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Center for Medicaid, CHIP and Survey & Certification
Centers for Medicare and Medicaid Services
U.S. Department of Health & Human Services
200 Independence Ave., S.W.
Washington, D.C. 20201

Re: California Department of Health Care Services request for waiver amendment

Dear Ms. Mann and Ms. Wachino:

We write in response to the State of California's request for an amendment to its 1115 waiver to impose mandatory copayments on all Medi-Cal beneficiaries. Over the past several months, California's Department of Health Care Services (DHCS) has been engaged in conversations with the federal Centers for Medicaid and Medicare Services (CMS) regarding the state's request to obtain federal approval for these copayments. The Western Center on Law and Poverty and National Health Law Program are strongly opposed to the state's proposal and asks CMS to reject the state's request.[1]

First, the copayments are unrelated to, and inconsistent with, the existing 1115 waiver as they will actually deter people from seeking care. The proposed copayments also violate federal Medicaid law on cost-sharing. There are also procedural defects with the state's request. Not only does the state's cost analysis fail to include the impact on beneficiaries and any supporting justification for the copayments, there was also minimal public discussion and scant analysis of how these copayments would impact access to care. Finally, there is the human cost to the state's proposal, as mandatory copayments unfairly shift cost burdens to persons who are the most medically vulnerable. The consequences for imposing such costs are dire. For these reasons, we urge CMS to protect California Medi-Cal beneficiaries and reject the state's request.

[1] This letter follows our May 13, 2011 initial letter of opposition.

The Cost-sharing amendment is unrelated to and inconsistent with California's existing 1115 waiver. The state's waiver request is an amendment to California's "Bridge to Reform" Section 1115 waiver that was granted by CMS in November of 2010. The 1115 waiver was intended to:

- Create the mechanism to transition low-income persons into health coverage prior to the implementation of the Affordable Care Act (ACA);
- Reduce uncompensated care by expanding the Safety Net Care Pool (SNCP);
- Move seniors and persons with disabilities into managed care plans; and
- Improve the infrastructure for California's public hospital system.[2]

This waiver was originally designed to expand coverage while stabilizing the county hospital safety-net system and establishing more care management and coordination through medical homes and managed care. This amendment - seeking to impose copayments of $5 for routine office visits, $3-5 for prescriptions, $50 for emergency room visits, and $100-200 for hospital stays - is wholly inconsistent with that purpose. Rather, this amendment is being offered only to circumvent the usual process of seeking a waiver so that the state can quickly implement changes with a devastating human cost while avoiding a robust stakeholder dialog. There is no other demonstrable value for seeking this change other than to save the state money and to circumvent existing statutory requirements.

As the state embarks on the implementation of health reform, the Department seeks to impose cost-sharing at levels and on populations never seen before in California or other states. The proposed amendment on cost-sharing will actually deter Medi-Cal beneficiaries from seeking care, in direct conflict with the intent of the original 1115 waiver to reduce uncompensated care. California's SNCP provides funds for uncompensated care given to individuals with no third party coverage. Mandatory copayments were not part of the cost-neutrality conversation during waiver negotiations, nor were they contemplated at all in the initial waiver application, which was negotiated with many months of input and evaluation as to potential impacts. CMS should not let the state simply add these provisions on to the existing waiver as an "addendum", when its relationship to the rest of the waiver is tenuous at best. It is inappropriate for this waiver.

