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August 6, 2021

The Honorable Xavier Becerra, Secretary  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Ave., S.W.  
Washington, D.C. 20201

**RE: Vermont Global Commitment to Health 1115  
Extension Application**

Dear Secretary Becerra:

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 underserved people. We appreciate the opportunity to comment on Vermont's request to extend the Global Commitment to Health project.

NHeLP has serious concerns about Vermont's proposed extension. Specifically, Vermont's requests to waive the institution for mental diseases exclusion for mental health facilities, to waive the inmate exclusion, to impose premiums on children in families with incomes over 195%, and to eliminate retroactive coverage should all be rejected, as they do not comply with the requirements of § 1115 of the Social Security Act.

## I. HHS Authority Under § 1115

For the Secretary to approve a project pursuant to § 1115, the project must:

- be an “experimental, pilot or demonstration” project;
- be likely to promote the objectives of the Medicaid Act;
- waive compliance only with requirements in 42 U.S.C. § 1396a; and
- be approved only “to the extent and for the period necessary” to carry out the experiment.

Discussing each of these limitations a bit further:

*First*, the state must propose to conduct an “experimental, pilot, or demonstration” project. This demands a “novel approach” to program administration.<sup>1</sup> To evaluate whether a proposed project is a valid experiment, the Secretary needs to know what will be tested and how, at the point in time when the project is being approved.

*Second*, the project must promote the Medicaid Act’s objectives. Congress has made clear that the purpose of Medicaid is to enable states “to furnish[] medical assistance” to individuals “whose income and resources are insufficient to meet the costs of necessary medical services” and to provide “rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.”<sup>2</sup> Thus, the “central objective” of the Medicaid Act is “to provide medical assistance.”<sup>3</sup>

*Third*, the Secretary can only waive provisions set forth in section 1396a of the Medicaid Act. The Secretary cannot waive requirements contained in sections 1396b-1396w-5.<sup>4</sup>

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<sup>1</sup> *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994).

<sup>2</sup> 42 U.S.C. § 1396-1; 1396d(a) (defining “medical assistance” as provision of, or payment for, specified health care and services).

<sup>3</sup> *Stewart v. Azar*, 366 F. Supp. 3d 125, 138 (D.D.C. 2019); *id.* at 144 (rejecting “promoting health” as an independent objective because the Medicaid Act is “designed ... to address not health generally but the provision of care to needy populations” through a health insurance program).

<sup>4</sup> See Social Security Act, § 1115(a)(1).



Once the Secretary has acted under section 1115(a)(1) to waive compliance with designated provisions in section 1396a, section 1115(a)(2) provides that the costs of “such project” are “regarded as expenditures under the State plan” and, thus, paid for under the same statutory formula that applies for a state’s expenditures under its State plan.<sup>5</sup> Section 1115(a)(2) does not create an independent “expenditure authority” for the Secretary to allow a state to ignore provisions of the Medicaid Act outside of section 1396a or to rewrite the provisions in section 1396a or any other provision outside of section 1396a. To the contrary, it is a “clean-up” provision that merely provides the authorization necessary for federal reimbursement of expenditures for a project that has been approved under section 1115(a)(1).

*Fourth*, section 1115 allows approvals only “to the extent and for the period necessary” to carry out the experiment.<sup>6</sup> Congress did not enact section 1115 to permit the Secretary to make long-term policy changes. We acknowledge that, in 2017, CMS issued an Informational Bulletin announcing its intent “[w]here possible, . . . [to] approve the extension of *routine, successful, non-complex*” Section 1115(a) waivers for a period up to 10 years. Ctr. for Medicaid & CHIP Servs., CMS, CMCS Informational Bulletin 3 (Nov. 6, 2017) (emphasis added). However, we urge CMS to disregard this Bulletin because it is contrary to section 1115. It conflicts with, among other things, the statute’s limitation of approvals to experimental, pilot, or demonstration projects (not for “routine” projects) and only for the period necessary to carry out the experiment (not to maintain a successful experiment as an ongoing policy). For the same reasons, CMS should reject Vermont’s request to renew “long-standing features” of its project for a period of 10 years.<sup>7</sup> To the extent that any of these long-standing features

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<sup>5</sup> *Id.* § 1115(a)(2).

