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Secretary Brent Earnest
New Mexico Human Services Department- Office of the Secretary
ATTN: Medical Assistance Division Public Comments
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VIA EMAIL (madrules@state.nm.us)

Re: Comments on Proposed Regulations, Volume 41, Register 27

New Mexico Human Services Department (HSD),

We submit these comments to express strong opposition to HSD's proposed changes to retroactive coverage and premium requirements for Medicaid patients. These changes would limit access to healthcare for New Mexican families and violate federal law. New Mexicans do not want these changes and they have not been approved by the federal government.

The purpose of Medicaid is to provide medical assistance to individuals and families "whose income and resources are insufficient to meet the costs of necessary medical services."[1] The Medicaid Act also requires that a state plan for medical assistance provide safeguards to ensure that eligibility is determined, and that services are provided, "in a manner consistent with the simplicity of administration and the best interests of recipients."[2]

New Mexicans overwhelmingly oppose these cuts to Medicaid. Throughout the entire Centennial Care 2.0 waiver application process, patients, providers, stakeholders, researchers, advocates and community members voiced near unanimous opposition to these changes. While the Department scaled back some of its proposed cuts and changes, these regulations would implement many harmful policies.

HSD has struggled to effectively administer basic Medicaid in compliance with federal law. The federal court has issued multiple Orders and appointed a special master to address these issues. CMS has also placed HSD under a corrective action plan. The special master recommended against the Medicaid cuts in the HSD Waiver Application. It is disappointing and concerning that the Department continues to waste valuable resources imposing policies that illegally restrict access to Medicaid and that are not required by federal law, or even approved by CMS, under these circumstances.

[1] 42 U.S.C. § 1396-1.
[2] 42 U.S.C. § 1396(a)(19).

First, these proposals are illegal. To be approved under Section 1115, a Medicaid waiver must: (1) implement an "experimental, pilot, or demonstration" project; (2) be limited to Medicaid provisions in 42 U.S.C. §1396(a); (3) be "likely to assist in promoting the objective" of the Medicaid Act; and (4) be limited to the extent and period necessary to carry out the experiment.[3] Section 1115 "was not enacted to enable states to save money or evade federal requirements but to 'test out new ideas'...A simple benefit cut, which might save money, but has no research or experimental goal, would not satisfy this requirement."[4] The Center for Medicare and Medicaid Services (CMS) does not have authority to approve these illegal changes.

We urge the Department to withdraw the proposed changes that will harm New Mexicans, and to focus implementation of the waiver on policies that will improve access to healthcare, not deter it.

1. 8.200.400.14 - Retroactive Medicaid should not be phased out

Medicaid is a vital safety net for families in poverty and on the brink of poverty. HSD's proposal to phase out retroactive coverage would end an important protection for patients that pays medical bills incurred in the three months before an eligible patient applied for Medicaid. Many of these patients do not know if they qualify for Medicaid until after they've been sick and visited the doctor or hospital. It may be months before families can successfully apply for coverage.

Hospital bills are especially devastating for families on limited income, often ranging from $10,000 to over $100,000. Keeping retroactive coverage intact ensures those bills are paid. Without it, hospitals, clinics and other providers will not be paid for the care given to Medicaid eligible patients. As a result, providers would have to shoulder additional uncompensated care costs and would be unable to provide high quality care to all patients.

Federal law does not allow states to waive retroactive eligibility

42 U.S.C. § 1396d requires medical assistance to include care and services if provided "in or after the third month before" the patient's application. Although retroactive coverage is mentioned in 42 U.S.C. §1396a, the requirements are found independently in 42 U.S.C. § 1396d, outside of the 1115 waiver authority. Thus, even with CMS approval, the regulation would violate federal law.

HSD has not and cannot justify eliminating this important protection for patients.

HSD's reasons for ending retroactive coverage are unsubstantiated and do not justify the severe financial hardship that families will undergo. In previous statements, HSD indicated one reason for eliminating retroactive coverage is due to the Department's shift to "real-time enrollment." HSD has been unable to implement real-time enrollment decisions that might reduce the need for retroactive coverage, and has not been able to meet previous Department timelines in implementing this enrollment change. In fact, HSD has no timeframe for

[3] 42 U.S.C. § 1315 (codification of Section 1115).
[4] *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994).

implementation of real time eligibility. Even if real-time enrollment could be implemented, the need for retroactive coverage would not end. Real-time enrollment cannot be achieved in every case because not all patients will have income or citizenship documents that are electronically verifiable at the time of enrollment. Families living in rural areas and in deep poverty are often unable to apply within three months of services and may not be able to complete the application process within 45 days. These patients would be penalized with massive bills.

