

October 7, 2016

Honorable Sylvia Mathews Burwell  
Secretary, Department of Health and Human Services  
200 Independence Avenue SW  
Washington, DC 20201

Dear Secretary Burwell:

The Center on Budget and Policy Priorities and the Georgetown University Center for Children and Families appreciate the opportunity to submit comments on Kentucky HEALTH, Kentucky's proposal for a demonstration project under section 1115 of the Social Security Act. Kentucky HEALTH would make harmful changes in Kentucky's highly successful Medicaid expansion. Our comments explain that these changes shouldn't be approved, because they would keep eligible people from enrolling and keep others from getting the care they need. We also provide comments on the changes Kentucky is proposing for its health care delivery system.

*State's Proposal Would Reverse Kentucky's Gains in Coverage and Care*

Kentucky has made impressive progress in extending health coverage to its residents under health reform, cutting in half the share who are uninsured and covering over 400,000 newly eligible people in Medicaid. The expansion of coverage is leading to improvements in health. Harvard University researchers surveyed low-income adults in Kentucky and Arkansas — southern states that expanded Medicaid — and Texas, which hasn't expanded, at the end of 2013, 2014, and 2015. The 2014 survey found improvements in affordability and access to care after the first year of expansion in Kentucky and Arkansas, but didn't find significant changes in use of health care services or health among the three states. By the end of 2015, however, low-income adults in Kentucky and Arkansas received more primary and preventive care, visited emergency departments less often, and reported better health than low-income adults in Texas.<sup>1</sup>

Kentucky is proposing to significantly change its current program by imposing premiums and a work requirement, eliminating coverage of non-emergency medical transportation, delaying the effective date of coverage, and penalizing people who don't renew their coverage on time. Key features of Kentucky's proposal are modeled on Indiana's demonstration project called the Healthy Indiana Plan 2.0 (HIP 2.0). As the evaluation of HIP 2.0 shows, these changes would likely decrease participation by eligible people and make it harder for many who do enroll to get the care they need.<sup>2</sup>

---

<sup>1</sup> Sommers, Blendon, and Orav, "Both the 'Private Option' and Traditional Medicaid Expansions Improved Access to Care for Low-Income Adults," *Health Affairs*, January 2016.

<sup>2</sup> Judith Solomon, "Indiana Medicaid Waiver Evaluation Shows Why Kentucky's Medicaid Proposal Shouldn't Be Approved," Center on Budget and Policy Priorities, August 1, 2016.

Major elements of Kentucky's proposal do not meet the criteria for 1115 demonstration projects established by the Centers for Medicare and Medicaid Services (CMS). Demonstrations must increase and strengthen coverage for low-income individuals, increase access by stabilizing and strengthening provider networks available to Medicaid beneficiaries, improve health outcomes, or increase the efficiency and quality of care through transformation of health care delivery systems.<sup>3</sup> Our comments on key elements of Kentucky's proposal show that the changes Kentucky is proposing don't meet these criteria. Moreover, the most often-cited rationale for the proposal delivered by Kentucky's governor and members of his administration is that it would save money. Courts have repeatedly found that saving money is not a sufficient or appropriate basis for approving a demonstration project under section 1115.<sup>4</sup>

### *CMS Shouldn't Allow Kentucky to Make Eligibility for Coverage Contingent on Work or Work-Related Activities*

Kentucky's proposal to require Medicaid beneficiaries to work, volunteer, or go to school in order to maintain their Medicaid benefits would reduce access to health care, unravel the gains made by the state's Medicaid expansion, and increase poverty. The experience of the Temporary Assistance for Needy Families (TANF) program demonstrates that imposing a work requirement on Medicaid would lead to the loss of health coverage for substantial numbers of people who are unable to work or face major barriers to finding and retaining employment. Moreover, the research indicates that a work requirement would produce such a result with little or no long-term gains in employment. In fact, if the resulting loss of coverage led to deterioration in health for some people, a work requirement could end up making it *harder* for some adults to work or remain employed.

