



August 9, 2013

Re: Comments on Rhode Island 1115 Waiver Extension Request: March 12, 2013 and Addendum, July 10, 2013

Submitted via e-mail to: [Rhodelsland1115Waiver@ohhs.ri.gov](mailto:Rhodelsland1115Waiver@ohhs.ri.gov)

These comments are submitted on behalf of The Economic Progress Institute and Rhode Island KIDS COUNT. Section A includes comments on the July 10, 2013 Addendum. Section B includes comments on the March 12, 2013 Waiver Extension Request.

#### **A. Comments on July 10, 2013 Addendum**

##### **Section 1**

##### **Reduction in parent/caretaker eligibility from 175% to 133% FPL**

This change is estimated to result in the loss of coverage for approximately 7,200 currently enrolled parents. The vast majority (6,100) are enrolled in Rite Care and the others are enrolled in Rite Share, the premium assistance program. This change will be effective January 2014 when the new MAGI rules are in effect. Around half of these parents have income below the threshold for a premium requirement. The rest (in families with income above 150% FPL – 175% FPL) are required to pay a monthly premium of \$61.

The waiver document indicates that “it is the state’s expectation that these individuals will be able to access health insurance coverage with a qualified health plan through the State’s Insurance Exchange.” (p. 5)

Under new state law (RIGL 40-8.11-3), parents with income below 175% FPL who enroll in the Exchange will be entitled to state funded premium assistance through a new “health insurance financial assistance program”. EOHHS is requesting approval for expenditure authority for this program (p. 6 ).

EOHHS must implement a process to redetermine the Medicaid eligibility of parents under MAGI rules or under other Medicaid categories (e.g., pregnancy, disability, Title XV) before the parent is closed to coverage. The waiver document should outline this process.

EOHHS must also provide parents who are ineligible for Medicaid with a determination of eligibility for coverage through the Exchange, the amount of Advance Premium Tax Credit and Cost Sharing Reduction as well as the amount of state premium assistance from the new “health insurance financial assistance program” for which the parent is eligible.

The waiver document should outline this transition process for parents.

Since EOHHS is requesting authority to use federal funds for the new health insurance financial assistance program, EOHHS should track whether the parents who lose Medicaid coverage in January 2014, take up coverage through the Exchange and document the income of the parents who do and do not take up coverage. This information should also be tracked after January 2014 for new parents applying for coverage through the Exchange to evaluate whether the state premium assistance is encouraging enrollment.

### **Affordable Coverage and Personal Responsibility**

#### Children are Medicaid Eligible and Enrolled in Rite Care

The waiver document characterizes the proposal to eliminate cost-sharing requirements for households with income between 150% - 250% FPL as applying to “Children are Medicaid eligible and enrolled in Rite Care, Parent/Caretaker Relative(s) enrolled in commercial insurance” (p. 5). However, the recently enacted change to state law (RIGL 40-8.4-4) simply eliminates cost-sharing for children enrolled in Rite Care. There is no requirement that the parent is enrolled in commercial insurance as a condition of the elimination of cost-sharing for the children. The waiver document should be changed to reflect this.

#### Children are Medicaid Eligible and Enrolled in Rite Share

The waiver document should be revised to request the allowance of cost-sharing for families enrolled in Rite Share from applying the requirement to the children to applying the cost-sharing requirement to the parent. As stated in the waiver document, there should be “equity” for children enrolled in Rite Care or Rite Share, but the equity should, and must, be that there is no cost-sharing requirement for children enrolled in Medicaid. If Rite Share is a viable option for the family, (i.e., it is more cost-effective for EOHHS to enroll the family in the parent’s employer-sponsored insurance (ESI) than to cover the children through Rite Care), the parent will be offered the benefit of insurance at a lesser cost than enrolling in coverage through the Exchange. If the parent decides not to enroll in ESI to take advantage of coverage for him/herself, the children will be enrolled in Rite Care.

The waiver document should specify that if the parent fails to enroll in ESI, the children will be enrolled in Rite Care. This reflects the current rule (DHS Medicaid Rules, 0349.05.10.05) and the maintenance of effort requirement in the ACA mandates that this protection for children remain in effect.

### Households up to 175% FPL

We are glad that there will be some additional assistance available to help parents with income below 175% FPL purchase coverage through the Exchange. As noted above, since the state is requesting to use expenditure authority for this “health insurance financial assistance program”, the waiver document should specify how the impact of this expenditure authority will be evaluated.

The state law (RIGL 40-8.11-3) provides that the formula for calculating the assistance to which a parent is entitled includes the premium that the parent would have paid under the rules in effect on December 31, 2013. These rules provide that parents with income equal to or less than 150% FPL do not have a cost-sharing requirement, while those in families with income at/above 150% FPL to 175% FPL have a cost-sharing requirement of \$61. The waiver document should be amended to reflect this distinction.

The waiver document should also specify that parents with income between 100% and 175% FPL who are not Medicaid eligible solely due to immigration status (e.g., lawful permanent resident subject to the 5 year bar) will qualify for this new program.

Finally, the waiver document should set forth how parents will access this new assistance.

### **Requirement to apply for health insurance prior to receipt of services provided under the CNOM expenditure authority**

The CNOM expenditure authority includes both coverage for populations not otherwise eligible for Medicaid and services that are either not usually covered by Medicaid or which are provided to individuals who are not Medicaid eligible.

