January 30, 2018

The Honorable Alex Azar,
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W. Washington, DC 20201

Dear Secretary Azar:

The undersigned organizations appreciate the opportunity to comment on New Mexico's request to extend the Centennial Care 2.0 section 1115 demonstration project, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on December 6, 2017. We fully support New Mexico's proposals to improve and strengthen care coordination, test new value-based payment arrangements, extend coverage to former foster youth up to age 26, and expand home visiting and family planning services.

However, we have concerns with other aspects of the demonstration request that should be addressed during the approval process, which are outlined below. Moreover, the state hasn't provided its hypotheses for numerous provisions of the demonstration request, such as the waivers of retroactive eligibility, Transitional Medical Assistance (TMA), and Early Periodic Screening Diagnostic and Treatment (EPSDT).

Support for New Mexico's Request to Expand Substance Use Disorder Treatment

We support New Mexico's proposal to cover up to 30 days of residential treatment for people with substance use disorders (SUD) in both fee-for-service Medicaid and managed care as part of the full continuum of services needed for people with SUDs. Among other services, New Mexico is seeking Medicaid reimbursement for Screening, Brief Intervention, and Referral to Treatment (SBIRT) services, which the Substance Abuse and Mental Health Services Administration (SAMHSA) considers an evidence-based approach to delivering early intervention and treatment services to both people with SUDs and those who are at-risk of developing SUDs. Because the International Classification of Diseases (ICD-9-CM) system classifies substance use disorders as a mental disorder, facilities providing residential treatment are currently considered Institutions of Mental Disease (IMDs). Residential treatment is part of the standard of care for substance use disorders, and residential treatment facilities for SUD are very different and not nearly as restrictive as institutions that housed people with mental illness in 1965, when the IMD prohibition was enacted. Without Medicaid coverage for residential treatment, beneficiaries have limited options for care and recovery. Low-income individuals with a substance use disorder need the same access to residential treatment as those with moderate and high incomes who can afford residential treatment especially given the opioid epidemic in New Mexico. Thus we support this limited waiver of the IMD exclusion.

Proposal to Waive the IMD Exclusion for non-SUD Diagnosis is Impermissible

In addition to requesting authority to provide Medicaid reimbursement for up to 30 days of residential treatment for people with SUD, New Mexico's proposal requests a much broader waiver of the IMD exclusion to provide "inpatient services in an IMD so long as the cost of care is the same as, or more cost effective, than a setting that is not an IMD." Broad waivers of the IMD

exclusion are not permissible under section 1115, which allows states to waive provisions in section 1902 of the Social Security Act. The IMD exclusion is in section 1905. It is widely accepted that legislation would be needed to alter the IMD exclusion for mental health services.[1]

Several states have been granted permission through 1115 waiver authority to provide limited, well-defined IMD services for inpatient substance use disorder treatment in conjunction with an evidence-based SUD services continuum of care or well-defined SUD related outcome measures as New Mexico is requesting as well. However, New Mexico's request to provide Medicaid reimbursement for inpatient psychiatric services is not specific to SUD treatment services and goes much further.

Premiums Create Barriers to Care

New Mexico's proposal would require individuals with incomes between 100 and 138 percent of the poverty line to pay $10 in monthly premiums in 2019, increasing to $20 per month in 2020. Individuals must pay their monthly premium to effectuate coverage, and if they aren't able to pay or aren't aware of the requirement, they would be locked out of coverage for 90 days. Individuals could only regain coverage after completion of the 90-day lockout *and* upon payment of any unpaid premiums.

No state has ever been allowed to require beneficiaries to pay unpaid premiums after a lockout period as a condition of regaining coverage, and allowing a state to do so would not meet the objectives of the Medicaid program. Such a policy would likely cause people who are disenrolled for unpaid premiums to remain uninsured indefinitely because of the high cost of reenrollment. For example, if the state imposes a $20 monthly premium, and an individual misses three months of premium payments, they would need $80 to reenroll ($60 for past premiums and $20 for the first month of coverage).

