

October 21, 2021

Secretary Xavier Becerra
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Utah Primary Care Network Extension Request

Dear Secretary Becerra,

The undersigned organizations appreciate the opportunity to comment on Utah's request to extend its "Utah Primary Care Network" section 1115 demonstration from July 1, 2022 through June 30, 2027. The state is asking to continue many of the authorities in its current demonstration, including the authority to provide reduced benefits to adults with dependent children.

We note for the record that the version of the application that the public had available to it to comment on was updated on the CMS website on October 19, 2021 without any notice – just two days before the close of the public comment period. We believe the proper process is to provide a corrected notice and a new or extended comment period (i.e., with 30 days to review the updated application). At a minimum, in future cases, we urge you to send an email to those on your electronic section 1115 mailing list informing them of a change in the application materials and that a determination has been made by CMS that it was not a substantive change that required the public comment period to be extended.

As explained below, we support Utah's proposal to provide housing-related services and supports and to provide care coordination services to people leaving jail or prison, but we urge you to reject the state's request to reduce covered services for parents. This proposal does not further the objectives of the Medicaid program as it reduces coverage. Moreover, the original rationale for the reduction in benefits for a mandatory coverage group (i.e. Section 1931 parents) to finance coverage for another group of adults has no credible hypothesis in a post-Affordable Care Act world where the state can receive generous federal matching funds to cover these adults. Finally, we note the state no longer needs Section 1115 to create an eligibility pathway for adults previously receiving coverage through the Primary Care Network (PCN) program.

Reducing Benefits for Parents Does Not Promote the Objectives of Medicaid and Is No Longer an Experiment

The state is requesting continued authority to provide a reduced benefit package to adults with dependent children, which it has done since the demonstration's inception in 2002. Taking benefits away from eligible enrollees who are entitled to the benefits under federal law, by definition does not promote the objectives of Medicaid to provide coverage.

Under the demonstration, parents in both Section 1931 and Adult Expansion eligibility groups do not receive certain state plan benefits and the amount of other benefits are limited. For example, eyeglasses and non-emergency transportation are not covered, and there are limitations on the number of occupational and physical therapy visits. Unlike parents, adults without dependent children receive full state plan benefits.

Utah's current demonstration also waives the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit for 19-and-20-year-olds in the parent eligibility group. EPSDT guarantees that children and young adults under age 21 receive comprehensive services that are necessary for their growth and healthy development. The waiver of EPSDT for 19-and-20-year-olds only applies to the state's lowest income parents given your predecessor rightly denied Utah's request to waive EPSDT for 19-and-20-year-olds in the expansion population.¹

As the state acknowledges in its application, the original purpose of reducing benefits for parents was to fund its Primary Care Network program, which provided limited preventive and primary care benefits to non-elderly adults. The adults covered through the PCN program are now eligible for full benefits through the adult expansion group with a generous federal matching rate of 90 percent. The state provides coverage to the Adult Expansion eligibility group using section 1115 expenditure authority, rather than through its state plan. There is no reason to use expenditure authority to cover these adults when they can be covered through the state plan. Covering expansion adults through expenditure authority rather than through the state plan can't be used to justify differential treatment of parents and other adults eligible under Medicaid expansion.

Utah seeks to continue discriminating against parents by restricting their benefits compared to other adults. For example, if there are two beneficiaries who need physical therapy following an accident or injury --one is a parent and the other is not -- the beneficiary who is not a parent would be able to receive all of the therapy appointments that are medically necessary while the beneficiary with children would be limited to only 16 visits within a year. *There is no justifiable purpose to continue to allow the state to limit benefits for parents especially since this differential treatment reduces coverage for one group of adults compared to another, which does not promote the objectives of Medicaid.*

