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VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

**Re: Iowa Wellness Plan §1115 Demonstration
Application**

Dear Sir/Madam:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. We appreciate the opportunity to provide comments to both of Iowa's proposed § 1115 Demonstration Applications, the Iowa Wellness Plan (IWP) and the Marketplace Choices Plan (MCP).

NHeLP recommends that HHS not approve the IWP and the MCP applications for § 1115 authority exactly as requested. The applications include provisions that clearly or arguably are not authorized by any law. We urge HHS to address these problems and require Iowa to bring the proposals to a legally approvable form. We urge HHS to work with Iowa to achieve a Medicaid Expansion that will serve future Medicaid enrollees well, including those inside Iowa benefiting from these proposals and those in other states who may pursue similar proposals. We request that HHS zealously enforce its stated policies and the legal limits of Medicaid § 1115 demonstration law, to ensure progress in Iowa without opening the door to policies that ignore the fundamental nature of Medicaid as an entitlement program.

Second, we ask that before HHS takes action on this request, it take steps to address its own "stewardship of federal Medicaid resources." GAO, *Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lack of Transparency* at 32 (June 2013). As the GAO recently 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.” *Id.*

A. Legal Authority for Premium Assistance

In its MCP application, Iowa proposes to conduct a § 1115 demonstration program to use individual market premium assistance to implement a Medicaid Expansion. It is our understanding that Iowa proposes to conduct *individual* market premium assistance relying on authority at § 1905(a). However, the statute and legislative history create serious questions about the validity of this claimed authority. Section 1905(a) defines “medical assistance” and, for the most part, is a listing of services that can or must be included in this definition. By contrast, Congress has dealt with premium assistance in other, specific provisions of the Act. Congress has authorized states to conduct *group* or *employer* coverage premium assistance, which are unambiguously and carefully detailed in statute at §§ 1906 and 1906A. Notwithstanding two very recent policies from HHS (in regulatory and sub-regulatory guidance), there is no history of statutory or regulatory guidance for § 1905(a) authority. Given the uncertainty of the statutory authority and the untested regulatory framework, we believe it is incumbent upon HHS to be extremely cautious and exacting in the approval of any such authority, and even more so for related waivers. HHS should hold tightly to the principles announced in its March 2013 Question and Answer document. And under these circumstances, HHS must also be unmistakably clear as to the waiver authorities being granted and their legal limits.

B. Single State Agency

In addition to premium assistance authority concerns, Iowa’s request, as currently written, fails to ensure that the single state Medicaid agency will remain in charge of the Medicaid program for affected populations, as the Medicaid Act requires.¹ The application does not provide the general public or HHS with information and specifics establishing that the single state agency will continue to make administrative and policy decisions for the program. By law, the single state agency must be in control and accountable for developing and implementing Medicaid coverage. While Iowa may not formally delegate away Medicaid authority, it in effect surrenders control over the majority of benefits for an entire category of enrollees. As currently proposed, Iowa will not control many benefits package details, authorization criteria, and provider contracts and terms but will leave these to health plans. The application only envisions a “written agreement” between the state and the issuers “outlining expectations” of the state. Such an agreement does little to reduce the concern that the health plan would act as an independent entity with its own authority contrary to what Medicaid law permits. NHeLP is very supportive of HHS requiring written agreements between the involved entities to satisfy the legal requirement for a single state agency, clearly delineating roles and responsibilities, with the ultimate authority and responsibility housed in the Medicaid agency. However, the application is sparse on details and the mere presence of a written agreement “outlining expectations” does not satisfy this requirement. HHS should require more of Iowa as a condition of approval. While assuring consumer protections and enabling ongoing reporting and monitoring, this would also address

¹ 42 U.S.C. § 1396a(a)(5).

some of the GAO's conclusions that find HHS processes lack the supporting evidence required to justify deviations from historical requirements. GAO, *supra.* at 32.

