Medicaid enrollees do not need to be specifically deterred from using the ER.*** Research shows that a very small portion of Medicaid enrollees use the ER for non-emergency care, and that portion is comparable to the portion of privately covered individuals who use the

ER inappropriately.[26]

- ***Increased cost sharing for non-emergency use of the ER has not been shown to improve appropriate ER use.*** There is a growing body of literature that suggests that non-emergency ER copays are not an effective means to reduce ER utilization in Medicaid.[27] In fact, they may even be counterproductive and encourage enrollees to avoid using the ER even when it is medically necessary. Indiana's program evaluations have yet to show whether or not their higher copays have affected appropriate use of the ER and CMS should not approve this request for other states until it has seen the results from Indiana's pilot.

Non-emergency transportation

Omitting NEMT does not align with the goals of the Medicaid program nor 1115 waivers.

- ***Lack of transportation is a significantly greater barrier to health care access for the Medicaid-eligible population than the general population.*** A 2012 study based on National Health Interview Survey data published in the *Annals of Emergency Medicine* found that between 1999 and 2009, only .6 percent of those with private insurance reported that transportation was a barrier to accessing timely primary care treatment, while seven percent of Medicaid beneficiaries did.[28] As a program designed to specifically meet the needs of low income people, Medicaid should continue to provide a service that helps to address this barrier.

- ***In line with the goals of the Medicaid program, providing NEMT can support better health outcomes and lower health care costs.*** Studies have consistently shown that providing Medicaid enrollees with transportation to non-emergency care results in fewer missed appointments, shorter hospital stays, and fewer emergency room visits. Alternatively, poor access to transportation is related to lower use of preventive and primary care and increased use of emergency department services.[29]

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[26] Boukus, Ellyn R, Emily Carrier and Anna Sommers. "Dispelling Myths About Emergency Department Use: Majority of Medicaid Visits Are for Urgent or More Serious Symptoms", Center for Studying Health System Change, July 2012, available online at http://www.hschange.com/CONTENT/1302/

[27] Karoline Mortenson, *Copayments Did Not Reduce Medicaid Enrollees' Nonemergency Use of the Emergency Departments,* 29 HEALTH AFFAIRS 1643 (2010); David J. Becker et al., *Co-payments and Use of Emergency Department Services in the Children's Health Insurance Program,* 70 MED. CARE RES. REV. 514 (2013).

[28] Annals of Emergency Medicine, National Study of Barriers to Timely Primary Care and Emergency Department Utilization Among Medicaid Beneficiaries, March 2012, http://www.annemergmed.com/article/S0196-0644%2812%2900125-4/abstract

[29] Community Transportation Association, "Medicaid Non-Emergency Transportation (NEMT) Saves Lives and Money", August 2014, available at: http://web1.ctaa.org/webmodules/webarticles/articlefiles/NEMTpaper.pdf

- ***Waiving NEMT has proven to pose a barrier to care in other Medicaid expansions and does not have a valid demonstration purpose.*** This proposal has been tested in other states, and has proven to negatively impact Medicaid expansion enrollees. In Iowa, there have been several program evaluations that provide substantial data supporting the need for NEMT to support enrollees' access to critical medical services. In Iowa:
    - Those in poor health were the most affected by the lack of NEMT services.[30]
    - The lack of NEMT affected Medicaid enrollees at all income levels, and affected the lowest income enrollees the most. Almost 20 percent of expansion enrollees with incomes below 100 percent of poverty and 10 percent of those with incomes above poverty reported needing help with transportation to a healthcare visit.[31]
    - The lack of NEMT most affected individuals' access to regularly scheduled, non-emergency medical trips for behavioral health services, substance abuse treatment, and dialysis treatment.[32] These are critical health services where missing an appointment could make treatment less effective or, in the case of dialysis, have catastrophic and costly health consequences.

- **Waiving NEMT does not align with the other elements of the KY HEALTH program.** Two major pieces of the KY HEALTH plan, the My Rewards Account and the inclusion of a deductible, are intended to promote preventive care and healthy behaviors and discourage unnecessary ER use. The program should be designed to support enrollees' efforts to meet the wellness requirements that can help lower their out of pocket costs for certain services. It is incongruous to have a wellness program structure yet omit a benefit (NEMT) that would make it easier for enrollees to complete the program requirements. In addition, Kentucky's stated goals in its waiver requests include better chronic disease management and improved substance use disorder treatment and a reduction in the substance use epidemic in the state, waiving NEMT would work against both of these goals, inhibiting people's access to these types of care.

Mandatory Renewal/Open Enrollment Period

Kentucky's proposed "lock-out" for failure to timely renewal is not consistent with the objectives of the Medicaid program and should be denied as it would pose an undue hardship on enrollees.

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[30] Bentler et al, *Non-Emergency Medical Transportation and the Iowa Health and Wellness Plan, University of Iowa*, March 2016, submitted to CMS as part of 1115 waiver evaluation, available online at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Wellness-Plan/ia-wellness-plan-nemt-rpt-mar-2016.pdf

[31] Ibid

[32] Ibid

Kentucky HEALTH proposes that individuals who do not timely renew Medicaid coverage will be "locked out" of coverage for six months. Such as request is not consistent with the objectives of the Medicaid program, as CMS found in a recent similar request from Indiana. As in Indiana, such a request should be denied. CMS rightly recognized that many low-income individuals face challenges in completing the renewal process such as language access and problems getting mail. CMS also found that mental illness or homelessness can make completing the renewal process difficult and that gaps in coverage that would result from a lockout could lead to harm.

Other Issues

The proposal to use Medicaid funds to cover the personal expenses associated with obtaining a GED should be denied.

While we understand and support the state's desire to increase education among Kentuckians, this is not an appropriate use of Medicaid funds. Medicaid is not an all-purpose poverty alleviation program, but rather a healthcare program. States should not be allowed to use Medicaid funds for education instead of healthcare. We would encourage Kentucky to use other funds, outside of the Medicaid program, to help more people to obtain their GED.

Thank you for the opportunity to comment on this important program. Should you have any questions, please don't hesitate to contact Dee Mahan, Medicaid Program Director dmahan@familiesusa.org.

Respectfully Submitted,

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