Additionally, the purpose of a section 1115 demonstration is to test new approaches to delivering services that have the potential to improve Medicaid coverage for beneficiaries. While we do not believe that there was ever a legitimate research purpose for reducing Medicaid benefits of parents, the state has had already "experimented" with this policy for *almost twenty years*. Furthermore, the state's purported hypothesis for reducing parent benefits is that it will "not negatively impact" these beneficiaries. By comparison, the state hypothesizes that the demonstration "will improve the health and well-being" of the Adult Expansion population, continuing to show the disparate treatment between the two adult coverage groups, based solely on parental status. Utah's so-called experiment does not meet the statutory requirements that an experiment is likely to assist in furnishing coverage, and in fact, does the opposite compared when compared to the coverage provided to the expansion group. We urge you to deny the state's request.

¹ Utah "Primary Care Network" Amendment Approval, December 23, 2019, <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ut-primary-care-network-amendment-appvl-12232019.pdf>.

The Secretary Should Deny Pending Requests that Would Create Barriers to Coverage

Utah has two other pending proposals that would jeopardize health coverage of Medicaid beneficiaries – its “Fallback Plan” amendment and “Per Capita Cap (PCC)” demonstration. The state indicates in its application that it is not requesting federal action on these proposals as part of its extension, but it is not withdrawing these requests. We ask you to deny these pending applications as they would create barriers to coverage and harm beneficiaries.

The PCC demonstration seeks to impose a limit on federal spending on expansion and state-defined “targeted” adult groups, which would incentivize the state to cut eligibility or benefits to reduce costs if the “cap” was reached. CMS also lacks the legal authority to approve such a policy. The requirements for Medicaid matching payments are in section 1903 of the Medicaid Act, while section 1115 demonstrations can only waive provisions in section 1902.

Additionally, in both the PCC and Fallback proposals, the state seeks to disenroll and deny expansion adults’ eligibility for six months if they commit an “intentional program violation (IPV).” As we have stated in previous comments, this proposal fails to meet the core purpose of the Medicaid program by taking away coverage to eligible enrollees and would violate federal statute and regulations.²

Utah proposes additional problematic provisions in its “Fallback” amendment, including waiving hospital presumptive eligibility determinations, requiring monthly premiums, disenrollment for failure to pay those premiums, and imposing a premium surcharge for non-emergent use of the emergency department, all for expansion adults. These policies would result in coverage loss and poor access to health care, and they should not be approved under section 1115.

An Extension Should Be Limited to Three Years Under Federal Law

Utah is asking to extend its current demonstration for five years. Section 1115 of the Social Security Act allows the Secretary to approve demonstration projects only “for the period... necessary” for the state to carry out the project and in no case for no more than five years.³ After initial approval, subsections (e) and (f) of section 1115 are clear that extensions of approved demonstrations are limited to three years unless a demonstration involves dual eligibles (in which case, the extension may be approved for five years).

The state’s current demonstration only covers dental benefits for dual eligibles; the main focus of the demonstration is on non-dual adult populations and benefits. As such, the state’s extension request, subject to the modifications recommended below, should be approved for no longer than three years.

² Letter from Center on Budget and Policy Priorities and Georgetown University Center for Children and Families on Utah’s “Per Capita Cap 1115 Demonstration,” September 13, 2019, https://ccf.georgetown.edu/wp-content/uploads/2019/09/Utah_CCF-and-CBPP-Comment-Letter_Final.pdf; Letter from Center on Budget and Policy Priorities and Georgetown University Center for Children and Families on Utah’s “Fallback Plan Amendment,” December 6, 2019, https://ccf.georgetown.edu/wp-content/uploads/2019/12/UtahFallback_CCF-and-CBPP_Letter_FINAL.pdf.

³ Social Security Act § 1115(a)(1).

