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September 7, 2017

Brian Neale
Director, Center for Medicaid & CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

RE: Public Comment: Iowa Health and Wellness Plan §1115 Demonstration Amendment (Project Number 11-W-00289/5)

Submitted electronically via
https://public.medicaid.gov/connect.ti/public.comments/answerQuestionnaire?qid=1891715

Dear Mr. Neale,

UnityPoint Health appreciates the opportunity to provide input on the proposed amendment to the §1115 Demonstration to eliminate the provision of three months of retroactive benefits for all Iowa Medicaid eligibility groups currently receiving retroactive coverage. As proposed, coverage for eligible Medicaid applicants will become effective on the first day of the month in which the application for Medicaid was filed or as otherwise allowed in the State Plan. Pending CMS approval, this benefit reduction will become effective on October 1, 2017. We are extremely concerned not only with the substance of the amendment but also with the public notice process.

As background, this regulatory proposal originated as a "Cost Containment Strategy" within subsection 15(a)(7) of the Health and Human Services Appropriations Bill (House File 653) of the Iowa Legislature.[1] The fiscal impact was estimated to save the State of Iowa $4,821,814 in FY 2018 and FY 2019. As drafted by Iowa Medicaid Enterprise, the stated goals and objectives of this amendment are "to reduce program costs, while ensuring that mechanisms, such as presumptive eligibility and retroactive coverage for the month in which the Medicaid application is filed, are in place to guarantee

[1] House File 653 (2017), Subsection 15(a)(7) – "Elimination of the three-month retroactive Medicaid coverage benefit for Medicaid applicants effective October 1, 2017. The department shall seek a waiver from the centers for Medicare and Medicaid services of the United States department of health and human services to implement the strategy. If federal approval is received, an applicant's Medicaid coverage shall be effective on the first day of the month of application, as allowed under the Medicaid state plan."

individuals have continued access to necessary services."[2] As stated in the public notice, this amendment is estimated to impact 3,344 potential Medicaid enrollees monthly and result in an annual savings of $36,751,782 with $9,695,261 of that total credited to the State of Iowa. Table 1 represents the State's enrollment and fiscal projections[3] with the addition of eligibility group percentages. This amendment will impact roughly 6.4% (40,000+) enrollees annually.

TABLE 1. Impact of Eliminating Retroactive Eligibility

Eligibility Group	Avg. Monthly Enrollees		Annual Savings		State Share	
	#	%	$	%	$	%
Medicaid						
Child	1,129	33.8%	$9,502,208	25.9%	$3,986,176	41.1%
Adult	668	20.0%	$6,027,803	16.4%	$2,528,663	26.1%
BCCT	1	0.0%	$14,250	0.0%	$4,184	0.0%
Elderly	6	0.2%	$262,791	0.7%	$110,241	1.1%
Disabled	157	4.7%	$4,368,799	11.9%	$1,832,711	18.9%
Health and Wellness Plan	1,384	41.4%	$16,575,930	45.1%	$1,233,285	12.7%
Medicaid Total	**3,344**		**$36,751,782**		**$9,695,261**	

For the following reasons, **UnityPoint Health is opposed to Iowa's cost containment strategy** and urges CMS to disapprove the proposed Retroactivity waiver to section 1902(a)(34) that would supplement the existing Iowa Wellness Plan Title XIX waivers.

The State did not comply with the required Public Notice process.

The public notice was deficient and did not contain "An estimate of the expected increase or decrease in annual enrollment" as set forth in the Iowa Wellness Plan Demonstration (11-W-00289/5) special terms and conditions (STCs) related to public notice and required by 42 CFR § 431.408(a)(1)(i)(C). The public notice stated that "Elimination of retroactive coverage is expected to reduce monthly enrollment by 3,344 enrollees and reduce annual Medicaid spending by $36.8 million."[4] While the State provided projected monthly enrollment decreases, this was not annualized and therefore did not appropriately put the public on notice of the magnitude of the proposed change. As a result, we request that the CMS require the State to follow the public notice process outlined in the demonstration special terms and conditions and resubmit its application accordingly.

Iowa's proposed amendment to eliminate retroactive eligibility from existing Title XIX waivers is not similarly situated to other CMS approved waivers.