<sup>6</sup> *Id.* § 1115(a); *see also id.* §§ 1115(e)(2), (f)(6) (limiting the extension of “state-wide, comprehensive demonstration projects” to one initial extension of up to 3 years (5 years, for a waiver involving Medicare-Medicaid eligible individuals) and one subsequent extension not to exceed to 3 years (5 years, for Medicare-Medicaid waivers)).

<sup>7</sup> Vt. Agency of Human Servs., *Vermont Global Commitment to Health 1115 Demonstration Renewal Application 6*, 51-60 (2021), <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/vt-global-commitment-to-health-pa4.pdf> [hereinafter “Application”].



continue to have experimental value, the State has not articulated why it would need an additional 10 years to complete its experiment.

### **Waiving the IMD Exclusion for Mental Health Institutions for Mental Diseases**

Vermont requests federal financial participation (FFP) for services provided in mental health institutions for mental diseases (MH IMDs).<sup>8</sup> This request should not be approved. First, the IMD exclusion lies outside of § 1396a, and it cannot be waived.<sup>9</sup> As noted above, § 1115(a)(2) does not create an independent “expenditure authority” for the Secretary to allow a state to ignore provisions of the Medicaid Act outside of § 1396a.

Second, Vermont is not proposing a genuine experiment, demonstration, or novel approach. Vermont first received a MH IMD waiver 25 years ago, in 1996. Eight years later, in 2004, CMS started to phase out the waiver because it was not innovative or experimental.<sup>10</sup> The waiver was completely phased out by January 1, 2006.<sup>11</sup> However, in 2012, Vermont applied again for an IMD waiver, in order to ensure FFP would be available prior to building a new 25-bed State psychiatric hospital.<sup>12</sup> While CMS reaffirmed that FFP is not available for IMDs, CMS did permit Vermont to use “managed care savings” to fund services in IMDs.<sup>13</sup> Vermont continued

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<sup>8</sup> Because Vermont has a unique and long history of MH IMD waivers, we are focusing our comments on Vermont’s request for a MH IMD waiver. However, we note that Vermont is also requesting a waiver of the IMD exclusion for residential substance use disorder (SUD) services. This is also an impermissible use of Section 1115, for many of the same reason that Vermont’s request for FFP for enrollees in MH IMDs is impermissible. *See, e.g.* Cathren Cohen et al., Nat’l Health Law Program, *Medicaid Section 1115 Waivers for Substance Use Disorders: A Review* 8-11 (June 8, 2021), <https://healthlaw.org/resource/medicaid-section-1115-waivers-for-substance-use-disorders-a-review/>.

<sup>9</sup> Social Security Act § 1115(a)(1).

<sup>10</sup> U.S. Gov. Accountability Office, *States Fund Services for Adults in Institutions for Mental Disease Using a Variety of Strategies* 29 (2017), <https://www.gao.gov/assets/690/686456.pdf>.

<sup>11</sup> Pacific Health Pol’y Group, Vermont Global Commitment to Health Section 1115(a) Medicaid Demonstration Interim Evaluation Report # 1, including Evaluation of IMD Expenditures, 39-40 (March 30, 2018), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/Global-Commitment-to-Health/vt-global-commitment-to-health-interim-eval-rpt-03302018.pdf> [hereinafter “IMD Expenditure Evaluation”].

<sup>12</sup> *Id.* at 40.

<sup>13</sup> *Id.*



to fund IMDs via this mechanism until CMS required Vermont to start phasing out this authority.<sup>14</sup> But once again, Vermont came back with a new theory, and requested and received an IMD waiver pursuant to CMS' 2018 Dear State Medicaid Letter encouraging states to apply for FFP for services in MH IMDs.<sup>15</sup>

