Kentucky Equal Justice Center
222 South First Street, Suite 305
Louisville, KY 40202

July 14, 2017

Department for Health & Human Services
Centers for Medicare & Medicaid Services
Division of Medicaid Expansion Demonstrations
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Comments on Proposed Modifications to Kentucky's 1115 Waiver Application

Dear Sir/Madam:

I am an attorney with Kentucky Equal Justice Center, a civil legal aid program that works closely with legal aid organizations and community partners across Kentucky, focusing on low income Kentuckians. Our advocates assist individuals and families who receive public assistance benefits, including Medicaid. Two of our employees have assisted numerous individuals to enroll in Medicaid as kynectors, now as assisters. We appreciate this opportunity to provide feedback on these proposed modifications to the Kentucky HEALTH 1115 Waiver application.

Last October, I submitted comments to CMS stating my objections to the proposed 1115 Waiver. In those comments, I stated that the purpose of an 1115 Waiver is to allow a state to demonstrate how it could increase access to medical care, improve provider networks, improve health outcomes or to improve quality of care. Kentucky's waiver application does not attempt to do any of these things. These proposed changes, presented as modifications "to support ease of administering program operations" make the waiver application even more harmful to Kentuckians. They shift the burden of what will prove to be an administrative nightmare to Medicaid members. This waiver will create new barriers to medical care.

It is well known that Kentucky's Medicaid expansion was extremely successful, resulting in almost 440,000 individuals gaining access to medical insurance, many for the first time. Instead of celebrating this improvement, DMS initially proposed a waiver that will, by its own estimates, eliminate 89,000 individuals from Medicaid. Now, with these modifications, an additional 9,000 people are estimated to lose coverage – a total of 97,000. Just these numbers alone belie DMS's assertions that this waiver is anything but an attempt to cut as many Medicaid expansion folks from the roles as possible, a goal that is totally opposite to the goals a state is required to demonstrate to gain approval from CMS.

Static Community Engagement and Employment

The original waiver proposed graduated hours of community engagement starting at 5 hours, and increasing every quarter up to a total of 20 hours. This modification would eliminate this gradual approach, and instead impose a 20 hour work requirement immediately on individuals already enrolled in Medicaid. DMS is making this change partly to align with SNAP work

requirements for non-exempt able-bodied individuals (ABAWDS), who are required to work 80 hours a month. But even SNAP allows ABAWDS to have 3 months of benefits before this rule is imposed. This new, stricter work requirement, coupled with the 6 month disenrollment for non-compliance, will mean many individuals currently on Medicaid will be terminated without any opportunity to even attempt compliance. In addition, because the waiver proposes to eliminate retroactive coverage, even if such an individual is later able to re-enroll, they may incur significant medical debt in the meantime, or forego medical care altogether. This is a recipe for disaster.

Disenrollment for Failure to Report a Change in Circumstances

In this modification, DMS proposes to expand the list of reasons why someone would get disenrolled or locked out of coverage for 6 months. In addition to failure to pay premiums and failure to comply with work requirements and failure to recertify timely, DMS now adds a disenrollment disincentive for failure to report any change in circumstances ***within 10 days.*** While Medicaid members are already required to report changes within 10 days, they are not disenrolled within 10 days. This change is truly draconian. Many Medicaid members work during the day, have limited minutes on their phones, or have constantly changing work hours. DMS seems to expect individuals to be reporting every week about changes in their lives at the risk of losing health insurance. This is totally unreasonable. In addition, the modification document states that "Kentucky now seeks to apply the same six-month disenrollment penalty for these **intentionally fraudulent member actions**." This suggests that DMS will equate any failure to report anything within 10 days with fraud. There is no mention here of DMS's obligation to provide an advance notice of adverse action, provide an opportunity for an individual to request a hearing, or allow an individual to request continued benefits pending an appeal. All of these things are required under federal Medicaid law. There is also no mention of whether DMS intends to refer all such "offenders" to the County or Commonwealth Attorney for prosecution for Medicaid fraud. It is beyond belief that this proposed modification is anything other than an attempt to dis-enroll massive numbers of individuals from Medicaid, and cannot possibly meet the test for waiver approval.

Maintenance of Current Presumptive Eligibility Sites

The original waiver application proposed an expansion of presumptive eligibility sites, to allow people to enroll in temporary coverage when they need it, before they are able to complete a full application. This was proposed as a way to keep uncompensated care from rising under the waiver. That reason to expand presumptive eligibility still exists. Now, however, DMS is proposing instead a Fast Track process for enrollment. This will require an individual to pre-pay their premium and activate coverage as early as the first day of the month of application. This fails to take into consideration that many low-income individuals will not have the funds to pay a premium right away, and will therefore *not* be able to fast track their application. This will delay enrollment, and coverage, for many individuals. Again, this modification is not designed to improve access or care for Medicaid members, but to increase barriers to care. This modification, too, is inconsistent with the purposes of an 1115 waiver.

CMS should deny these modifications and deny Kentucky's 1115 Waiver application

The original waiver application did not meet the criteria set by CMS for waiver approval, including increasing access to care, improving health and creating efficient delivery systems. These modifications do not improve this waiver application. In fact, they make it worse. Kentucky's proposed 1115 waiver will create barriers to care and place more burdens on low-income, working Kentuckians and on our most vulnerable citizens. This waiver will not expand on Kentucky's successful Medicaid expansion and the tremendous health gains that have resulted from that expansion. Instead, the health of low-income Kentuckians will deteriorate. We urge CMS to deny approval of Kentucky's proposed waiver.

Sincerely,

Anne Marie Regan
Senior Staff Attorney
Kentucky Equal Justice Center