January 30, 2018

**VIA ELECTRONIC SUBMISSION**
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: New Mexico Centennial Care Section 1115 Demonstration Renewal Application

Dear Sir/Madam:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and under-served people. We appreciate the opportunity to provide these comments on New Mexico's proposed Centennial Care Renewal Application.

While NHeLP supports adult Medicaid expansion, we recommend that the Department of Health & Human Services (HHS) not approve the Centennial Care project as proposed. While it includes several true experimental pilots that we support, such as a pilot to improve access to long-acting reversible contraceptives for women who want to use them and another to provide in-home prenatal and postpartum care, the application also proposes numerous waivers likely to impede access to coverage and care for low-income New Mexicans. These provisions do not promote the objectives of the Medicaid program and should not be approved, including:

- Premiums with disenrollment and lockouts for nonpayment;
- High copayments for nonemergency use of the Emergency Department (ED);
- Waiving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for 19-20 year olds;
- Forcing traditional parents and caretakers to accept a thinner benefit package;
- Limiting family planning eligibility to individuals with no other health insurance who are under 50;

- Phasing out retroactive eligibility and requiring premium prepayment to begin coverage; and
- Terminating Transitional Medical Assistance for low-income parents.

Finally, New Mexico requests a waiver of the IMD exclusion to allow federal funding to pay for up to 30 days of inpatient care for individuals with SUD and some with mental health conditions. We support efforts to expand access to mental health and SUD treatment modalities, but we believe that resources should be focused on proven, community-based treatments supported by available evidence. The state does not justify the need for additional inpatient beds and we are wary of the potential consequences of investing funds in institutional care on New Mexico's laudable history of effective community-based care.

In sum, these changes, separately and together, do not comply with the requirements of § 1115 of the Social Security Act and will harm Medicaid enrollees' access to vital health care services.

**I. HHS authority and § 1115**

To be approved pursuant to § 1115, New Mexico's application must:

- propose an "experiment[], pilot or demonstration,"
- waive compliance only with requirements in 42 U.S.C. § 1396a,
- be likely to promote the objectives of the Medicaid Act, and
- be approved only "to the extent and for the period necessary" to carry out the experiment.[1]

The purpose of Medicaid is to enable states to furnish medical assistance to individuals whose income is too low to meet the costs of necessary medical care and to furnish rehabilitation and other services to help these individuals attain or retain the capacity for independence and self-care.[2] New Mexico's proposal cannot be approved as proposed because it is inconsistent with the provisions of § 1115.

**I. Imposing mandatory premiums and cost sharing**

New Mexico proposes several new waivers to impose required premiums on low-income enrollees and high copayments above legal limits. These proposals are not innovative and, if implemented, would present substantial barriers to coverage and care.

The effects of cost sharing and premiums on health care utilization have been widely studied and are well understood.[3] Congress was well aware that premiums and cost sharing can create substantial barriers to coverage and care for low-income individuals when it created and then modified the Medicaid cost sharing limits over the years. Notably, in 1982, Congress enacted flexibilities for Medicaid to impose limited cost sharing and

[1] 42 U.S.C. § 1315(a).
[2] *See* 42 U.S.C. § 1396-1.
[3] See, e.g., David Machledt & Jane Perkins, NAT'L HEALTH LAW PROGRAM, *Medicaid Premiums & Cost Sharing and Premiums* (March 2014), http://www.healthlaw.org/publications/browse-all-publications/Medicaid-Premiums-Cost-Sharing.

premiums on some Medicaid beneficiaries.[4] At the time, Congress deliberately separated the cost sharing provisions into a separate and independently binding section of the Medicaid statute outside § 1396a.[5] Again in 2005, with Deficit Reduction Act, Congress broadened state flexibilities by adding a second independent premium and cost sharing provision section at § 1396o-1.

New Mexico's attempt to use § 1115 to impose cost sharing and premiums beyond the existing statutory flexibilities contradicts clear Congressional intent, attempts to waive independent provisions outside §1396a, is not consistent with the objectives of the Medicaid program, and serves no experimental purpose. These waivers may not be approved.

In addition to all the normal requirements of § 1115 demonstrations outlined above, any waiver of cost sharing limits must also meet the experimental conditions laid out in 42 U.S.C. § 1396o(f) (described below.). The State's proposal has not satisfied these requirements.

Most importantly, these proposals represent a step backward for New Mexico's Medicaid program and would likely lead to low income individuals and families delaying or forgoing necessary care. None of these proposals should be approved.

### a. Premiums for expansion adults with incomes over 100% FPL

The Medicaid statute prohibits premiums for expansion adults and generally for almost all Medicaid enrollees with incomes below 150% FPL.[6] New Mexico proposes to impose mandatory premiums for expansion adults with incomes just above poverty level.

New Mexico's requests for § 1115 authority to waive certain premium and cost sharing limits are not approvable because they will not test anything novel, because Congress clearly intended the premium and cost sharing provisions as independent requirements outside of §1396a, and because these waivers are not likely to promote the objectives of the Medicaid program.