The new state law (RIGL 40-8.11-3(b)) requires that any individual receiving benefits under a state funded health care assistance program must apply for any health insurance for which he/she is eligible, including insurance available through the Exchange. A logical application of the law is that only individuals who are receiving full Medicaid coverage need to apply for other insurance as a condition of receiving this “CNOM coverage”. This would include, for example, Budget Population 8 (parents pursuing behavioral health treatment with a child in state custody), Budget Population 14 (women screened for breast or cervical cancer), Budget Population 18 (persons living with HIV), Budget Population 19 (non-working disabled adults). Many of the individuals in these populations will be eligible for Medicaid under the expansion. Those with income higher than Medicaid and below the specified limit for each population would need to apply for “other health insurance for which he/she is eligible”.

The waiver document should be amended to reflect the populations (and services, if EOHHS believes that the new requirement to apply for “other health insurance” applies to CNOM

services provided to non-Medicaid individuals) to which this new requirement applies, when the individual is exempt from the requirement (e.g., where the cost to the person is not “de minimus”) and the enrollment assistance that will be provided to individuals required to comply with this requirement.

## **Section 2. Requested Changes to the Waiver**

### **Strategic areas (p.8)**

**Strategic area 4: Improve coverage and eligibility policies and procedures to achieve timely appropriate coverage and intervention to prevent higher cost care and forestall the need for Medicaid coverage.**

Since Rhode Island operates its entire Medicaid program (with limited exceptions) under this 1115 Waiver, it is not appropriate to have a strategic goal of “forestalling the need for Medicaid coverage” as part of the Waiver goals. The strategic goals need to encompass the entire Medicaid programs. It should be one of the strategic goals of the Medicaid program to ensure that eligible Rhode Islanders can easily enroll in the program (whether for acute/primary care coverage or for long-term care) and to maintain coverage. It should be a goal of the Medicaid program to put in place interventions and programs to prevent high cost care among all Medicaid recipients. It is also a goal of many of the CNOM expenditure authority requests to use Medicaid funding to prevent certain populations from needing Medicaid funded long term care services. To reflect these 3 distinct goals, we suggest changing this strategic goal to read: “Improve coverage and eligibility policies and procedures to achieve timely, appropriate coverage; implement interventions to prevent higher cost care and provide services to forestall the need for Medicaid-funded long term care services.

For the same reasons, we suggest amending the 4<sup>th</sup> objective (p. 10) to read: Prevent/forestall the need for Medicaid funded long-term care services among at-risk, vulnerable populations. Note: this would be consistent with how this objective is explained in the “with waiver” analysis on p. 14: “Many of these strategies are designed in order to prevent or forestall the need for more costly long-term care services.”

### **Table 1 (p. 9)**

Add to the table: (1) Health Insurance Financial Assistance Program – to provide financial assistance to parents with income at/below 175% FPL to purchase health insurance coverage through the Health Benefits Exchange. (2) Rlte Share Premium Assistance – to enroll parents (non-Medicaid eligible) with Medicaid-eligible children in parent’s employer sponsored coverage and require cost-sharing from parents with income equal to or above 150% FPL.

## **Plan for Evaluation Activities (p. 17-18)**

It appears that the response to CMS' request to "provide additional information regarding hypotheses and an evaluation design regarding the state's proposed revisions to the demonstration" is that the state will do this for each new initiative on a going-forward basis. This does not seem adequate. The waiver extension document should list each "new initiative" and should articulate what the new initiative is intended to accomplish (i.e., the hypothesis) and how the state will measure the outcome.

For example, OHHS is requesting expenditure authority to implement a "health insurance financial assistance program" to help parents with income at/below 175% FPL enroll in coverage through the Health Benefits Exchange. The "hypothesis" is that this funding, along with the federal tax credits, will be sufficient to encourage very low income parents (who previously would have been able to enroll in Rite Care) to enroll in insurance. How will EOHHS evaluate this?

As EOHHS develops updates to the Waiver's Evaluation Design, EOHHS should include members of the affected communities and advocates, not only the "Waiver's Quality and Evaluation Work Group" which is comprised of state agency staff.

## **B. Comments on Items in March 2013 submission**

### **Section VIII. Waiver List. Request #9. Out-stationing waiver.**

We oppose this waiver request and ask that EOHHS withdraw it. In support of this new waiver request, EOHHS asserts that the availability of the contact center, the navigator program, the in-person assistors and the new web-based application will make the need for out-stationed eligibility workers obsolete. This is not true in the short-term: the out-stationing rule requires EOHHS to ensure there is assistance available at disproportionate share hospitals as well as community health centers. Services must also be provided at Indian Health Clinics. While there will be staff at the community health centers available to help with enrollment under a HRSA grant, it is not certain that there will be help for pregnant women and children to enroll in Medicaid at the hospitals or at the Indian Health Center. This is also not true for the long-term, i.e., over the 5-year period of the waiver, since funding for navigators and assistors is time limited. While the web-based application and new verification procedures will make it easier to apply for Medicaid, low-income pregnant women and children will continue to need application assistance. Using Medicaid funds to provide in-person assistance to these populations at health centers, DSH hospitals and the Indian Health Clinic is a good use of resources, and required by federal law.

Thank you for your consideration of our comments. We look forward to your response.

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