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October 7, 2016

The Honorable Secretary Sylvia Burwell
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Kentucky HEALTH Program Demonstration

Dear Secretary Burwell:

We appreciate the opportunity to comment on Kentucky's proposed HEALTH Program (KHP) § 1115 Demonstration. The National Health Law Program (NHeLP) protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state level.

NHeLP recommends that HHS not approve the KHP demonstration as proposed. The application includes numerous provisions unauthorized by any federal law and harmful to enrollees. We are aware of numerous attempts by HHS (and consumer advocates) to alert the Kentucky administration that their proposal needed to be amended to be legally approvable, and the state's administration has simply failed to make the necessary changes despite those repeated and clear statements from HHS. We are deeply concerned by the state administration's unilateral effort to undermine a remarkably successful program and jeopardize care for hundreds of thousands of individuals.

As you know, Kentucky's existing expansion covers over 425,000 Kentuckians and has been a national model for successful expansion. As a state that already expanded Medicaid, Kentucky's new proposal to alter the successful expansion should face a high "do no harm" standard for approval. We urge HHS to work with Kentucky to preserve Medicaid expansion without harming current enrollees or setting precedents that threaten enrollees in other states who may be affected by similar proposals. In its review, we urge HHS to zealously enforce its stated policies and the words of the Social Security Act's § 1115.

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A. Existing Enrollees

HHS has approved several Medicaid expansion § 1115 demonstrations that include unprecedented waivers that in many cases negatively impact access to care for consumers and also conflict with the legal requirements for such demonstrations. HHS likely approved some of these waivers because, in exchange for the waivers, HHS could secure a Medicaid expansion that would cover thousands of individuals in an unexpanded state. The baseline in these states was an uncovered low-income adult population.

But applications like Kentucky's, which request modifying coverage for individuals *already* enrolled, create an entirely different cost-benefits analysis because their adult group is already covered. HHS should set a higher standard for approving extensions or amendments to existing Medicaid expansion programs if they risk worsening access to care for current enrollees. Moreover, approving such harmful provisions in an already expanded state could encourage widespread regression. We urge HHS to note a simple fact: of states recently seeking Medicaid expansion waivers, seven out of eight (AR, AZ, IA, IN, KY, NH, OH) are states that *already* expanded, and the eighth (UT) is only seeking to cover a small fraction of the potential coverage group. At this point, waivers have become a tool of regression and not a vehicle for full expansion. As such, HHS should not approve any waivers in Kentucky that will fuel even more regression and worsen care for current expansion enrollees, as our discussion below illustrates.

Kentucky itself projects that if its proposed amendments are approved, over 55,000 adults will lose coverage.[1] In addition, Kentucky not only proposes to worsen coverage for Medicaid expansion enrollees, it *also* includes traditional Medicaid enrollees in the demonstration. These individuals are subject to harmful waivers to varying degrees depending on their category of coverage. And, of the adults expected to lose coverage, over 10,000 are traditionally eligible enrollees. The proposal would reduce access to care for a broader scope of current enrollees and set a dangerous precedent for Medicaid enrollees nationwide. We note, finally, the budgetary savings created by these reductions in eligibility appear to be the primary motivation for Kentucky's proposal. Courts have ruled that saving dollars cannot be the basis for a demonstration.[2] We recommend that CMS reject this proposal and maintain a clear line that excludes non-expansion populations from potentially harmful waivers targeted at expansion populations.

[1] Kentucky HEALTH Section 1115 Demonstration Waiver application, page 19 (August 2016), available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-pa.pdf#page=1&zoom=auto,792,805.

[2] *Newton–Nations v. Betlach*, 660 F.3d 370, 381 (9th Cir. 2011) (citing *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994)).

