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*via email to* kyhealth@ky.gov
Commissioner Stephen Miller
Department for Medicaid Services
275 E. Main Street
Frankfort, KY 40621

**RE: Kentucky Department for Medicaid Services Proposed §1115 Demonstration Waiver**

Commissioner Miller:

I write on behalf of Kentucky Equal Justice Center, a civil legal services program that works closely with the four legal aid organizations and community partners across Kentucky, focusing on low income or otherwise vulnerable Kentuckians. Our advocates assist individuals and families learn about, enroll, and troubleshoot their healthcare from all sources, with a particular focus on Medicaid. We appreciate this opportunity to provide feedback on this proposed demonstration project with the Kentucky Medicaid program before being submitted to the Centers for Medicare and Medicaid Services called Kentucky HEALTH.

The health law fellowship at KEJC exists in part to monitor new laws in the area of health on behalf of all low income or otherwise vulnerable Kentuckians. This includes tremendous focus on the Affordable Care Act (ACA), specifically the new category of Medicaid eligibility for adults age eighteen to sixty-four with incomes up to 133% of the federal poverty line, known as part of the expansion population.[1] Medicaid Expansion in

[1] Patient Protection and Affordable Care Act, Pub. L. No. 111-148 § 2001(a), 124 Stat. 119, 271 (2010) (codified as amended at 42 U.S.C. § 1396a (2012)) [hereinafter ACA § 2001(a)]. Prior to the ACA, the federal Medicaid statute limited coverage for non-elderly adults to very low-income parents, people with “permanent and total” disabling conditions, and pregnant women. Social Security Amendments of 1965, Pub. L. No. 89-97, § 1901, 79 Stat. 286, 343-44 (1965). The only way states could cover so-called “childless adults” was through a Section 1115 demonstration waiver that had to be budget neutral for the federal government. CINDY MANN, THE NEW MEDICAID AND CHIP WAIVER INITIATIVES 11 (2002), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/the-new-medicaid-and-chip-waiver-initiatives-background-pa per.pdf. The ACA Medicaid expansion for adults adds a new category of eligibility to the Medicaid statute and provides enhanced federal funds to help cover the cost of covering this new category. ACA § 2001(a).

Kentucky has improved the health of vulnerable Kentuckians and significantly reduced otherwise unmet medical needs.[2] Medicaid Expansion and our extremely successful marketplace, kynect, are the backbone of our seeing one of the largest reductions in uninsured in the country.[3] Medicaid Expansion is improving the health of Kentucky, and lays the groundwork fpr the opportunity to transform our Medicaid and indeed our health system.[4] Our director, Rich Seckel, has remarked that "health is infrastructure and coverage is foundational", and Medicaid expansion is that foundation for around half a million Kentuckians.

The Kentucky Equal Justice Center asks the Kentucky Department for Medicaid Services to support and enhance Medicaid Expansion in Kentucky, and use a Section 1115 demonstration waiver as it is intended, to expand eligibility and enhance services for low income Kentuckians and those currently Medicaid eligible. Kentucky HEALTH creates unnecessary barriers by adding consumer cost sharing, more complex administration, confusion, penalties, and actual lock-outs from healthcare for those same Kentuckians.

We agree with the goals of empowering Kentuckians to seek and gain employment, noting that the majority of Kentuckians eligible for Medicaid because of Medicaid Expansion currently are already working.

We agree with the goal of encouraging healthy lifestyles and ensuring long-term fiscal sustainability for Kentucky taxpayers and the Kentucky budget. That sustainability is not possible without Medicaid Expansion as proposed in Kentucky HEALTH. Medicaid Expansion improves enrollees' financial security which helps those same enrollees move out of poverty if otherwise possible.[5] Like we all heard from multiple consumers

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[2] In the first two years of the Medicaid expansion, there has been a 40% reduction in unmet medical needs among long-income Kentuckians. Joseph Benitez, et al., "Kentucky's Medicaid Expansion Showing Early Promise on Coverage and Access to Care," *Health Affairs* 35, no. 3 (2016) online at http://content.healthaffairs.org/content/early/2016/02/16/hlthaff.2015.1294

[3] Kentucky and Arkansas both saw a 12.9% decrease in uninsured 2013-2015, the largest decrease in the nation. Dan Witters, "Arkansas, Kentucky Set Pace in Reducing Uninsured Rate," *Gallup,* February 4, 2016 online at http://www.gallup.com/poll/189023/arkansas-kentucky-set-pace-reducing-uninsured-rate.aspx.