After over two decades of experience with MH IMD waivers, Vermont is no longer conducting a time-limited experiment. To put it another way, Vermont is not demonstrating anything. Instead, Vermont continues to “test” hypotheses that it has tested numerous times before. For example, one of Vermont’s main goals for the present MH IMD waiver request is to “[r]educ[e] utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings.”<sup>16</sup> However, Vermont has tested this before and found that funding IMDs *did not* reduce emergency department (ED) lengths of stay.<sup>17</sup> What’s more, Vermont’s findings in the 2018 evaluation echoed those from the federally authorized Medicaid Emergency Psychiatric Demonstration (MEPD) program, a three-year IMD demonstration ending in 2015 that was authorized by Section 2707 of the Affordable Care Act.<sup>18</sup> The MEPD also set out to determine if increased federal funding for IMDs would reduce ED visits and lengths of stay in the ED and concluded that “[c]ontrary to expectations that access to IMD care would decrease the time beneficiaries spent awaiting inpatient beds, no changes in ED boarding times were observed during MEPD.”<sup>19</sup> Further, the analysis noted that “the finding was robust across statistical models,

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<sup>14</sup> *Id.*

<sup>15</sup> See CMS, Dear State Medicaid Director Letter, SMD# 18-011, Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance (Nov. 13, 2018), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>.

<sup>16</sup> Application at 13-14.

<sup>17</sup> IMD Expenditure Evaluation at 53-54 (In 2013, when Vermont began investing “managed care savings” in MH IMDs, the average wait time per month was 53 hours. In 2016, in year 4 of that demonstration, the wait time was 56 hours per month. The percent of individuals waiting more than 24 hours for a bed on any given day also steadily rose during the demonstration, from 36% in 2013 to 52% in 2016).

<sup>18</sup> See Crystal Blyer et al., *Medicaid Emergency Psychiatric Services Demonstration Evaluation, Final Report*, Volume I MATHEMATICA POLY RSCH. (Aug. 18, 2016), <https://innovation.cms.gov/Files/reports/mepd-finalrpt.pdf>

<sup>19</sup> *Id.* at 77.



making it one of our strongest findings,” though it noted that such a finding could be masked by an increased need for emergency and inpatient service during the demonstration period.<sup>20</sup> The MEPD evaluation also found that in those states that had sufficient data to draw conclusions, “[t]he results do not support our hypothesis that ER visits would decrease as a result of MEPD.”<sup>21</sup>

As noted above, § 1115 allows approvals only “to the extent and for the period necessary” to carry out the experiment, yet Vermont has obtained FFP for IMDs via various waivers since 1996.<sup>22</sup> Congress did not enact § 1115 to permit the Secretary to make long-term policy changes.

Should CMS grant this renewal, it should at least reject Vermont’s request to modify the special terms and conditions (STC) to permit FFP for IMD stays over 60 days.<sup>23</sup> CMS rejected this request in 2019, and it should do so again.<sup>24</sup> The prohibition on FFP after 60 days is a standard provision that has appeared in the STCs for all states that have been granted a IMD exclusion for psychiatric hospitals since 2019.<sup>25</sup>

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<sup>20</sup> *Id.*

<sup>21</sup> *Id.* at 49.

<sup>22</sup> Social Security Act § 1115(a).

<sup>23</sup> Application at 26.

<sup>24</sup> CMS, *Approval Letter for Vermont Global Commitment to Health Amendment 71* (Dec. 5, 2019), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/Global-Commitment-to-Health/vt-global-commitment-to-health-cms-appvl-demo-amend-12052019.pdf>

<sup>25</sup> See CMS, *District of Columbia Behavioral Health Transformation Initial Approval 31* (Nov. 5 2019); <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/dc/behavioral-health-transformation/dc-behavioral-health-transformation-cms-appvl-11062019.pdf>; CMS, *Idaho Behavioral Health Transformation Approval 17* (April 17, 2020), <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/id-behavioral-health-transformation-ca.pdf>; CMS, *Healthy Indiana Plan Amendment Approval 43* (Dec. 20, 2019) <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/in-healthy-indiana-plan-support-20-tech-crrctns-appvl-12202019.pdf>; CMS, *Washington State Medicaid Transformation Project Amendment Approval 51* (Nov. 6, 2021), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wa/wa-medicaid-transformation-ca.pdf>; CMS, *Oklahoma Section 1115 Institutions for Mental Disease Waiver for Serious Mental Illness/Substance Use*



