JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

September 15, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

**Subject: MaineCare 1115 Demonstration Project Application**

Dear Administrator Verma:

Thank you for the opportunity to comment on Maine's proposed MaineCare 1115 demonstration project. As discussed below, we believe that several of Maine's proposals are counterproductive, and we appreciate the opportunity to point out how those proposals will disadvantage low-income older MaineCare members.

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources. We are joined by the Center for Medicare Advocacy, the Medicare Rights Center, and the National Council on Aging in opposing Maine's 1115 demonstration application.

As discussed in more detail below, Maine's proposal would negatively impact the older persons and persons with disabilities who rely on Medicaid. In particular, we are concerned with proposals to impose emergency department copays, eliminate retroactive eligibility for certain MaineCare members, and impose transfer penalties on Medicaid-compliant annuities,

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve an "experimental, pilot, or demonstration project … [that] is likely to assist in promoting the objectives" of the Medicaid program. As explained below, Maine's proposals cannot be approved because, separately and together, they are inconsistent with the provisions of Section 1115.

## Imposing Emergency Department Copayments Would Dissuade Beneficiaries from Seeking Necessary Care

Maine proposes to impose a $10 copayment on persons who use a hospital emergency department (ED), if the ultimate diagnosis is listed on Appendix A (*e.g.*, using the ED for what is later diagnosed as severe asthma or chronic obstructive pulmonary disease). The charge will be imposed even when a prudent layperson would have gone to the ED

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or when a person's physician advised him or her to go to the ED. These copayments, which would be imposed on older MaineCare members and others, should be rejected.

Importantly, the proposed copayments conflict with *non-waivable* provisions of the Medicaid Act. Section 1115 allows for waiver of provisions within 42 U.S.C. § 1396a, but copayment-related provisions are found outside of § 1396a. These provide limited authorization for copayments, along with beneficiary protections.[1]

First, under Sections 1396o(a)(2)(D), 1396o(b)(2)(D), and 1396o-1(b)(3)(B)(vi)—all non-waivable—cost-sharing may not be imposed on "emergency services." Emergency services include services necessary to evaluate or stabilize any condition for which a "prudent layperson" would understand the need for immediate medical attention.[2] But Maine's proposed copayments would be imposed even if the person used the ED for an *emergency*. For instance, an older MaineCare member suffering a severe asthma attack, who prudently reports to the emergency department, would be charged the copayment based on the State's ultimate, post hoc diagnosis.[3] The State would likewise impose a copayment on a person who suffers acute respiratory problems or difficulty breathing, if the State later codes the underlying diagnosis as COPD or bronchitis.[4]

These copayments would be especially punitive towards older Medicaid beneficiaries, since they are more likely to experience such health issues and often face greater barriers to accessing care. It would be entirely unfair to penalize a layperson for choosing emergency room care when he or she is experiencing breathing difficulty, weakness, or pain; this is particularly true in the case of an older adult who may have a cognitive impairment. Additionally, older adults are less likely to have access to their own transportation, and MaineCare's Non-Emergency Transportation service may not be able to assist them in getting to a physician's office.

Next, a separate federal statute would be violated even if the proposed copayments were imposed for true *non-emergency* services. Section 1396o-1(e) allows copayments to be imposed *only if* they are below a certain amount and meet the following conditions: (1) the Medicaid beneficiary has an actually available and accessible alternative to the ED for the service, (2) the hospital informs the individual, after conducting the EMTALA screen, of the copayment and the name and location of alternative provider, and (3) the hospital provides a referral to that alternative provider.[5] Maine's proposal does not comply with these nonwaivable requirements.

In addition, the proposed copayments fail to comply with any of the five conditions set forth in 42 U.S.C. § 1396o(f) for approval of copayments that do not comply with the requirements discussed above.

[1] *See* 42 U.S.C. §§ 1396o, 1396o-1.
[2] 42 CFR § 447.51.
[3] Application at 20 (listing "severe persistent asthma, uncomplicated" as a diagnosis which triggers the copayment).
[4] Application at 20-21.
[5] *Id*. § 1396o-1(e).

