Medicaid Cuts in Centennial Care 2.0

Legislative Health and Human Services – 9/20/17

Medicaid is Vital to New Mexico

900,000 people

Medicaid covers over 900,000 New Mexicans.

2/3 of children

Two-thirds of our children get healthcare through Medicaid.

$4 to $1 Match

NM receives $4 in federal matching funds for every $1 the State spends on Medicaid.

50,000 Jobs

Medicaid supports over 50,000 jobs in NM, mostly in our healthcare system.

NM center on law and poverty

Prepared by the New Mexico Center on Law and Poverty, September 20, 2017.
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The Human Services Department (HSD) released its draft application to renew the state's Medicaid waiver (Centennial Care 2.0). The plan would take effect for the five years between 2019-2024. HSD is seeking feedback from stakeholders in October 2017, and then intends to submit a final application to the federal government in November 2017.

The plan includes harmful and costly cuts to Medicaid. Disrupting healthcare coverage will create financial hardships for our families, drive up long term costs for the state's healthcare system, and lose significant federal matching funds for Medicaid that help sustain jobs and our economy in New Mexico. The changes include:

- **Patient Fees (Premiums and Co-Pays):** Charging new monthly premium fees and co-pays for children, the working disabled, and other low-income adults living near the poverty level will cause thousands of people to lose Medicaid coverage and access to necessary medical care;
- **Ending retroactive coverage** that protects patients from debt by paying for the past medical bills that a person had in the three months before applying for Medicaid;
- **Ending a "transitional Medicaid" program** that will result in coverage loss for families living in poverty when they take on new jobs, promotions, or have temporary changes in earnings;
- **Reducing health benefits** for parents living in deep poverty, eliminating federally required EPSDT coverage for 19-20 year olds, and giving the HSD secretary broad authority to cut more health benefits in the future.

The plan should instead focus on improving access to care. Some promising practices are included to coordinate care more effectively and promote health literacy and better outcomes, such as targeted home visitation for young children and providing transitional care for people re-entering the community from detention facilities. These proposals should be encouraged and implemented with strong evaluation systems and feedback from stakeholders.

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Medicaid Premiums and Co-Pays: Hidden Taxes for Low-Income Families

Centennial Care 2.0 would charge new premiums and co-pays for Medicaid patients, mostly for children, working disabled individuals and low-income adults living near the poverty line -- for example, a parent who earns $1354 a month. Co-pays for brand name prescriptions and non-emergent use of the ER would apply to every Medicaid patient regardless of income.

Thousands of people will lose healthcare coverage. Numerous studies of other states that charged similar Medicaid premiums have found that patients struggled to keep up with the monthly fees and thousands of people lost their healthcare coverage.[i]

Fees prevent access to essential healthcare services. Studies also show that co-pays deter people from seeking necessary care, leading to poor health outcomes and overuse of the emergency room.[ii]

Fees penalize New Mexicans who are doing their best with limited resources. Even co-pays that seem "nominal" add up, especially for children and adults with chronic medical conditions or disabilities. Families should not have to choose between food, rent, or healthcare.

Our healthcare system will be strained with higher costs, especially in rural areas. Patients without coverage turn to the emergency room, resulting in more costly services that must be paid for by government indigent care funds or higher private insurance premiums.[iii]

"It is misguided for the state to save money on the backs of our most vulnerable children. In the long-term, increased burdens on behavioral and physical health for New Mexican families and children will cost the state millions more than these premiums and co-pays will yield. – J. Paul Taylor Task Force

"[Our County] [u]rges HSD not to impose premiums on adults…These adults may choose to opt out of the Medicaid program and may go without diagnosis, treatment, and/or medications resulting in greater risk of requiring a more expensive but uncompensated level of care such as emergency department visits and hospital patient admissions." – County Manager

*Quotes taken from written comments submitted to HSD regarding Centennial Care 2.0 concept paper

The state budget could see long-term costs due to higher administrative costs (as some states have found it more expensive to administer premiums than what they can collect), untreated and aggravated health conditions, increased use of the ER, and more uncompensated care that is paid through government safety net funds.[iv]