B. Premiums and Cost Sharing Generally

Kentucky's § 1115 application contains premium and cost sharing features (each discussed below) which are not approvable under § 1115. Specifically, the proposal repeatedly violates three core requirements for § 1115 demonstrations:

- Section 1115 explicitly circumscribes waiver authority in Title XIX to requirements contained in § 1902.[3] Anything outside of § 1902 is not legally waivable through the §1115 demonstration process. Sections 1916 and 1916A are requirements independent of § 1902 and cannot be waived through § 1115. Moreover, any waiver of Medicaid cost sharing must comply with the waiver requirements of § 1916(f) – the only legal channel for such waivers. Kentucky attempts to waive cost sharing requirements like the $8 copay limit for nonemergent use of the emergency department through § 1115 without meeting § 1916(f) requirements.[4] CMS cannot legally approve such a waiver absent these requirements, let alone the fact that heightened ED copayments are poor policy (See discussion below.)
- A § 1115 demonstration is precisely that, a demonstration. Kentucky's requests for § 1115 authority regarding premiums and cost sharing are not approvable because they will not test anything novel, given the well-known results of redundant studies on the effects of cost sharing and premiums. For example, a principal feature that Kentucky seeks to waive, premiums for low-income enrollees, has been repeatedly tested and consistently shown to depress enrollment – including for the very populations of adults that is the focus of the Kentucky proposals. *See* David Machledt and Jane Perkins, *Medicaid Cost Sharing and Premiums* (March 2014), available at: http://www.healthlaw.org/publications/browse-all-publications/Medicaid-Premiums-Cost-Sharing.
- Finally, § 1115 demonstrations must also be "likely to assist in promoting the objectives" of the Medicaid program. The objective of Medicaid is to furnish health care to low-income individuals. Many of the enhanced premium and cost sharing elements in Kentucky's proposal cannot be approved because they would reduce access to care. The Social Security Act, particularly § 1916A, provides states with a great deal of flexibility to impose premiums, cost sharing, and similar charges. Yet, Kentucky seeks to run past these options to implement proposals which research has established are harmful to low-income people, and which will clearly result in interrupted care, lost opportunities, and churning.

C. Premiums

Kentucky's proposed plan includes a monthly premium charged to Medicaid expansion enrollees and § 1931 parents and is listed as "optional" for the medically frail. These

[3] Social Security Act (SSA) § 1115(a)(1).

[4] The state attempts to claim that this charge would not be a copayment because it is part of the My Rewards account, but that account represents real money beneficiaries can use for services like dental care. The state's proposed charge acts exactly like a copayment charged to that account, despite the state's baseless claim that it is not a copayment.

populations, all below 150% FPL, are legally exempt from Medicaid premiums. Kentucky's stated intent to instill "beneficiary responsibility" ignores the fact that Medicaid's legal cost sharing system already provides generous flexibility for states to create strong incentives for enrollees to avoid unnecessary care. Kentucky's proposal, in contrast, is not approvable by HHS.

Under current law, HHS should not approve monthly contributions for any individuals below 150% FPL.[5] "Any enrollment fee or similar charges" are illegal for this very-low-income population, whether they are called monthly fees, assessments, contributions, or premiums. [6] Kentucky's monthly premium or "contribution" meets the federal definition of a premium or similar charge. Given that monthly contributions are not permitted for this population below 150% FPL, *termination* for non-payment of contributions should also never be approved. Even if, contrary to law, HHS considered a waiver of the premium prohibition, it should still not be approvable because, given the well-established studies on the impact of premiums on low-income people, there is no experimental value to premiums nor do they promote the objectives of the Medicaid program, as required by § 1115(a).[7] **These studies may be confirmed by Kentucky's *own* finding that over 55,000 individuals will lose coverage over the course of the demonstration**.[8] Ohio, which proposed a similar waiver, similarly found that over 125,000 people would lose coverage in its demonstration, which CMS rejected.[9] Premiums for those living on incomes below 100% FPL are especially concerning, since they contradict both the structure of the ACA and numerous Medicaid cost sharing protections set at 100% FPL. No enforceable premiums have been approved to date for this population. We note, however, that, under the law, premiums are equally impermissible for individuals below 150% FPL whether they are mandatory or optional.

Kentucky's proposed premiums should also be denied because they expand the scope of eligibility groups subject to premiums. As mentioned earlier, the KHP proposal premiums also target § 1931 adults. HHS should not extend premium provisions, which have sometimes targeted expansion enrollees, to traditional Medicaid populations. We note further that Kentucky describes "optional" premiums for the medically frail, leading to the possibility that some such individuals will not enroll because they cannot afford the premiums, or take on premium debt, or pay them despite extreme hardship. Instead of helping furnish care to low-income individuals, this premium provision will decrease participation in KHP, leaving more of these especially vulnerable populations in need.

