

September 13, 2019

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 Center on Budget and Policy Priorities and the Georgetown University Center for Children and Families appreciate the opportunity to comment on Utah’s “Per Capita Cap 1115 Demonstration” proposal. The Center on Budget and Policy Priorities is a nonpartisan research and policy organization based in Washington, D.C. Founded in 1981, the Center conducts research and analysis to inform public debates and policymakers about a range of budget, tax and programmatic issues affecting individuals and families with low or moderate incomes. The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve high-quality, affordable health coverage for America’s children and families. As part of the McCourt School of Public Policy, Georgetown CCF conducts research, develops strategies, and offers solutions to improve the health of America’s children and families, particularly those with low and moderate incomes.

The centerpiece of Utah’s current proposal is a request to implement a partial expansion of Medicaid for adults with incomes below the poverty line that would give Utah enhanced matching funds at the 90 percent rate available for full expansion to 138 percent of the poverty line. The state also seeks authority to cap enrollment in its partial expansion based on available state funds, and it seeks a per capita cap on state and federal expenditures for its partial expansion.

You have already informed Utah that its proposal for a partial expansion at enhanced match and its proposal for an enrollment cap won’t be approved, decisions with which we agree. Given the per capita cap proposal assumes enhanced match will be provided, the per capita cap proposal also appears to be moot. The enforcement mechanism proposed for the per capita cap is that federal match would be provided at Utah’s regular matching rate to the extent expenditures exceeded the cap. Without enhanced match the current proposal for a per capita cap is unworkable.¹

¹ For the record, we do not believe waiver authority can or should be used to impose a per capita cap on Medicaid expenditures, whether structured as Utah’s current proposal or otherwise. But because the Utah proposal is moot, we are not providing a full analysis in these comments. Should Utah submit a new proposal that takes the decision to deny enhanced match into account, we will provide comments on that proposal.

Utah is proposing a new demonstration project separate from its longstanding Primary Care Network (PCN) demonstration, which would remain in place. Certain groups of beneficiaries—the Adult Expansion Population and Targeted Adults—who are now in the PCN would transition to the new demonstration. These include parents with incomes above Utah’s previous eligibility limits for parents and the poverty line and other adults with incomes below poverty. These are the groups that would be considered “newly eligible” and eligible for enhanced match were Utah to fully expand. Utah seeks to carry over previously approved provisions of the PCN to the new waiver, including the authority to take coverage away from people who don’t meet a work requirement and a waiver of EPSDT benefits for 19- and 20-year old enrollees. Given your decision not to allow enhanced matching funds for partial expansion, key elements of the proposal for a new demonstration covering these groups who are now covered under the PCN can’t be approved.

We have submitted comments opposing the enrollment cap, the work requirement, and the EPSDT waiver among other features of the PCN, and we continue to object to these provisions, which the state seeks to carry over to the new demonstration.² In addition, as set forth below, we want to register our opposition and objections to Utah’s proposal to take coverage away from enrollees when the state decides the enrollee has committed an “intentional program violation” should the state decide to continue seeking this authority and should you decide to consider it despite the denial of other key provisions of the state’s proposal.

At the same time, we want to express our support for the state’s proposal to provide continuous eligibility to adults. Low-income adults experience frequent changes in income that can lead to frequent interruptions of coverage and care. Continuous eligibility allows Medicaid beneficiaries to maintain provider relationships and continuity of health care services at least until their next redetermination of eligibility when they can make an orderly transition to new coverage if their income makes them ineligible for Medicaid. We also support providing housing-related services and supports to enrollees in the Targeted Adult group.

Proposal to Take Coverage Away from People Deemed to Commit an “Intentional Program Violation” is Outside the Secretary’s Waiver Authority and Fails to Promote the Objectives of Medicaid.

The state is requesting a waiver of sections 1902(a)(10) and 1902(a)(52) to enable it to prohibit reenrollment and deny eligibility for a period of 6 months for individuals in the Adult Expansion Population (including Targeted Adults) who commit an “Intentional Program Violation.” (IPV). The state estimates that 500 individuals per year would be locked out of coverage as a result of this policy. The Secretary does not have the authority under section 1115 to grant such a waiver and even if the Secretary did have such authority, a waiver that takes coverage away from eligible enrollees would by definition not promote the core purpose of Title XIX, which is to provide coverage to eligible individuals.

²We request that our previous comments be included in the administrative record for this proposal. The comments are available at https://ccf.georgetown.edu/wp-content/uploads/2018/08/PCN-Amendment-Comments_August-2018-1-1.pdf and <https://ccf.georgetown.edu/wp-content/uploads/2012/03/PCN-Amendment-Comments-final.pdf>

The state defines an IPV as one of seven different actions, ranging from “intentionally submitting a signed application containing false or misleading statements in an attempt to obtain medical assistance” to “not reporting a required change within 10 days after the change occurs, and the individual knew the reporting requirements, and the intent was to obtain benefits they were not entitled to receive.” The proposal treats an IPV as “a Medicaid overpayment.” Individuals determined to have committed an IPV would be issued an “order of default” including the overpayment amount and time period of the overpayment. The 6-month lock-out period would begin the month following the issuance of this order. Exemptions would be available for individuals who show undue hardship or who qualify for Medicaid on some basis other than Adult Expansion (e.g., pregnancy or disability).

Section 1128J(d)(4)(B) of the Social Security Act defines the term “overpayment” as “any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such title.” For this purpose, the term “person” “does not include a beneficiary.” In other words, under federal law, Medicaid beneficiaries cannot receive an “overpayment.” This statutory framework aligns with how Medicaid works. Medicaid, like Medicare is a health insurance program that makes payments not *to* beneficiaries but *on behalf of* beneficiaries to providers and managed care plans. By the plain terms of section 1115, the Secretary has the authority to waive provisions of section 1902 but not the Medicare and Medicaid Program Integrity provisions in section 1128J that govern Medicaid overpayments.

Even if the Secretary has the authority to waive section 1128J(d)(4) (which the Secretary plainly does not), the proposed 6-month lock-out wouldn’t promote the objectives of the Medicaid program. As Judge Boasberg has repeatedly reminded the Secretary in multiple opinions, the “central purpose of the Act” is the provision of medical assistance to beneficiaries, including both expansion and non-expansion populations. As the state acknowledges, implementation of the IPV lock-out may cause “approximately 500 individuals per year” to lose eligibility for six months. The state provides no basis for its estimate; the coverage loss could easily be higher, since the determination of an IPV will be made by Medicaid agency staff who are accountable for the agency’s fiscal performance, not by impartial hearing officers, much less judges independent of the fiscal pressures on the executive branch. Whatever the actual coverage losses, they are antithetical to the “central purpose” of the Medicaid statute.

If an individual intentionally applies for Medicaid and knows that the information in the application is false, and, based on that false information is enrolled in Medicaid, the individual has committed eligibility fraud. Procedures for addressing beneficiary fraud have been spelled out in federal regulation since 1983. If there is reason to believe that a beneficiary has defrauded the Medicaid program, the state Medicaid agency “must refer the case to an appropriate law enforcement agency,” 42 CFR 455.15(b). There is no provision in these regulations for prosecution of beneficiary fraud by state agency staff, much less for a six-month lock-out of an otherwise eligible individual or for recovery of an “overpayment” that the individual has not received and by statute cannot receive. This proposal would violate the federal statute and federal regulations.

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