Simply put, premiums depress enrollment. Ample evidence, including studies from a series of Medicaid and CHIP waiver projects in the late 1990s and early 2000s, clearly and consistently shows the same patterns.[7] People facing premiums are less likely to begin

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[4] Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 133 (adding 42 U.S.C. § 1396o.)
[5] At the time, the House of Representatives Committee on Energy and Commerce noted: "[A] large number of States have sought waivers of current law relating to the imposition of cost sharing under the demonstration authority at section 1115 of the Act. The Committee believes that this bill gives the States sufficient flexibility in this regard to make further exercise of the Secretary's demonstration authority unnecessary." H. R. Rep. No. 97-757 (1982), Report on Medicaid and Medicare Part B Budget Reconciliation Amendments of 1982 (August 17, 1982).
[6] 42 U.S.C. §§ 1396o, 1396o-1; 42 C.F.R. § 447.55(a).
[7] *See*, *e.g.*, Brendan Saloner et al, *Medicaid and CHIP Premiums and Access to Care: A Systematic Review*, 137 PEDIATRICS e20152440 (2016); Samantha Artiga et al., KAISER FAM. FOUND., *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings* (June 1, 2017), http://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/; David Machledt & Jane Perkins, *supra* note 3.

coverage, more likely to drop coverage and more likely to become uninsured.[8] Those effects magnify as income decreases.[9] Uninsured individuals experience poorer health outcomes and much higher financial strain due to medical costs.[10] Medicaid is designed as a health coverage program for adults who cannot afford other insurance. Proposals to impose premiums directly contradict the primary objective of this program – to furnish them medical assistance.

Section 1115 waivers also must test a valid hypothesis with a reasonable experimental design. New Mexico's premium proposals fail on both counts and should not be approved.

### b. Possible premium riders for dental and vision services

Medicaid law does not permit premium riders for elements of Medicaid coverage. While this was a common feature of private health coverage prior to the ACA, Medicaid is not designed to mimic commercial insurance. Rather, its purpose is to meet the unique needs of low-income individuals. The law does gives states flexibility to select specific optional benefits to cover, but once selected, the State must offer the same benefit package to all Medicaid enrollees eligible for state plan benefits. States are also permitted to charge reasonable cost sharing for many services. However, charging a monthly rider for coverage of a particular service is not cost sharing.

New Mexico's proposal to charge extra for certain services would set a terrible precedent for the Medicaid program. It adds administrative burden and unnecessary complexity, while likely putting these important services out of reach for many beneficiaries. Charging more for added benefits is therefore not consistent with the objectives of Medicaid.

We also note that the state is not even proposing a specific policy change, but rather seeking approval for the possibility of an undescribed future policy. Therefore, the state has not provided enough detail to allow for meaningful comment. Section 1115 only grants the Secretary permission to waive provisions of § 1396a "to the extent and for the period necessary" to conduct an experiment likely to further Medicaid objectives. Here we have no concrete proposal, let alone a valid experiment or a proposal ripe or appropriate for approval.

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[8] In 2003, for example, Oregon experimented with charging sliding scale premiums ($6-$20) and higher copayments on some groups in an already existing § 1115 demonstration for families and childless adults living below poverty. Nearly *half* the affected demonstration enrollees dropped out within the first nine months after the changes. Bill J. Wright et al., *The Impact of Increased Cost Sharing on Medicaid Enrollees*, 24 HEALTH AFF. 1106, 1110 (2005); Jill Boylston Herndon et al, *The Effect of Premium Changes on SCHIP Enrollment Duration*, 43 HEALTH SERVS. RES. 458 (2008);

[9] "Research examining the impact of premiums in public programs has found that participation falls off sharply as the premium amount increases" Julie Hudman & Molly O'Malley, KAISER COMM'N ON MEDICAID & THE UNINSURED, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations (*Mar. 2003), http://www.academia.edu/6759690/Health_Insurance_Premiums_and_Cost-Sharing_Findings_from_the_Research_on_Low-Income_Populations. *See also,* Salam Abdus et al, *Children's Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children*, 33 HEALTH AFF. 1353 (2014); Leighton Ku and Teresa A. Coughlin, *Sliding-Scale Premium Health Insurance Programs: Four States' Experiences*, 36 INQUIRY,471 (1999); Saloner et al, *supra* note 7; Samantha Artiga et al., *supra* note 7.

[10] KAISER FAM. FOUNDATION, *Key Facts about the Uninsured Population* (Nov. 29, 2017), https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/.

### c. Copayments for nonemergency use of the emergency department (ED) and non-preferred medications

New Mexico has requested § 1115 demonstration authority to charge heightened copays of $25 per visit for nonemergency use of the ER and $10 for non-preferred drugs. Such high copays are only permissible for individuals above 150% of FPL; individuals below 150% can only be charged nominal copayments for these services.[11] As noted above, Congressional has made its intent regarding copayment flexibilities and limits abundantly clear.

Section 1115 cannot be used to waive these excessive copayment for multiple reasons. First, as mentioned earlier, the cost-sharing limits in §§ 1396o and 1396o-1 are independent, free-standing provisions of the Medicaid statute outside § 1396a. Second, Congress expressly prohibited any waiver of cost sharing provisions set forth in federal law unless the experiment meets the tightly circumscribed requirements laid out in § 1396o(f). New Mexico's copayment proposal includes no reference to these requirements, and the few details provided fail on multiple counts. In particular: (1) The use of ED copayments has been extensively studied (as described below) and, therefore, does not "test a unique and previously untested use of copayments." 42 U.S.C. § 1396o(f)(1); (2) The waiver seeks to impose the payments for five years—well beyond the two year limit imposed by statute, *id.* § 1396o(f)(2); (3) The proposed copayments offer no benefits to Centennial Care members, only risks of deterring appropriate ED use, contrary to the requirements of 42 U.S.C. § 1396o(f)(3); (4) The copayments would apply to all nonexempt Centennial Care members, without any experimental design, let alone "the use of control groups of similar recipients of medical assistance in the area," *id.* § 1396o(f)(4); and finally (5) The copayments are not voluntary, nor do they provide "provision for assumption of liability for preventable damage to the health of recipients . . . resulting from involuntary participation." *Id.* at § 1396o(f)(5). This statute prohibits the Secretary from authorizing New Mexico's proposed ED copayments.