C. Limits of § 1115 Waiver Authority

Prior to addressing specific features of the requested waivers, we believe it is important to address one repeated misapplication of § 1115 authority within these waiver applications. § 1115 explicitly circumscribes waiver authority in Title XIX to requirements contained in § 1902.² Anything outside of § 1902 is not legally waivable through the 1115 demonstration process. Despite this legal fact, Iowa repeatedly requests waiver of requirements that lie outside of § 1902. These waiver requests, sometimes explicit and other times necessitated by their objectives, include attempts to skirt requirements in § 1906, § 1916, § 1916A, § 1927, and § 1937. None of these waiver requests are permissible because the substantive requirement rests outside of 1902 and independently requires state compliance. In other words, any reference to the provision in section 1902, which could be waived, does not and cannot also waive the independent, freestanding requirements of these Medicaid Act provisions. Such waivers are also patently contrary to all of HHS' stated regulation and policy on premium assistance.³

In particular, Iowa also seeks to waive several requirements contained within § 1937. However, as Iowa designs a Medicaid Expansion implementing § 1937 benefits, it cannot waive § 1937 requirements which lie outside of § 1902. Iowa attempts to avoid this problem by identifying citations in § 1902(a) to waive – but none of these change the fact there is an independent requirement at § 1937. Consequently, Iowa cannot properly waive EPSDT (protected at § 1937(a)(1)(A)(ii)), FQHC or RHC services (protected at § 1937(b)(4)), any EHB services including maternity care and pediatric dental and vision services (protected at § 1937(b)(5)), or family planning services and supplies (protected at § 1937(b)(7)). Moreover, placed outside of 1902 by Congress these provisions have been repeatedly amended to be strengthened, thus evidencing their core roles as objectives of the Medicaid Act.

Finally, Iowa cannot, in this proposal, circumvent these requirements in § 1937 by requesting waiver of § 1902(k)(1). Iowa's MCP proposal (along with IWP) is predicated on receiving enhanced matching funds (100% FMAP in 2014) for its Medicaid Expansion population. However, under § 1903(i)(26), Iowa cannot receive any matching funds for the Medicaid Expansion population that are not tied to coverage of § 1937 benefits. To put it simply, HHS cannot waive elements of § 1937 *and* pay enhanced FFP.

² SSA, § 1115(a)(1).

³ See 42 C.F.R. § 435.1015(a)(2), requiring the agency to furnish "all benefits for which the individual is covered under the State plan that are not available through the individual health plan." In the preamble to this regulation, HHS clearly explained that it "will only consider demonstrations under which states make arrangements with the health plan to provide wraparound benefits and cost sharing assistance." 78 Fed. Reg. 42186. See also "Medicaid and the Affordable Care Act: Premium Assistance," HHS FAQ, March 29 2013, page 2, stating that "HHS will only consider proposals that ... [m]ake arrangements with the QHPs to provide any necessary wrap around benefits and cost sharing."

D. EPSDT

Iowa has requested § 1115 demonstration authority to waive the EPSDT requirement for the 19 and 20-year olds who may enroll in the IWP and MCP. HHS cannot approve a waiver of EPSDT because EPSDT is specifically required in § 1937 and broadly required by Medicaid law.

As described in Part C above, § 1937(a)(1)(A)(ii) requires that all Medicaid ABP plans cover EPSDT. This requirement should apply to both the IWP demonstration population below 100% FPL and the MCP population above 100% FPL, since both groups are ultimately eligible for an ABP (unless medically frail).

EPSDT waiver is also not permitted under Medicaid law more broadly. No feature of a § 1115 application can be approved if it is inconsistent with the objectives of the Medicaid Act.⁴ Congress designed Medicaid with a sweeping requirement to cover EPSDT for children out of the recognition that research has repeatedly documented that poverty-level children need a range of enabling and developmental interventions. On numerous occasions since introducing it in 1967, Congress has amended the Medicaid Act EPSDT provisions – to strengthen them and require states to do more to address the ills that low-income and vulnerable children disproportionately face. Young people are one of the core populations of the Medicaid program and to diminish EPSDT – the most essential and enduring feature of coverage for children and youth – is clearly inconsistent with the objectives of the Medicaid program.

Iowa justifies this request based on a need to promote consistency with the commercial market. Yet, HHS has already made clear that, *even in the case of individual market premium assistance*, when a state explicitly purchases private coverage for an individual, the *state must wrap around* required EPSDT services. This is confirmed in regulation at 42 C.F.R. §435.1015(a)(2) and premium assistance guidance from HHS issued in March 2013. We urge CMS: Do not back away from this clearly articulated principle. Rather, be clear that waiver of EPSDT is not permitted for premium assistance (in this case, above 100% FPL) under HHS' own regulations and guidance, and it would be an unfair result to not extend the same protection to *more vulnerable* individuals in non-premium assistance expansions (in this case, below 100% FPL).