Vermont's own IMD waiver evaluation does not support the premise that stays over 60 days would reduce readmissions.<sup>26</sup> The data Vermont relies upon only states that readmission rates were lower for lengths of stay between 16-29 days and dropped to near zero for lengths of stay over 29 days.<sup>27</sup> While this may support the need for stays up to 30 days—authority which Vermont already has—it does not support a need for stays over 60 days. Further, while the State correctly notes that some studies have found length of stay is one of many factors associated with readmissions, other studies suggest that there is not a relationship between premature discharge and readmissions.<sup>28</sup>

Prohibiting FFP for stays over 60 days incentivizes states to quickly remedy barriers to discharge, thus serving as a guardrail against inappropriately long periods of institutionalization. At least one commenter at the state level noted that in her experience in Vermont, length of stay is often more indicative of a lack of sufficient community-based treatment capacity, not acuity.<sup>29</sup> A University of Vermont Medical Center study supports this

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*Disorder Approval* 19 (Dec. 22, 2020), <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ok-imd-waiver-smi-sud-ca.pdf>; CMS, *Utah Primary Care Network Amendment Approval* 64 (Dec. 16, 2020), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/ut-primary-care-network-ca.pdf>

<sup>26</sup> See Application at 27.

<sup>27</sup> Vt. Agency of Human Servs, *Phasedown Plan for IMDs* 14 (Dec. 31, 2018), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/Global-Commitment-to-Health/vt-global-commitment-to-health-phase-down-plan-12312018.pdf> (Stating that the Vermont's findings from operating IMDs "suggest that psychiatric stabilization often warrant stays over 15 and even 30 days. . ." but not reaching conclusions about stays beyond 60 days).

<sup>28</sup> Compare Glorimor Ortiz, *Predictors of 30-day Postdischarge Readmission to a Multistate National Sample of State Psychiatric Hospitals*, 42 J. FOR HEALTHCARE QUALITY 228, 222-225 (2019), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6716555/> J (finding that length of stay was the strongest predictor of rehospitalization within 30 days, but that other variables such as race and marital status also influenced readmission rates) with John S. Lyons et al, *Predicting Readmission to the Psychiatric Hospital in a Managed Care Environment: Implications for Quality Indicators*, 154 AM. J. PSYCHIATRY 337, 339 (1997), <https://www.researchgate.net/publication/14156271> (finding no evidence to suggest that premature discharge was associated with readmission either within 30 days or 6 months, and instead concluding that "patients with more severe and persistent difficulties and with higher levels of impairment were at greater risk" of readmission).

<sup>29</sup> Application at 122.



conclusion.<sup>30</sup> The study examined patients who had stays in a psychiatric unit of a hospital longer than 30 days over a four-year period and found that the majority of delays in discharge were due to barriers to discharge, not clinical need.<sup>31</sup> The two most common reasons for “barrier days” were “delay in group home placement” and “no housing—no support system.” Other reasons for delay included “no outpatient treatment readily available,” “no transportation for outpatient treatment,” and “delay in nursing facility or assisted living placement.”<sup>32</sup> While Vermont assures CMS that even if it is permitted to obtain FFP for stays over 60 days it will still be able to maintain an average length of stay of 30 days, that is cold comfort to the individual who is “stuck” in a facility for months due to a delay in placement.

Finally, removing the day limit for FFP for MH IMDs could undermine hard-won civil rights for people with disabilities and decades of federal policy initiatives stressing the importance of increasing community integration.<sup>33</sup> MH IMDs are by definition institutional settings where individuals with disabilities receive services, and decisions regarding funding for services in IMDs will inevitably have an impact on where people with disabilities receive services. In passing the Americans with Disabilities Act, Congress found that “historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem.”<sup>34</sup> Providing FFP for large institutional settings without any guardrails or day limits could reify discriminatory presumptions about the ability of individuals with disabilities to receive services in community-based settings and undermine the integration mandate articulated by the Supreme Court in *Olmstead v. LC*. In short, this request promotes the segregation of people with mental illnesses.