Although Kentucky's proposal includes an exemption for people who can't work, it would be administratively challenging to identify and track people whose disabilities or circumstances ought to exempt them. State TANF programs have failed notably on this front, with studies showing that TANF recipients who are sanctioned for not meeting a work requirement have significantly higher rates of disability than those who are not sanctioned.<sup>5</sup> It can be difficult and burdensome for people with disabilities, family care responsibilities, or other significant problems or limitations to prove their inability to meet a work requirement.

In addition to being ineffective in increasing employment over time, a work requirement would add considerable complexity and costs to Kentucky's Medicaid program. State experience in implementing TANF work requirements suggests that adding similar requirements to Medicaid could cost states thousands of dollars per beneficiary.<sup>6</sup> The proposal states that Kentucky would have to "ensure appropriate resources are available and to monitor the impact of this new requirement," but Kentucky does not describe how this would be accomplished.

---

<sup>3</sup> Centers on Medicare & Medicaid Services, About Section 1115 Demonstrations at <https://www.medicare.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html>

<sup>4</sup> For example, see *Newton-Nations v. Betlach*, 660 F.3d 370 (9<sup>th</sup> Cir. 2011)

<sup>5</sup> LaDonna Pavetti, Michelle Derr, and Emily Sama Martin, "Assisting TANF Recipients Living with Disabilities to Obtain and Maintain Employment: Conducting In-Depth Assessments," Mathematica Policy Research, Inc., February 2008.

<sup>6</sup> Gayle Hamilton *et al.*, "National Evaluation of Welfare-to-Work Strategies: How Effective Are Different Welfare-to-Work Approaches? Five-Year Adult and Child Impacts for Eleven Programs," Manpower Demonstration Research Corporation, December 2001, Table 13.1.

In arguing for a work requirement, Kentucky repeatedly notes CMS' support for states that choose to offer supported employment benefits. If Kentucky is interested in increasing employment opportunities, it could offer supportive employment services to individuals with disabilities as a number of states have done. Like CMS, we are supportive of these efforts, which in no way resemble the work requirement Kentucky seeks to impose.

### *CMS Should Not Approve Kentucky's Proposal for Premiums, Accounts, and Cost-Sharing*

All Kentucky HEALTH enrollees except pregnant women, children, and those found to be medically frail would be required to pay monthly premiums ranging from \$1 to \$15 a month. Premiums for people with incomes over the poverty line would increase each year after their first year in the program up to \$37.50 a month in the fifth and subsequent years. Coverage wouldn't be effective until the first premium is paid. If premiums aren't paid within 60 days, people with incomes below the poverty line would be enrolled but they would have to pay copayments for most health care services. People with incomes above the poverty line would not be enrolled. People with incomes above the poverty line who don't pay their premiums after a 60-day grace period would be locked out of coverage for six months.

Enrollees would have two types of accounts: a \$1,000 account funded by the state used to pay services falling within a \$1,000 deductible and a "My Rewards" account that can be used to obtain benefits such as vision and dental care not otherwise available to enrollees. The state would provide funds in the rewards account based on certain behaviors such as completing a job assessment, participating in community service, and completing a health risk assessment.

Extensive research (including research from Medicaid demonstration projects conducted prior to health reform) shows that premiums significantly reduce low-income people's participation in health coverage programs.<sup>7</sup> It appears that that has also been the case in Indiana where the state has not met its enrollment targets.<sup>8</sup> Charging premiums to current enrollees and new applicants in Kentucky is likely to result in reduced participation. In fact, the state's own projections show a decrease in participation amounting to about 56,000 adults over the 5-year period the demonstration project would be in effect. Moreover, the state's budget neutrality calculations show that the state expects to cover about 86,000 fewer people under the waiver than it would cover without the waiver.

Even if Kentucky is allowed to charge premiums to beneficiaries with incomes above the poverty line, Kentucky should also not be allowed to implement a six-month lock-out for people who don't pay their premiums. CMS recently did not allow Arizona to impose a lock-out on this group of beneficiaries.