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[5] *See* SSA §§ 1916(c), 1916A(b)(1)(A). There are very limited exceptions to this rule, for certain populations, that are not broadly applicable to the Medicaid expansion population. *See, e.g.*, § 1916(d).
[6] SSA § 1916A(a)(3)(A).
[7] 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).
[8] Kentucky HEALTH application, page 19.
[9] Healthy Ohio Section 1115 Demonstration Waiver: Summary, page 3, available at: http://medicaid.ohio.gov/Portals/0/Resources/PublicNotices/HealthyOhio-Summary.pdf.

The Kentucky premiums are also flawed in three more ways. First, Kentucky makes contradictory statements about compliance with the aggregate cap. Its stated premium of $1 for individuals at 0% FPL would of course exceed that statutory cap, and so should require a waiver of § 1916(f) to be implemented.[10] Second, the increasing premiums feature of the demonstration is paternalistically described as "educating" individuals but is in fact an attempt to punish individuals who remain in Medicaid expansion (or § 1931 eligibility) for multiple years – essentially a first step towards Medicaid time limits that have no basis in eligibility. Third, the punitive nature of the provision is evidenced by the fact that the supposedly "educational" premiums exceed the Marketplace premiums, with the maximum premium almost *double* the Marketplace premium for individuals at 101% FPL. These features are all illegal, illogical, and poor health policy.

D. Premium Waiting Period and Lockouts

Kentucky requests waiver authority to (1) delay enrollment of eligible individuals until a month in which they pay their premiums or 60 days, (2) bar individuals who have been terminated for failure to pay premiums from re-enrolling for 6 months, and (3) bar individuals who have been terminated for failure to complete redetermination from re-enrolling for 6 months. These waiting period and lockout provisions are a direct violation of the statutory requirement to enroll eligible individuals with "reasonable promptness."[11] In all three cases, the requested waiver of this provision should not be approved because it clearly does not promote the objectives of Medicaid nor does it have any experimental value. As a matter of policy, waiting periods will do great harm to many individuals who will receive coverage *later* after applying, and we note that many individuals become eligible for Medicaid contemporaneous with serious and urgent medical needs. (See also the discussion of retroactive eligibility waiver below). Similarly, lockouts will severely harm individuals who need coverage but cannot afford to pay their past debts. Both policies grossly contradict the basic intent of the Affordable Care Act and well-established policy best practice of encouraging continuity of care in health coverage, as well as Kentucky's stated goal of decreasing churning. We note they will also harm Kentucky's provider infrastructure, as providers will continue to treat uninsured patients.

With the lockouts, Kentucky attempts to mitigate harm by allowing individuals to re-enroll (after premium lockouts) by paying past debt and taking a course or (after redetermination lockouts) by taking a course. In the case of premium lockouts, it will be very difficult for enrollees – most of them living in poverty – to collect the *three* months of premiums needed to re-enroll. In all cases, the required class has no basis in law and is demeaning to enrollees. In any event, any effort to mitigate the harm of lockouts does not cure the underlying illegality of them.

In addition to a waiver of § 1902(a)(8), Kentucky also requests a waiver of § 1902(a)(3) to implement the waiting period and lock out. We are not aware of any previous waiver

[10] Kentucky HEALTH application, page 31.
[11] SSA § 1902(a)(8).

of this critical due process protection, and we strongly recommend that HHS never approve a waiver of this requirement. A waiver of this requirement in the context of Medicaid application, coupled with a waiver of reasonable promptness, would allow states to keep legal beneficiaries in limbo, without benefits or a path to benefits other than payment of premiums which themselves were charged contrary to the terms and objective of the Social Security Act. In addition to being a terrible policy, we believe this would open the state and CMS to near certain litigation in the near future.