[4] A seminal study on the impact of a state's decision to expand Medicaid coverage to more adults looked at data across states covering 10 years—5 years prior to expanding coverage and 5 years after. The study found that expanding Medicaid was associated with a significant reduction in mortality. B.D. Sommers, et al., "Mortality and Access to Care Among Adults After State Medicaid Expansions," *New England Journal of Medicine* (2012: 367: 1025-34) available online at http://www.nejm.org/doi/pdf/10.1056/NEJMsa1202099.

[5] Louija Hou et al., "The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Well-Being," National Bureau of Economic Research Working Paper No.

at public hearings, there is much more to moving out of poverty in Kentucky than being told to and being monitored with additional bureaucratic processes.

We ask that the Kentucky Department for Medicaid please include in any proposals to transform Medicaid in Kentucky the authority upon which those transformations rely, and any existing data from any similar experiments in or outside of Kentucky. "Section 1115 waivers are supposed to test new and experimental projects, so it makes sense that states should be looking to propose waivers to test different, previously untried Medicaid designs."[6] We heard Governor Bevin say there is little new in this proposed demonstration project, and would like to see the proposal compared to data for what has been tried before in other states upon which the state relies. Ignoring the impossibility of "testing" concepts that have been tested, why would Kentucky want to mimic known failure? By our research, Medicaid member contributions, and cost-sharing of any amount, even one percent of income, for those eligible by household income for Medicaid have shown decreases in enrollment and accessing of care.[7] We

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22170, Issued April 2016, available online at http://nber.org/papers/w22170; Nicole Dissault, "Is Health Insurance Good for Your Financial Health?" *Liberty Street Economics,* Federal Reserve Bank of New York, June 6, 2016 online at http://libertystreeteconomics.newyorkfed.org/2016/06/is-health-insurance-good-for-your-financial-health.html#.V4lHI6It7VJ.

[6] 9 Saint Louis U. J. Health L and Pol'y 265 (2016)

[7] LEIGHTON KU & VICTORIA WACHINO, CTR. ON BUDGET & POLICY PRIORITIES, THE EFFECT OF INCREASED COST-SHARING IN MEDICAID: A SUMMARY OF RESEARCH FINDINGS 7 (2005), http://www.cbpp.org/research/the-effect-of-increased-cost-sharing-in-medicaid (indicating researchers estimate that premiums as low as one percent of income reduce enrollment by fifteen percent for families earning at or below poverty). In 2003, Oregon increased sliding scale premiums for Medicaid beneficiaries with incomes from zero to 100% of poverty. Id. at 8 (stating that people with no income were charged six dollars a month and those at the poverty level were charged twenty dollars per month, in turn causing enrollment to drop by about half with about three-quarters of those who dropped out of the Medicaid expansion program becoming uninsured). Research looking at those with incomes between 100-150% also shows that premiums reduce enrollment. See Salam Abdus et al., Children's Health Insurance Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children, 33 HEALTH AFF. 1353, 1357 (2014) (showing that a ten-dollar increase in monthly Medicaid premiums for families earning between 100 and 150% of poverty resulted in a 6.7% reduction in Medicaid and the Children's Health Insurance Program coverage and a 3.3% increase in the uninsured). Only one study of Kansas children in families earning 151 to 200% of poverty shows no negative impact from premiums. See Genevieve Kenney et al., Effects of Premium Increases on Enrollment in SCHIP: Findings from Three States, 43 INQUIRY 378, 380 (2006). In Kentucky, where a twenty dollar premium was introduced for children in families from 150 to 200% poverty, there was a

support transforming Medicaid payment and care delivery as well as total health system transformation, redesigning how Kentucky provides and pays for accessible, equitable, and affordable care to improve the health of vulnerable and all Kentuckians, but ask that those redesigns be data-driven, and that data be publicly available.

**Medicaid Covers State Plan Populations**

Beginning January 2014, individuals below 138% of FPL are a Medicaid state plan population and, thus, can no longer be considered non-Medicaid populations.[8] As a result, HHS can no longer use the expenditure authority to ignore Medicaid requirements. Rather, the State must either fully comply with all Medicaid requirements or obtain a waiver that meets all of the requirements of § 1115 for experimental/demonstration projects, and in the case of cost-sharing, § 1916(f). Kentucky HEALTH underscores the legal prohibition on treating the expansion population as a non-Medicaid population.