Recognizing that no state has been allowed to terminate coverage for beneficiaries with incomes below the poverty line for nonpayment, Kentucky proposes to replicate Indiana's approach of penalizing these beneficiaries by charging them copayments and not providing them with access to a rewards account. This approach has been shown to leave beneficiaries worse off in Indiana and shouldn't be replicated in Kentucky. In Indiana enrollees who had to make copays were more likely

---

<sup>7</sup> Laura Snyder and Robin Rudowitz, "Premiums and Cost-Sharing in Medicaid," Kaiser Commission on Medicaid and the Uninsured, February 2013, <https://kaiserfamilyfoundation.files.wordpress.com/2013/02/8416.pdf>.

<sup>8</sup> Solomon, fn. 2.

to use the emergency room, both in general and for non-emergency reasons. They also had lower rates of primary care use and preventive care use, suggesting that they were more likely to lack adequate access to preventive and primary health care services.

The structure of the Kentucky accounts is extremely complex and not evidence-based. Enrollees can roll-over up to 50 percent of the deductible account to their rewards account at the end of the year. In Indiana, most enrollees didn't even know about their accounts or understand how they worked calling into question whether the possibility of rolling funds over could act as an incentive. Moreover, the design of the incentive itself penalizes people with health problems who need more than \$500 in care during the year, because they can't qualify for a roll-over. Enrollees would also be able to receive the balance in their accounts up to \$500 after being employed with commercial insurance for *eighteen months*. It is unlikely very many enrollees would qualify for this incentive. Moreover, behavioral economics research finds that individuals are more likely to respond to immediate gratification than to a delayed reward especially one with such a stringent eligibility requirement.<sup>9</sup>

***CMS should not approve Kentucky's request to make coverage contingent on payment of an initial premium.***

Kentucky would delay coverage for beneficiaries until they make a premium payment. As noted, beneficiaries with incomes below the poverty line would be defaulted into a plan with co-payments on the first day of the month the 60-day period expires. Beneficiaries with incomes above the poverty line would not be enrolled.

The proposal requires individuals to remain without Medicaid coverage for up to 60 days until they make a premium payment. For individuals with incomes below the poverty line, leaving people without coverage for 60 days makes little sense if they can't afford the premiums. If coverage does not begin until up to two months after a low-income individual has applied, the individual will not be able to get his or her prescriptions covered in the interim and they may not be able to get other health care services they need. If they do receive care, health-care providers will not be able to receive reimbursement. Delaying coverage in this manner does not further the objectives of the Medicaid program.

Indiana's experience shows that the waiting period for coverage may also decrease participation. According to the evaluation of the first year of Indiana's program, in any given month, as many as 30,000 people are in a "conditional eligibility status" — i.e., have been found eligible within the past 60 days but are not enrolled because they haven't made premium payments. Of those, only two-thirds enroll by the end of their 60-day payment period.

***CMS should not approve Kentucky's request for an "open enrollment" period.***

Kentucky proposes to lock people out of coverage if they don't complete their annual re-determination of coverage in a timely manner. Individuals would be locked out of coverage for six months unless they come back within a three-month period following the termination of coverage

---

<sup>9</sup> Maia Crawford, "Healthy Behavior Incentives: Opportunities for Medicaid," Center for Health Care Strategies, November 2014.

for not completing the renewal process before the end of their 12-month enrollment period. In order to come back earlier, beneficiaries would have to complete a financial or health literacy course.

CMS has already found that a similar request from Indiana is not consistent with the objectives of the Medicaid program. 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. Kentucky's proposal would likewise keep beneficiaries from obtaining access to necessary health care and should also be rejected.

### ***CMS Should Not Approve Kentucky's Request to Waive the Non-Emergency Transportation Benefit***

Kentucky seeks to waive the NEMT benefit for enrollees in Medicaid expansion's new adult group, saying the benefit is underutilized by the group. Yet Kentucky reports that *140,000 non-emergency trips* were utilized in a single year, which contradicts the claim of underutilization.