[2] "Notice of Iowa Department of Human Services Public Comment Period to Amend the 1115 Demonstration Waiver", published at https://dhs.iowa.gov/public-notices on June 27, 2017.
[3] Notice of Iowa Department of Human Services Public Comment Period to Amend the 1115 Demonstration Waiver, published June 27, 2017 at https://dhs.iowa.gov/public-notices.
[4] Id.

In 2013, Iowa through the Iowa Department of Health Services (IDHS) proposed this waiver authority in its original Iowa Health and Wellness Plan §1115 demonstration applications[5], and CMS denied this waiver authority. While Iowa's request was denied, CMS has approved waivers of the 3-month retroactive eligibility requirement in Indiana, Arkansas, and New Hampshire.[6] ***The approved waivers were all conditional, requiring states to implement safeguards to protect Medicaid beneficiaries from unpaid medical costs incurred just prior to Medicaid eligibility.*** Indiana expanded its presumptive eligibility program and implemented a prior claims payment program to cover retroactive costs for the waiver's mandatory (non-expansion) parents and individuals age 19 and 20. Arkansas and New Hampshire were required to ensure that eligibility determinations were timely and without gaps in coverage. Although Iowa has a presumptive eligibility program, the proposed Iowa amendment does NOT provide additional/expanded safeguards to ensure timely eligibility determinations or prevent gaps in coverage for the estimated 3,344 enrollees that will be impacted monthly. As evidenced by the flat nature of the State's supporting data (i.e. no reduction in the number of enrollees impacted is anticipated over the course of months or years), **simply waiving the three-month retroactive eligibility is not anticipated by itself to encourage continuous coverage**. This is a cost containment measure for the State of Iowa that originated in an appropriations bill. Rather than providing supportive mechanisms or activities to encourage continuous coverage outside elimination of the three-month retroactive eligibility provision, the Iowa Legislature has authorized the use of excess funds garnered from cost containment strategies to defray increased contract costs resulting from these strategies.[7] It is unclear how shifting savings to enforcement efforts will encourage continuous beneficiary coverage.

In the State's response[8], our concern was not addressed. When explaining its position on the potential health and financial impacts of this change, the State's response reiterates that some pre-existing provisions impacting coverage are retained or diminished but not entirely eliminated (i.e. retaining presumptive eligibility and continuing retroactive determinations from the date of filing). This concedes the fact that the reduction in retroactive eligibility (which now ranges from 1 to 31 days) is not accompanied by new or expanded safeguards to promote continuous coverage. While the public notice and response do not estimate the number of Medicaid enrollees assisted with continuous coverage through presumptive eligibility and monthly date of filing retroactive eligibility, it is clear that these provisions do nothing to promote continuous coverage for at least 3,344 enrollees on a monthly basis impacted by this change. This amendment reduces benefits without any offsetting safeguards, which is a change from prior CMS guidance.

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[5] Iowa Department of Human Services, Iowa Wellness Plan 1115 WAIVER APPLICATION, August 2013, page 40, accessed at http://dhs.iowa.gov/ime/about/initiatives/iowa-health-and-wellness-plan/ihawp-fed-docs.

[6] Musumeci, M., Hinton, E., & Rudowitz, R. Issue Brief: Key Themes in Section 1115 Medicaid Expansion Waivers, Henry J. Kaiser Family Foundation, March 14, 2017, updated June 14, 2017, accessed at http://www.kff.org/medicaid/issue-brief/key-themes-in-section-1115-medicaid-expansion-waivers/.

[7] House File 653 (2017), Subsection 16(b) – "If the savings to the medical assistance program from cost containment efforts exceed the cost for the fiscal year beginning July 1, 2017, the department may transfer any savings generated for the fiscal year due to medical assistance program cost containment efforts to the appropriation made in this division of this Act for medical contracts or general administration to defray the increased contract costs associated with implementing such efforts."

[8] Section 1115 Demonstration Amendment to the Iowa Wellness Plan Project #11-W-00289/5 filed on August 2, 2017

The scope of Iowa's proposed amendment goes beyond the CMS guidance to "Align Medicaid and Private Insurance Policies for Non-Disabled Adults" and is not aligned with State legislative intent.