E. Federally qualified health centers/Rural health clinics

In its MCP application, Iowa requests permission to waive §§ 1902(a)(10)(A), 1902(a)(15), and 1902(bb), to “not cover all” FQHCs/RHCs and to limit reimbursement to QHP rates. On this topic we endorse and incorporate herein all of the comments of the National Association of Community Health Centers, opposing these FQHC/RHC waivers. We believe these waivers are not permissible because:

- Iowa cannot waive § 1937 FQHC/RHC requirements through § 1115, since those requirements lie outside of § 1902.⁵

⁴ SSA, § 1115(a).

⁵ See § 1937(b)(4) and 42 C.F.R. § 440.365.

- § 1903(i)(26), forbids payment of any FFP for Medicaid Expansion enrollees unless they receive § 1937 benefits.
- In any event, Iowa's waiver requests do not include § 1902(k), the provision that actually requires compliance with § 1937 benefits.
- Iowa's state notice and comment proposals never included provisions to waive FQHC/RHC services.

We note, finally, that Iowa's proposal discusses waiver of FQHC/RHC *providers* and *rate rules*, but is silent as to the core legal requirement, which is to provide all FQHC/RHC *services*.⁶ Thus, even if the requested waivers were approvable, HHS would need to require Iowa to demonstrate how it would successfully provide all of these *services* with reduced health center networks and rates.

F. Cost-sharing generally

Iowa's § 1115 application contains numerous cost-sharing features (each discussed below) which are not approvable under § 1115. Specifically, the proposals all repeatedly violate three core requirements for § 1115 demonstrations:

- Iowa repeatedly attempts to waive requirements of §1916 and 1916A through § 1115 without using the only appropriate legal channel for such waivers, compliance with the waiver requirements of §1916(f). As mentioned earlier, § 1115 demonstration authority is only available for waiver of provision inside §1902 – not free-standing provisions like §1916 and §1916A.⁷
- An § 1115 demonstration is precisely that, a demonstration. Iowa's repeated requests for §1115 authority around cost-sharing are not approvable because, as proposed, they will not test anything. The principal feature Iowa seeks to waive – premiums for low-income enrollees – has already been tested repeatedly and consistently shown to *depress* enrollment – including for the very population of adults that is the focus of the Iowa proposals.
- Section 1115 demonstrations must also be “likely to assist in promoting the objectives” of the Medicaid program. The objective of the Medicaid program is to *furnish* health care to low income individuals. Many of the cost-sharing elements in Iowa's proposal cannot be approved because they, to the contrary, *reduce* access to care. The Medicaid Act, particularly § 1916A, already provides States like Iowa with a great deal of flexibility to impose premiums, cost sharing, and similar charges. Yet, Iowa and other states seek to run past these options, never using them, to implement proposals that the research has already established are harmful to low-income people – provisions that will clearly result in interrupted care, lost opportunities, and churning.

⁶ See § 1937(b)(4)(A), requiring provision of all “services” described in 1905(a)(2), which itself also refers to “services” offered by FQHCs/RHCs.

⁷ SSA, § 1115(a)(1).

G. Monthly Contribution

One of the central features of both the IWP and MCP proposals is a monthly contribution system to begin in 2015 (for applicants above 50% of FPL). Iowa proposes this contribution on a tiered system that approximates 3% of income. The drafters of the proposals appear to deliberately obscure the description of the fee in an attempt to make it straddle the premium and cost sharing requirements. This attempt to bypass the requirements of the Medicaid Act should not be allowed. Iowa has clearly proposed a premium and the premium requirements thus apply. Medicaid law does not normally allow monthly premiums for enrollees with income below 150% of FPL.⁸ Such a monthly charge – whether called a “contribution,” “fee,” “assessment,” or any other name – is a “similar charge” to a premium and thus prohibited under law.⁹ The possibility for a consumer to obtain a waiver of the premium for complying with prevention requirements does not cure the illegality of otherwise imposing the premium. Nor would the legal problem be cured by a “hardship waiver,” even if such standard were adequately defined in the applications, which it is not. HHS cannot legally approve these requests.

The illegality of allowing such premiums is even clearer because Iowa has not requested – in prior notice or these applications – any demonstration authority for charging Medicaid enrollees premiums. (See Iowa Wellness Plan §1115 application, page 38-39, requesting waiver of quarterly 5% aggregate cap and nominal copay limits, but not prohibition on premiums). Clearly, Iowa could never apply a premium to a state plan population exempt from premiums *without* some kind of waiver. However, the waiver of Medicaid premium prohibitions for individuals below 150% of federal poverty would also not be legally permissible under the §1115 demonstration authority Iowa seeks *with* this application. As discussed in Part B above, only requirements established in §1902 may be waived under §1115. Although §1902(a)(14) references the authorities of §§1916 and 1916A, this does not change the fact that §1916 and 1916A are free standing requirements which lie outside of §1115.