Kentucky notes that Indiana and Iowa both have waived the NEMT benefit and claim doing so has not obstructed access to care in those states. In comments on these state's proposals to waive the NEMT benefit, we have shown that the data from Indiana and Iowa suggest otherwise. For example, a recent state evaluation in Indiana found transportation problems were the top-cited reason Medicaid expansion enrollees gave for missing a medical appointment. The evaluation also found that transportation difficulties were much more prevalent among people with incomes below 25 percent of the poverty line.

Transportation help is critical for many low-income beneficiaries to access needed care, especially so in a state like Kentucky where many beneficiaries live in rural areas and have to travel long distances for medical appointments. We urge CMS to reject Kentucky's proposal to waive the NEMT benefit.

### ***Kentucky Should Implement Its Premium Assistance Program Without a Waiver***

We question whether a waiver approach is necessary to expand the state's Health Insurance Premium Payment (KyHIPP) program as the state is already operating this program under section 1906 authority. Beneficiaries eligible under the expansion who have access to employer-sponsored insurance could be enrolled in the current program and be required to participate if cost-effective. This would be a reasonable approach to take for people in the expansion group who have access to employer-sponsored insurance, although the state's projections of how many beneficiaries would have access to cost-effective employer-sponsored insurance appears unduly optimistic.

Section 1115 waiver authority is needed to charge premiums and limit benefits in KyHIPP -- both which would constitute a step backwards for families in Kentucky. Kentucky would require that enrollees in employer coverage pay the same premiums as those in Kentucky HEALTH by deducting the enrollee's share from the amount the state pays for the employer coverage. While we support the state's plan to reimburse premiums in advance of a payroll deduction, implementation would have to be closely monitored in light of the state's plan to "implement a system to ensure members are maintaining coverage before monthly payments are made."

With respect to *benefits* we are concerned that the application states that the member will have access to all Kentucky HEALTH benefits (or if applicable KCHIP benefits) through a wrap-around; yet the state is requesting a waiver of amount, duration and scope (Section 1902(a)(10)(B) “To the extent necessary to enable Kentucky to allow individuals to receive the benefits provided through their employer-sponsored plan.”)

Instead of charging premiums and limiting benefits, Kentucky should fashion an approach that builds on the existing KyHIPP program, using a state plan approach that doesn’t require waiver authority.

We have three additional comments on the state’s premium assistance proposal:

- *Inclusion of children enrolled in Kentucky’s CHIP program:* We have concerns regarding the inclusion of children enrolled in Kentucky’s CHIP program in KyHEALTH and KyHIPP even though their parents have incomes above 138 percent of the poverty line making the parents ineligible for Medicaid in most cases. Subsidizing employer-sponsored insurance for children in these families may be a worthwhile approach, but it should be pursued through state plan authority – and in the case of KCHIP children through a voluntary approach. Unlike children eligible for Medicaid, KCHIP children must be uninsured to be eligible. Families enrolling their children in KCHIP with access to ESI have made a choice not to pick up that coverage – most likely because it is too expensive. Including children eligible for KCHIP would also face a higher bar to meet cost-effectiveness tests, because parents are not receiving publicly subsidized coverage. Details on how this would work in practice are not addressed in the application.
- *Available providers:* Kentucky should clarify which providers will be available to participants in the premium assistance program. The proposal states that members will have access to network providers in their employer-sponsored plan. We are aware that enrollees in some other states’ HIPP programs only have access to ESI network providers who are also Medicaid providers.
- *Cost-effectiveness:* We support the definition of cost-effectiveness outlined in the application, and urge that the state’s assessment of cost-effectiveness be made publicly available and included in the state’s evaluation plan. The evaluation plan requires tracking of the cost of wraparound services, but it does not mention administrative costs or overall costs of the program although administrative costs are an acknowledged component of the cost-effectiveness definition. This oversight is particularly surprising on the state’s part given their emphasis on budgetary savings as a key goal of the waiver. Given the paucity of data on the cost-effectiveness of premium assistance programs in general, and administrative costs of these programs in particular, we recommend that CMS require that Kentucky carefully and thoroughly evaluate cost effectiveness if a premium assistance approach is pursued under waiver authority.