A robust body of research finds that imposing premiums on low-income individuals decreases their participation in health coverage programs. A recent literature review by the Kaiser Family Foundation examined 65 papers published between 2000 and March 2017 on the effects of premiums and cost sharing on low-income people enrolled in Medicaid and CHIP. The authors concluded that premiums are a barrier to obtaining Medicaid and CHIP coverage, with the largest effect among those with incomes below poverty. The research shows that while some individuals losing Medicaid or CHIP coverage move to other coverage, many become uninsured. Those with lower incomes are most likely to become uninsured. Once uninsured, people face increased barriers to accessing care, greater unmet health needs and increased financial burdens.[2]

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[1] For example, the President's Commission on Combating Drug Addiction and the Opioid Crisis, Draft Interim Report (2017), page 3, stating in regards to the IMD exclusion: "The Commission recognizes that legislation would be necessary to repeal the exclusion in its entirety." https://www.whitehouse.gov/sites/whitehouse.gov/files/ondcp/commission-interim-report.pdf

[2] Samantha Artiga, Petry Ubri and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017, http://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

In Oregon, for example, nearly half of adults disenrolled from Medicaid after premiums increased to a maximum of $20. Many former enrollees became uninsured and faced barriers to obtaining care.[3] Similarly, a recent study of the Healthy Indiana Plan, which requires adults to pay between $1 and $27 in monthly premiums to enroll in a more comprehensive plan, found that 55 percent of eligible individuals either did not make their initial payment or missed a payment.[4]

Moreover, recent research shows that state savings from premiums are limited. Studies find that potential increases in revenue from premiums are offset by the use of more expensive services, such as emergency room care, and costs in other areas -- such as resources for uninsured individuals, and administrative expenses.[5] For example, a recent study looking at Arkansas' Independence Accounts found that they were not cost effective to implement because the administrative costs were so high. The state collected $426,457 from eligible enrollees, but spent $595,135 in co-payment protections.[6] In addition to spending more than it collected, the state spent $9 million to contract with a vendor to manage the accounts.[7]

The research is clear that premiums decrease participation in Medicaid and increase uninsurance and hardship. States should no longer be permitted use 1115 waiver demonstrations to test the effect of premiums in Medicaid.

Copayments and Missed Appointment Fees Would Deter Needed Care

The proposal also requests authority to charge a $10 copayment for non-preferred prescription drugs and a $25 copayment for emergency department (ED) use that the state claims is "non-emergent." New Mexico states its hypothesis for these copayments as, "Copayments for certain service will drive more appropriate use of services, such as reducing non-emergent use of the emergency department." However, this hypothesis is inconsistent with a significant body of research showing that copayments are a barrier to obtaining appropriate care. Moreover, under section 1916(f) of the Social Security Act (the Act), a state that wants to impose cost-sharing that exceeds statutory limits must meet specific criteria:

1. The state's proposal will test a previously untested use of copayments;
2. The waiver period cannot exceed two years;
3. The benefits to the enrollees are reasonably equivalent to the risks;
4. The proposal is based on a reasonable hypothesis to be tested in a methodologically sound manner; and
5. Beneficiary participation in the proposal is voluntary.

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[3] *Op cit.,* Artiga, Ubri, and Zur 2017.
[4] *Ibid.,* see also The Lewin Group, "Healthy Indiana Plan 2.0: POWER Account Contribution Assessment, Prepared for Indiana Family and Social Services Administration (FSSA)," March 2017. Premiums in Healthy Indiana are generally set at 2 percent of household income or $1 a month for people with incomes below 5 percent of the poverty line.
[5] *Op cit.,* Artiga, Ubri, and Zur 2017.
[6] By making monthly contributions to their accounts, enrollees were "protected," or not required to pay co-payments for services rendered in the subsequent. The $595,135 represents state spending to offset the enrollee's co-payment obligation.
[7] Joseph Thompson, et al., "Arkansas Experience with Health Savings Accounts in a Medicaid Expansion Population," Arkanasa Center for Health Improvement, June 27, 2017, https://academyhealth.confex.com/academyhealth/2017arm/meetingapp.cgi/Paper/18272.