We also do not believe that the monthly contribution is consistent with the objectives of the Medicaid Act or serves any valid demonstration purpose. Premiums are a well-established barrier to individuals obtaining and maintaining insurance coverage, and this is why Congress generally prohibits them for low-income Medicaid populations (who, by definition, cannot afford life’s basic necessities, much less an insurance premium).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 six months after the changes.¹¹ Another multi-state study of low-income health programs found that premiums amounting to 1% of family income reduce enrollment by nearly 15%, while premiums set to 3% of family income, as proposed in Iowa’s demonstration, cut enrollment in

⁸ § 1916(c). There are very limited exceptions to this rule, for certain populations, not broadly applicable to the Medicaid Expansion population. See, e.g., § 1916(d)

⁹ § 1916A(a)(3)(A).

¹⁰ Premiums have only been permitted in exceptional categories, such as for states expanding coverage to workers with disabilities.

¹¹ Bill J. Wright et al., *The Impact of Increased Cost Sharing on Medicaid Enrollees*, 24 Health Affairs 1106, 1110 (2005).

half.¹² Clearly, allowing Iowa to implement premiums would serve to depress enrollment – perhaps drastically -- while thwarting the objectives of Medicaid and demonstrating nothing.

Cost-sharing and premiums are bad health care policies and we broadly oppose them because of the harm they cause consumers. But *some* forms of cost-sharing, while not good policy, are at least permissible under law. Iowa's requested premiums are both bad policy *and* illegal. If Iowa is insistent on pursuing a flawed theory of "personal responsibility," HHS must work with the state to transform the illegal premium scheme into a system of permissible nominal cost-sharing, including full compliance with related regulations, such as those concerning non-enforceable cost-sharing.

H. Termination for non-payment

Even if, *arguendo*, HHS permitted monthly contributions per Iowa's applications, the IWP and MCP schemes are still not legal because of the consequences for non-payment.

- If HHS allowed Iowa to use § 1115 alone to waive the limitation on premiums below 150%, it would not follow that Iowa should be allowed to terminate anyone for nonpayment.
- If Iowa transitioned from the monthly contributions to a system based on incurred cost-sharing, that might comply with the statutory bar against premiums, but it would not change the fact that termination for non-payment is also not allowed for cost-sharing and – perhaps more important – that to implement such cost sharing the state would need to obtain a waiver pursuant to 1916(f).

Therefore, we believe there is no legal way for Iowa to broadly terminate individuals below 150% FPL for failure to pay monthly contributions (or cost-sharing). Under Medicaid law, Iowa could only apply and enforce such monthly contributions for some individuals *over* 150%.

We also believe that termination for non-payment is patently contrary to the objectives of Medicaid (furnishing care low-income individuals) and serves no valid demonstration purpose. Furthermore, considering that one of Iowa's central stated purposes for its § 1115 requests is to *reduce* churn, it is a glaring contradiction for Iowa to pursue this termination for non-payment policy which is a clear churn *accelerator* – we noted earlier that premiums at 3% of income have been found to cut enrollment in half.¹³ Finally, this termination policy, when combined with the attempt to eliminate retroactive coverage, means that many terminated individuals will go without coverage *exactly* when they try to access the health system (e.g., after an accident or acute event), which will harm providers and promote "cost-shifting," also contrary to the stated goals of this demonstration.

¹² Leighton Ku and Teresa Coughlin, *Sliding-Scale Premium Health Insurance Programs: Four States' Experiences*, 36 Inquiry 471, 476 (Winter 1999-2000).

¹³ Leighton Ku and Teresa Coughlin, *Sliding-Scale Premium Health Insurance Programs: Four States' Experiences*, 36 Inquiry 471, 476 (Winter 1999-2000).