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<sup>30</sup> Eve Hoar, *Inpatient Psychiatry Barrier Days Analysis* (May 31, 2017), [https://mentalhealth.vermont.gov/sites/mhnew/files/documents/News/82/Inpatient\\_Psychiatry\\_Barrier\\_Days\\_Analysis.pdf](https://mentalhealth.vermont.gov/sites/mhnew/files/documents/News/82/Inpatient_Psychiatry_Barrier_Days_Analysis.pdf) (of 180 patients who had stays of 30 days or more during the study period, 62% of the delays in discharge were due to barriers to discharge, not clinical need).

<sup>31</sup> *Id.*

<sup>32</sup> *Id.* at 4.

<sup>33</sup> President's New Freedom Comm'n on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America* (2003), <https://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/FullReport.htm>.

<sup>34</sup> 42 U.S.C. § 12101(a)(2).





## Waiving the Inmate Exclusion

Vermont requests FFP for state plan Medicaid services provided to residents incarcerated in Vermont prisons or jails for 90 days prior to release. While we support Vermont's goal of providing transition services to returning citizens, a § 1115 waiver is not the appropriate vehicle.

First, § 1115 only permits waiver of those requirements found in 42 U.S.C. § 1396a.<sup>35</sup> Payments for services to "inmates of a public institution" is prohibited, and this prohibition lies outside of 42 U.S.C. § 1396a.<sup>36</sup> Thus, the Secretary does not have authority to waive or to authorize a state to ignore it.

Second, Vermont's request does not contain enough information to meaningfully comment on whether the State is conducting a bona fide experiment and whether the proposed waiver is limited to the extent and period necessary to conduct the experiment. Vermont's stated goal is to reduce recidivism. It asserts that it will do so by connecting individuals to physical and mental health appointments in the community immediately following release, by ensuring that treatment is not interrupted upon release, and by filling medications prior to release.<sup>37</sup> Vermont also notes that because Black Vermonters are disproportionately incarcerated, reducing recidivism generally would promote health equity and "reduce the detrimental physical and psychological impact of time spent in correctional settings."<sup>38</sup> While certain evidence-based interventions can reduce recidivism, Vermont does not articulate why FFP for *full state plan services* for 90 days prior to release would reduce recidivism. Nor does Vermont explain how individuals in prisons and jails will be able to receive full state plan services. The interventions proposed, including connecting individuals to appointments immediately prior to release and refilling medications before and after release, are limited in scope and would not seem to require 90 days of full state plan benefits. While we support Vermont's goals, a § 1115 waiver can only be granted for an experiment and only "to the extent . . . necessary" to carry out the experiment.<sup>39</sup>

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<sup>35</sup> *Id.*

<sup>36</sup> 42 U.S.C. § 1396d(a)(30)(A).

<sup>37</sup> Application at 20.

<sup>38</sup> *Id.*

<sup>39</sup> Social Security Act, § 1115(a)(1).



Third, Vermont's reliance on the "The Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act" of 2018 is misplaced.<sup>40</sup> The SUPPORT Act does not state that § 1115 demonstrations are available to waive the inmate exclusion, instead it only requires CMS to issue guidance on providing transition services via § 1115 demonstration programs.<sup>41</sup> Section 5032 does not create new authority for the Secretary to grant § 1115 waivers. Further, the Secretary has not issued guidance regarding how a § 1115 demonstration program might be used to improve reentry.

While NHeLP strongly believes states can and should provide transition services to returning citizens, there are other avenues for Vermont to pursue this laudable goal without running afoul of the Medicaid Act.<sup>42</sup>

### **Imposing Premiums on Children Ages 0 to 18**

Vermont is requesting to continue its waiver of § 1396a(a)(14) to impose premiums ranging from \$15 to \$60 per month on children ages 0 to 18 with household incomes above 195% of FPL.<sup>43</sup> Section 1115 cannot be used to allow Vermont to charge these premiums. The substantive limits on premiums exist outside of § 1396a, and as a result, cannot be waived under § 1115. Time and again, Congress has made clear its intent to insulate the limits on premiums and cost-sharing from waiver under § 1115. In 1982, Congress removed the substantive limits on premiums and cost-sharing from 1396a and transferred them to a new § 1396o, which imposes independent obligations on states.<sup>44</sup> Since then, Congress has

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<sup>40</sup> Application at 19.

<sup>41</sup> Support Act of 2018, § 5032, Pub. Law No. 115-271, 132 Stat. 3894, 3965.