On March 14, 2017, Health and Human Services Secretary Tom Price, M.D., and CMS Administrator Seema Verma cosigned a letter to the nation's governors affirming the Department's intent to work with states to improve the Medicaid program.[9] The alignment of Medicaid and private insurance policies for **non-disabled adults** was listed among keys areas for improved collaboration, including "waivers of enrollment and eligibility procedures that do not promote continuous coverage, such as presumptive eligibility and retroactive coverage." Using the State of Iowa's supportive data in Table 1, **the majority (58.6%) of those impacted will be mandatory (non-Health and Wellness plan) beneficiaries and will comprise a disproportionate amount (87.3% or $8,461,975) of projected State savings**. **"Non-disabled adults"[10] comprise 61.5% of impacted monthly enrollees but account for only 40% ($3,876,373) of projected State savings**. As proposed, this amendment overreaches the non-disabled adult category and we oppose application of this waiver to this significantly larger beneficiary group. Given that the Legislature forecasted a two-year savings of $4,821,814[11], we do not believe that this larger population with an annual Medicaid savings of $9,695,261 and total cost avoidance of $36,751,782 should be included within this application.

The State's response[12] does not address its deviation from the Price-Verma letter, which lists presumptive and retroactive eligibility strategies as viable areas for improvement related to "non-disabled adults." The State's response does acknowledge that "some commenters had concerns with the populations affected . . . and . . . that the fiscal or enrollment projections are not aligned with projections made by the Iowa legislature. . . . The State is mandated to follow the language of House File 653 (2017), which neither limits the proposed changes to only the new adult Medicaid population nor indicates specific financial projections or considerations." The IDHS is misstating its directive and the underlying legislative intent of HF 653 in a manner that will negatively impact Medicaid enrollees.

- Scope of what is required: We agree with IDHS on two underlying premises – HF 653 requires the IDHS to (1) implement seven cost containment strategies, including a strategy to eliminate the three-month retroactive Medicaid coverage benefit; and (2) seek a CMS waiver for the elimination strategy.
- At issue: The scope (i.e. targeted population) of the strategy identified as "elimination of the three-month retroactive Medicaid coverage benefit for Medicaid applicants." It is not reasonable

[9] Department of Health and Human Services media release, "Secretary Price and CMS Administrator Verma Take First Joint Action: Affirm Partnership of HHS, CMS, and States to Improve Medicaid Program," published on March 14, 2017 at https://www.hhs.gov/about/news/2017/03/14/secretary-price-and-cms-administrator-verma-take-first-joint-action.html.

[10] Defined as Medicaid eligibility groups of mandatory adults, BCCT, elderly, and Health and Wellness Plan enrollees (or exclude the child and disabled groups) as set forth in Table 1.

[11] NOBA to Graybook (HF 653) – "Implementing this cost containment measure is estimated to save the State $4,821,814 in FY 2018 and FY 2019." NOBA (Notes On Bills and Amendments) is the Fiscal Note / Analysis that accompanies House appropriations bills and details fiscal estimates. Graybook references the enrolled version of HF 653. Accessed at https://www.legis.iowa.gov/docs/publications/NOBA/858029.pdf

[12] Section 1115 Demonstration Amendment to the Iowa Wellness Plan Project #11-W-00289/5 filed on August 2, 2017

to interpret an instruction contained within the context of an appropriations bill without reference to the Legislative fiscal note and the inherent executive authority within the Iowa Department of Human Services. When taken in context, it is clear that the Legislature did not intend this cost containment strategy to impact all Medicaid applicants.