I. 5% Aggregate Cap

To be clear, we oppose the premium requirements of these proposals. However, we want to address yet one more problem with them. Iowa has requested §1115 demonstration authority to apply the 5% aggregate cap on Medicaid premiums and cost-sharing on an annual basis in both the IWP and MCP. While Medicaid law does provide states the flexibility to tabulate the aggregate cap on a monthly or quarterly basis, it does not allow the aggregate limit to be applied *annually*. Iowa therefore seeks waiver authority to allow annual calculation of the aggregate cap, but as described above, the requirements of §1916 and §1916A cannot be ignored or waived for the populations subject to the waiver (as they are state plan populations described in the Medicaid Act). HHS cannot approve this change to the aggregate cap. We note there is no clear reason why Iowa would need annual caps to accomplish the objectives of this waiver – quarterly caps would not be a barrier towards the state’s goals. Furthermore, considering that low-income individuals have little disposable income and the 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.¹⁴

J. Copayments for Non-emergent ER Use

Iowa has requested §1115 demonstration authority to charge heightened copays of \$10 per visit for non-emergent use of the ER in both the IWP and MCP. Such copays are only permissible for individuals above 150% of FPL; individuals below 150% can only be charged nominal copayments.

- The Medicaid Act clearly and consistently protects individuals living below 100% FPL, in particular. Recent regulations give states exceptional permission to charge as much as \$8 for non-emergent ER visits.¹⁵ Yet, Iowa wants to ignore the law and charge the lowest income enrollees \$2 more. These people already will have “skin in the game,” and CMS should approve no more than an \$8 copay for non-ER use of the ER. Any higher copay must be obtained through 1916(f)’s public notice and comment process and five tightly circumscribed requirements for a copayment waiver.
- For individuals from 100% to 150% FPL, the maximum permissible charge for non-emergent use of the ER is also set at \$8.¹⁶ The heightened \$10 copayment is thus also impermissible for this population, for the same reasons as described for the population below 100% FPL.

¹⁴ To be clear, we would like to provide an example as to why an annual cap would be 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 the year, but had one health crisis month with high-utilization (ex. multiple ER 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.

¹⁵ 42 C.F.R. § 447.54.

¹⁶ 42 C.F.R. § 447.54.

We also urge HHS to require Iowa, if it does impose a legal copayment, to explain how it will ensure compliance with statutory requirements that, prior to charging any copay for non-emergent use of the ER, there must be an “actually available and accessible” alternate care option and that the facility must provide notice that the care to be provided is non-emergent care subject to additional charges, identify the alternative care option, and provide the enrollee with a referral.¹⁷

Finally, Iowa suggests (at page 28 of the MCP application) that it will consider retroactive claims data to identify non-emergent use of the ER. However, we note that emergent use of the ER should be defined by the perception of possibility of a dangerous condition by a reasonably prudent layperson. Going to the ER because of chest pain, reasonably suggesting a heart attack, should not subject an individual to a retroactive copayment just because the claim ultimately paid was for a different non-emergent condition. And, if at the time the individual sought care in the ER, they should not be charged the non-ER copayment amount if there were not actually available and accessible alternatives.

K. Cost-sharing for Family Planning and Family Planning Services and Supplies, Preventive Services including Prenatal Care, and Maternity Care

The Application makes no mention of cost-sharing for family planning services and supplies or prenatal care. Section 2303(c) of the Affordable Care Act (ACA) clarified that Medicaid benchmark and benchmark-equivalent coverage is required to cover family planning services and supplies without cost-sharing. Additionally, section 2713 of the Public Health Service Act, which HHS has made clear applies to ABPs, requires plans to cover certain preventive services, including contraception and prenatal care, without cost-sharing.¹⁸ HHS should confirm with the state that the QHPs will cover family planning services and supplies and prenatal care without cost-sharing. Table 3: Iowa Essential Health Benefit Benchmark Plan Covered Benefits notes that plans will be required to cover “ACA required preventive services.” However, the corresponding footnote 5 refers only to “screenings” and not “services.” CMS should clarify that all of § 2713’s preventive *services and* screenings will be covered without cost-sharing.

Further, federal Medicaid law requires Iowa to exempt pregnant women potentially impacted by this Application from cost-sharing or premiums for all pregnancy-related services.¹⁹ We urge HHS to confirm with the state that QHPs will comply with the requirement that pregnant women pay no cost-sharing or premiums for pregnancy-related services throughout their pregnancies and through the end of the month of the 60th day postpartum.

L. Non-emergent Transportation

¹⁷ § 1916A(e)(1).

¹⁸ ACA § 1001, 42 U.S.C. § 300gg-13(a)(1)-(4) (amending § 2713 of the Public Health Services Act); see also Medicaid and Children’s Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment; Final Rule, 78 Fed. Reg. 42160, 42224 (July 15, 2013).

