July 14, 2017

New Mexico Human Services Department
Office of the Secretary
ATTN: Medical Assistance Division Public Comments
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

VIA EMAIL

Comments on Proposed Rules to Amend NM Administrative Code 8.302.2 (Billing for Medicaid Services) and 8.308.14 (Cost Sharing)

Dear New Mexico Human Services Department,

We submit these comments on behalf of the undersigned organizations to express our strong opposition to the Human Services Department's (HSD) proposal to implement higher co-pay fees for Medicaid patients, targeting low-income adults who live near the poverty level, working disabled individuals and children in the Children's Health Insurance Program.

Higher fees for Medicaid are a direct hit to the pocketbooks of our families. They fly in the face of the values expressed by Governor Martinez who repeatedly assured the public that our families would not be "penalized" or asked to "carry the burden" for the state's budget challenges. Co-pays impose hidden fees on those least able to bear the costs – people living near poverty, low-income families with children, and people with disabilities.

Co-pays have been studied and repeatedly shown to reduce access to care or shift costs to healthcare providers. These fees delay necessary care, damage our healthcare system by forcing patients to seek care in emergency rooms, and create long-term costs for the State. The fees also yield minimal savings because providers often cannot collect the fees from low-income families.

The proposed rules will create significant administrative costs and burdens at a time when HSD is under court order for the improper administration of benefits programs including Medicaid. The Department should not attempt to impose new harmful fees when it still has not taken corrective actions to comply with federal law and the directives of the court.

The Department also faces widespread opposition to this proposal by stakeholders, and is proceeding without a legislative mandate. HSD's own subcommittee of the Medicaid Advisory Council -- a federally required advisory body of stakeholders, medical providers and experts -- rejected a similar proposal for co-pays last year. This year, the Legislature did not recommend co-payments in the language of House Bill 2 for the current fiscal year 2018.

We are disappointed that HSD is choosing to move forward unilaterally despite the harms to our families and serious concerns about the impact on our healthcare system.

I. Imposing higher co-pay fees in Medicaid will reduce patient access to care and contribute to more emergency room visits.

The State has recognized the harms of imposing cost-sharing and chose not to implement a law in 2009 that would have imposed co-pays on non-emergency uses of the emergency room. At that time, HSD, itself, cited the following concerns: "...negative consequences for recipients, causing individuals to delay or forgo needed care."; "cost sharing can be a barrier to access"; "imposing cost sharing could lead to higher costs overall, can lead to poorer health outcomes for recipients"; and "co-pays would create additional administrative burden for providers and could also lead to revenue losses for some providers."[1]

A wide body of research shows that shifting costs to low-income Medicaid patients results in them losing access to medically necessary care and creates difficulties in filling essential prescriptions. This results in untreated conditions, which lead to adverse consequences that include poorer health and higher use of far more expensive services, such as emergency rooms.

The RAND Health Insurance Experiment (HIE) - the landmark study on this issue – followed families for over a decade, assigning them randomly to either a health insurance plan that required co-pays or a no-cost plan. While the HIE showed that imposing patient fees reduced overall use of services and total health spending, the reduction came from essential and non-essential care in roughly equal proportions. By reducing essential care, the HIE found that the patient fees correlated with worse health outcomes for the poorest and sickest recipients.[2]

In Minnesota, a survey of a group of patients found that more than half of the patients reported being unable to get their prescriptions on at least one occasion in the previous six months because of co-pays. Around one-third of those who failed to get essential medications had higher use of the emergency room and hospital admissions for related medical issues.[3] In Utah, research found that when small co-pays of $2 or $3 per service were imposed on Medicaid beneficiaries below the poverty line, it led to a significant reduction in healthcare access.[4] Even though the co-pays were considered "nominal," four out of ten Utahans reported the co-pay increases as "serious" financial hardships, with many reporting the need to resort to coping strategies like reducing the amounts they spent on food and housing or stretching their prescriptions.[5] In 2003, Oregon implemented comprehensive and substantial co-pays for its adult Medicaid recipients. Research there found Medicaid patients avoided preventative care and instead used more costly hospital emergency care.[6]

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[1] NM Legislative Finance Committee, Fiscal Impact Report for HB 438 "Medicaid Cost Sharing for Emergency Room Services, 2 (Mar. 6, 2009), *available at* http://www.nmlegis.gov/Sessions/09%,20Regular/firs/HB0438.pdf.
[2] 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).
[3] 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).
[4] 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).
[5] *Id.*
[6] 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

Another study published in the Journal of the American Medical Association looked at the consequences of imposing co-pays on prescriptions for adults receiving public assistance in Quebec. The study found that after the fees were imposed, low-income adults filled fewer prescriptions. This led to significant increases in adverse events, including death and hospitalization as well as emergency room use.[7]

II. Co-pay fees penalize low-income New Mexicans, especially those with chronic health conditions and disabilities, and patients living in places where healthcare services are limited or unavailable.

Medicaid fees penalize New Mexican families who are doing the best they can with limited resources. Despite what may seem like a nominal fee - for example, $5 for an office visit to $50 for hospital visits - co-pay fees can be unmanageable for anyone on a fixed income who has to use much more of their limited resources to meet other basic needs. This is especially true for low-income individuals with disabilities or chronic health conditions who must make multiple visits to the doctor or need to fill multiple prescriptions. This forces New Mexicans into choices no person should ever have to make between rent, food, gas, medicine and other necessities.

