

December 6, 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 "Fallback Plan" that would amend its Primary Care Network (PCN) demonstration. 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.

Under Utah's proposal, the state would receive enhanced match to cover adults with incomes up to 138 percent of the poverty line but would retain authority to cap enrollment based on available state funds. We support Utah's decision to fully expand Medicaid, but we oppose its proposal to cap enrollment. We agree with your determination that an enrollment cap isn't allowable, because capping enrollment would be "tantamount to partial expansion."¹ We also maintain our position in earlier comments that enrollment caps are not allowable, because they don't promote the objectives of the Medicaid program. Our earlier comments also opposed Utah's work requirement, and its EPSDT waiver, and we remain opposed to these provisions.²

¹ Letter from CMS Administrator Seema Verma to Utah Governor Gary Herbert, August 16, 2019, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/per-capita-cap/ut-per-capita-cap-correspondence-ltr-20190816.pdf>.

²We request that our previous comments be included in the administrative record for this proposal. The comments are available at https://public.medicaid.gov/connect.ti/public.comments/showUserAnswers?qid=1896899&voteid=320465&nextURL=/connect.ti/public.comments/questionnaireVotes?qid=1896899&sort=respondent_commonName&dir=asc&startrow=51&search= and <https://ccf.georgetown.edu/wp-content/uploads/2012/03/PCN-Amendment-Comments-final.pdf>

Our comments below explain 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,” its proposal to charge premiums to enrollees with incomes over the poverty line, its proposal to impose a co-payment in the guise of a premium surcharge for those who use the emergency room for non-emergency care, and its proposal for authority to make significant changes to benefits without amending its waiver. We also write in support of Utah’s proposal to provide housing-related services and supports to certain enrollees with recommendations for improving the proposal.

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 750 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.

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 750 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.

Premiums Will Decrease Coverage and Create Barriers to Health Care

Utah proposes to charge \$20 monthly premiums to enrollees with incomes over the poverty line (\$30 for a married couple). Except for the month of application and retroactive coverage months, premiums would have to be paid prior to the coverage month to avoid disenrollment. Once disenrolled, people would have to pay past due premiums to regain coverage unless they wait six months to re-enroll.

The proposal estimates that 40,000 enrollees would have to pay premiums and 3 percent of these enrollees would lose coverage for non-payment. That estimate is likely far too low given the impact of premiums on low-income people and Utah's particularly harsh plan to disenroll enrollees if they don't pay a premium for the following month without any grace period to catch up on their payments.

Extensive research (including research from Medicaid demonstration projects conducted prior to health reform) shows that premiums significantly reduce low-income people's participation in health

coverage programs.³ These studies show that the lower a person's income, the less likely they are to enroll and the more likely they are to drop coverage due to premium obligations. People who lose coverage most often end up uninsured and unable to obtain needed health care services.

The experience of enrollees in the Healthy Indiana Plan is directly on point. Over a 22-month study period, 7 percent of enrollees with incomes over the poverty line were disenrolled for non-payment of premiums. An additional 23 percent of those who could have enrolled or been disenrolled never enrolled because they didn't pay the premium needed to start coverage. Utah's design, which requires a premium before a month of coverage is similar to Indiana's, although Indiana gives enrollees 60 days to make a premium payment.

In proposing to charge premiums, Utah isn't testing anything that hasn't been tried before — both before the ACA, and in Indiana and other states currently. Utah's hypothesis is that people who pay premiums will get more preventive care. Evidence from these experiments with charging premiums beyond what is allowed under the Medicaid statute clearly shows that charging premiums makes it more likely that Medicaid beneficiaries lose their health coverage and become uninsured, or that they are less likely to sign up for coverage in the first place, making it less likely that they get preventive or other types of care.

Further, beneficiaries may have difficulty submitting their premium payment each month as many low-income people lack the banking or credit resources to establish an automatic payment. An experiment that is likely to fail and cause people to lose coverage and have poorer access to health care shouldn't be approved under section 1115.

Utah's Proposal to Charge a Premium for Non-Emergent Use of the Emergency Room is an Unlawful Co-pay

Utah proposes to impose a \$10 premium surcharge on enrollees who use the emergency room (ER) for non-emergency care. The proposal states Utah changed its previous proposal to impose a co-pay for such visits to a premium, because co-pays decrease reimbursement to providers who may not collect the co-pay. The hypothesis the state includes in its proposal still calls the charge a co-pay, however.