1. The use of ED copayments has been extensively studied (as described below) and, therefore, Maine's proposal does not "test a unique and previously untested use of copayments." 42 U.S.C. § 1396o(f)(1)
2. Maine seeks to impose the copayments for five years—well beyond the two-year limit imposed by statute. § 1396o(f)(2).
3. The proposed copayments offer no benefits to MaineCare members, and instead threaten to deter appropriate ED use, contrary to the requirements of 42 U.S.C. § 1396o(f)(3).
4. The use of copayments applies to all members, without "the use of control groups of similar recipients of medical assistance in the area," in violation of § 1396o(f)(4).
5. (5) The copayments are not voluntary and provide no "provision for assumption of liability for preventable damage to the health of recipients . . . resulting from involuntary participation." § 1396o(f)(5).

Finally, even if these affordability protections were waivable under Section 1115, the proposed use of copayments is both not experimental and not likely to promote the objectives of Medicaid. Over the last 35 years, cost sharing has been one of the most heavily studied aspects of the Medicaid program and these studies have produced redundant, consistent findings: copayments harm low-income people by causing them to forego medically necessary care.[6] Moreover, studies of Medicaid and CHIP nonemergency ED copayments specifically, including peer-reviewed evaluations of nonemergency ED copayments, consistently show that: (1) Medicaid enrollees use the ED at comparable rates to private pay patients if you factor in their health status, and are no more likely to use the ED for non-urgent visits; and (2) copayments are ineffective at reducing nonemergency ED use.[7]

**Eliminating Retroactive Coverage Will Deprive Low-Income Persons of Needed Coverage**

The proposed waiver seeks to eliminate retroactive eligibility under 42 U.S.C. § 1396a(a)(34), which requires retroactive coverage for the three months prior to the month of application, provided that the applicant otherwise meets the eligibility requirements during the months and has incurred medical expenses. Maine alleges its proposed eligibility change is "consistent with private insurance coverage," and designed to have providers determine insurance status at the time of delivering the service and encourage people to enroll early to receive preventive care.

Maine's request ignores the important benefits of retroactive coverage. When the

[6] *See* David Machledt & Jane Perkins, National Health Law Program, *Medicaid Premiums and Cost Sharing* (March 2014) available at http://www.healthlaw.org/publications/search-publications/Medicaid-Premiums-Cost-Sharing#.U5cW-ij3Ijw.

[7] *Id.*; Mona Siddiqui et al., *The Effect of Emergency Department Copayments for Medicaid Beneficiaries Following the Deficit Reduction Act of 2005*, 175 JAMA INTERNAL MED. 393 (2015); Karoline Mortensen, *Copayments Did Not Reduce Medicaid Enrollees' Nonemergency Use of Emergency Departments*, 29 HEALTH AFFAIRS 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).

retroactive coverage guarantee was established in 1972, the Senate Finance Committee noted that the provision would "protect[] persons who are eligible for [M]edicaid but do not apply for assistance until after they have received care, either because they did not know about the [M]edicaid eligibility requirements or because the sudden nature of their illness prevented their applying." This statement is just as true now as it was 45 years ago. A person in need of health care cannot be expected to make instantaneous applications for Medicaid coverage. She may be hospitalized after an accident or unforeseen medical emergency. She may also be unfamiliar with Medicaid, or unsure about when her declining financial resources might fall within the Medicaid eligibility threshold. The three-month retroactivity window is a rational and humane response to these concerns. We note and emphasize again that retroactive eligibility is only available to persons who meet Medicaid eligibility standards for the month[s] in question.

Maine claims that eliminating Medicaid retroactivity is consistent with private insurance coverage. This rationale makes little sense, given the substantial differences between Medicaid and commercial insurance. The principal difference is the fact that commercial insurance relies on premium payments, while Medicaid coverage is based upon a determination that a person has limited financial resources and thus cannot afford private coverage. Retroactive coverage is not allowed in commercial insurance because the program's financing relies on premium payments in advance, before a person knows the medical services that he or she may require in any particular month. The same is not true in Medicaid, which does not require premiums from its low-income beneficiaries.