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HSD's Premium Proposal

Table 3 – Proposed Monthly Premiums for Incomes above 100% FPL

FPL Range	Annual Household Income (HH of 1)	Applicable Categories of Eligibility (COE)	Monthly Premium 2019	Household Rate 2019	Monthly Premium Subsequent Years of Waiver (state's option)	Household Rate Subsequent Years of Waiver (state's option)
101-150%	$12,060-$18,090	OAG, WDI, TMA	$10	$20	$20	$40
151-200%	$18,091-$24,120	WDI, TMA, CHIP	$15	$30	$30	$60
201-250%	$24,121-$30,150	WDI, TMA, CHIP	$20	$40	$40	$80
251-300%	$30,151-$36,180	TMA, CHIP	$25	$50	$50	$100

- Native American members will be exempt from premiums;

HSD's Co-Pay Proposal

Table 4 – Proposed Co-payments

	Children's Health Insurance Program (CHIP)	Working Disabled Individuals (WDI)	Expansion Adults	All Other Medicaid
Population Characteristics and Service	Age 0-5: 241-300% FPL Age 6-18: 191-240% FPL	Up to 250% FPL	Co-pays for individuals with income greater than 100% FPL.	
Outpatient office visits • Preventive visits exempt • BH outpatient exempt	$5/visit	$5/visit	$5/visit	No co-pay
Inpatient hospital stays	$50/stay	$50/stay	$50/stay	No co-pay
Outpatient surgeries	$50/surgery	$50/surgery	$50/surgery	No co-pay
Prescription drugs, medical equipment and supplies • Psychotropic drugs and family planning drugs/supplies exempt • Not charged if non-preferred drug co-pay is applied	$2/prescription	$2/prescription	$2/prescription	No co-pay
Non-Preferred prescription drugs • Psychotropic drugs and family planning drugs/supplies exempt	$8/prescription All FPLs and COEs, certain exemptions will apply			
Non-emergency ER visits	$8/visit All FPLs and COEs, certain exemptions will apply			

The following populations would be exempt from all copayments:

- Native Americans;
- ICF-IID individuals;
- QMB/SLIMB/QI1 individuals;
- Individuals on Family Planning-Only;

Ending Retroactive Coverage Will Throw Families into Financial Debt

Centennial Care 2.0 would end retroactive coverage – a protection that pays for any hospital and medical bills that a person had over the past three months before signing up for Medicaid, only if they would were eligible for Medicaid at the time of service, but not enrolled yet.

Retroactive Coverage Protects Our Families and Healthcare System:

- Without retroactive coverage, **just one hospitalization could turn into crushing medical debt for a family** that should have been enrolled in Medicaid. Hospital bills can range from $10,000 to well over $100,000, leaving patients on limited incomes stuck with huge bills that cannot be paid and will be sent to collections agencies.[v]

- People **often don't know they qualify for Medicaid** until they get sick and must go to the hospital or see a doctor. Retroactive coverage ensures those bills are paid. According to HSD's own numbers, 10,000 individuals needed this protection in 2016.

- This coverage also **protects people when it is impossible to sign up Medicaid right away** because of illness, hardship, transportation difficulties, disability, or barriers with getting service at an Income Support Division (ISD) office to apply for Medicaid. Even with "real-time enrollment", there will be cases where individuals cannot sign up, or a healthcare provider cannot submit application paperwork, right away.

"On many occasions, pediatric patients of all ages present in life-threatening conditions requiring intensive care and transfer to regional referral centers without having Medicaid established….these situations can be so dire that applying for Medicaid is not a parent's first priority…

Loss of retroactive Medicaid would likely result in large losses to hospitals, health systems, and private practitioners."

– Brian Etheridge, MD, FAAP, President, NM Pediatric Society

*Quote taken from written comments submitted to HSD regarding Centennial Care 2.0 concept paper

- If Medicaid doesn't cover these bills, **hospitals and healthcare providers will not be paid**, leaving them with uncompensated care costs and unable to offer high quality care – especially safety net clinics and hospitals that treat a higher share of Medicaid patients.