Finally, a higher copay would serve no valid demonstration purpose nor promote the objectives of the Medicaid Act. Even nominal cost sharing has been shown to impede low-income populations from accessing care.[12] A growing body of literature suggests that nonemergency ED copays, when implemented, have not reduced nonemergency ED utilization in Medicaid.[13] CMS itself, in a recently released bulletin on best practices to

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[11] 42 U.S.C. § 1396o(a)(3), (b)(3).

[12] Leighton Ku, Elaine Deschamps, and Judi Hilman, CTR. ON BUDGET & POL'Y PRIORITIES, *The Effects of Copayments on the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program* (2004), www.cbpp.org/files/11-2-04health.pdf; Joel F. Farley, *Medicaid Prescription Cost Containment and Schizophrenia: A Retrospective Examination* 48 MED. CARE 440 (2010); Daniel M. Hartung et al., *Impact of a Medicaid Copayment Policy on Prescription Drug and Health Services Utilization in a Fee-for-Service Medicaid Population*, 46 MED. CARE 565 (2008).

[13] General evidence suggests that increased copays may discourage unnecessary *and* necessary ED care, especially for low-income enrollees. *See* J. Frank Wharam et al., *Emergency Department Use and Subsequent Hospitalizations among Members of a High-Deductible Health Plan*, 297 JAMA 1093, 1098 (2007) and Joe V. Selby et al., *Effect of a Copayment on Use of the Emergency Department in a Health Maintenance Organization*, 334 NEW ENG. J. MED. 638 (1996). Evidence specific to Medicaid and CHIP finds that there is no discernible effect on ED utilization (emergency or nonemergency) for Medicaid enrollees. *See* Karoline Mortensen, *Copayments Did Not Reduce Medicaid Enrollees' Nonemergency Use of Emergency*

reduce unnecessary ED use, acknowledges that strategies like expanding access to primary care or providing health homes for frequent ED users may be effective, but suggests that increased copays for nonemergency use are problematic.[14] A heightened copay, therefore, offers no positive experimental value and would undermine the objective of the Medicaid Act to furnish medical assistance for enrollees.

If the state still insists on charging copays in the face of this evidence, recent regulations provide substantial flexibility to charge as much as $8 for nonemergency ED visits and the same for non-preferred drugs for populations below 150% FPL.[15] New Mexico should limit its copayments to these statutory limits and standards, which require no waiver or experiment to implement. The copayments as proposed simply do not meet the requirements for an approvable 1115 or 1916(f) waiver.

Finally, even if the Secretary approved any heightened copayments then HHS would need to carefully monitor New Mexico's compliance with all the other statutory requirements for cost sharing, including that:

- All statutory exemptions, including those for pregnant women, are faithfully applied.[16]
- The ED copay screening and referral process is robustly implemented. Prior to charging a copay for non-emergent ED services, there must be an "actually available and accessible" alternate care option and that the facility must provide notice that the care to be provided is non-emergent care subject to additional charges, identify the alternative care option, and provide the enrollee with a referral.[17]
- The required exception process for non-preferred drug copays is well-publicized, easy to access, and timely.[18]

### d. Elimination of the 5 percent aggregate cap on cost sharing

New Mexico is not the first state to propose loosening Medicaid's out-of-pocket spending maximum, but it is among the first to request excluding certain copayments from the aggregate limit. To our knowledge, CMS has never approved such a waiver, and should not approve this one. First, the Secretary may not waive statutory cost sharing limits using § 1115 because they are outside § 1396a. Second, New Mexico has not presented a valid experimental purpose and design for waiving the cap that is likely to promote Medicaid objectives, let alone a controlled study meeting the additional requirements at §1396o(f).

The monthly/quarterly 5 percent household limit is an important shield to excessively high out-of-pocket costs. Medical bills tend to cluster into a single month or quarter. For families

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*Departments*, 29 HEALTH AFF. 1643 (2010); David J. Becker et al., *Co-payments and the Use of Emergency Department Services in the Children's Health Insurance Program*, 70 MED. CARE RES. REV. 514 (2013); Mona Siddiqui, Eric T. Roberts, and Craig E. Pollack, *The Effect of Emergency Department Copayments for Medicaid Beneficiaries Following the Deficit Reduction Act of 2005*, 175 JAMA INTERNAL MED. 393 (2015).

[14] CMS, *Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings* (Jan. 16, 2014), http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-16-14.pdf; see *also* WASH. STATE HEALTH CARE AUTHORITY, *Emergency Department Utilization: Assumed Savings from Best Practices Implementation* (2013).

[15] 42 C.F.R. § 447.54.

[16] 42 C.F.R. § 447.56(a).

[17] 42 U.S.C. § 1396o-1(e)(1).

[18] 42 C.F.R. § 447.53(e).

with children on public insurance, the average peak month accounts for 43 percent of annual out-of-pocket spending, while the average peak quarter accounts for 58 percent of annual spending.[19] So the aggregate cap is a very important protection to limit medical debt.