- *Appropriations instruction*: An appropriations bill is the legislative vehicle for budget items. Because an appropriations bill differs from substantive legislation, its text should be interpreted in context and should be narrowly construed to its purpose. Not atypical of appropriations bills, the cost containment measures in HF 653 are identified as strategies in a general list, devoid of implementation details. The strategy identified is "Elimination of the three-month retroactive Medicaid coverage benefit for Medicaid applicants." This language by itself does not contain the detail required for implementation. Rather the directive is for the department to implement the strategy. It is not reasonable to insert "all", "each," or "every" before "Medicaid applicants" when it is absent and this interpretation is not supported by the Fiscal Note.
- *Fiscal note*: It is simply false that HF 653 and the Iowa Legislature did not provide specific fiscal projections in support of this cost containment strategy. We do not need to educate IDHS about the format of appropriations bills and the existence of fiscal notes to provide details. For HF 653, specific fiscal projections were provided for each of the cost containment strategies, including the retroactive benefit coverage.[13] When the projected annual savings for Medicaid in this amendment is more than four times the annual savings indicated in the fiscal note, it is not reasonable to believe that IDHS has included the appropriate population within this amendment. Rather, a reasonable interpretation would be that the Legislature had intended a subset of the Medicaid population, and not the entire population, to be subject to this benefit reduction. IDHS is aware of the fiscal note and has not justified this discrepancy nor any efforts to reconcile these figures.
- *Legislative mandate and discretion of IDHS*: Most troubling is the repeated statement by IDHS that it is simply following the mandate of the Legislature, which implies that IDHS has no discretion. If this were in fact the case, then the elimination of the three-month retroactive benefit coverage could be reasonably interpreted to mean that no retroactivity exists at all. As stated in this application, IDHS will be applying retroactive coverage benefits from the date of filing until the beginning of that month. This interpretation is reasonable, in context of the appropriations language, although it is not directly stated. It is clear that the IDHS does have discretion in how this strategy is to be implement and IDHS should use due diligence to interpret its scope within the entire context of the legislative process.
- *Non-disabled Medicaid population*: The elimination of the three-month retroactive benefit coverage was not included as a Medicaid cost containment strategy list in the Governor's initial recommendations at the start of the Legislative session. Given the timing of the Price-Verma letter and the appropriations process, it is reasonable to assert that this letter instigated its revival and interest in the State of Iowa. This letter suggested retroactive

[13] See footnote 10.

benefits as a strategy for non-disabled, which is much different from the entire Medicaid population.

The retroactivity cost containment strategy simply shifts costs, does not proactively reduce costs, and places an undue financial burden on vulnerable populations.

Given that the State has not proposed any mechanism or activity to promote continuous coverage, this cost containment policy will not reduce overall healthcare costs but rather shift these costs to patients and essential health care providers. Lack of coverage will only add to the financial difficulties already faced by individuals who are eligible for Medicaid. For institutions that serve a disproportionate share of Medicaid beneficiaries, the result will be a disproportionate share of the $36 million total landing in charity care and bad debt expenses. This significant amount may lead some institutions to reduce services.

In addition, this policy establishes an inconsistent deadline for a population with very few resources making them particularly vulnerable to extreme financial strain and liability. As proposed, an applicant's Medicaid coverage will become effective on the first day of the month of application. People with healthcare expenses at the beginning of the month are treated differently than people with healthcare expenses at the end of the month. If a person has an injury or severe illness on the 30th of the month as opposed to the 1st of the month, there is little time to submit a Medicaid application. This creates unnecessary burdens for individuals and their caregivers during a time of crisis (i.e. focused on receiving treatment and getting well) and provides unequal application requirements based on the timing of an illness/injury which is often beyond an individual's control. To similarly situate applicants, retroactive coverage should be based on a number of days (i.e. 30-days) as opposed to a monthly basis.

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UnityPoint Health (UPH) is one of the nation's most integrated healthcare systems. Through more than 30,000 employees and our relationships with more than 280 physician clinics, 33 hospitals in metropolitan and rural communities and home care services throughout our 9 regions, UPH provides care throughout Iowa, Illinois and Wisconsin. On an annual basis, UPH hospitals, clinics and home health provides a full range of coordinated care to patients and families through more than 4.5 million patient visits. In Iowa, UPH is the largest healthcare provider, serving roughly one out of every three Iowans.

On behalf of our Medicaid patients and their families and caregivers, UnityPoint Health appreciates the opportunity to provide input during this public comment period. **While we recognize the budget difficulties in the State of Iowa, we cannot support this cost containment strategy as proposed and urge CMS to disapprove this amendment. This amendment does not align with legislative intent, does not promote continuous coverage, and has impacts beyond the non-disabled adult population.** UPH had submitted similar comments in opposition during the public notice process undertaken by the Iowa Department of Human Services. To discuss UPH comments or for additional information on

any of the addressed topics, please contact Sabra Rosener, Vice President and Government Relations Officer, Government & External Affairs at sabra.rosener@unitypoint.org or 515-205-1206.

Sincerely,

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