In addition, not every New Mexico hospital or clinic is equipped to help a person enroll in Medicaid at the time of service or before an appointment has been scheduled. Although HSD expects every healthcare provider to take steps to enroll patients through Presumptive Eligibility or Medicaid On-Site Application Assistance (PE/MOSAA), these services are only available in certain clinics and they require personnel from HSD or training of their staff by HSD. Patients would be left dependent on the mercy of providers and the Department.

Even if Medicaid enrollment assistance is available in a clinic or hospital, there will be cases where patients are unable to apply for Medicaid before receiving treatment- such as emergency situations or when patients are transferred between facilities. Any safeguard for these instances would no longer be available if HSD eliminates retroactive coverage. This will result in compounding medical debt and financial burden for the lowest income families in New Mexico. We strongly urge the Department to not implement this proposed regulation.

2. <u>8.296.400.9 - HSD should not impose new premiums.</u>

HSD's proposal to charge low-income patients with new monthly premium fees could cause tens of thousands of New Mexicans to lose healthcare coverage. The proposed regulations specifically target adults living on the edge of poverty with incomes just above 100% FPL. Individuals who cannot pay monthly premiums will be locked out of Medicaid for a minimum of three months. Such individuals will only be allowed to receive Medicaid coverage again upon the completion of the three-month "lock-out" period and receipt of the mandatory premiums. Medicaid is a critical safety net for these individuals to receive life-saving and medically necessary treatments without suffering financial ruin.

HSD has not investigated or analyzed the impact of premiums on access to care for low-income patients. Instead, HSD continues to ignore a large body of research that clearly shows premiums, even at nominal levels, cause families to lose healthcare.[5] HSD also continues to disregard the widespread opposition from New Mexicans to this proposal. The proposed premiums for adults should be withdrawn for the following reasons:

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[5] See Michael Hendryx, *et al*, "Effects of a Cost-Sharing Policy on Disenrollment from a State Health Insurance Program", *Social Work in Public Health*, 27, 7:671-686 (2012); Bill J. Wright et al., "The Impact of Increased Cost Sharing on Medicaid Enrollees", *Health Affairs* 24, no.4:1106-1116 (Jul/Aug. 2005); Matthew J. Carlson and Bill Wright, "The Impact of Program Changes on Enrollment Access, and Utilization in the Oregon Health Plan Standard Population", Prepared for the Office for Oregon Health Policy and Research, *Sociology Faculty Publications and Presentations*, Paper 14 (March 2005); Gene LeCouteur, er al, *The Impact of Medicaid Reductions in Oregon: Focus Group Insight* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured)(Dec. 2004); Utah Department of Health Center for Health Data, *Utah Primary Care Network Disenrollment Report* (Salt Lake City, UT: Utah Department of Health Center for Health Data, Office of Health Care Statistics)(Aug. 2004).

CMS does not have legal authority to waive statutory provisions that prohibit premiums for families with incomes below 150 percent of the federal poverty level.

Imposing premiums on Medicaid participants through the Section 1115 process requires waiving federal requirements in violation of the Medicaid Act. Section 1115 waivers only extend to provisions in 42 U.S.C. 1396a. However, cost sharing requirements, including premiums, are regulated by 42 U.S.C. 1396o and 1396o-1. By its terms, Section 1115 authorizes the federal government to waive only those Medicaid requirements contained in 42 U.S.C. §1396a. Therefore, these statutes operate outside the permissible section of 1396a and the patient protections they provide cannot be waived by CMS through the 1115 process. HSD must immediately withdraw this illegal proposal.

Premiums will result in massive losses of coverage

Research has consistently found that monthly premiums fees for Medicaid coverage results in a large share of Medicaid patients losing their coverage. A study conducted by the Urban Institute in the 1990s found a 16% decline in Medicaid enrollment when patients were charged premiums that equaled one percent of their family income, a 49% decline in enrollment when patients were charged premiums that equal three percent of family income, and 74% when patients were charged premiums that equaled five percent of family income.[6] New Mexico can expect to see similar drops in enrollment as the proposed premiums are very similar to those in the study.

In 2003, Oregon increased premiums for its Medicaid expansion program through waiver authority on a sliding scale from $6 to $20 per month, eliminated the exemptions from premiums for those with no income, and denied enrollment for six months to any enrollee that missed or was late in making a single payment. Within nine months, 50,000 people lost coverage, with three-quarters becoming uninsured.[7] Those who lost coverage were four to five times more likely to report using the emergency room for their usual source of care than people who were able to maintain their enrollment in Medicaid.[8]

Premiums deter access to healthcare- worsening health outcomes and driving up costs in the healthcare system.