The state's proposal, particularly with regard to proposed $25 ED and $10 non-preferred drug copayments, presents serious risks to Medicaid enrollees' health and financial status. Multiple peer-reviewed studies convincingly demonstrate the near impossibility of correctly classifying "nonemergency" ED visits at the individual level.[20] The relationship between presenting symptoms and ultimate diagnosis is confused and overlapping, meaning the ED copayment can easily be misapplied even for true emergencies.[21] Nonetheless, New Mexico proposes nonemergency ED copays triple the legal limit, and also seeks to exclude them from the aggregate cap. This would expose adults at the lowest incomes to extraordinary and disproportionate financial risk, even for a single trip to the ED.

Excluding these copayments from the aggregate cap would likely make adults at the lowest incomes avoid the ED even for serious health emergencies due to fear of owing a high copayment. Delayed care in emergencies can have life threatening consequences. CMS should not approve this waiver.

**e. Missed appointment fees**

We believe that missed appointment copayments fall outside the scope of what the Medicaid statute permits, as they do not relate directly to a reimbursable service actually rendered. CMS has considered missed appointments part of a providers' normal cost of doing business, though it acknowledges that an MCO could arrange to directly reimburse its providers for missed appointments.[22] In this proposal, New Mexico has provided no description of how it would implement this policy (i.e. tracking missed appointments) or how it would evaluate the policy experiment according to the requirements of 1916(f). The State offers no guardrails for what would qualify as a reasonable excuse. Nor has it established that missed appointments are even a problem for the Medicaid program. With so little detail to consider, we find no reason for CMS to approve this proposal to charge missed appointments fees.

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[19] Thomas M. Selden et al., *Cost Sharing in Medicaid and CHIP: How Does It Affect Out-of-Pocket Spending?* 28 HEALTH AFF. w607, w614 (online ed. 2009), http://content.healthaffairs.org/content/28/4/w607.

[20] Robert A. Lowe & Andrew B. Bindman, *Judging Who Needs Emergency Department Care: A Prerequisite for Policy-Making*, 15 AM. J. EMERGENCY MED. 133 (1997); Gail M. O'Brien et al., *"Inappropriate" Emergency Department Use: A Comparison of Three Methodologies for Identification*, 3 ACADEMIC EMERGENCY MED. 252 (1996); Maria C. Raven et al., *Comparison of Presenting Complaint vs Discharge Diagnosis for Identifying "Nonemergency" Emergency Department Visits*, 309 JAMA 1145 (2013).

[21] This is why CMS deemed diagnosis-based classification systems inappropriate for this purpose. The legal standard is based on the judgment of a prudent layperson based on her symptoms. 78 Fed. Reg. 42278.

[22] CMS and the ORAL HEALTH TECHNICAL ADVISORY GROUP, *Policy Issues in the Delivery of Dental Services to Medicaid Children and Their Families*, 10 (Sept. 22, 2008), http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/policy-issues-in-the-delivery-of-dental-services.pdf.

## II. Delaying and reducing coverage through lockouts and eliminating retroactive eligibility

Recent data from Indiana's HIP 2.0 program only reinforces that lockouts and waiting periods create a substantial burden that keeps otherwise eligible individuals from getting and keeping Medicaid coverage.[23] We believe those approvals should never have been granted, and given the subsequent evidence, certainly no additional waivers for lockouts should be approved.

### a. Prospective coverage and lockouts for nonpayment of premiums

New Mexico's proposes to require expansion eligible individuals with incomes between 101-138% FPL to pay a premium prior to beginning coverage, and to lock existing enrollees out of coverage for at least 3 months for falling behind on premium payments. Both policies create situations where otherwise eligible individuals will face foregoing needed care or incur large medical debts because they have no coverage. Both are inconsistent with the objectives of Medicaid. While commercial insurance may have some similar features, Medicaid is expressly designed to meet the unique needs of low-income population that makes them unable to afford other health insurance. These sorts of barriers are exactly what Medicaid is intended to avoid.

Many eligible individuals do not sign up for Medicaid until they have a serious health event. They may not know how to apply or they may not know they are potentially eligible. Requiring such individuals to pay a premium and then wait until the following month for coverage to begin means that some will face huge medical bills after an emergency health care event even though they are otherwise Medicaid eligible. This proposal is mean-spirited and is not experimental. It has entirely predictable negative consequences. Indiana implemented a similar prepayment requirement for adults in the 101-138% FPL group, and found that fully 23% of otherwise eligible individuals got tripped up by this financial barrier and did not fully enroll. Nearly half never reapplied.[24]

Similarly, the Medicaid Act does not authorize any "lockouts" for non-payment of premiums. Regulations prohibit any eligibility consequence beyond termination.[25] Lockouts unnecessarily increase the number of uninsured, contradict efforts to promote continuity of care, and will harm New Mexico's provider infrastructure (as providers will continue to treat uninsured patients).

New Mexico's proposal appears to delay reenrollment indefinitely until back payments are repaid. We note further that there is also no authority in Medicaid to require, as New Mexico has proposed, that applicants pay debts that accrued due to non-payment of

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[23] In all, 57,189 of roughly 195,000 (29%) who ever faced a required premium were disenrolled or not enrolled due to nonpayment at least once. LEWIN GROUP, *Indiana HIP 2.0: POWER Account Contribution Assessment*, ii (Mar. 31, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf.

[24] *Id.* at 12.

[25] 42 C.F.R. § 447.55.

premiums associated with prior terminations and lock-outs. Suffice it to say that HHS cannot approve illegal application recoupments, for illegal premiums, that have been charged prior to illegal terminations and corresponding illegal lock-outs.