**Premiums and Cost Sharing Generally**

Section 1115 demonstrations must also be "likely to assist in promoting the objectives" of the Medicaid Act. The objective of Medicaid is to furnish health care to low-income individuals.[9] Based on what we know about premiums and cost sharing from demonstration projects in other states, and common sense, the premium and cost-sharing elements in this proposal do not colorably assist in promoting the objective of furnishing health care to low-income Kentuckians and we ask they be reconsidered entirely. There is no experimental value to premiums or other contribution to low-income Kentuckians, and in fact come at a high risk to those same Kentuckians Medicaid is designed to protect.[10]

"The federal Medicaid statute has always limited state discretion to impose cost sharing and, since 1972, premiums too. While the premium and cost sharing provisions have been amended numerous times, the most important statutory development occurred in

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thirty percent decrease in enrollment. Id. at 380, 386. In New Hampshire, where premiums increased by five dollars per month for children 185 to 300% poverty, there was an eleven percent decrease. Id. at 381, 386.

[8] Patient Protection and Affordable Care Act, Pub. L. No. 111-148 § 2001(a), 124 Stat. 119, 271 (2010) (codified as amended at 42 U.S.C. § 1396a (2012), 133% with 5% disregard

[9] National Health Law Program, http://www.healthlaw.org

[10] For example, in 2003, Oregon experimented with charging sliding scale premiums ($6-$20) and higher copays on some groups in an already existing § 1115 demonstration for families and childless adults below poverty. Nearly half the affected demonstration enrollees dropped out within the first nine months after the changes. Bill J. Wright et al., The Impact of Increased Cost Sharing on Medicaid Enrollees, 24 Health Affairs 1106, 1110 (2005).

1982 when Congress moved the premium and cost sharing protections from Section 1902(a)(14) of the Social Security Act to a new Section 1916 to curtail the Secretary of HHS's ability to grant Section 1115 waivers for premium and cost sharing demonstrations."[11], [12] Secretary Burwell also cannot approve these cost sharing elements because they reduce access to care. "The Secretary of the U.S. Department of Health and Human Services has no statutory authority to grant Section 1115 waivers that allow states to impose premiums on Affordable Care Act-eligible adults."[13]

The Medicaid Act, particularly § 1916A, already provides with a great deal of flexibility to impose premiums, cost sharing, and similar charges, but not for the populations included in Kentucky HEALTH.[14], [15] The requirements of § 1916 and § 1916A cannot be ignored or waived for the populations subject to the demonstration (as they are state plan populations described in the Medicaid Act). HHS can only approve this change to the aggregate cap if the proposal complies with the additional requirements at § 1916(f). We note that annual caps also should not be approved by HHS because the HIP 2.0 application list does not specifically request waiver authority to apply caps on an annual basis, and HHS should only consider waiver requests that are explicitly stated and subject to comment. Considering that low-income individuals have little disposable income and the adverse impacts of cost sharing on this population are well known, applying the aggregate cap on a yearly basis would not be consistent with the objectives of Medicaid or serve any demonstration purpose.[16]

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[11] 9 Saint Louis U. J. Health L and Pol'y 265 (2016) at 282-283.

[12] Social Security Act, Pub. L. No. 74-271, § 1902(a)(14), 49 Stat. 620 (1935) (codified as amended at 42 U.S.C. § 1396a(14) (2012)); Social Security Act, § 1916 (codified as amended at 42 U.S.C. § 1396o (2012)).

[13] 9 Saint Louis U. J. Health L and Pol'y 265 (2016)

[14] Social Security Amendments of 1965, Pub. L. No. 89-97, § 1902(a)(14), 79 Stat. 286, 346 (1965) (codified as amended at 42 U.S.C. § 1396a(14) (1965)) The 1965 Amendments, [P]rovide that (A) no deduction, cost sharing, or similar charge will be imposed under the plan on the individual with respect to inpatient hospital services furnished him under the plan, and (B) any deduction, cost sharing, or similar charge imposed under the plan with respect to any other medical assistance furnished him thereunder, and any enrollment fee, premium, or similar charge imposed under the plan, shall be reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to the recipient's income or his income and resources.

[15] See Potter v. James, 499 F. Supp. 607, 609-610, 613 (M.D. Ala. 1980) (striking down two dollar copays and citing Moody v. Holzworth, Civil Action No 76-349-N, striking down a similar statute requiring a one dollar copay). The court allowed cost sharing of fifty cents to three dollars for optional prescription drugs holding that such amounts were "nominal in amount" and thus allowed by Section 1902(a)(14). Id. at 608

[16] To be clear, we would like to provide an example as to why an annual cap would be so detrimental. An individual at 60% FPL would earn $6,894 per year. Her 5% aggregate cost-sharing cap would be $29 per month or $86 per quarter. If she used minimal health care during

To meet the Governor's purpose to "prepare them [Medicaid enrollees] for the commercial market"[17], we propose implementing an optional cost sharing program, so that enrollees can opt-in to premiums if, as the Governor suggested in his press conference on June 22, Kentuckians would prefer to contribute. In Iowa, for example, enrollees have an opt-out rule, where Medicaid recipients can have their premiums waived on a month to month basis by checking a box on their premium bill that they have a financial hardship and are unable to pay.[18],[19]