<sup>42</sup> See, e.g., Jess Jannetta, Urban Institute, *Strategies for Connecting Justice-Involved Populations to Health Coverage and Care* (March 2018), [https://www.urban.org/sites/default/files/publication/97041/strategies\\_for\\_connecting\\_justice-involved\\_populations\\_to\\_health\\_coverage\\_and\\_care.pdf](https://www.urban.org/sites/default/files/publication/97041/strategies_for_connecting_justice-involved_populations_to_health_coverage_and_care.pdf) (describing opportunities for states to use Medicaid administrative claiming to allow state employees, MCOs, carved out behavioral health systems, or community based organizations to provide assistance with enrollment, eligibility, and identification and linkages to providers in the community).

<sup>43</sup> Application at 48, 52.

<sup>44</sup> Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, 96 Stat. 324, 367.



made repeated changes to the limits, confirming that changes in the flexibilities available to states to charge premiums must come from Congress, not from HHS.<sup>45</sup>

In addition, the premiums are not experimental and conflict with the objectives of the Medicaid Act. Redundant research has already proven that premiums deter and reduce enrollment among this population.<sup>46</sup> Numerous studies, conducted over the course of two decades, have examined the effects of imposing premiums in Medicaid and CHIP. These studies show the same patterns – people facing premiums are less likely to enroll, more likely to drop coverage, and more likely to become uninsured.<sup>47</sup> Nothing in the application suggests

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<sup>45</sup> See Omnibus Reconciliation Act of 1987, Pub. L. No. 100-203, § 4101(d)(1), 101 Stat. 1330, 1330-141 to -142 (authorizing premiums on pregnant women and infants with incomes over 150% of FPL); Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6408(d)(3)(B), (C), 103 Stat. 2106, 2269 (codified at 42 U.S.C. § 1396o(d)) (authorizing premiums for certain working individuals with disabilities who have incomes over 150% of FPL); Deficit Reduction Act of 2005, Pub. L. 109-171, § 6041-6043, 120 Stat 6, 81, 85, 86 (2006) (adding 42 U.S.C. § 1396o-1).

<sup>46</sup> See, e.g., Samantha Artiga, Petry Ubri, and Julia Zur, Kaiser Family Found., *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings* (2017), <https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/>; Brendan Saloner et al., *Medicaid and CHIP Premiums and Access to Care: A Systematic Review*, 137 PEDIATRICS e20152440 (2016), <http://pediatrics.aappublications.org/content/137/3/e20152440>.

<sup>47</sup> See, e.g., Leighton Ku & Teresa Coughlin, *Sliding Scale Premium Health Insurance Programs: Four States' Experiences*, 36 INQUIRY 471 (1999/2000) (finding that among low-income enrollees, premiums as low as 1% of household income reduce enrollment by approximately 15%, and premiums of 3% of household income reduce enrollment by approximately 50%) (attached); Leighton Ku & Victoria Wachino, Ctr. On Budget & Policy Priorities, *The Effect of Increased Cost-sharing in Medicaid: A Summary of Research Findings 7* (2005), <https://www.cbpp.org/archiveSite/5-31-05health2.pdf> (compiling existing research and concluding “[e]vidence indicates that premiums reduce Medicaid participation and make it harder for individuals to maintain stable and continuous enrollment” and noting that at least four states reconsidered, abandoned, or discontinued policies to implement premiums in Medicaid or CHIP due to concerns about declining enrollment and adverse health consequences); Genevieve Kenney et al., *Effects of Premium Increases on Enrollment in SCHIP: Findings from Three States*, 43 INQUIRY 378, 380 (2006) (finding that imposing premiums on CHIP enrollees reduced initial enrollment and led to substantial disenrollment, and in some states disproportionately affected non-white individuals) (attached); Margo



that Vermont is proposing to test a novel use of premiums. In fact, the State does not provide any rationale as to why it is necessary to continue the waiver, much less for a period of 10 years.