Medicaid law requires the opposite of delaying eligibility. It requires States to establish eligibility and provide coverage with reasonable promptness.[26] There is no plausible argument that delaying enrollment into Medicaid for numerous months helps furnish medical assistance, meaning that the lockout and prepayment proposals are inconsistent with the objectives of Medicaid.

### b. Phasing out retroactive eligibility

Medicaid requires states to provide retroactive coverage for enrollees.[27] New Mexico has requested § 1115 demonstration authority to waive this requirement for most Medicaid enrollees to reduce administrative costs. This important Medicaid protection enacted by Congress to meet the unique challenges faced by the low-income populations helps shields Medicaid-eligible individuals from financially devastating medical debts. It also improves provider's financial stability (and willingness to participate in Medicaid) by reducing uncompensated care claims.

New Mexico currently receives about 10,000 retroactive eligibility claims requests per year, even with a prospective eligibility system in place for safety net hospitals and clinics.[28] Imposing major financial burdens 10,000 enrollees per year, or forcing them to simply forego needed care, is hardly justifiable to save some administrative hassle for managed care organizations, which is the primary stated purpose for this waiver.[29] The State acknowledges that "the majority of commenters expressed strong opposition to eliminating" retroactive eligibility, but the only response has been to delay the elimination by a single year.[30] The state suggests that it will have a real-time eligibility system in place by the end of 2018, but new enrollment systems are notoriously difficult to implement smoothly, and even if successful, real-time eligibility determinations would not help individuals who incur expenses before they are even able to submit an application. Nor would it help individuals subject to required premiums (if approved) who need to wait until the end of the month after their first payment for coverage to begin.

This waiver would apply broadly to most Medicaid enrollees. The only explicit exemptions listed in the application are for Native American enrollees and nursing facility residents, though in some attached powerpoints the exemptions allude to exempting fee-for-service enrollees.[31] It is not clear from the application whether the exemption for nursing facility residents could also create a new institutional bias in the Medicaid program. Such a policy

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[26] 42 U.S.C. § 1396a(a)(8).
[27] 42 U.S.C. § 1396a(a)(34); 42 C.F.R. § 435.915.
[28] STATE OF NEW MEXICO HUMAN SERVS. DEPT., *Application for Renewal of Section 1115 Demonstration Waiver Centennial Care Program: Centennial Care 2.0* [hereafter "NM Application"], at 43, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/nm-centennial-care-pa.pdf.
[29] *Id.*
[30] *Id.* at 1062.
[31] *Id.* at 44.

might steer an individual to nursing facility care where her initial expenses qualify for retroactive coverage, instead of community-based care with HCBS, where those retroactive expenses would go uncompensated (or be charged directly to the individual or her family.)

There simply is no demonstration value to the State's request to waive retroactive eligibility. The state's only apparent justification is administrative simplicity – or saving money. The entirely predictable result will be: (1) thousands more low-income individuals experiencing medical debt collections and bankruptcy; (2) more providers incurring losses; and (3) more individuals experiencing gaps in coverage when some providers refuse to treat them because the providers know they will not be paid retroactively by Medicaid. This policy promises very concrete harms, particularly since the State proposes to apply this provision to a broad swath of Medicaid enrollees, who may have already required hospital or home- and community based long term care prior to applying.

### c. Eliminating Transitional Medical Assistance

New Mexico also proposed to eliminate coverage for Transitional Medical Assistance (TMA), a mandatory eligibility category that provides temporary coverage up to 12 months for parents and caretakers whose income increases above the parent and caretaker eligibility limit. The state suggests that most parents currently enrolled in TMA would be eligible for the adult Medicaid expansion group or for Marketplace coverage. But Marketplace coverage carries substantially higher out-of-pocket costs compared to TMA, and so would coverage in the adult Medicaid group if the State's proposed premiums for expansion adults are approved.

The Secretary has no TMA would clearly raise out-of-pocket costs substantially for some authority to waive the statutory requirement for TMA through § 1115. TMA is located in § 1396r-6, which is an independent and free-standing provision of the Medicaid Act outside §1396a. Eliminating parents and caretakers and would also likely lead to higher uninsurance rates. When Wisconsin cut coverage for low-income parents expecting most to transition to subsidized Marketplace or employer-based coverage, over 40% never made the transition and are presumed uninsured.[32] Therefore, eliminating TMA is not likely to promote the objectives of Medicaid and should not be approved.

## III. Limiting benefits

### a. Restricting parents and caretaker coverage to a limited Alternative Benefit Plan

The state has proposed to limit access to regular state plan benefits for parents and caretakers covered under § 1931 of the Social Security Act. This mandatory eligibility group would instead receive a skimpier benefit package under the state's expansion Alternative Benefit Plan (ABP). Specifically the ABP does not cover vision or hearing aids and has stricter limits on physical, occupational and speech therapy, home health services and other services.[33]

[32] Kids Forward, *The Wisconsin Approach to Medicaid Expansion*, 3 (Dec. 2017), http://kidsforward.net/publication/new-report-the-wisconsin-approach-to-medicaid-expansion/.
[33] NM Application, at 22.

There is no experimental value in this proposed benefit cut for very low-income parents. The state cites only the need to "ensure the Medicaid program's long term affordability and sustainability" – in short, to reduce the budget. The state mentions consolidating individuals into a single benefit package, but in the same paragraph admits that medically frail individuals will continue to receive state plan services because they are "exempt." So the state will now have to screen all parents and caretakers for medical frailty – a complex and flawed process – instead of the administratively simpler path of covering all persons in this eligibility group through the state plan.