## Complexity

The sheer complexity of these premium waivers raises a number of legal and policy concerns by adding administrative burdens to the state agencies and Medicaid enrollees and overall administrative costs to Medicaid. The Jane and Bruce Robert Professor of Law, Ms. Sidney D. Watson, in the Center for Health Law Studies at the Saint Louis University School of Law described these unnecessary and costly complexities in this non-exhaustive description:

> Individualized premium statements must be prepared and mailed monthly, and premium payments collected and correctly credited. In Iowa, Michigan, and Montana, the state must track not only monthly premium payments, but also healthy behaviors, good cause, and hardship exemptions that reduce premium obligations. Indiana has to move some people who fail to pay premium payments from one health plan to a different one, and make sure providers and consumers are aware of the change in covered benefits. Indiana, Michigan and Arkansas are using

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the year, but had one health crisis month with high-utilization (ex. multiple ED trips), she is protected by a limit of $29 for that month or $86 for that quarter, and that might be her total cost-sharing responsibility for the full year. If an annual limit was used, however, she could pay as much as $345. This would be the equivalent of what she would pay if they if she had the same crisis every quarter. Put another way, under the law, her cost for one event is limited to 5% of the cost of a quarter, but under an annual cap, her cost is 5% of her annual income.

[17] Kentucky HEALTH Waiver Proposal, Section 1, page 4.

[18] 9 Saint Louis U. J. Health L and Pol'y 265 (2016)

[19] IOWA WELLNESS PLAN, supra note 46, at 12; IOWA MARKETPLACE CHOICE PLAN, supra note 46, at 17. The waivers do not define "hardship" and the premium statement reads: By checking the hardship box you are stating that you have spent or will spend your monthly income on food, housing, utilities, transportation or other health care, and are unable to pay your . . . member contribution for this month. Claiming financial hardship will count for this month only, not amounts due for past months. How to Read Your Statement, IOWA DEP'T HUM. SERVS., http://dhs.iowa.gov/sites/default/files/ IHAWP_how_to_read_your_statement_FINAL_0.pdf (last visited Mar. 18, 2016)

> debit cards and must contract with a third party administrator to create and maintain the accounts, including making payments to providers for cost sharing and determining whether enrollees have funds that can carry over from year to year.
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> Second, these premium waivers are so complex, they are likely to generate consumer confusion that creates barriers to enrollment. All of these demonstrations say that one of the goals of the premium waivers is to help people make the transition to using private insurance. But private insurance does not operate like these Section 1115 waivers. People with employer sponsored insurance have their premium contributions automatically deducted from their paychecks. Medicare beneficiaries have their premiums automatically deducted from their Social Security checks. Yes, people with Marketplace plans and other individual insurance have to pay monthly premiums, but they generally have higher and more stable incomes than these Medicaid beneficiaries, particularly those with income below poverty.[20]

Professor Watson also pointed to the difficulty, if not impossibility of the state and federal governments' ability to evaluate such complex demonstrations to know whether which, if any, or in what combination elements in this proposal are impacting health status for members:

> Third, the complexity of these premium waivers makes it difficult, and maybe impossible, to evaluate the impact of the premiums on enrollment and dis-enrollment, family finances, access to care, and health status. It may be impossible to untangle the impact of premium costs when they are imbedded in a whole array of other experiments including HSAs, healthy behaviors, and consumer preference for copays versus premiums.[21],[22]

HHS must require the Kentucky to explain the full breadth of what it tested with respect to the population with the previous demonstration project, the results of those tests, how the lessons learned from that project have affected the new proposal, and what new experiments will be conducted regarding this population with the new project. We would like to see all of that information included in the proposal initially. Those lessons must be based on accurate and relevant data.[23]

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[20] 9 Saint Louis U. J. Health L and Pol'y 265 (2016)

[21] Id, at 281.

[22] See generally MATHEMATICA POLICY RESEARCH, MEDICAID 1115 DEMONSTRATION EVALUATION DESIGN PLAN (2015), https://www.medicaid.gov/medicaid-chip-program-informa tion/by-topics/waivers/1115/downloads/evaluation-design.pdf (plan for a national, cross-state evaluation of several different types of Section 1115 demonstrations, including premium waivers).