- Although HSD says its proposal will reduce administrative tasks for insurance companies, **this is no excuse for denying people the healthcare coverage they qualify for.**

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Reducing Health Benefits for Parents Living in Deep Poverty and Children

Centennial Care 2.0 cuts important health benefits that will result in:

- Financial Hardships: Parents living in deep poverty will be forced to pay more out of pocket for healthcare services making it more difficult to overcome poverty and care for their children.

- Untreated Health Conditions, Lost Productivity and Lost Work Opportunities: The services being cut are necessary to live and work productively, including hearing aids, eyeglasses, orthotics and physical, speech and occupational therapy.

- Damaged Healthcare Infrastructure for All Patients: Cuts to Medicaid benefits will shift costs to healthcare providers, straining a system that already faces numerous workforce shortages.

1. Cuts to health benefits for parents & caretakers living in deep poverty: Centennial Care 2.0 cuts health benefits for parents and caretakers with dependent children who make roughly only 45% of the poverty level – less than $923 per month for a family of four. These patients currently receive the full Medicaid package of benefits. The Human Services Department (HSD) is proposing to limit their health benefits to what is known as the "Alternative Benefit Package" (ABP). While the ABP provides a minimum set of "essential health benefits" required under the law, switching to this package for families living in deep poverty would mean reduced services in key areas:

- Hearing aids and hearing testing would not be covered.
- Vision coverage would be restricted and eyeglasses would only be covered for individuals who have cataracts removed.
- Coverage for disposable medical supplies would be limited to diabetic and contraceptive supplies. Foot orthotics, such as shoes and arch supports, would only be covered when part of a leg brace or diabetic shoes.
- Short-term physical, speech or occupation therapy would be limited to two consecutive months per condition. Long-term therapies would not be covered at all.
- Community benefits would only be covered for people identified as "medically frail". Nursing facility care would generally not be covered except after being discharged after a hospitalization to your home when skilled nursing services are medically necessary on a short-term basis.

II. Eliminates EPSDT protections for children who are 19-20 years old: The plan would no longer require New Mexico to provide the federally required Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for 19 and 20 year olds – a comprehensive benefit that ensures children and young adults get necessary medical screenings and treatments for healthy development at every age.

III. Allows for drastic cuts in the future, including to transportation services: The plan gives the HSD Secretary total discretion to redesign the Alternative Benefits Package, including by cutting transportation services and other benefits that will prevent low-income families from accessing care.

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Ending Transitional Medicaid Assistance Interrupts Coverage and Financial Stability

Centennial Care 2.0 seeks to end Transitional Medicaid Assistance. This program currently extends Medicaid enrollment temporarily for up to a year to the lowest income parents and caretakers who have changes to their incomes that make them no longer qualified for Medicaid.

These families are transitioning from living in deep poverty to taking on new jobs, promotions or full-time work. However, their employers may not offer coverage and for low wage workers, health insurance is still unaffordable on the private market. Families with incomes between 138% to 225% of the poverty level are especially at risk of not being able to afford basic monthly living expenses or health insurance, even with the help of subsidies.[vi]

Transitional Medicaid Assistance was established to provide continuity of care while supporting individuals and families to obtain financial stability.

Ending Transitional Medicaid Assistance would:

- **Create hardships for low income families.** Ending Transitional Medicaid for parents living in deep poverty will make it more difficult for families to become financially secure and have continuous access to healthcare when they take new jobs or promotions. These families often have significant debts to overcome and may not be offered healthcare in their jobs.

- **Disrupt coverage and worsen health outcomes.** Studies have shown that Medicaid enrollees who experience gaps in coverage because of churning often experience poor health outcomes. They tend to delay seeking routine care or skip needed treatments. When they move between coverage types, they must switch plans, resulting in changes in their doctor, disruptions in medical care, and complications with access to medications.

- **Increase administrative costs**. Fluctuating wages or other circumstances, such as healthcare crises, may affect an individual's ability to maintain work, causing them to churn in and out of Medicaid coverage. Patients churning in and out of public benefit programs costs states significant amounts to the budget. Recent research on the SNAP program found that each time a case churns, it costs the State an additional $74.00.