If the state's true goal were administrative simplification, it could simply align its ABP with the state plan benefit package like most other expansion states, thus providing all Medicaid eligible adults with a similar benefit package. Rather, New Mexico seeks to ratchet down coverage for as many people as possible. This waiver should not be approved.

**b. Eliminating Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for 19- and 20 year olds**

In a similar effort to restrict crucial benefits for apparent budget reasons, the state also seeks to eliminate access to EPSDT for 19 and 20 year olds. The EPSDT standards recognize that children and adolescents are not little adults and that they are going through a time of rapid brain and body development. Thus, their health care needs differ from those of adults. The benefit is designed to ensure that, regardless of where they live, low-income children in the United States can obtain ongoing assessment and, if problems arise, care and treatment that recognizes 21st century standards of care:

> The EPSDT benefit is more robust than the Medicaid benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The goal of EPSDT is to assure that individual children get the health care they need when they need it – the right care to the right child at the right time in the right setting.[34]

Congress designed Medicaid with clear requirements to cover EPSDT for children and youth under age 21.[35] These statutory provisions have been repeatedly amended and strengthened over the years, as research repeatedly documents that poverty-level children and youth need a range of enabling and developmental interventions. Even when it created the option for more limited-benefit ABPs, Congress explicitly ***required*** that 19 and 20 year olds continue to receive EPSDT benefits.[36] To waive EPSDT would disregard to Congress' clear and repeated signals regarding its intent with respect to EPSDT coverage. Various other states, including Arkansas, Utah and Indiana, have recently made similar proposals to waive EPSDT for older youths, but CMS did not approve a single one.

Additionally, the Secretary lacks authority to waive the EPSDT requirement for ABPs because that requirement is not in § 1396a, but § 1396u-7. We note also that New Mexico would not be eligible to receive enhanced matching funds for an ABP that did not include

[34] CMS, *EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* (June 2014), *available at* https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf.
[35] 42 U.S.C. § 1396d(a)(4)(B).
[36] 42 U.S.C. § 1396u-7(a)(1)(A).

EPSDT, since § 1396b(i)(26) only authorizes Medicaid expansion matching funds for providing ABP benefits that include EPSDT.

EPSDT is the most essential and enduring feature of coverage for children and youth. To diminish its scope is clearly inconsistent with the objectives of the Medicaid program. As noted above, Congress has included EPSDT in the Medicaid Act as a detailed, comprehensive program to cover preventive and treatment services for children and youth under age 21. EPSDT entitles individuals ages 19 and 20 to receive comprehensive screening services, as well as any of the services listed in the Medicaid Act when necessary to "correct or ameliorate" illnesses and conditions discovered during a screening.[37]

Research confirms that individuals ages 19 and 20 face unique and significant health challenges. For example, this population experiences high rates of mental illness and substance use disorder. Approximately 21% of 19 year-olds and 24% of 20 year-olds have had a diagnosable mental illness other than a developmental or substance use disorder in the past year.[38]

This population also experiences high rates of sexually transmitted infections. According to the Centers for Disease Control and Prevention (CDC), individuals ages 15 to 24 face the highest risk of acquiring STIs "for a combination of behavioral, biological, and cultural reasons."[39] CDC data show that individuals ages 15 to 24 account for 25% of the sexually active population, but 50% of new STIs.[40] In 2015, young people ages 13 to 24 accounted for more than 1 in 5 new HIV diagnoses.[41] Young people with HIV are the least likely out of any age group to be linked to care (55%) and to have a suppressed viral load (44%).[42]

Eliminating EPSDT will make it less likely that these serious health conditions will be prevented or detected early through screening services, which is required to include screening for mental illness, substance use, and STIs for 19 and 20 year-olds.[43] Notably, research shows that early diagnosis and treatment of many of these conditions can dramatically improve health outcomes.[44]

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[37] 42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).
[38] Substance Abuse and Mental Health Servs. Admin. (SAMHSA), *Results from the 2016 National Survey on Drug Use and Health: Mental Health Detailed Tables, Adult Mental Health Tables, Table 8.1B*, https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2016/NSDUH-DetTabs-2016.htm#lotsect9pe (last accessed Jan. 30, 2018).
[39] Ctrs. for Disease Control and Prevention, Div. of STD Prevention, *Sexually Transmitted Disease Surveillance 2015* 62 (2016), https://www.cdc.gov/std/stats15/STD-Surveillance-2015-print.pdf.
[40] Ctrs. for Disease Control and Prevention, *Fact Sheet: Incidence, Prevalence, and Cost of Sexually Transmitted Infections in the United States* (2013), http://www.cdc.gov/std/stats/sti-estimates-fact-sheet-feb-2013.pdf.
[41] Ctrs. for Disease Control and Prevention, *HIV among Youth*, http://www.cdc.gov/hiv/risk/age/youth/index.html?s_cid=tw_drmermin-00186 (last updated Oct. 26, 2017).
[42] *Id*. Suppressed viral load means having a very low or undetectable amount of HIV virus in the bloodstream. This indicates low risk of HIV transmission and lower risk of opportunistic infections.
[43] AM. ACAD. OF PEDIATRICS & BRIGHT FUTURES, *Recommendations for Preventive Pediatric Health Care* (2017), https://www.aap.org/en-us/Documents/periodicity_schedule.pdf.
[44] *See, e.g.*, Ctrs. For Disease Control and Prevention, *2015 STDs Treatment Guidelines, HIV Infection: Detection, Counseling, and Referral*, https://www.cdc.gov/std/tg2015/hiv.htm (last updated Jan. 4, 2017) ("Early diagnosis of HIV infection and linkage to care are essential not only for the patients' own health but

Unfortunately, adolescents also have considerably lower rates for well-care visits (46%) than other age groups, even with EPSDT in place.[45] Stripping the EPSDT benefit altogether would likely make this situation worse, when available evidence points to a need to increase attention on access to care and screening for this critical age group. In addition, without EPSDT and with the thinner ABP benefit package, these youth will simply not have access to certain medically necessary treatment services, such as vision services and limited speech and rehabilitation benefits, that are available under EPSDT.