[23] Healthy Indiana Plan 2.0 1115 Waiver Application, 28, available at:

## Designation of Medically Frail

The proposal does not provide sufficient information regarding the criteria or the screening tool that will be used to determine whether an individual is "medically frail" and therefore facing different eligibility expectations for this demonstration. The proposal never specifies the definition that will be used to make this determination. We ask that Kentucky should confirm that it will treat as "medically frail" all individuals. As a floor, meet the definition set forth in the Medicaid statute and regulations, and not just those who are identified based on an arbitrary predetermined percentage of the population. The Department for Medicaid Services should also clarify how the choice of an ABP or traditional Medicaid coverage will be presented to medically frail enrollees to help them make an informed decision about coverage. It is disturbing that the hypothesis appears to be that those in the expansion population will have greater access to quality services. There is too much room for confusion, and indeed actual confusion already based on meetings and questions and public comments, about this designation. It is also pejorative and inaccurate in common usage for the many members of the population it attempts to define, which we find troubling. The struggle to understand these designations as population groups has been so time consuming and costly as to be eliminated in favor of simple income metrics, and have been so ripe to conflict to have made it to the courts.[24]

## Fiscal Responsibility

This proposal is not fiscally responsible for the Commonwealth. Kentucky HEALTH contains many of the same elements analyzed Government Accountability Office's report on existing 1115 Demonstration Projects failure to ensure budget neutrality.[25] The Government Accountability Office has specifically listed the ways in which HHS did not ensure their own budget neutrality, and put the correlating state budgets at risk by

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http://www.medicaid.gov/MedicaidCHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2.0/in-healthyindiana-plan-support-20-pa.pdf.

[24] Spry, 487 F.3d at 1276; see also Newton-Nations v. Betlach, 660 F.3d 370 (9th Cir. 2011) (dispute over whether certain people subject to copays pursuant to a waiver were an expansion group or medically needy for purposes of entitlement to Section 1916 protections and thus outside the reach of the Secretary's waiver authority).

[25] GAO, Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lack of Transparency at 32 (June 2013). The GAO concluded, "HHS's [budget neutrality] policy is not reflected in its actual practices and, contrary to sound management practices, is not adequately documented….[T]he policy and processes lack transparency regarding criteria."

added and unbalanced administrative cost.[26]

Common sense dictates that it is not cost effective to create a system to track and collect single dollars. The administration can look to the fiscally successful, perhaps unjustly profitable, managed care organizations in Kentucky, most of which are private companies to see that their business practice was to not collect small cost sharing from Medicaid enrollees in part because of doing so is not a cost effective business practice. Arkansas's Republican Governor eliminated their Medicaid member cost sharing requirements for their lower income enrollees because of fiscal responsibility, the state simply could not justify their tax payers spending more to collect less.[27],[28]

Kentucky Equal Justice Center has reviewed and suggests the Kentucky Department of Medicaid review the Kentucky Center for Economic Policy's fiscal analysis of Medicaid Expansion. Even without that analysis, Medicaid expansion is straight-forward in terms of its cost, it is, in state budget terms, controlled and manageable. When Kentucky's Medicaid budget is different than anticipated, it is because of unfunded mandates--programs that were not included in the budget but now have to be funded (the brain injury slots, for example), not a lack of efficiency of Medicaid itself. "Repealing Medicaid expansion would blow a massive hole in the state's budget, imposing a negative fiscal impact of up to $919 million over the next few years.[29] At the same time, repeal would cause the state to miss out on the creation of 28,000 jobs and up to $30.1 billion in economic activity, as well as jeopardizing the 12,000 jobs that Medicaid expansion has already created."[30]

Our neighbor Indiana's Medicaid Expansion via a demonstration project under Section 1115 authority also has the state match beginning in 2017, often cited by Governor Bevin as a reason for this experimentation and changes to our Medicaid program.

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[26] GAO Letter to The Honorable Orrin Hatch and The Honorable Fred Upton re: Medicaid Demonstrations: HHS's Approval Process for Arkansas's Medicaid Expansion Waiver Raises Cost Concerns at 3 (Aug. 8, 2014)

[27] "The bottom line is it became clear to administrators of the Arkansas Private Option Medicaid program that they were spending far more than they were collecting when attempting to administer premiums and cost sharing for people below 100% of the federal poverty line. You can read the language in the Arkansas legislation at Section 4(b) where the purpose of this change is to "limit the state's exposure to additional costs." Searing, Adam. Arkansas Finds Collecting Medicaid Premiums and Copays from People in Poverty Not Cost Effective, February 6, 2015.

[28] State of Arkansas, 90th General Assembly, Regular Session, 2015, Senate Bill 96. http://www.arkleg.state.ar.us/assembly/2015/2015R/Bills/SB96.pdf

[29] 4 Commonwealth of Kentucky, "Kentucky Medicaid Expansion Report: 2014" (2015), available at http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf

[30] Huelskoetter, Thomas. The Impact of Reversing Kentucky's Health Care Reforms. November 13, 2015.