¹⁹ 42 U.S.C. §§ 1916(a)(2)(B), 1916(b)(2)(B); 42 C.F.R. § 447.53(b)(2).

Medicaid requires coverage of non-emergent transportation.²⁰ Iowa has requested § 1115 authority to not provide non-emergent transportation to either IWP or MCP enrollees and states the reason for this is to ascertain whether or not it will “pose a barrier” for enrollees. In essence, Iowa is questioning whether, in a rural state with long distances to providers, it will create an access barrier to individuals in and slightly above poverty to *not* provide them with transportation assistance. This demonstration should not be approved because the answer is already self-evident; it will undoubtedly create a barrier. In any event, transportation as a barrier to medical care is already well understood (and has been since Medicaid was passed in 1965) such that waiver of this requirement cannot possibly be testing anything novel. Furthermore, since reducing transportation will only reduce access to medical coverage, this also does not comply with the objectives of the Medicaid program as required by § 1115(a). Allowing the state to ignore Medicaid’s requirements for this important enabling service would be a dangerous step toward Medicaid losing its essential quality as a program designed to meet the needs of low income people.

M. Retroactive Eligibility

Medicaid requires states to provide retroactive coverage for enrollees.²¹ Iowa has requested § 1115 demonstration authority to waive this requirement. This waiver should not be allowed because there is no demonstrative value to the 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. In particular, the gaps in coverage it would *create* are a glaring contradiction to the purported purpose for Iowa’s IWP and MCP, which is to *prevent* gaps created by churn.

We note that Iowa’s proposed policy objective in requesting waiver of retroactive eligibility is to coordinate eligibility with the Marketplace, which can effectuate eligibility on the first day of the following month (and some cases the first day of the second following month). To achieve this goal, Iowa would – in addition to waiving retroactive eligibility – need to *also* waive Medicaid point-in-time eligibility.²² Subjecting Medicaid applicants to prospective waiting periods to effectuate enrollment would lead to tragic health outcomes and even more significant losses for providers. HHS should not approve any waiver of point-in-time eligibility. In any event, Iowa should not be allowed to waive such a critical and enduring feature of the Medicaid program without specifically requesting authority to waive this requirement, which it has not done.

N. Freedom of Choice

²⁰ See 42 C.F.R. § 431.53 and State Medicaid Manual § 2113.

²¹ § 1902(a)(34); 42 C.F.R. § 435.914 (redesignated at §435.915 in 77 Fed. Reg. 17143).

²² The MCP proposal suggests, though does not explicitly confirm, that Iowa might plan to enroll individuals in FFS Medicaid until the Marketplace enrollment is effective. See MCP application, page 12.

The MCP application request to limit access to family planning providers violates federal law and should be rejected. The application requests that HHS waive § 1902(a)(10)(A) to “enable Iowa to not cover all family planning providers.” However, it appears that the state actually seeks to waive § 1902(a)(23)(B) which guarantees Medicaid beneficiaries have freedom of choice of family planning services and supplies and are entitled to go out-of-network regardless of whether there are available in-network family planning providers.²³ Allowing Iowa to waive this requirement would impermissibly restrict beneficiaries’ access to family planning providers. HHS and a number of district and federal circuit courts of appeal have consistently made clear that states must cover family planning services and supplies provided by any qualified provider, including out-of-network providers.²⁴ We therefore urge HHS to deny the State’s request and require it to allow beneficiaries to go out-of-network for family planning services without cost-sharing or referrals, *regardless of the availability of in-network providers*. To this end, HHS should make clear that any waiver of § 1902(a)(23) (or § 1902(a)(10)(A)) does not include any waiver of § 1902(a)(23)(B) requirements.²⁵ In all cases, HHS should not approve any waiver request that does not include a specific and accurate description of the Medicaid requirement to be waived and an explanation of the authority and reason for that specific waiver.

Iowa has also requested authority to cover individuals with available employer coverage through a health insurance premium payment model (i.e., premium assistance). However, Medicaid law already provides authority for states to conduct such premium assistance through § 1906. Iowa cannot use a § 1115 demonstration – which only allows waivers of provisions in § 1902 – to override Congress’ clear intent for group/employer premium assistance to be governed by § 1906. As such, Iowa would also need to comply with the specific requirements in § 1906; for example, to wrap around all cost-sharing and to only use such premium assistance when cost-effective.