Utah’s Proposal to Provide Housing-Related Services and Supports Would Promote the Objectives of Medicaid

In contrast to the previously discussed requests, the state’s request to include its November 2019 proposal to provide voluntary Housing-Related Services and Supports (HRSS) in its demonstration would promote the objectives of Medicaid by covering evidence-based services that help individuals with complex needs achieve housing stability. This in turn can improve access to appropriate health services, health outcomes, and in some cases reduce health care expenditures.⁴ We support approval of Utah’s request to provide HRSS and encourage the state to provide these important services to all Medicaid beneficiaries who need them, rather than only initially providing them to the Targeted Adult Population.

We recommend that Utah work with supportive housing providers in the state to broaden Utah’s proposed need-based criteria to include all beneficiaries who need HRSS. Utah’s proposed need-based criteria will likely exclude many who have serious health conditions and are experiencing homelessness or at imminent risk of homelessness who need HRSS, including people currently experiencing homelessness who have serious health conditions but do not meet the definition of chronic homelessness. We also recommend that Utah reconsider its proposal to have “[i]ndividuals’ ongoing need for HRSS... verified every six months.” Improvements in health care utilization and costs stemming from supportive housing services are often measured in years. A six-month verification is an unnecessary administrative burden on providers, and a one-year timeline is a more appropriate for redetermining an individuals’ ongoing need for HRSS.

Care Coordination Services During the Last 30 Days of Incarceration Would Support Continuity of Care for Justice-Involved Medicaid Enrollees

We support Utah’s goal of using Medicaid to promote continuity of care for justice-involved people and connect people exiting jail and prison to community-based Medicaid providers.

As the state’s proposal explains, people in jail and prison have high rates of chronic physical and behavioral health conditions but often go without needed health care while incarcerated and return home without adequate access to medications or care coordination.⁵ Once home, health care often falls by the wayside as people face competing demands, including securing housing, finding work, connecting with family, and fulfilling court-ordered obligations. These gaps in care contribute to a litany of poor health outcomes⁶ and compound the harmful effects of mass incarceration and the over-policing of people of color, particularly for Black and Hispanic people.⁷

⁴ Ehren Dohler *et al.*, “Supportive Housing Helps Vulnerable People Live and Thrive in the Community,” Center on Budget and Policy Priorities, May 31, 2016, <https://www.cbpp.org/research/housing/supportive-housing-helps-vulnerable-people-live-and-thrive-in-the-community>.

⁵ Kamala Mallik-Kane and Christy A. Visher, Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration, Urban Institute, February 2008, <https://www.urban.org/sites/default/files/publication/31491/411617-Health-and-Prisoner-Reentry.PDF>.

⁶ Laura M. Maruschak, Marcus Berzofsky, and Jennifer Unangst, “Medical Problems in State and Federal Prisoners and Jail Inmates, 2011-12,” U.S. Department of Justice, Bureau of Justice Statistics, <https://www.bjs.gov/content/pub/pdf/mpsfpi1112.pdf>.

⁷ Wendy Sawyer and Peter Wagner, “Mass Incarceration: The Whole Pie 2020,” Prison Policy Initiative, March 24, 2020, <https://www.prisonpolicy.org/reports/pie2020.html>; Wendy Sawyer, “Visualizing the Racial Disparities in Mass Incarceration,” Prison Policy Initiative, July 27, 2020, <https://www.prisonpolicy.org/blog/2020/07/27/disparities/>.

Medicaid has an important role to play in ensuring that people who are incarcerated get the coverage and care they need when returning home. Utah has already taken important steps to improve Medicaid enrollment for eligible people leaving jail and prison by suspending instead of terminating Medicaid coverage. CMS also recently awarded the state with a planning grant to assess the need for and opportunities to cover multi-disciplinary mobile crisis services in Utah's Medicaid program, which would help prevent unnecessary incarceration of people with behavioral health conditions. In addition, Salt Lake and Sevier counties participate in the Stepping Up initiative, a nationwide effort to reduce the number of people with mental illness in county jails.