Indiana paid for that 5% FMAP state match in their budget by increasing cigarette taxes and provider assessments. Indiana is also able to specifically rely on their provider assessments which are capped in Kentucky. Kentucky's hospitals secured a cap in the hospital provider tax in SFY 2005, which has resulted in a decline in total provider tax revenues every year since 2008. Since 2014, we know that billions of dollars have been paid directly to providers as a result of Medicaid Expansion. This would be a rational basis for looking to this and other revenue sources and recipients of the Medicaid dollars in Kentucky. Lifting the cap on the hospital provider tax would have generated $120 million in additional revenue in fiscal year 2015.

### *Administrative Costs Outweigh ANY and ALL Alleged Savings*

Arkansas is not our only example.[31] Virginia included premium payments in its Children's Health Insurance Program but found that the cost of collecting premiums exceeded the revenue collected.[32] Arizona studied this concept pre-ACA and found similar results specifically that even maximizing all premiums and cost-sharing (and assuming successful collection among other risk factors) would still cost the state three times what they could possibly collect.[33]

### Community Engagement: Work Requirement

We oppose conditioning Medicaid eligibility on compliance with work, volunteer, or work search activities. Work search, a much lower standard and therefore obviously work requirements are an illegal condition of eligibility in excess of the Medicaid eligibility criteria clearly enumerated in Federal law.[34] Medicaid is a medical assistance program, not a jobs program. We would support creation of a higher quality of life and a raised minimum wage and higher wage job opportunities and supports to get there in Kentucky, but cannot support the idea of conditioning access to life saving healthcare to that goal. Although states have flexibility in designing and administering their Medicaid programs, the Medicaid Act requires that they provide assistance to all individuals who qualify under federal law, and courts have held additional eligibility requirements to be

[31] http://www.arktimes.com/ArkansasBlog/archives/2015/01/23/hutchinsons-private-option-plan-would-nix-cost-sharing-and-savings-accounts-below-poverty-line

[32] http://www.healthreformgps.org/wp-content/uploads/Handle-with-Care-How-Premiums-Are-Administered.pdf

[33] Arizona Health Care Cost Containment System. "The Fiscal Impact of Implementing Cost-Sharing and Benchmark Benefit Provisions of the Federal Deficit Reduction Act.", 2, 5-6, 2006

[34] See generally SSA § 1902

illegal. [35],[36] Section 1115 cannot be used to short circuit the Medicaid protections, because the community engagement activities, work, and work search as described in no way promote the objectives of the Medicaid Act or demonstrate anything about the objectives of Medicaid. From a practical stand point, work requirements applied to health coverage get it exactly backwards. An individual needs to be healthy to be able to work, and a work requirement can prevent an individual from getting the health care they need to be able to work. We note finally that in almost any system in which eligibility is conditioned or attached to work search, there are likely to be serious violations of nondiscrimination laws, as persons with disabilities may end up with fewer benefits or higher costs due to their condition or the lack of adequate systemic supports to foster their employment. We urge the administration and the Department of Medicaid Services to be clear with Kentuckians that Medicaid is health coverage, period. This proposal could be interpreted as to perceive access to healthcare as some kind of standard of living cash assistance, which it is not. Healthcare does not replace income, but income is very difficult and sometimes impossible to generate without healthcare.

We are concerned that states will abuse the confusion of beneficiaries who may think the Medicaid and work search programs are somehow linked. We wholeheartedly support efforts by this administration to create independent and voluntary employment supports for lower income individuals, as accessible employment supports are services that our clients, particularly those with disabilities, have sought and been denied for decades.

**Non-emergency Medical Transportation (NEMT)**

NEMT is an essential benefit for Kentucky Medicaid enrollees. It is cost effective and important element in improving health outcomes and reducing costs, both of which are goals of Kentucky HEALTH. Medicaid enrollees are a chronically underinsured, and prior to the ACA, largely uninsured population with known additional barriers to care. For example, 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 so.[37] Studies have consistently shown that providing transportation to non-emergency care

[35] Id. §§ 1902(a)(10)(A), (B)

[36] Camacho v. Texas Workforce Comm'n, 408 F.3d 229, 235 (5th Cir. 2005), aff'g, 326 F. Supp. 2d 803 (W.D. Tex. 2004) (finding that Texas could not "add additional requirements for Medicaid eligibility"). See generally Carleson v. Remillard, 406 U.S. 598 (1972) (invalidating state law that denied AFDC benefits to children whose fathers were serving in the military where no such bar existed in federal law governing eligibility

[37] 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

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.[38]

Medicaid Expansion has also provided the funding for actual vehicles, relieving that cost from the public transportation block grants.[39] There are many cost and budget analysis we would like to see, including the administration of the rewards program, and explanation of why the cost overruns and inefficiencies seen thus far in similar programs in other states potentially would not exist in Kentucky.