O. Appeals

Iowa’s MCP application appears to request an “appeals” system which does not comply with Medicaid due process or the U.S. Constitution and cannot be approved in the current form by HHS. Regardless of the fact that Iowa may enroll some Medicaid-eligible individuals into private market coverage via premium assistance, these individuals remain Medicaid enrollees and subject to Medicaid due process protections.

While Iowa (in the MCP application) indicates it will retain the Medicaid appeals process for review of eligibility and monthly contribution payment decisions, it proposes to rely on the QHP appeals process for coverage and provider access decisions.²⁶ However, Medicaid enrollees must have access to the Medicaid appeals system, and the unique features of that system (including continued benefits), for all Medicaid covered services. It might be appropriate for Iowa to create an internal plan appeals process, so long as it does not interfere with the individual’s right to obtain a timely decision, generally within

²³ Iowa Marketplace Choice Plan application, page 23. Section 1902(a)(10)(A) requires the State to provide coverage for family planning services and supplies to “all individuals” who meet eligibility requirements. § 1902(a)(10)(A). See § 1902(a)(23)(B).

²⁴ See CMS, State Medicaid Manual, § 2088.5.

²⁵ Iowa Marketplace Choice Plan application, page 23-24.

²⁶ Iowa Marketplace Choice Plan application, page 21.

90 days of the date of the request or within days in expedited circumstances. For any enrollee in Medicaid – whether in premium assistance or not – core Medicaid due process protections such as the right to notice, fair hearing, and aid paid pending appeal, must be preserved and can never be waived by HHS. This foundational principle should not be moved.

P. Due Process in ACOs

Iowa's proposal requests waiver of Freedom of Choice (§ 1902(a)(23)) to implement Accountable Care Organizations (ACOs). ACOs are a delivery system reform idea with some promise but many uncertainties, yet, if tested in a small number of reasonably-sized demonstrations, represent exactly the type of experiment that § 1115 is designed to test and evaluate. However, we believe Iowa's intent to utilize ACOs requires significantly more detail to be approved. Iowa must explain how this new system will comply with all other Medicaid requirements. Most importantly, we have serious concerns about violations of Medicaid due process requirements in the ACO context. If an individual's medical provider has a direct financial stake in the provision of a service, it is unclear how the individual can meaningfully pursue that treatment option if the doctor disagrees, or if the individual would even *find out* that treatment option is available. We believe HHS would need to develop clear policies to redress this and similar due process problems, including but not limited to requirements for providers to provide patients with clear information about all treatment options, the right for patients to request second opinions from doctors not aligned with the ACO, oversight specifically focused on identifying health care stinting, and continued benefits when services and care are denied or terminated. While Iowa could request § 1115 authority to waive § 1902(a)(23) freedom of choice, it cannot waive Constitutional due process requirements.

Q. Disease Management

We are supportive of attempts by Iowa to improve disease management for high-risk individuals. However, as described in the Iowa IWP proposal, it appears that the state may be considering disease management compliance as an additional hurdle for high-risk individuals to get an exemption from the monthly contribution requirement.²⁷ Setting aside the underlying illegalities of the monthly contribution scheme discussed earlier, HHS should clarify that Iowa cannot create additional barriers for the sickest populations. Such a policy would be discriminatory and not permissible under Medicaid law.

R. Facilitated-enrollment of Current IowaCare Enrollees

Enrollees in Iowa's current IowaCare § 1115 demonstration will be disenrolled and eligible for the new proposed IWP and MCP § 1115 demonstrations. Although Iowa makes clear it will provide notice to these enrollees, it is unclear if Iowa will facilitate enrollment of the members into the IWP and MCP demonstrations. Assuming the IowaCare program is terminated, HHS should require Iowa to facilitate enrollment of IowaCare enrollees into the new demonstrations. This process should include clear

²⁷ See Iowa Wellness Plan application, page 7.

requirements for notice as well as outreach, education, and consumer assistance to help individuals make informed plan selections. If individuals make no plan selection, then they should be auto-assigned into a plan that includes their PCP and other providers in network, and consider other factors such as geography and enrollment other family members. We note that Iowa and its budget neutrality vendor (Milliman) assume a 100% take-up rate for IowaCare enrollees; such assumptions could only be reasonable and the basis of good-faith budget neutrality calculations with a facilitated-enrollment system.²⁸ We note further that transition of current IowaCare eligibles was a top issue in state level comments.²⁹

S. Hypotheses and Evaluation

Although the IWP and MCP proposals include numerous hypotheses to be tested, we believe that only a small number of them are requests to undertake activities that can be tested (as described above). In all cases, the hypotheses must be tested using a well-designed experiment followed by comprehensive analysis. HHS should not approve these proposals until Iowa has clarified the methodologies that will be used to conduct meaningful demonstration analysis. HHS also should not approve these proposals until it has clarified with the state and the public its own rule for oversight, monitoring and enforcement during the life of the proposal.