Kentucky *also* requests a waiver of "[e]ligibility" in § 1902(a)(10)(A) to implement the waiting period. We do not believe there is any reason for HHS to entertain this request since it is functionally equivalent to the requested waiver of § 1902(a)(8). At the same time, the potential problems with waivers allowing modifications of underlying eligibility categories, and the related precedents they set, are extremely grave. HHS should avoid approving such waivers at all costs.

Ultimately, we rank waivers of §§ 1902(a)(3), 1902(a)(8), and 1902(a)(10) eligibility among the most dangerous waivers HHS could possibly approve. These provisions are cornerstones of the Medicaid entitlement for enrollees, as it is codified into the statute. They are the provisions that require states to enroll eligible individuals and allow such individuals to redress the failure of the state to do so. HHS should not waive these provisions under any circumstances.

E. Copayments

Kentucky proposes a graduated copayment (from $20 to $75) for nonemergency use of the ED that far exceeds the statutory Medicaid limit of $8, but the state does not include details on how it will apply the conditions of § 1916(f) that must be met to waive Medicaid cost sharing. Instead, the state tries to claim that this would not be a true copayment because it would come out of the *My Rewards* account. But individuals would be able to use *My Rewards* funds to pay for noncovered services and if they leave the program they would eventually receive the balance of that account from the state. The funds in the *My Rewards* account would be real dollars; and the ED charge would act exactly like a copayment charged retroactively. CMS thus cannot legally approve this ED copayment provision until the state has met all the requirements of § 1916(f). We note further that Kentucky makes no mention of *any* waiver request for these ED copayments on its waiver list, and thus the waiver should also not be approved because it has never been specifically requested, and transparency demands that it be clearly requested.

The state must also show that its experiment is a novel use of copayments likely to promote the objectives of Medicaid. Several studies of Medicaid and CHIP nonemergency ED copayments show that they are ineffective at reducing nonemergency ED use.[12] One major problem is that no one has yet developed a system

[12] Mona Siddiqui et al., *The Effect of Emergency Department Copayments for Medicaid Beneficiaries Following the Deficit Reduction Act of 2005*, 175 JAMA INTERNAL MED. 393 (2015); Karoline Mortensen, *Copayments Did Not Reduce Medicaid Enrollees' Nonemergency Use of Emergency Departments*, 29

to accurately and reliably distinguish between "nonemergency" and "emergency" ED visits. We encourage CMS to work with the state to implement other approaches to reducing nonemergency ED use that have proven more effective in practice and are less likely to reduce beneficiaries' access to care, such as improved care coordination for frequent users.[13] This proposal is poorly conceived, incomplete, punitive, and would likely worsen beneficiaries' health outcomes.

F. Deductibles

The KHP proposal includes provisions to include a mechanism termed a "Deductible." While this provision does not implement a real deductible as commonly understood, we urge HHS to avoid approving any policy using such a name. We believe it would create confusion for other states that might pursue more problematic deductibles and may confuse consumers who may avoid care thinking they will be forced to pay a deductible. Moreover, evaluations of the Healthy Indiana Program, which uses a very similar, largely state-funded "deductible," found that a majority of enrollees do not understand that preventive services are covered free of charge. Fully five years after implementation, 78% of the original HIP members either wholly misunderstood or were unaware that preventive services could be accessed free of charge.[14] This benefit structure thus adds to enrollee confusion and may discourage enrollees from utilizing highly cost-effective preventive care.

G. My Rewards Accounts and Enhanced Benefits

Adding to the complexity of Kentucky's proposal is the My Rewards Accounts and enhanced benefits system. These provisions will not succeed in incentivizing or educating consumers, because consumers will not understand the provisions. Experiences with previous 1115 demonstrations show that many consumers do not understand how these incentive systems work and are unaware of the types of "benefits" that may be available.[15] Historically, about a quarter of the HIP enrollees had never heard of that program's "POWER account," which has a similar rollover incentive and healthy behavior benefits. This year's HIP 2.0 evaluation found that fully 40% of

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HEALTH AFFAIRS 1643 (2010); David J. Becker et al., *Co-payments and the Use of Emergency Department Services in the Children's Health Insurance Program*, 70 MED. CARE RES. REV. 514 (2013)

[13] Wash. State Healch Care Authority, Emergency Department Utilization: Assumed Savings from Best Practices Implementation, (2013), http://www.hca.wa.gov/documents/legreports/Report-3ESHB2127EmergencyDeptUtilization.pdf.