## Waiving Retroactive Coverage

Vermont is also requesting to continue its waiver of retroactive coverage for individuals in populations six and eight (CFC Moderate Needs Group and VPharm Group).<sup>48</sup> There is nothing experimental about eliminating retroactive coverage – states have been permitted to waive the requirement since at least the 1990s.<sup>49</sup>

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Rosenbach et al, Mathematica Pol'y Research, Inc., *National Evaluation of the State Children's Health Insurance Program: A Decade of Expanding Coverage and Improving Access* (2007), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/rosenbach9-19-07.pdf> (noting that premiums and lockout provisions have been found to reduce retention in CHIP); Jill Boylston Herndon et al., *The Effect of Premium Changes on SCHIP Enrollment Duration*, 43 HEALTH SERVS. RES. 458 (2008), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2442374/> (finding that increasing premiums from \$15 to \$20 for children in families from 151-200% of FPL decreased length of enrollment); Georgetown Univ. Health Pol'y Inst., Ctr. for Children & Families, *Cost Sharing for Children and Families in Medicaid and CHIP* (2009), [http://ccf.georgetown.edu/wp-content/uploads/2012/03/Cost\\_sharing.pdf](http://ccf.georgetown.edu/wp-content/uploads/2012/03/Cost_sharing.pdf) (compiling research from eleven states showing that new or increased premiums reduce enrollment and/or increase disenrollment in CHIP); Laura Dague, *The Effect of Medicaid Premiums on Enrollment: A Regression Discontinuity Approach* 37 J. HEALTH ECONOMICS 1 (2014) (finding that an increase in premiums from \$0 to \$10 each month reduced the likelihood of individuals remaining enrolled in Medicaid/CHIP for a full year by 12%) (attached).

<sup>48</sup> Application at 54.

<sup>49</sup> See, e.g., MACPAC, *Medicaid Retroactive Eligibility: Changes Under Section 1115 Waivers* (2019), <https://www.macpac.gov/wp-content/uploads/2019/08/Medicaid-Retroactive-Eligibility-Changes-under-Section-1115-Waivers.pdf> (listing the 30 demonstration projects with a waiver of retroactive coverage as of August 2019 and noting that none of the states "have conducted a formal evaluation of the effects of these policies").



In addition, waiving retroactive coverage does not promote the objectives of the Medicaid Act.<sup>50</sup> All available evidence indicates that eliminating retroactive coverage reduces access to coverage and care among low-income individuals, leaving them with unmet health care needs and/or substantial medical debt.<sup>51</sup> Here, the waiver could cause significant financial hardship for individuals in the VPharm Group who need multiple and/or expensive prescription drugs.

Vermont does not even attempt to articulate an experimental purpose for its waiver. The State simply asks to continue the waiver for a period of 10 years without providing any justification at all. That is not sufficient under § 1115.

## Conclusion

For the above stated reasons, we urge the Secretary to reject Vermont's request to permit FFP for services provided in MH IMDs, to waive the inmate exclusion, to impose premiums on some children ages 0-18, and to waive retroactive coverage.

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<sup>50</sup> See *Stewart v. Azar*, 313 F. Supp. 3d 237, 265 (D.D.C. 2019) (finding that waiving retroactive coverage will, "by definition, reduce coverage" for low-income individuals not currently enrolled in Medicaid).

<sup>51</sup> See, e.g., Natalie Kean, Justice in Aging, *Medicaid Retroactive Coverage: What's at Stake for Older Adults when States Eliminate this Protection?* (2019), <https://justiceinaging.org/wp-content/uploads/2019/09/Medicaid-Retroactive-Coverage-Issue-Brief.pdf>; Harris Meyer, *New Medicaid Barrier: Waivers Ending Retrospective Eligibility Shift Costs to Providers, Patients*, MODERN HEALTHCARE (Feb. 11, 2019), <https://www.modernhealthcare.com/article/20190209/NEWS/190209936/new-medicaid-barrier-waivers-ending-retrospective-eligibility-shift-costs-to-providers-patients>.



We appreciate your consideration of our comments. If you have any questions, please contact Jennifer Lav ([lav@healthlaw.org](mailto:lav@healthlaw.org)) or Catherine McKee ([mckee@healthlaw.org](mailto:mckee@healthlaw.org)).

Sincerely,

A handwritten signature in black ink, appearing to read "Jennifer Lav".

Jennifer Lav  
Senior Attorney

