mhpa Medicaid Health Plans of America

August 17, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted Electronically to: https://www.regulations.gov/

Re: Comments on Kentucky HEALTH - Application and CMS Special Terms and Conditions (STCs)

Dear Administrator Verma:

Medicaid Health Plans of America (MHPA) appreciates the opportunity to comment on Kentucky's demonstration project "Kentucky Helping to Engage and Achieve Long Term Health (KY HEALTH)," in light of the district court's decision in Stewart v. Azar, No. 18-152 (D.D.C. June 29, 2018). MHPA member plans are committed partners with the Centers for Medicare & Medicaid Services (CMS) and states in strengthening Medicaid and ensuring that the program improves the delivery of care for low-income Americans.

MHPA is the national trade association representing 93 private-sector health plans that contract with state Medicaid agencies in 39 states plus DC to provide comprehensive, high-quality health care to more than 25 million Medicaid enrollees in a coordinated and cost-effective way. According to a recent analysis by PWC, 73 percent of all Medicaid enrollees received their care through a private Medicaid health plan in 2017 (up from 66 percent in 2014),[1] this number continues to rise annually as more states turn to the expertise of managed care plans to help manage health care for a growing number of Medicaid enrollees with diverse needs.

In responding to this comment opportunity, MHPA would like to reaffirm our support for the flexibility afforded to states in the administration of the Medicaid program through Section 1115 waivers. As a partner to states—and the federal government—MHPA appreciates the importance of state flexibility and allowing states to design coverage for low-income populations in a way that most directly meets each state's unique needs and goals. MHPA further appreciates the recent efforts this administration has taken to give states even more flexibility in their use of Section 1115 waivers.

[1] Gottlieb, Ari, *The Complicated State of Medicaid in the United States: Stability Amidst Considerable Future Uncertainty,* PWC, October 2017.

Paired with this flexibility, we also strongly support the thorough evaluation of the impact of state proposals on access to affordable coverage as well as continuity of coverage and quality of care. Our comments below outline key considerations for evaluating the Kentucky HEALTH demonstration application with these factors in mind. Specifically, MHPA suggests the following:

- Waiver Proposals Should Align with Important Health and Coverage Goals of the Medicaid Program
- CMS Should Also Consider Necessary Investments in Infrastructure and Processes Needed to Support Community Engagement Programs and Their Evaluations
- MHPA Encourages CMS to Consider Potential Longer-Term Implications of Waivers on Access and Continuity of Coverage

We thank you for your consideration of our comments and below we lay out these points in more detail.

Waiver Proposals Should Align with Important Health and Coverage Goals of the Medicaid Program

As stated, MHPA strongly supports the flexibility afforded to states through Section 1115 waivers as they allow states to advance their goals for the Medicaid program. However, we believe it is important to ensure that waivers do not disrupt access to coverage or health goals of the Medicaid program. As such, approval and evaluation of demonstrations should consider the impact of state proposals on access to coverage, continuity of care and health. CMS has a long history of conducting similar programmatic evaluations.

In their demonstration application, Kentucky has proposed to include employment and community engagement as a condition of eligibility for some of their Medicaid beneficiaries. While MHPA understands that the intent of the community engagement and employment initiative is to encourage able-bodied adults to find work or other activities within their community, we are concerned that the challenges to meeting these requirements will lead to Medicaid beneficiaries losing coverage unnecessarily or causing coverage "churn".

Recent analysis of Arkansas' community engagement requirement highlights our concerns. A study of the early implementation of Arkansas' community engagement requirement finds that almost 30% of beneficiaries required to meet (or be designated exempt) from Arkansas' work requirement, did not meet the requirements.[2] Many of the beneficiaries that were unable to meet the work requirement may have faced barriers to demonstrating compliance with the requirements such as lack of internet access, inability to navigate the web portal, or lack of adequate information about the work requirements or the portal.[3]

Further, while we are heartened that Kentucky exempts certain beneficiaries from these requirements (i.e. the medically frail), it is not entirely clear that protections are in place to ensure that these beneficiaries will be able to easily be exempted from these requirements or will be able to demonstrate that they are exempt. While some of the beneficiaries may be identified through state administrative data, others may not be identified through these processes. For example, although Arkansas was able to identify many beneficiaries that were either exempt or had met work requirements under the Supplemental Nutrition Assistance Program (SNAP), there were 351 beneficiaries that reported meeting these requirements or exemptions that were not identified by the state.[4] Additionally, other employment requirement exemptions like full time student status or substance abuse treatment require monthly documentation.