Finally, New Mexico provides no experimental hypothesis, design or justification for this benefit cut beyond a vague reference to program fiscal sustainability. Moreover, while the state merely suggests – without providing detail – that it would exempt medically frail youth only adds another layer of bureaucracy and does not cure the harm of cutting EPSDT. Timely access to these crucial Medicaid services for developing minds and bodies improves long-term outcomes in health, educational achievement and future earnings.[46]

### c. Restricting access and eligibility for family planning services and supplies

We support New Mexico's decision to provide family planning services and supplies to individuals who are not otherwise eligible for Medicaid. However, New Mexico now proposes changes that would restrict access to these critical services. Most notably, the proposal would limit eligibility for this limited benefit category to individuals under 50 years old who have no insurance (with the exception of certain individuals enrolled in Medicare).

Restricting access to this program by insurance status will raise numerous problems. For example, a younger woman who may be insured under her parents' plan might seek to maintain confidential access to contraceptives through Medicaid. Other insured individuals may face obstacles to receiving family planning services and supplies, such as harsh medical management techniques or an employer that refuses to cover some or all family planning services.

New Mexico has also selected an apparently arbitrary age limit for family planning services simply to cut back on enrollment. The average age for menopause is 51 years of age and according to the National Institute on Aging menopausal transition begins between the ages of 45 and 55.[47] Some women need family planning services well beyond the age of 50. Obviously, many men need family planning services well beyond the age of 50.

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also to reduce the risk for transmitting HIV to others. As of March 2012, U.S. guidelines recommend all persons with HIV infection diagnoses be offered effective antiretroviral therapy."); NAT'L INST. OF MENTAL HEALTH, *Recovery after an Initial Schizophrenia Episode*: *What is RAISE?* (2017), https://www.nimh.nih.gov/health/topics/schizophrenia/raise/what-is-raise.shtml (describing research findings that coordinated specialty care (CSC) is more effective than usual treatment approaches to schizophrenia and that CSC is most effective when received early).

[45] CMS, *Paving the Road to Good Health: Strategies for Increasing Medicaid Adolescent Well-Care Visits*, 7 (Feb. 2014).

[46] Alisa Chester and Joan Alker, GEORGETOWN UNIV. HEALTH POL'Y INST., *Medicaid at 50: A Look at the Long-Term Benefits of Childhood Medicaid* (July 2015), http://ccf.georgetown.edu/wp-content/uploads/2015/08/Medicaid-at-50_final.pdf.

[47] The Menopause Years, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, https://www.acog.org/Patients/FAQs/The-Menopause-Years (last visited Jan. 28, 2018); What is Menopause, NAT'L INST. ON AGING, https://www.nia.nih.gov/health/what-menopause (last visited Jan. 28, 2018).

The Medicaid statute does not authorize creation of these additional conditions of eligibility nor would they be likely to promote Medicaid objectives. Rather, this ill-conceived proposal will reduce access to family planning services and as a result, lead to higher unintended pregnancies. It also directly undermines another element of New Mexico's application - a true pilot initiative expressly intended to improve access to long-acting reversible contraceptives. The Secretary should not approve this arbitrary and poorly designed family planning waiver.

## IV. Waiving the exclusion on federal matching funds for Institutions for Mental Disease

We support New Mexico's effort to expand access for prevention and treatment of Substance Use Disorders (SUD). This growing crisis has become a national public health emergency, and the Medicaid expansion is a powerful tool states can use to leverage funding for treatment and prevention efforts. We recognize that the state already covers effective therapies like Medication Assisted Treatment (MAT), and is proposing to expand evidence-based Screening, Brief Intervention, and Referral to Treatment (SBIRT) to identify individuals who have a problem and point them toward resources that can help.

However, we do not support New Mexico's proposal to seek a waiver of the IMD exclusion for inpatient stays up to 30 days.[48] Managed care regulations already permit MCOs to receive federal funding for stays up to 15 days per month.[49] A waiver to lengthen that period for the IMD exclusion is unnecessary, unwise, and unapprovable.

First, the Secretary may only waive provisions in § 1396a, and the IMD exclusion is codified in § 1396d.