New Mexico's proposal does not meet these criteria; in fact, the state doesn't even acknowledge these statutory criteria. Moreover, the state proposes to use a broad standard of non-emergency care that could keep people from getting the emergency care they need. Not only could this broad standard of non-emergency care harm beneficiaries, but the copayment itself could prevent people from seeking care. The review of the literature on premiums and cost-sharing discussed above found that even small levels of cost sharing, in the range of $1 to $5, are associated with reduced use of care, including necessary services. The review cites numerous studies that have found that cost sharing has negative effects on individuals' abilities to access needed care and health outcomes, and increases financial burdens for families.[8]

The state is also requesting authority to forgo tracking out-of-pocket spending that is needed to ensure that premiums and co-pays imposed on beneficiaries don't exceed Medicaid's five percent aggregate out-of-pocket spending maximum. New Mexico states that such tracking is no longer necessary since premiums are set at 2 percent of income and that the only copayments beneficiaries are subject to would "only be imposed based on the choice of the beneficiary to access such services." The state would need a waiver under section 1916(f) of the Act to implement such a proposal, but New Mexico did not include information on how it meets the statutory criteria for such a waiver in its proposal. Moreover, such a policy could harm the financial security of Medicaid beneficiaries, and is inconsistent with the purpose of an out-of-pocket spending maximum, which is intended to protect individuals from financial harm. Finally, obtaining health care isn't a choice; beneficiaries shouldn't be penalized for getting the care they need by having to pay more than they should under Medicaid rules.

Finally, New Mexico is seeking authority to impose a $5 missed appointment fee after a beneficiary has missed three scheduled appointments in a given calendar year without prior notification by the beneficiary to the provider. This proposal does not take into account any hardship a beneficiary may experience in seeking medical care, such as lack of transportation, ability to notify the provider in a timely manner, mental health challenges etc., and would therefore create unacceptable barriers to care.

Retroactive Eligibility and Transitional Medical Assistance are Crucial for Beneficiaries and Providers

New Mexico's proposal would end Medicaid payments for medical costs that beneficiaries incurred up to three months before enrolling in Medicaid if they were eligible for Medicaid during that period. The state is proposing to phase-in this policy by reducing the period of retroactive eligibility from 3 months to one month in 2019, and eliminating it altogether starting in 2020.

First, New Mexico's proposal isn't specific as to which eligibility groups would be subject to the retroactive coverage waiver. The proposal states that *most* (non-SSI) Centennial Care members would be subject to the waiver. Retroactive coverage is an important Medicaid protection because it prevents medical debt and even bankruptcy and provides financial security to vulnerable beneficiaries, especially seniors and adults with disabilities who need long-term services and supports and may not be familiar with Medicaid or its eligibility rules.

[8] Op cit., Artiga, Ubri, and Zur 2017.

While the New Mexico indicates in its proposal that about 10,000 beneficiaries requested retroactive coverage in 2016, the financial protection for these individuals could have been significant. For example, data from Indiana showed that, on average, individuals with medical bills incurred prior to enrollment owed $1,561 to providers, which Medicaid would pay.[9] Ending retroactive coverage would pose significant financial harm to both Medicaid beneficiaries and safety net providers.

In addition to protecting vulnerable individuals, retroactive coverage helps ensure the financial stability of safety net providers by paying for medical services that would otherwise have been uncompensated. Retroactive coverage provides reimbursement to hospitals and other safety net providers for care they have provided during the three-month period, helping them meet their daily operating costs and maintain quality of care.