**Exclusion of Appeal Rights and Grievance Procedures; Public Hearing concerns**

KEJC firmly believes that a public benefit comes with the right to a public hearing. With this proposal, pieces of those protections are eroded. Medicaid requires states to provide retroactive and point-in-time coverage for enrollees, and provide them with access to Medicaid with "reasonable promptness."[40] This proposal requested § 1115 demonstration authority to waive these requirements, specifically Section 1903(a)(3) and (a)(8). We oppose that request. This Application includes no evidence of any demonstrative value to that request. The entirely predictable result will be: (1) more low-income individuals experiencing medical debt collections and bankruptcy; (2) more providers – especially safety net hospitals – incurring losses; and (3) more individuals experiencing gaps in coverage when some providers refuse to treat them because the providers realize they will not be paid retroactively by Medicaid. This policy has dubious hypothetical benefits and very concrete harms.

We urge you to reconsider the waiver of retroactive eligibility, immediate enrollment rights, and also the amount of time and opportunity for Kentuckians to be heard about changes to our Medicaid program. We note that Governor Bevin agrees that we should only change Medicaid with a transparent process. However, despite Governor Bevin's assurance of "taking every step to ensure the process [of applying for a Section 1115 Demonstration Waiver] is open and accessible to the public"[41] the administration

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[38] http://web1.ctaa.org/webmodules/webarticles/articlefiles/NEMTpaper.pdf

[39] https://insurancenewsnet.com/oarticle/transportation-officials-leery-of-potential-medicaid-waiver-effects

[40] SSA §§ 1902(a)(3) and (a)(34); 42 C.F.R. § 435.914 (redesignated at §435.915 in 77 Fed. Reg. 17143).

[41] "As part of this administration's continuing commitment to transparency, we are taking every step to ensure the process is open and accessible to the public," continued Gov. Bevin. "Today marks the beginning of a 30- day public comment period in which we will be engaging the public and soliciting their feedback on this draft waiver proposal. In addition to the input we have already received from Medicaid providers, advocates, consumers and other stakeholders, we encourage Kentuckians to take advantage of the

has distorted and manipulated the standards set out in 42 CFR 431.408 and we hope that you can reconsider that and add greater transparency.

Federal regulation require "postal and Internet email addresses where written comments may be sent and reviewed by the public."[42] The administration has provided postal and email addresses where written comments may be sent, but no meaningful ability to review public comments. Legislators at the Task Force on Vulnerable Kentuckians hearing in Beattyville, Kentucky commented how easy it is to make comments online, but there was no way to submit comments others could read on this Application.

What the administration did provide, on the Cabinet for Health and Family Services' website, in line with the Frequently Asked Questions, overview, and formal public notice documents, is "Kentucky HEALTH Waiver Praise". Describing the public comments from the hearings as praise is disingenuous. It is not transparent, and a directly misleading representation of the comments at the public hearings.. We hope the administration clarifies in all communication with the public and the federal government that the in person public comments were overwhelmingly critical. Not one person spoke in support of the substance of the Application at the first hearing, and the trend continued at all three.

The "Praise" document was available at the same time the Application became available to the public, which means the "praise" either was from parties who had not seen the Application, or from parties with access to the Application prior to the public, which would exclude those comments from the "public comment" category. As such, we ask that they not be included in any reviews of public comments made in the final proposal.

At the public hearings, the administration made comments that led advocates to believe public comments submitted via the process announced in the Kentucky HEALTH Formal Public Notice and website would never be available for the public to review and moved Kentucky Voices for Health to create an alternate email address to use to collect public comments. We would ask that the administration clarify the intended processes for public comments, including how they will be reviewed, by whom, and how they will be reported and incorporated in the application to HHS.

Gov. Bevin did hold "two public hearings in geographically distinct areas of the State"[43],

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many different avenues and opportunities to provide thoughtful responses regarding the proposal we are presenting." Press Release, Gov. Matt Bevin, June 22, 2016, available at http://chfs.ky.gov/NR/rdonlyres/CDF0CCEE-0C11-4CB1-A20F-47E23EA334EC/0/nr062216.pdf

[42] 42 CFR 431.408(a)(1)(iii)