Second, long-term treatment in IMDs is not a best practice for people with mental health diagnoses and those needing substance use disorder treatment.[50] Individuals with short-term stays are more likely to leave the hospital on their planned discharge date and have a greater chance of finding employment.[51] While NHeLP supports using Medicaid to increase

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[48] NM Application at 25.
[49] 42 C.F.R. § 438.6(e).
[50] A review of older studies shows there is little difference in many outcome measures between short and long-term stays in large psychiatric hospitals, but longer term stays are significantly associated with poorer social functioning. Overall, thus, short-term stays would seem preferable. O. Babalola et al., *Length of Hospitalisation for People with Severe Mental Illness,* 1 COCHRANE DATABASE OF SYSTEMATIC REVS., Art. CD000384 (2014). Treatment of substance use disorder does not require institutional placement or treatment but instead may occur in a variety of settings, a decision made by the treating clinician based on an array of factors. ASAM, The American Society of Addiction Medicine, ASAM Standards of Care for the Addiction Specialist Physician (2014), https://www.asam.org/docs/default-source/practice-support/quality-improvement/asam-standards-of-care.pdf?sfvrsn=338068c2_10; Corey Davis and Hector Hernandez-Delgado, NAT'L. HEALTH LAW PROGRAM, *Medicaid and the Affordable Care Act: Vital Tools in Addressing the Opioid Epidemic* (Feb. 7, 2017) , http://www.healthlaw.org/publications/browse-all-publications/Medicaid-ACA-Vital-Tools-Addressing-Opioid-Epidemic#.WmdbK6inE2w; *see also* SAMHSA, Treatments for Substance Use Disorders, https://www.samhsa.gov/treatment/substance-use-disorders (explaining that long-term residential treatment is uncommon, with shorter term residential treatment being much more common and partial hospitalization or intensive outpatient treatment serving as alternatives to inpatient or residential treatment).
[51] Babalola et al., *supra* note 50.

access to SUD and mental health services, funding IMDs focuses on the crisis rather than the cause and diverts resources away from the necessary long-term fixes of appropriate community-based services. Moreover, § 2707 of the Affordable Care Act authorized a three-year IMD demonstration, which has already produced data suggesting that funding inpatient institutional beds increased federal costs without decreasing delays in accessing care.[52]

Third, New Mexico's proposal offers few assurances that there will be sufficient guardrails in place to avoid the harms that the IMD exclusion would otherwise prevent. Per both 2015 and 2017 CMS guidelines, states are required to "indicate how inpatient and residential care will supplement and coordinate with community-based care in a robust continuum of care in the state."[53] The proposal offers minimal information on monitoring and oversight processes for residential facilities to ensure quality care. There are no indications the State will increase staffing and resourcing to enforce standards of care, adequately monitor such facilities, promptly investigate any allegations of abuse and neglect, and protect patients' rights. Residential care should be strictly limited to circumstances where outpatient and community-based services would not be sufficient and where more intensive inpatient treatment is needed in conjunction with these other services. And residential facilities should have to develop individualized treatment plans designed to achieve patient discharge at the earliest possible time. This proposal provides only a passing reference to such transitions with scant detail.[54]

Allowing New Mexico to increase its reliance on institutional placement is potentially harmful to the individuals seeking treatment and the overall system of care in the state. Accordingly, no additional waiver of the IMD exclusion should be requested or granted, given the available evidence suggesting that increased access to inpatient treatment is not an effective solution.

We believe the State could effectively increase availability of community-based SUD and mental health treatment without pursuing a waiver of the IMD exclusion. Directing resources to less-expensive, community-based services – instead of inpatient facilities – could more effectively and efficiently meet the needs of the population without increasing the risk of more institutional placements.[55] Moreover, the promotion of institutional placement in lieu of community-based care could violate the Americans with Disabilities

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[52] Crystal Blyer, *et al*, MATHEMATICA POL'Y RES., *Medicaid Emergency Psychiatric Services Demonstration Evaluation, Final Report* (Aug. 18, 2016).
[53] CMS, State Medicaid Director Letter (Nov. 1, 2017), https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf (regarding "Strategies to Address the Opioid Epidemic.")
[54] NM Application, at 32.
[55] *See* Corey Davis and Hector Hernandez-Delgado, NAT'L. HEALTH LAW PROGRAM, *Medicaid and the Affordable Care Act: Vital Tools in Addressing the Opioid Epidemic* (Feb. 7, 2017), http://www.healthlaw.org/publications/browse-all-publications/Medicaid-ACA-Vital-Tools-Addressing-Opioid-Epidemic#.WmdbK6inE2w; *See also* SAMHSA, *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies* (2014), http://store.samhsa.gov/shin/content//SMA14-4848/SMA14-4848.pdf.; *see also* Susan D. Phillips et al., *Moving Assertive Community Treatment into Standard Practice (2001); Alan Rosen et al., Assertive Community Treatment—Issues From Scientific And Clinical Literature With Implications For Practice,* 44 J. OF REHABILITATION RES. & DEV. 813, 815-816 (2007); BAZELON CENTER, *Supportive Housing: The Most Effective and Integrated Housing for People with Mental Disabilities* 1 (2010), http://www.bazelon.org/wp-content/uploads/2017/04/supportive-housing-fact-sheet.pdf.

Act, Section 504 of the Rehabilitation Act of 1973, and Section 1557 of the Affordable Care Act. These violations may be attributable both to the State that is administering the programs and, for the purposes of Sections 504 and 1557, to CMS for encouraging and approving the use of federal funds in this manner.

**Conclusion**

NHeLP strongly objects to any efforts to use § 1115 to skirt essential provisions that Congress has placed in the Medicaid Act to protect Medicaid beneficiaries and ensure that the program operates in the best interests of the population groups described in the Act. As demonstrated above, many provisions of New Mexico's Centennial Care 1115 extension proposal are inconsistent with the standards of § 1115 and with other provisions of law. We appreciate your consideration of our comments. If you have questions about these comments, please contact David Machledt (machledt@healthlaw.org) or me.

Respectfully submitted,

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