MHPA is concerned that the types of reporting requirements related to community engagement requirements as demonstrated in Arkansas, as well as the barriers that both eligible and exempt beneficiaries may face in demonstrating compliance or exemption, likely increase complexity for - and burden on – beneficiaries and could unnecessarily result in disruptions in coverage. The implications of not being able to meet these requirements or demonstrate exemption, especially for the working poor who may already be facing added challenges in maintaining a job, may cause a loss in needed health coverage. Access to coverage and continuity of care is vital for this low-income population and it is important that any community engagement and/or employment requirements be designed with the unique needs and circumstances of this population in mind.

[2] Brantley, E. and Ku, L. (August 2018), First Glance At Medicaid Work Requirements In Arkansas: More Than One-Quarter Did Not Meet Requirement, Health Affairs blog available at https://www.healthaffairs.org/do/10.1377/hblog20180812.221535/full/

[3] Ibid.

[4] Ibid.

Medicaid managed care organizations advocate for a holistic reform to better serve vulnerable individuals including addressing the underlining social determinants of health. We serve as a life-services hub with the goal of helping members becoming financially, and socially secure in their communities.

CMS Should Also Consider Necessary Investments in Infrastructure and Processes Needed to Support Community Engagement Programs and Their Evaluations

As states, CMS and stakeholders pursue these policies, it is important to assess the administrative burden associated with implementing new policies and program changes. To implement new programs, states often need to modify eligibility systems, create systems to document eligibility compliance for beneficiaries and coordinate with providers and plans, invest time in processing and communicating with beneficiaries about new program changes, as well as offering trainings to implement these requirements in a way that does not cause undue burdens on states, beneficiaries, and other stakeholders. While estimates vary, projections indicate states will experience cost and administrative burden in implementing these new work requirements and will have on-going costs to maintain them.

Additionally, to support state efforts, health plan partners in many states will also need to make investments to support state goals, comply with new requirements, as well as support beneficiaries in complying with requirements and maintaining coverage. Health plans have sought to facilitate a smooth transition for these programs by building "best in class" models that include job counseling services etc.

In reviewing waiver applications and in developing the STCs, CMS should consider the significant investments needed to administer these requirements. To this end, we recommend CMS evaluate the administrative burden—and associated complexity—on states, state partners (e.g. health plans, other state agencies, providers, etc.) and beneficiaries when reviewing community engagement requirements. Assessing the administrative burden is particularly important given that these requirements are only applicable to a subset of enrollees.

MHPA Encourages CMS to Consider Potential Longer-Term Implications of Waivers on Access and Continuity of Coverage

As CMS moves forward in approving waivers—especially those that include community engagement or employment requirements—we urge CMS to consider the objectives of creating a system that supports improving the overall US health in the long term and does not create gaps in care and coverage, or expand unmet need that will ultimately lead to lower overall quality of care and health outcomes and result in increased health system costs.

Our member plans understand the importance of "continuity of insurability." Managed care has been proven to be effective in reducing healthcare costs (e.g. decrease ER utilization) while promoting care coordination. All pathways in Medicaid must consider the Medicaid beneficiaries as a whole across all of their realms of health.

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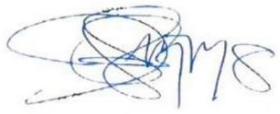
MHPA thanks CMS for the opportunity to provide feedback on Kentucky's Medicaid waiver application. Our member plans look forward to continuing to work with CMS in improving and strengthening Medicaid coverage.

Sincerely,



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