The Medicaid statute allows cost-sharing for non-emergency use of the ER under specific conditions, including a finding that the enrollee has an "actually available and accessible" alternate service provider.⁴ Otherwise, states cannot impose cost-sharing on emergency services under Medicaid rules. Section 1916(f) of the Social Security Act sets specific criteria for states that wants to impose cost-sharing that exceeds statutory limits:

- The state's proposal will test a previously untested use of copayments;
- The waiver period cannot exceed two years;

³ Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost-Sharing on Low-Income Populations: Updated Review of Research Findings," The Kaiser Family Foundation, June 2017, <http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Premiums-and-Cost-Sharing-on-Low-Income-Populations>.

⁴ Section 1916A(e) of the Social Security Act.

- The benefits to the enrollees are reasonably equivalent to the risks;
- The proposal is based on a reasonable hypothesis to be tested in a methodologically sound manner; and
- Beneficiary participation in the proposal is voluntary.

Utah’s proposal fails to meet or even mention these criteria. Calling what is a co-pay tied to utilization of a service a premium can’t serve as an end run around these requirements.

And charging co-pays or a premium surcharge isn’t likely to keep people from using the ER. Co-pays for non-emergency use of the ER didn’t change beneficiaries’ use of the ER or primary care, research shows.⁵ States can, however, reduce ER use by expanding access to primary care services and targeting interventions at populations that frequently use the ER.⁶

Even if the charge is treated as a premium, it shouldn’t be approved. It fails to define a non-emergency visit, doesn’t state how the state would determine that a visit wasn’t an emergency, nor does it explain how providers would participate in such a decision. It also doesn’t make any allowance for the non-availability of alternative providers when people may have no choice but to go to the ER. Moreover, adding a \$10 surcharge to a \$10 monthly premium would make it even more likely that people would lose coverage for non-payment. The state assumes 1,500 to 2,000 people would have to pay the surcharge, and it’s likely many of them would be at risk of losing coverage.

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

In contrast to much of Utah’s demonstration proposal, the state’s request to provide voluntary Housing-Related Services and Supports (HRSS) would promote the objectives of Medicaid by covering evidence-based services that help individuals with complex needs achieve housing stability, which in turn can improve access to appropriate health services, health outcomes, and in some cases reduce health care expenditures.⁷ 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

⁵ Mona Siddiqui, Eric T. Roberts, Craig E. Pollack, “The Effect of Emergency Department Co-payments for Medicaid Beneficiaries Following the Deficit Reduction Act of 2005,” *JAMA Internal Medicine*, January 26, 2015.

⁶ Jessica Schubel and Judith Solomon, “States Can Improve Health Outcomes and Lower Costs in Medicaid Using Existing Flexibility,” Center on Budget and Policy Priorities, April 9, 2015, <https://www.cbpp.org/research/health/states-can-improve-health-outcomes-and-lower-costs-in-medicaid-using-existing>

⁷ 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>.

homelessness or at imminent risk of homelessness who need HRSS, including people currently experience 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.

Utah Should Not Be Allowed to Make Significant Changes to its Demonstration Without Requesting an Amendment and Following Medicaid Transparency Rules

Utah asks for permission to make an array of changes to the PCN without submitting an amendment proposal should it decide to make such changes at a future date. While it’s not clear that all the changes would require an amendment—for example, changing benefits might be accomplished through a state plan amendment—changes such as eliminating retroactive enrollment and implementing prospective enrollment for people with incomes over the poverty line should be subject to notice and comment. Utah should not be given advance permission to make such changes without adherence to transparency rules.

Advance permission to make significant midstream changes that themselves require waiving Medicaid provisions is at odds with Medicaid demonstration authority. Demonstrations with evaluation plans shouldn’t be changed without permission from the Secretary after a determination that the statutory objectives are still being met, that the evaluation will not be adversely affected, and that budget neutrality will be maintained.

We are particularly concerned about Utah’s request to change eligibility criteria and services for HRSS. While some language in the proposal suggests that Utah would use the authority to “identif[y] additional populations to be added through the [state’s] administrative rulemaking process,” we strongly urge CMS to make clear that Utah cannot use any such authority to limit the populations eligible for HRSS or narrow the scope of HRSS services further than the criteria established upon the demonstration’s implementation. The loss of HRSS could have devastating effects on beneficiaries’ housing stability and health outcomes, including homelessness and preventable health crises.

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).