Using Medicaid to fund care coordination services during the last 30 days of incarceration would build on the state's other strategies to help to close gaps in care during reentry. However, Medicaid coverage during the last 30 days of incarceration alone would not be enough to improve care transitions and connection to community-based care. While we strongly support this objective, we recommend that the state agency, with input from community-based providers in the state, identify and specify to CMS the services that will be provided during the last 30 days of incarceration to improve access to medication-assisted treatment and antipsychotic medications (and any additional outcomes included in the evaluation), and how the state will "bridge relationships between community-based Medicaid providers and justice-involved populations prior to release."

One strategy the state could adopt is to use Medicaid to cover "in-reach" services where case managers, clinicians, or peer support professionals visit people in jail or prison to help them prepare to return home. In-reach services enable providers to assess people's health, establish rapport, develop an individualized care plan, and schedule future appointments. In-reach services could also connect people to housing and employment resources. People leaving incarceration report that finding work and housing are among their most urgent needs, making it difficult to prioritize their health care.⁸ Stable employment and housing greatly improve people's chances of staying out of jail and prison, but people who were formerly incarcerated experience homelessness at nearly 10 times the rate of the general public and face an unemployment rate of over 27 percent.⁹ Homelessness and housing instability create barriers to quality care and contribute to higher utilization of costly emergency services.

We also recommend that Utah include additional measures in its evaluation of whether the demonstration improves continuity of care. While tracking prescriptions is important, the state could also monitor the use of emergency, outpatient, and community-based services, and conduct qualitative surveys of people who get services through the demonstration. This would provide a more comprehensive picture of the demonstration's impact on access to care.

Finally, we recommend that Utah clarify that people with all kinds of substance use disorders — including but not limited to opioid use disorder — are eligible for such services. While deaths

⁸ Kamala Mallik-Kane, Ellen Paddock, and Jesse Jannetta, "Health Care after Incarceration: How Do Formerly Incarcerated Men Choose Where and When to Access Physical and Behavioral Health Services?" Urban Institute, February 2018, https://www.urban.org/sites/default/files/publication/96386/health_care_after_incarceration.pdf.

⁹ Lucius Couloute, "Nowhere to Go: Homelessness Among Formerly Incarcerated People," Prison Policy Initiative, August 2018, <https://www.prisonpolicy.org/reports/housing.html>; Lucius Couloute and Daniel Kopf, "Out of Prison & Out of Work: Unemployment among formerly incarcerated people," Prison Policy Institute, July 2018, <https://www.prisonpolicy.org/reports/outofwork.html>.

from opioids make up a large share of drug overdose deaths in Utah, deaths attributed to alcohol use outnumber drug overdose deaths nationwide and deaths from stimulants are on the rise in Utah.¹⁰

Conclusion

Thank you for your willingness to consider our comments. While we recommend renewing Utah's section 1115 demonstration project, we urge you to reject the state's request to continue reducing benefits for parent, protect Utahans who rely on Medicaid, and work with the state to transition its adult expansion eligibility group to state plan authority.

Our comments include numerous citations to supporting research, including direct links to the research for HHS' benefit in reviewing our comments. We direct HHS to each of the studies cited and made available to the agency through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act.

If you need additional information, please contact Joan Alker (jca25@georgetown.edu) or Judith Solomon (Solomon@cbpp.org).

American College of Obstetricians and Gynecologists
Center on Budget and Policy Priorities
Community Catalyst
Families USA
First Focus on Children
Georgetown University Center for Children and Families
National Alliance on Mental Illness
National Association of Pediatric Nurse Practitioners
National Multiple Sclerosis Society
Primary Care Development Corporation

¹⁰ F.B. Ahmad, L.M. Rossen, P. Sutton, "Provisional Drug Overdose Death Counts," Centers for Disease Control and Prevention, 2021, <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>; M.B. Esser et al., "Deaths and Years of Potential Life Lost from Excessive Alcohol Use: United States, 2011-2015," Centers for Disease Control and Prevention, 2020, <https://www.cdc.gov/mmwr/volumes/69/wr/mm6939a6.htm>.