Studies also show that individuals who lose healthcare coverage due to premium increases face additional barriers to accessing care, have greater unmet healthcare needs, and have more

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[6] L. Ku & T. Coughlin, Sliding Scale Premium Health Insurance Programs : Four States' Experiences, Inquiry, 36: 471-480 (Winter 1999-2000), available at www.urban.org/publications/1000270.html.

[7] L. Ku & V. Wachino, "The Effect of Increased Cost-Sharing in Medicaid", Center on Budget and Policy Priorities, 8 (July 2005), *available* at http://www.cbpp.org/files/5-31-05health2.pdf.

[8] *Id.*

financial burden to carry.[9] Research also shows that these negative effects are among individuals with the greatest healthcare needs.[10]

While the state may see short-term financial gain due to people losing Medicaid, it will pay over the long term by damaging the healthcare system. The uninsured rate will rise with new premiums, increasing uncompensated care costs for healthcare clinic and hospitals. All those seeking care will feel this impact, as more individuals who have lost their Medicaid coverage are forced to seek care in emergencies room, contributing to more expensive and lower quality care.

The administrative costs of premiums do not justify their collection from low-income patients.

The administrative costs of imposing premiums are also higher than the small amount of money that could be collected through premiums. In 2001, Virginia imposed a $15 per child month premium for children between 150 and 200% FPL. The state spent $1.39 to collect every $1.00, and put about 6,000 children at risk of losing coverage for failure to pay.[11] In 2006, Arizona's Medicaid agency conducted an analysis of the new levels of cost sharing permissible under the Deficit Reduction Act of 2005. The report found that the state would incur almost $16 million in administrative costs to collect $5.6 million in co-pays and premiums.[12] HSD has struggled to effectively administer the Medicaid program, including implementing real time enrollment and providing uniform worker manuals to correctly administer the current program and ensure compliance with federal law and guidance. Correctly administering the new proposed premiums will require significant resources and efforts, including ensuring proper determinations of premiums, based on correct income attestations, and exemptions of enrollees. The Department must also ensure timely and correct notification is provided to all enrollees subject to these new requirements. HSD has historically struggled to do this properly.

The premium proposals violate the objectives of the Medicaid Act

Section 1115 waivers are also limited to experiments, pilots and demonstrations that will further the objectives of the Medicaid Act to improve access to care. Premiums have been tested and studied. The research shows that monthly premiums result in families losing healthcare. HSD has not evaluated the potential loss of healthcare coverage for patients, detrimental health outcomes, cost shifting to providers, or even the administrative costs or burdens to the agency itself.

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[9] See generally, *supra* note 5.

[10] See Carlson and Wright, *supra* note 7; see *also* Rachel Solotaroff, et al., "Medicaid Programme Changes and the Chronically Ill: Early Results from a Prospective Cohort Study of the Oregon Health Plan", *Chronic Illness* 1, (2005):191-205.

[11] L. Summer & C. Mann, *"Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences and Remedies"*, The Commonwealth Fund (June 2006). Available at: http://www.commonwealthfund.org/usr_doc/Summer_instabilitypubhltinschildren_935.pdf?section=4039.

[12] State of Arizona, Arizona Health Care Cost Containment System ("AHCCCS"), *"Fiscal Impact of Implementing Cost Sharing and Benchmark Benefit Provisions of the Federal Deficit Reduction Act of 2005"*, 2 (December 2006). Available at http://www.azahcccs.gov/reporting/Downloads/CostSharing/FINAL_Cost_Sharing_Report.pdf.

Premiums are ultimately a penalty for people with the highest healthcare needs that are living on the most limited of resources. New Mexicans need and deserve better healthcare options.

We urge the Department to abandon the proposed regulatory changes and instead limit implementation of New Mexico's waiver to items that will strengthen Medicaid and patient access to care. These include improvements to care coordination; expanding Centennial Home Visiting programs across the state that are culturally and linguistically relevant; implementing a seamless suspension process for individual being released from incarceration; taking advantage of opportunities to leverage federal funding in addressing other social determinants, such as supportive housing as well as establishing payment methodologies to better support primary care workforce development.

Should you have any questions, please contact the New Mexico Center on Law and Poverty at (505) 255-2840 or email William Townley, William@nmpovertylaw.org, or Abuko D. Estrada, abuko@nmpovertylaw.org.

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Signed on behalf of:

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