New Mexico is also seeking authority to end another important Medicaid protection — Transitional Medical Assistance (TMA). Under TMA, parents and caretaker relatives who lose Medicaid coverage due to increases in income remain in Medicaid for up to an additional 12 months. To our knowledge, no state has ever received such a waiver. Eliminating TMA would have a negative effect on the health and well-being of adults and their children's. Studies show that children are more likely to have health insurance if their parents are covered.[10] Losing coverage would mean children and their parents would go without needed medical care or that they would incur significant medical debt when they did seek care. For example, studies have shown that expanding Medicaid coverage results in fewer debts being sent to third-party collection agencies.[11]

Pre-Tenancy and Tenancy Support Housing Services Should be Extended to More People

There is growing evidence that for people with complex health needs, housing support services; such as help locating and apply for housing assistance, coaching on tenant rights and responsibilities, developing a support plan and connecting residents to community based supports help people maintain housing, access care, and improve their health. New Mexico proposes to target housing support services to 180 people with serious mental illness. While we support New Mexico adding these services to their Medicaid program and targeting these services to people with serious mental illness, we are troubled by the limited number of people who would receive the services. New Mexico's request targets Centennial Care members with serious mental illness. The proposal doesn't explain how it expects Centennial Care, or the contracted managed care organizations, to determine who, of their over 600,000 members,[12] would receive these services. Other populations, such as people with histories of chronic homelessness and those with substance use disorders could benefit

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[9] July 29, 2016 letter from the Centers of Medicare and Medicaid Services to the state of Indiana, available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf.

[10] Georgetown Center for Children and Families, "Healthy Parents and Caregivers are Essential to Children's Healthy Development," December 2016, http://ccf.georgetown.edu/wp-content/uploads/2016/12/Parents-and-Caregivers-12-12.pdf.

[11] Matt Broaddus, "Medicaid Improves Financial Well-Being, Research Finds," Center on Budget and Policy Priorities, April 28, 2016, http://www.cbpp.org/blog/medicaid-improves-financial-well-being-research-finds

[12] New Mexico Department of Human Services. January 19, 2018. New Mexico HSD Announces Managed Care Organizations for Centennial Care 2. [Press release]. Retrieved from http://www.hsd.state.nm.us/Newsroom.aspx.

from these services. In addition, if the state wants to demonstrate the effectiveness of these services limiting the services to 180 people will make it difficult to evaluate their impact.

EPSDT is Critical to Adolescent Health

Medicaid's pediatric benefit is strongly endorsed by the Academy of Pediatrics for children's and adolescents' coverage because it requires states to provide the comprehensive services that children need to grow and thrive. Because of the low-income of these families, services outside the Medicaid benefits package would likely be out of reach. EPSDT ensures that children and adolescents under age 21 have guaranteed access to a robust set of comprehensive and preventive health services, including services to treat mental illness. New Mexico is proposing to waive this important benefit protection for adolescents ages 19 and 20 simply for administrative ease to align the benefit package these adolescents receive with that of expansion adults. Such a policy jeopardizes coverage to important services and could lead to poor health outcomes. For example, treatment for mental illness is critical to the health of adolescent Native Alaskans and American Indians (AI/ANs) as suicide is the second-leading cause of death for AI/ANs between the ages of 10 and 34.[13]

Thank you for your willingness to consider our comments. If you would like any additional information, please contact Joan Alker (jca25@georgetown.edu) or Judy Solomon (Solomon@cbpp.org).

CC: Seema Verma, Brian Neale, Tim Hill, Judith Cash

Autism Behavior Services, Inc.
Center for Autism and Related Disorders
Center on Budget and Policy Priorities
Children's Defense Fund
Epilepsy Foundation
Family Voices
First Focus
Georgetown University Center for Children and Families
HIV Medicine Association
Justice in Aging
National Academy of Elder Law Attorneys
National Center for Law and Economic Justice
National Health Care for the Homeless Council
National Multiple Sclerosis Society
New Mexico Pediatric Society

[13] *Ibid.*