### *Comments on Kentucky’s Proposals for Changes in the Delivery of Care*

Kentucky is proposing a number of changes in how it delivers services to Medicaid beneficiaries. Some of these are worthy of support, while others should be changed before approval.

**Section 5: Delivery System and Payment Rates for Services.** Section 1115 demonstration projects are intended to test proposals that promote the objectives of the Medicaid program. Data collection and public reporting are essential components of testing new models of care delivery, and we support the state's proposal to expand data collection efforts to improve the interoperability of data and drive policy decisions using evidence. We further recommend that the state commit to publicly reporting the data at frequent intervals to ensure transparency.

**Section 5.1.1: Substance Use Disorder Delivery System Reform Pilot Program.** The shortage of providers to treat mental illness and substance use disorders shortages is a serious issue affecting many Medicaid beneficiaries. Kentucky's proposal would permit individuals with mental health or substance use disorders to access inpatient behavioral health treatment. However, this proposal would fail to meaningfully expand access to needed outpatient services. Innovative pilot programs aiming to expand access to behavioral health providers and services are worthy of support, but we do not believe that the majority of individuals with mental illness and substance use disorders need inpatient services; instead the state should invest in appropriate, community-based services. We recommend that Kentucky test strategies to support a strong behavioral health workforce without unnecessarily institutionalizing individuals in need of outpatient behavioral health services.

**5.1.2: Chronic Disease Management.** We support Kentucky's intent to invest in preventive health services and chronic disease management, particularly increasing access to the National Diabetes Prevention Program, which has a strong evidence base for effectively preventing diabetes. We also support the proposal to include incentives for managed care plans to support beneficiaries' participation in prevention programs where clinically indicated. However, as mentioned previously, Kentucky's proposal to impose premiums and copays would impose significant barriers to access needed care for many beneficiaries. Beneficiaries should have access to all needed health services, including chronic disease prevention programs, in order to improve their population health and prevent unnecessary utilization of acute care services.

**5.1.3: Managed Care Reforms.** We support Kentucky's stated goal of aligning financial incentives for managed care plans and providers, including developing provider-contracting strategies that include value-based payments to plans as well as from plans to providers. We also support the inclusion of process and outcomes measures as well as improvements to beneficiary services such as call centers. However, these strategies should not be employed to the detriment of beneficiary protections. The state's proposal to prevent managed care plans from waiving beneficiary copayments will prevent access to needed health services for members who are unable to pay, which will have a negative effect on provider and managed care plan quality improvement. If the state is truly interested in improving beneficiary quality and outcomes, it must facilitate—rather than inhibit—access to needed health services. Value-based payment strategies can align incentives to encourage plans and providers to offer appropriate, efficient care, and reward preventive and primary care. If the state chooses to limit access to coverage or care through premiums, cost-sharing, and work requirements, individuals will be less likely to access appropriate care and more likely to overuse the emergency department. These barriers to care make it more difficult for plans and providers to manage care, which can drive up the cost of care and cause value-based payments that would reward efficient care to fail. They could also inhibit the effectiveness of value-based payment strategies, because plans and providers would be unable to provide appropriate health services to improve their patients' health and achieve measurement goals.

**5.3: Health Plan Choice.** We oppose Kentucky’s proposal to lock Medicaid beneficiaries into a health plan by waiving the 90-day managed care choice period. Unlike the commercial market, many members will be enrolled into a health plan by default, without actively choosing the plan or reviewing the network or coverage the plan offers. Offering beneficiaries a minimum of 90 days after enrollment to review their plan options and change their plans is essential to protect beneficiaries’ access and continuity of care. We also note that this waiver request does not appear in the list of proposed waiver and expenditure authorities and should not be approved on that basis alone.

**5.8: Quality.** As noted above, we strongly support data collection and quality measurement. We urge Kentucky to commit to publicly reporting these data to ensure transparency and ongoing evaluation.

Thank you for your willingness to consider our comments. If you would like any additional information, please contact Judy Solomon (solomon@cbpp.org) or Joan Alker jca25@georgetown.edu).