We also have serious concerns with some of the Milliman budget neutrality analysis. We have earlier mentioned the unclear assumption of a 100% take-up rate for current IowaCare enrollees. For example, page 5 of the MCP budget neutrality report states, “The provision of premium assistance for the Marketplace Choice Plans is cost effective, improves access to care, and reduces the impact of churn.” There is no clear support for this conclusion, and it is unclear if this is a Milliman conclusion or merely the restating of Iowa’s prediction (and this quote is followed by what we understand to be a list of what Iowa “anticipates”). We urge HHS to scrutinize this report carefully. As we have noted, the GAO has published repeated and serious concerns with HHS’s failure to enforce its policies regarding cost-effectiveness. See GAO, *Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lack of Transparency* (June 2013) (citing previous reports).

T. Pregnant Women

The applications include notices stating that IWP will cover individuals not eligible for comprehensive Medicaid under an existing Iowa Medicaid group.³⁰ It is not clear how this statement affects pregnant women because it is not clear from the materials that Iowa has submitted whether the state currently provides comprehensive or only pregnancy-related benefits to this group. Consistent with its March 2012 rules, we urge HHS to confirm that Iowa will cover comprehensive benefits for pregnant women.³¹

²⁸ See Iowa Wellness Plan application, page 19, and Milliman budget neutrality report, page 5; Iowa Marketplace Choice Plan Milliman budget neutrality report, p. 4.

²⁹ See Iowa Wellness Plan application, page 41-42; Marketplace Choice Application, page 41.

³⁰ See e.g., Iowa Marketplace Choice Plan application, page 46.

³¹ See Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 77 Fed. Reg. 17144, 17148-49 (Mar. 23, 2012).

The MCP application makes no mention of what happens to women who become pregnant after enrollment in the Medicaid Expansion. We urge HHS to clarify with the state how it intends cover women who become pregnant after enrollment in the Medicaid Expansion, including how the state will ensure that these women have adequate and timely notice of their coverage options, including differences in benefits under the ABPs as compared to the State Plan benefit package.

The MCP application, though generally committing to compliance with the Essential Health Benefits requirements, entirely omits “maternity and newborn care” from the EHB Benchmark Plan Covered Benefits.³² All ABPs must cover the ten EHB categories, including maternity care.³³ HHS must require the ABP to cover all ten EHB categories, including maternity care.

U. EHB Requirement for Pediatric Dental and Vision

The MCP application, though generally committing to compliance with the Essential Health Benefits requirements, entirely omits pediatric dental and vision from the EHB Benchmark Plan Covered Benefits.³⁴ All ABPs must cover the ten EHB categories, including pediatric dental and vision.³⁵ The Iowa proposals should be required to include these essential child health services.

V. Abortion Services Covered Under the Hyde Amendment

The Application makes no mention of abortion coverage required by the Hyde Amendment. These services must be covered in the same manner as any other medically necessary services for which federal financial participation is available. HHS must require the ABP to explicitly cover all abortions that comply with the Hyde Amendment exceptions.

W. Medically Frail

If Iowa has any Native Americans who are members of Federally recognized tribes, 42 C.F.R. 440.315(f) may require their addition to the medically frail group (based on their inclusion under 42 C.F.R. 438.50(d)(2)).

Conclusion

In summary, we have numerous concerns with the legality of Iowa’s § 1115 demonstration application, as proposed. We urge HHS to address these concerns prior to issuing any approval. If you have questions about these comments, please contact Jane Perkins (perkins@healthlaw.org) or Leonardo Cuello (cuello@healthlaw.org). Thank you for consideration of our comments.

Sincerely,

³² See Iowa 1115 Waiver Application, page 15-18.

³³ ACA §§ 2001(c), 1302(b).

³⁴ See Iowa 1115 Waiver Application, page 15-18.

³⁵ ACA §§ 2001(c), 1302(b).

A handwritten signature in black ink, appearing to read "Emily Spitzer". The signature is fluid and cursive, with the first name "Emily" and the last name "Spitzer" clearly distinguishable.

Emily Spitzer,
Executive Director