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CITATIONS

PREMIUMS & COPAYS

[i] L. Ku & T. Coughlin, *Sliding-Scale Premium Health Insurance Programs: Four States' Experiences*, Inquiry, 36: 471-480 (Winter 1999-2000), *available at* http://www.urban.org/publications/1000270.html; L. Ku & V. Wachino, *The Effect of Increased Cost-Sharing in Medicaid*, Center on Budget and Policy Priorities ("CBPP"), 8 (July 2005), *available at* http://www.cbpp.org/files/5-31-05health2.pdf; J. Boylston Herndon, et al., *The Effect of Premium Changes on SCHIP Enrollment Duration*, Health Services Research, 43: 458-477 (Sep. 2007), *available at* http://onlinelibrary.wiley.com/doi/10.1111/j.1475-6773.2007.00777.x/abstract; T. Johnson, M. Rimsza, & W. Johnson, *The Effects of Cost-Shifting in the State Children's Health Insurance Program*, American Journal of Public Health, 96: 709-715 (April 2006), *available at* http://ajph.aphapublications.org/cgi/content/abstract/96/4/709; *Cost Sharing for Children and Families in Medicaid and SCHIP*. Georgetown University Health Policy Institute, Center for Children and Families, 3 (Sep. 2008), *available at* http://www.rwjf.org/files/research/3559.cost.sharing.pdf; *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, et al, *The Impact of Medicaid Reductions in Oregon: Focus Group Insights,* (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); *See* Carlson and Wright, *supra* note 11; *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.

[ii]Robert H. Brook et al., Rand Corp., *The Health Insurance Experiment: A Classic Rand Study Speaks to the Current Healthcare Reform Debate*, at 2 (2006); Melody Mendiola, et. al., *Medicaid Patients Perceive Copays as a Barrier to Medication Compliance,* Hennepin County Medical Center, Minneapolis, MN, presentations in 2004 and 2005 (reporting on a survey of 62 patients); Leighton Ku, et al., *The Effects of Copayments in the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program*, Center on Budget and Policy Priorities (Nov. 2004); Neal T. Wallace et al., *How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan*, HEALTH SERV. RES. 43(2): 515–530 (Apr. 2008), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2442363/pdf/hesr0043-0515.pdf; Robyn Tamblyn, et. al., *Adverse Events Associated with Prescription Drug Cost-Sharing among Poor and Elderly Persons,* JOURNAL OF THE AMERICAN MEDICAL ASSOC., 285(4): 421-429 (Jan. 2001).

[iii] 32 of New Mexico's 33 counties have been designated as Health Professional Shortage Areas (HPSAs) for primary care, dental care, and mental health. http://www.nmms.org/sites/default/files/images/nmhcwfc_2015report_final.pdf. *See also* Health Care Not Welfare Project, *Appropriate Rate Structure for Services Rendered and Estimated Percent of Co-Pays Collected Under the Medicaid Program*, Submitted to the Oklahoma Healthcare Authority (Jan. 2004), *available at* http://www.statecoverage.org/files/Appropriate%20Rate%20Structure%20for%20Services%20Rendered%20and%20Estimates%20Percent%20of%20Co-Pays%20Collected%20under%20the%20Medicaid%20Program.pdf.

[iv] 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. 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. Neal T. Wallace et al., *How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience*

from the Oregon Health Plan, HEALTH SERV. RES. 43(2): 515–530 (Apr. 2008), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2442363/pdf/hesr0043-0515.pdf

RETROACTIVE COVERAGE

[v] "The Uninsured, a Primer: Key Facts About Americans Without Health Insurance", 14 (Kaiser Family Foundation, October 2011). Available at: http://www.kff.org/uninsured/upload/7451-07.pdf; Anderson G. 2007. "From 'Soak The Rich' To 'Soak The Poor': Recent Trends In Hospital Pricing." *Health Affairs* 26(4): 780-789; Finkelstein A, et al. "The Oregon Health Insurance Experiment: Evidence From the First Year", (National Bureau of Economic Research, 2011). Available at http://www.nber.org/papers/w17190.

TRANSITIONAL MEDICAL ASSISTANCE

[vi] *See* Economic Policy Institute, Family Budget Calculator, August 2015 (using 2014 dollar estimates), available at: http://www.epi.org/resources/budget/. Households under 225% of the poverty level face monthly budget deficits because their income is typically insufficient to meet the average costs of housing, food, child care, transportation and other necessities.