The loss of retroactive eligibility would harm older adults, including those persons who rely on the Medicare Savings Programs to help pay Medicare premiums. These critically important programs reach older adults who are too poor to be able to afford Medicare, as well as people with disabilities who are working but need assistance with their Medicare premiums. Specified Low-Income Beneficiaries, Qualifying Individuals, and Qualified Disabled Working Individuals are eligible for help with their Medicare premiums during the 3-month retroactive eligibility period.[8] The cost savings are significant for these low-income individuals: for example, the $134/month Part B premium can easily consume more than 10 percent of income, and 3-months of retroactive eligibility can provide a net $400 benefit.

Overall, elimination of retroactive coverage fails to meet the basic requirements for a Section 1115 waiver. Making Medicaid "consistent with private coverage" is not evidence that such a proposal is likely to promote the objectives of the Medicaid Act. Nor does requiring hospitals and other providers to determine insurance status prior to delivering services promote the objectives of the Medicaid Act. Furthermore, failing to pay providers for giving care to a person made ineligible for coverage under this proposal would only weaken MaineCare's ability to maintain an adequate network of providers and would increase uncompensated care, thus harming the ability of providers to treat the most vulnerable low-income beneficiaries.

[8] Qualified Medicare Beneficiaries are not eligible for retroactive coverage. *See* 42 U.S.C. § 1396d(a).

In short, the elimination of retroactive coverage would not encourage earlier applications. Instead, it would create more situations where a low-income person is unable to afford necessary health care, penalizing both Medicaid beneficiaries and health care providers. Maine's proposal is clearly noncompliant with Section 1115 requirements, and should be rejected.

## CMS Does Not Have Authority to Disadvantage Applicants by Changing Statutory Eligibility Rules

Maine is asking to waive the 42 U.S.C. § 1396p(c)(1)(F) prohibition on imposing a transfer penalty for the purchase of Medicaid-compliant annuities and institute a minimum payout period. Section 1396p is not subject to a demonstration waiver. In addition, this proposal directly contradicts the objectives of the Medicaid Act as expanding the asset transfer penalty rules would have the effect of restricting eligibility for long-term supports and services (LTSS).

In its application, Maine states, "The inability to impose restrictions and transfer penalties on Medicaid-compliant annuities has resulted in MaineCare eligibility for individuals who have personal assets that could be used to purchase health insurance coverage or pay for medical bills." However, Congress explicitly sought to protect these annuities when it enacted § 1396p(c)(1)(F) and established guardrails to prevent abuse. These bright-line rules require that annuities be actuarially sound, irrevocable and non-assignable, provide equal payments for the duration of the annuity, and name the state as a beneficiary. It is up to Congress, not CMS, to change these rules.

Maine's proposal will disadvantage the spouses of persons needing long-term services and supports. Medicaid law permits community spouses to purchase an annuity and maintain a reasonable income stream, rather than be forced to spend down the couple's entire retirement savings before qualifying for Medicaid. Imposing a transfer penalty on such annuity purchases will force more Maine couples into poverty.

We emphasize that eligibility standards are an entirely inappropriate subject for demonstration waivers. The current Medicaid annuity rules were enacted by Congress in the 2005 Deficit Reduction Act. Neither Maine nor CMS has any authority to change those rules administratively, and the proposed limitation on eligibility is not the appropriate subject of a demonstration waiver.

## Conclusion

Each of these proposals—imposing co-payments, eliminating retroactive coverage, and penalizing annuity purchases—would limit access to care for low-income citizens of Maine. The State of Maine has failed to elucidate any experimental purpose, or to explain how these proposals would promote the Medicaid Act's objectives. Waivers should be used to improve coverage, not to eliminate or limit coverage, or divert Medicaid-eligible persons into private coverage. If CMS were to approve Maine's

proposal, CMS's action would be arbitrary and capricious.[9] We urge CMS to reject Maine's harmful proposals.

Thank you for the opportunity to comment. If any questions arise concerning this submission, please contact Jennifer Goldberg, Directing Attorney at Justice in Aging, at jgoldberg@justiceinaging.org.

Sincerely,

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[9] *See, e.g.*, Beno v. Shalala, 30 F.3d 1057, 1069-71 (9th Cir. 1994).