Nor is the proposed amendment consistent with the purpose for allowing states to obtain Medicaid Waivers at all. Social Security Act section 1115 (42 U.S.C. 1315) was enacted to allow states to waive certain provisions of federal Medicaid law in order to create an "experimental, pilot, or demonstration project" that furthers the overarching goals of the Medicaid program. *Id.* The proposed amendment has no value as a demonstration project, since the effects of cost-sharing is one of the most studied aspects of the Medicaid program.[3] Moreover, those studies have uniformly shown that mandatory cost-sharing causes beneficiaries to go without needed care, and often imposes greater costs than

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[2] http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/WaiverApprovalltr110210.pdf

[3] *See, e.g.*, LEIGHTON KU & VICTORIA WACHINO, THE EFFECT OF INCREASE COST SHARING IN MEDICAID: A SUMMARY OF RESEARCH FINDINGS (2005), http://www.cbpp.org/cms/?fa=view&id=321; SAMANTHA ARTIGA & MOLLY O'MALLEY, INCREASING PREMIUMS AND COST SHARING IN MEDICAID AND SCHIP: RECENT STATE EXPERIENCES (2005), http://www.kff.org/medicaid/upload/Increasing-Premiums-and-Cost-Sharing-in-Medicaid-and-SCHIP-Recent-State-Experiences-Issue-Paper.pdf; Thomas M. Seldon *et al.*, Cost sharing in Medicaid and CHIP: how does it affect out-of-pocket spending? 28 HEALTH AFF. W607 (online ed. 2009), http://content.healthaffairs.org/content/28/4/w607.full.

savings to the state and federal governments in the long term.[4] This request does not demonstrate anything new or unique, and it must be rejected.

Public processes did not adequately assess the impacts of this proposal. The state engaged in extensive vetting and public input on the initial 1115 waiver components with a variety of stakeholders, but that was not the case for this proposed amendment. While the proposal for mandatory copayments to be imposed on essentially all Medi-Cal beneficiaries was heard in both of the state legislative house's budget subcommittee on health and human services – i.e. two public hearings – those hearings were set with less than one week notice, covered multiple budget items, were very brief in length and included no presentation by the Department of supporting documentation or data regarding their impact on beneficiaries and on access to care. In fact, though analysis and questions were presented by the Legislature to DHCS during these hearings, the Department did not provide thorough responses to questions such as "Would copayments be a deterrent to obtaining affordable health services?" and "How would this proposal be applicable to persons with chronic health conditions?"

Likewise, the Department's formal request to CMS to amend the 1115 waiver also does not contain thorough analysis on this proposal. It does not take into account the cost shifts from primary to emergency care, the more costly provision of emergency care, or the disproportionate impact this would have on persons with chronic health conditions or disabilities.

The cost analysis does not include the required impact on beneficiaries or supporting justification for the proposed savings. Paragraph 7 of the Special Terms and Conditions (STCs) of the waiver require the state to provide certain details regarding the impact of the amendment on beneficiaries, including supporting documentation. No such report is provided with the application. While the request includes financial impact statements, the cost statements appear to merely reflect, without analysis, fiscal assumptions about spending. These statements are not adequate to demonstrate the true impact of these changes on access. CMS should not approve the amendment without a demonstration of its impact on low-income children and families, among others.

California should not be allowed to violate federal laws on cost sharing in Medicaid. As we previously stated in our May 13 letter, the state must be required to follow the federal law as it was enacted by Congress and consistent with the Deficit Reduction Act cost-sharing provisions, and must specifically follow Section 1396o(f) to deviate from any existing statutory cost-sharing requirements. This waiver request violates these laws that have been clearly iterated by the Health and Human Services Agency, as recently as February 2011, when Secretary Sebelius stated that copayments in excess of

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[4] *See, e.g.,* Stephen Zuckerman *et al., Missouri's 2005Medicaid Cuts: How Did They Effect Enrollees And Providers?* HEALTH AFF (online ed. Feb. 2009), http://content.healthaffairs.org/content/early/2009/02/18/hlthaff.28.2.w335.full.pdf+html (increased cost-sharing in Missouri's Medicaid program resulted in beneficiaries' seeking more expensive kinds of care); Neal T. Wallace *et al., How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan,* 43 HEALTH SERV. RES. 515 (2008) (when Oregon increased premiums and copayments for Medicaid beneficiaries, many individuals refrained from seeking preventative care and instead increased their reliance on more costly hospital emergency room care); Steven B. Soumerai *et al., Effects of Medicaid Drug-Payment Limits on Admission to Hospitals and Nursing Homes,* 325 NEW ENGLAND J. MED. 1072 (1991) (when New Hampshire's Medicaid program increased its copayments for prescriptions, beneficiaries became more likely to be admitted into hospitals or nursing homes, at great cost to the program).