[14] 3,955 of 16,830 current members in a survey reported no knowledge of the POWER account. 9180 respondents who knew about POWER accounts expected annual exams to be deducted from their accounts. This totals 78% of all respondents. *FSSA, Healthy Indiana Plan Demonstration Section 1115 Annual Report: Demonstration Year 5, 55-58 (2013), http://www.in.gov/fssa/hip/files/2012_HIP_Annual_Report.pdf*.

[15] THE LEWIN GROUP, INDIANA HEALTHY INDIANA PLAN 2.0: INTERIM EVALUATION REPORT 66-67 (2016), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-interim-evl-rpt-07062016.pdf (report commissioned by IN Family and Social Svcs. Admin.), stating that "survey data suggest that a large majority of HIP 2.0 members may not be aware of the HIP 2.0 policy that would allow them to get no-cost preventive care."

enrollees were unaware of the POWER account, and another roughly 15% said they knew about POWER accounts but reported – incorrectly – that they did not have one.[16]

Even among the minority who understand how such accounts work, the incentive structure favors the healthy. Indiana's original HIP program included an $1,100 "deductible" with a rollover opportunity, but barely a third of the HIP enrollees had any funds left in their account after a year, eliminating any "rollover" incentive for the vast majority of participants.[17] Furthermore, consumers with more challenges – whether health conditions or social determinants of health – will be less likely to meet the requirements, and this will likely be discriminatory in practice and worsen health disparities. This complex "incentive" structure offers very delayed rewards that few understand and even fewer benefit from.

The state appears to be using this incentive program to link cost sharing and benefits to conditions that are outside the scope of the Medicaid program, such as employment, education, and community service. While Medicaid should serve as a bridge to encourage linkages between different community resources, States should never condition access to care directly to a beneficiaries' engagement in these other areas. We urge HHS to not approve these provisions, and instead encourage Kentucky to achieve these goals by increasing the useful information available to consumers and developing other voluntary supports for them.

H. Retroactive Eligibility

Medicaid requires states to provide retroactive coverage for enrollees.[18] Kentucky has requested § 1115 demonstration authority to waive this requirement. Like other waivers requested by Kentucky, this waiver is not limited to Medicaid expansion enrollees and targets some traditional Medicaid enrollees. We strongly support CMS's recent rejection of Arizona's request to reapprove a retroactive eligibility waiver in its recent approval of that state's comprehensive waiver, and we urge CMS to deny this waiver as well. There is no demonstrative value to the state's 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 know they will not be paid retroactively by Medicaid. This policy has dubious hypothetical benefits and very concrete harms. For these same reasons, the § 1115 demonstration should not be approved because this does not promote the objectives the Medicaid. The request to extend the waiver to non-expansion populations increases the potential danger of an approval. In its application, Kentucky argues that Marketplace coverage means retroactive coverage is no longer needed, but this ignores

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[16] *Id.* at 3.

[17] Ind. Family & Soc. Servs. Admin. ("FSSA"), *Healthy Indiana Plan Demonstration Section 1115 2013 Annual Report & Interim Evaluation Report*, 31 (Oct. 2014), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/in-healthy-indiana-plan-pa.pdf.

[18] SSA §§ 1902(a)(34); 42 C.F.R. § 435.915.

the evidence that many individuals are eligible but not enrolled in both Medicaid expansion and Marketplace coverage, and could be enrolling for the first time soon.[19]

I. NEMT

Medicaid requires coverage of NEMT.[20] This is a core Medicaid requirement, applicable to all state plan enrollees. HHS cannot approve the waivers of NEMT requested in KHP under § 1115 authority. Section 1115 waivers can only be approved if they have a valid experimental purpose and promote the objectives of the Medicaid Act. There is no valid experimental purpose to not provide transportation – it is clear that beneficiaries will lose access to care. Furthermore, evidence from Iowa clearly demonstrates that its NEMT waiver disproportionately impacts women, people of color, and people with significant health or functional support needs, who are far more likely to report unmet transportation needs. The fact that this waiver has no legitimate beneficial element, and instead likely contributes to perpetuating or even exacerbating health disparities, clearly contradicts the objectives of the Medicaid Act.

