



January 30, 2018

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

RE: New Mexico Centennial Care – 2017 Extension Application

Dear Administrator Verma:

The American College of Physicians appreciates this opportunity to comment on the New Mexico Centennial Care 2017 Extension Application. The American College of Physicians is the largest medical specialty organization and the second largest physician group in the United States, representing 152,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

The College supports a number of the state's proposals, including promotion of the patient-centered medical home and efforts to facilitate the integration of behavioral health services into the primary care setting by extending Screening, Brief Intervention, Referral, and Treatment services to the Medicaid population. We also favor proposals that lift the IMD exclusion and expand access to treatment for patients with substance use disorder. However, we have a number of concerns and offer the following comments:

Benefit and Delivery System Proposal

Benefit and Delivery System Proposal #1: Modify the Alternative Benefit Plan and provide a uniform benefit package for most Medicaid-covered Adults

We are concerned that the Centennial Care 2.0 Waiver renewal proposes to eliminate Early and Periodic Screening and Diagnostic and Treatment (EPSDT) coverage for 19 and 20 year olds. ACP strongly supports EPSDT benefits and urges the CMS to reject this proposal.

Proposals to Advance Member Engagement and Cost Sharing Responsibilities

Member Engagement and Cost Sharing Proposal #2: Implement premiums for the adult expansion population with household income that exceeds 100% FPL

ACP is concerned that the state's proposal to implement premiums and cost sharing for the Other Adult Group expansion population with household income that exceeds 100% FPL will undermine access to care. The proposal would impose monthly premiums of \$10 in 2019 and provide the state the option of raising the premium to \$20 a month in subsequent years. The state also seeks to implement policies that would align Medicaid premiums parameters with those of subsidized private marketplace-based coverage, including eliminating retroactive coverage.

Evidence shows that applying premium increases and inflexible premium payment deadlines causes disenrollment from Medicaid (i). Although cost-sharing could be used to steer enrollees toward high-value care, an enrollee unable to pay an excessive premium may be more likely to go uninsured. One study shows that a premium increase from zero to \$10 a month reduces the length of enrollment by 1.4 fewer months (ii). A comprehensive literature review on the effect of imposing premiums and cost-sharing on Medicaid beneficiaries found that "a large body of research shows that premiums can serve as a barrier to obtaining and maintaining Medicaid and CHIP coverage among low-income individuals (iii)." Overall, aligning Medicaid expansion and marketplace-based insurance could represent an erosion of coverage for this population. ACP opposes the proposed three-month lock-out period for failure to pay premiums. Lock-out policies are unduly harsh and unnecessarily punish people without the financial resources to afford health insurance.

Member Engagement and Cost Sharing Proposal #3: Require co-payments for two distinct services for most Centennial Care members

ACP believes that Medicaid premiums and cost-sharing should be structured in a way that does not discourage enrollment or cause enrollees to disenroll or delay or forgo care due to cost, especially those with chronic disease. If cost sharing is applied it should be done in a manner that encourages enrollees to seek high-value services and health care physicians and other health care professionals. Further, ACP believes that Medicaid out-of-pocket costs should remain nominal and be subject to a cap (i.e., no higher than 5% of family income) for those with incomes above the poverty line.

ACP agrees that patients should receive care in the most appropriate health care setting. However, non-emergent use of the emergency department (ED) is minimal. MACPAC found that only 10% of Medicaid-covered ED visits made by nonelderly patients were unnecessary (iv). Evidence shows that patients use the ED for non-emergent care for a variety of reasons, including inability to access their regular primary care physician. Non-emergent use of ED may indicate that the patient cannot access the most appropriate clinician, such as a primary care physician or subspecialist. Patients may also be unable to determine if their symptoms, such as chest pain, require urgent attention, and such conclusions may only be possible with a physician evaluation. Further, evidence on whether copayments reduce non-emergent use of the ED is mixed (iii). One study found that "granting states permission to collect copayments for non-urgent visits under the [Deficit Reduction Act of 2005] did not significantly change ED or outpatient medical provider use among Medicaid beneficiaries," indicating that requiring cost-sharing may not effectively discourage unnecessary use of the ED. Requiring copayments will also create administrative burdens for physicians and other health care professionals who have to collect payments or provide information about alternative health care settings to enrollees who seek care in the ED. CMS should consider factors like primary care access and patient health literacy when deciding whether to

require cost-sharing for nonemergency use of EDs and consider policy alternatives that better enable patients to visit the proper health care setting.

ACP is concerned about the proposal to require a copayment for a non-preferred drug when a preferred drug is available. As previously stated, ACP can support cost-sharing if it is used to direct patients towards value-based services. This could be achieved with a properly-developed preferred drug list if inclusion is based upon a drug's effectiveness, safety, and ease of administration rather than solely based on cost. ACP recommends that Pharmacy & Therapeutic Committees be representative of, and have the support of, the health care professionals that will utilize the preferred drug list.

ACP appreciates the opportunity to comment on the waiver. If you have any questions regarding our comments please contact Ryan Crowley, Senior Associate for Health Policy at rcrowley@acponline.org.

Sincerely,

Jack Ende, MD, MACP
President
American College of Physicians

Betty Chang, MDCM, PhD, FACP
Governor
New Mexico Chapter
American College of Physicians

ⁱ Wright BJ, Carlson MJ, Allen H, Holmgren AL, Rustvold DL. Raising Premiums and Other Costs for Oregon Health Plan Enrollees Drove Many to Drop Out. *Health Aff.* December 2010; 29(12): 2311-2316.

ⁱⁱ Dague L. The effect of Medicaid premiums on enrollment: A regression discontinuity approach. *J Health Econ.* 2014;

ⁱⁱⁱ Artiga S, Ubri P, and Zur J. The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings. Kaiser Family Foundation. 2017. Accessed at <http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Premiums-and-Cost-Sharing-on-Low-Income-Populations>

^{iv} Medicaid and CHIP Payment and Access Commission. Revisiting Emergency Department Use in Medicaid. July 2014. Accessed at https://www.macpac.gov/wp-content/uploads/2015/01/MACFacts-EDuse_2014-07.pdf