$3.65 for populations at or below 100% of the Federal Poverty Level are not allowed.[5] If these statutes can be so easily dismissed or disregarded, what is their purpose? Given the grave impact on consumers, the minimal protection for vulnerable low-income people that these statutes offer must be upheld.

Cost-sharing is at odds with the goals of managed care. Cost-sharing will be felt most negatively by seniors and persons with disabilities (SPDs) who rely on care more frequently or have multiple disabling conditions. A main component of the waiver requires that these beneficiaries enroll in mandatory managed care. Cost-sharing and managed care are naturally at odds; managed care in and of itself is designed to do precisely what the state says they are trying to accomplish with mandatory co-pays, which is control costs and curb inappropriate utilization of care. Without waiting for this managed care expansion to even be implemented, the state is already undermining its effectiveness by imposing mandatory cost-sharing on the very same individuals who are relying on health plans to assist them in appropriately utilizing care. To make matters worse, this proposal will result in another rate cut to the providers and plans that do not to refuse care to those who cannot pay. Such a rate cut will make it more difficult to successfully implement mandatory managed care for higher health need populations. Certainly this was not contemplated by health plans who signed contracts with the state to serve these enrollees. Since providers are already strained by repeated Medicaid rate cuts, this may drive more providers out of the Medi-Cal program altogether. Medi-Cal beneficiaries cannot afford to lose access to providers when access is already difficult in many geographic regions and with certain specialty care areas. An adequate analysis of this impact on beneficiaries has yet to be produced.

The consequences of imposing mandatory copayments for Medi-Cal beneficiaries are dire. Numerous studies conclude that very low-income people, including Medicaid beneficiaries, defer necessary health care and often end up using higher cost forms of care when their routine treatment can no longer be delayed. A $5 co-pay for a routine office visit, as California requests under this amendment, could lead to a beneficiary putting off care, using the emergency department to access routine health care delivery, and ultimately experiencing adverse health episodes.[6] In addition to the state's request to impose $5 co-pays for all regular office and clinic visits, the state seeks to impose $3-5 co-pays for prescriptions drugs, $50 for emergency room visits, and $100-$200 for hospital stays. The state proposes to impose these copayments on the most vulnerable and poorest Medi-Cal recipients, including children and families of all income levels, and the elderly and persons with disabilities, and people with $0 of income. These copayments are truly unaffordable and will result in these individuals either refusing to seek care, or being refused care due to their inability to pay. Interestingly, one of the few groups who are actually protected from this unreasonable cost-sharing is the Low-Income Health Program waiver enrollees who would have no Medi-Cal coverage but for this waiver. Meanwhile, children, families, seniors and persons with disabilities bear the brunt of pain. Many of these individuals are clearly intended to be protected from cost-sharing under the Medicaid Act yet would not be under this waiver amendment, if approved.

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[5] Letter from Kathleen Sebelius, Sec'y Health & Human Serv. to Governors (Feb. 3, 2011), http://www.hhs.gov/news/press/2011pres/01/20110203c.html.

[6] *See,e .g.,* KU & WACHINO, *supra* note 3; ARTIGA & O'MALLEY, *supra* note 3; Seldon *et al., supra* note 3.

For the reasons stated above, we urge CMS to reject the state's request to amend the 1115 waiver to impose these mandatory cost-sharing obligations on those who can least afford it. We would be happy to answer any additional questions or discuss this further at your earliest convenience.

Sincerely,

Vanessa Cajina, Legislative Advocate
WCLP

Kim Lewis, Managing Attorney (LA Office)
NHeLP