[43] 42 CFR 431.408 (a)(3)

and in fact three hearing, but none in a population center.[44] Kentucky is a rural state, and has only two cities with populations over 70,000, Lexington and Louisville.[45] No public hearings were held in Lexington or Louisville. Requests were made by Kentuckians at the public hearing in Frankfort and Hazard to host public hearings in other regions of the Commonwealth, specifically Lexington, Louisville, Northern Kentucky, and somewhere in Western Kentucky.[46] After the Governor's proposal was announced and released on June 22, there were only three business days before the first public hearing in Bowling Green. The room was full, and no one made any positive comments about the proposal, but many more people had anticipated being able to participate via a live stream. There was a live stream, but it did not have any audio for a significant portion of the hearing, and poor audio throughout. The overall quality was so poor that live streaming the hearing from a cell phone via Periscope was an improvement that prompted public thanks from Kentuckians trying to watch remotely. The ability to hear in the room was not much better, noted by the "Female Audience Participant: I'm so sorry. There's so much noise to follow you in the back of the room. I can't hear anything." followed by the reporter also announcing she was unable to hear Mr. Adam Meier.

At the second public hearing, the next day, June 29th, less than a week after the announcement of the proposal for Medicaid Transformation in Kentucky, the perception of a disingenuous nature of the public comment process was more pronounced. The public hearing was scheduled from 1pm to 3pm. There was no live stream. Not only was the hearing room with seating for between 100-200 people overflowing, the overflow room with the hearing on screens was overflowing. People were sitting on the floor and standing in the hallway at 1pm waiting to speak. Not one member of the public was allowed to speak between 1pm and 2:30pm. It was not until around 2:35, ninety five minutes into a scheduled period with only twenty five more, were the first members of the public invited to speak and comment. People were outraged and shouting at the delay. People who had come to Frankfort to be able to make a comment left before their names were called. The perception in the room was that the administration did not want the public to speak and were filling as much of the scheduled two hours as possible to prevent more public comment. The administration did stay in the room past 3pm, and were generous in their willingness to stay, and we noticed and appreciated that – Secretary Glisson was clear she was willing to stay and listen – but that was said too late for Kentuckians I talked to in the hallway on their way

[44] http://chfs.ky.gov/dms/kh

[45] http://factfinder.census.gov

[46] "Schedule more KY Public Health Hearings. Give Kentuckians a Voice & Choice in Healthcare." Petitioning Governor Matt Bevin, Larry and Serena Owen. https://www.change.org/p/gov-matt-bevin-schedule-more-ky-public-healthcare-hearings-give-kentuckians-a-voice-and-choice-in-their-healthcare?recruiter=276009&utm_source=petitions_show_components_action_panel_wrapper&utm_medium=copylink

out. They still deserve to be heard. Many of the Kentuckians who had come to share their concern were unable to stay, and others did not trust that the administration would extend the hearing, based on the experience thus far.

While we also support that an individual should not have to exhaust the grievance process before filing elsewhere, we also believe that this proposal creates new scenarios and many new administrative processes that will need clear appeal and public grievance processes included, which are not referenced in this proposal. We mechanism for complainants and so it fosters resolution of issues without further action. We believe that the basic features of OCR's model 504 Grievance Procedure should be incorporated for all elements, specifically including all of the factors in the My Rewards program.[47] These features of a grievance process include: a timeframe for filing complaints, issuance of a written decision on the grievance no later than 30 days after filing; an appeal to a different individual or group with a written response within 30 days after filing the appeal; provision for providing accommodations, if needed, for the involved parties to participate in the grievance process. This model procedure also includes important notice about protection against retaliation and that use of the grievance procedure does not prevent filing a complaint elsewhere. In order to maintain flexibility for entities, we suggest that the basic features be required with the timelines left to the discretion of the entities.

Further, we do not want to require individuals who allege discrimination to have to exhaust any internal grievance or complaint procedures before being allowed to file an administrative complaint or pursue judicial remedies. While we recognize that some individuals may have a positive result when utilizing internal processes, it is likely that for some individuals a covered entity's internal processes will offer no likely positive outcome.

## Conclusion

KEJC would again like to commend and thank the Department for Medicaid Services for consideration of all data and greatest opportunities for the health improvements for all Kentuckians, especially those most vulnerable, our Medicaid members. This is of particular interest to legal services non-profits, having represented clients facing exclusions from healthcare for decades and generations. KEJC looks forward to our continuing conversations to meaningfully transform the health of Kentuckians with changing to the way we pay for and deliver care for all Kentuckians.

If you have any questions regarding these comments, please contact me at the information included below. Thank you for your consideration of our comments, which include some of the analysis of national experts including Families USA, National Health

[47] US DHHS OCR, Example of a Section 504 Grievance Procedure that Incorporates

Law Program, Community Catalyst and other.   Thank you for taking the considerable time to review the those of all Kentuckians who have reached out and consider adding additional opportunities for more Kentuckians.

Please also send a copy of any response prepared to these comments to the same contact information: carastewart@kyequaljustice.org

Sincerely,

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