To the extent HHS has (in our view, illegally) already approved such a waiver in Iowa and Indiana, we believe that HHS should wait until the analysis of those "demonstrations" is completed, and the accuracy of the analysis is verified, before authorizing any more experiments that are dangerous and likely to hurt beneficiaries. We believe that Kentucky relies on deeply flawed evidence from Indiana and Iowa to make its conclusion that NEMT is not important.[21] Those evaluations are poorly structured, inconclusive, and yet still reveal only that a subset of the expansion population regularly cannot get needed care due to a transportation problem, and that this group disproportionately includes individuals from key protected classes. In short, the need for an effective NEMT benefit persists and it is an important benefit to reduce health disparities. We believe that evidence from the states already testing NEMT waivers shows that such waivers do not help furnish care to Medicaid recipients.

J. Work Search Requirements

HHS should not approve any waiver permitting Kentucky to condition Medicaid eligibility on compliance with work search activities. Work search requirements are an illegal condition of eligibility in excess of the Medicaid eligibility criteria clearly enumerated in Federal law.[22] Medicaid is a medical assistance program, period. 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,[23] and courts have held additional eligibility requirements to be illegal.[24] Section 1115

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[19] Kentucky HEALTH application, page 45-46.
[20] *See* 42 C.F.R. § 431.53; CTRS. MEDICARE & MEDICAID SERVS., STATE MEDICAID MANUAL § 2113.
[21] Kentucky HEALTH application, page 45.
[22] *See generally* SSA § 1902.
[23] *Id.* §§ 1902(a)(10)(A), (B).
[24] *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

cannot be used to short circuit the Medicaid protections, because work search requirements do not promote the objectives of the Medicaid Act or demonstrate anything. 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 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 certain health conditions or disabilities may be unable to maintain enrollment due to their condition or the lack of adequate systemic supports to foster their employment.

We urge HHS to make clear to the state that any state work search programs cannot be tied to Medicaid or otherwise appear tied to Medicaid through incentive programs. We are concerned that states will abuse the confusion of beneficiaries who may think the Medicaid and work search programs are somehow linked. Aside from this, however, we wholeheartedly support efforts by Kentucky and other states 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.

K. Freedom of Choice for Family Planning Services and Supplies

The Kentucky HEALTH application includes a broad request for waiver of freedom of choice. We recommend that any approval is clear that there is no waiver of freedom of choice for family planning services and supplies, and include language similar to the language in HHS's freedom of choice waiver in Indiana: "No waiver of freedom of choice is authorized for family planning providers." [25] The Social Security Act specifically requires freedom of choice for family planning services and supplies, even in managed care arrangements.[26] HHS and a number of district and federal circuit courts of appeal have consistently made clear that enrollees are entitled to obtain family planning services and supplies from any qualified Medicaid provider whether in or out of network.[27] Therefore, HHS should clarify that, regardless of any approval of freedom of choice waiver requests in the Kentucky HEALTH, individuals remain entitled to obtain out-of-network coverage for family planning services and supplies, regardless of whether there are available in-network family planning providers.

Conclusion

In summary, we have numerous concerns with the legality of Kentucky's § 1115 demonstration application, as proposed. We fully support the use of § 1115 of the Social Security Act to implement true experiments. We strongly object, however, to any efforts to use § 1115 to skirt essential provisions that Congress has placed in the Social

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children whose fathers were serving in the military where no such bar existed in federal law governing eligibility).

[25] Letter from Marilyn Tavenner approving Health Indiana Plan 2.0, 6 (Jan. 25., 2015).

[26] SSA § 1902(a)(23)(B).

[27] *See* CMS, State Medicaid Manual, § 2088.5.

Security Act to protect Medicaid beneficiaries and ensure that the program operates in the best interests of the population groups described in the Act. We urge HHS to address our concerns prior to issuing any approval. If you have questions about these comments, please contact Leonardo Cuello (cuello@healthlaw.org). Thank you for consideration of our comments.

Sincerely,

Leonardo D. Cuello
Director, Health Policy