Co-pays for hospital visits and "non-emergent" use of emergency rooms also penalize patients living in areas where primary and preventive care is limited or unavailable. Patients throughout New Mexico, especially in rural areas, often end up hospitalized or in the emergency room to seek care because they cannot find primary care or other services in their community due to severe shortages in healthcare practitioners. 32 of New Mexico's 33 counties have been designated as Health Professional Shortage Areas (HPSAs) for primary care, dental care, and mental health.[8] According to the Legislative Finance Committee, New Mexico faces statewide shortages of at least 2,000 physicians, about 400 to 600 primary care physicians, over 3,000 registered nurses, and 155 dentists.[9] The workforce shortages are heaviest in rural and frontier areas, where over 30% of the population lives.[10]

Although the Human Services Department is expecting that hospitals will comply with federal requirements that co-pays can only be charged in the emergency room if a patient had alternative sources of care that were available and accessible to the patient, but were not used,[11] these alternatives do not exist throughout New Mexico. As a result, hospitals will be unable to collect the co-pays in many cases, thereby shouldering additional uncompensated care costs.

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[7] 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).
[8] New Mexico Healthcare Workforce Committee Report, 2015 Annual Report, at 6 (Oct. 1, 2015) *available at* http://www.nmms.org/sites/default/files/images/nmhcwfc_2015report_final.pdf.
[9] New Mexico Legislative Finance Committee, Adequacy of New Mexico's Healthcare Systems Workforce, at 6-7 (May 15, 2013).
[10] *New Mexico Healthcare Workforce Committee Report, supra* note 8.
[11] 42 U.S.C. 1396o-1(e)(1)(A).

The rules are also ambiguous creating a high risk that hospitals will charge the co-pays wrongfully or inconsistently between facilities. Unfortunately, HSD's proposal does not truly clarify standards for hospitals to determine when patients may be charged co-pays, and fails to define when alternative care is deemed "available and accessible" in a non-emergency setting. Federal statute is clear that the alternative care must be available "contemporaneously" with the services provided in the emergency room.[12] The HSD rules, however, only state that this care must be available in a "timely manner" (mirroring federal regulations in 42 C.F.R. 447.54) without providing further guidance for hospitals.

The rule's ambiguity raises numerous questions. If a patient is referred to a clinical provider but cannot be seen for several weeks, has the standard for accessible and available care been met? Would the standard be met if the alternative provider is outside of a 30-mile radius or if the patient cannot secure immediate transportation to the appointment? Is alternative care considered "accessible" if it is only available between 9am-5pm for a parent that works full-time and cannot take sick days? The Department must clarify the rules or they will be applied inconsistently and erroneously, forcing patients – including the homeless, people living in poverty, very low wage workers, people with disabilities and people in need of behavioral health treatment – to pay a fee or forego accessing necessary and urgent medical care.

Further confusion is raised by not using the federal regulatory language around what constitutes an emergency medical condition. Under 42 C.F.R. 114(a), an emergency condition is defined as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:(i) Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) Serious impairment to bodily functions; (iii) Serious dysfunction of any bodily organ or part." Rather than reflecting this clear and mandatory language, the Department chose to define "non-emergency" as "any healthcare service provided to evaluate and treat any medical condition such that a prudent layperson possessing an average knowledge of medicine and health determines that immediate unscheduled medical care is not required."[13] This is a different, more ambiguous standard than federal law. It does not provide enough guidance for patients to know when a co-pay would be required. The differences in standards surely will cause confusion with healthcare providers and managed care organizations, increasing the likelihood that individuals will be erroneously charged this co-pay.

III. The proposal will negatively impact healthcare providers.

Co-pays not only shift costs to low-income Medicaid patients, they also shift costs to healthcare providers. For New Mexico, this proposal will act as an additional, hidden provider rate cut to the already low rates that were cut in fiscal year 2017. Instead of collecting the co-pays directly through Medicaid, the agency expects hospitals and healthcare providers to obtain the payments.

[12] 42 U.S.C. 1396o-1(e)(4)(B)
[13] *See* NM Human Services Department, Proposed Amendments to NMAC 8.302.2.10(G)(12)(b).

In a 2004 study from Oklahoma, providers reported collecting only 29% of the co-pay amounts from Medicaid recipients.[14] This meant healthcare providers were forced to bear the burden of providing uncompensated services.

The administrative costs of attempting to collect the fees will further strain hospitals, private practices, and clinics, resulting in fewer providers willing to take Medicaid patients. This will put our state at even more of a disadvantage when we face severe workforce shortages and our healthcare providers are already strained to provide services.[15]

IV. Imposing cost-shifting fees will increase healthcare costs for the State.

While states may see small short term financial gains from imposing or increasing cost-shifting fees, they tend to see long term negative effects on state revenues and healthcare costs due to uncollected fees, untreated and aggravated conditions, increased use of emergency rooms, more uncompensated costs for hospitals and providers when the costs of the uninsured or co-pays are shifted to them, and overwhelming pressure on community-based services and free clinics. In the Oregon study (referenced in Section I), because Medicaid patients went without preventive care and instead used costlier services, imposing patient fees did not provide the budget savings that the state expected.[16] In 2006, Arizona conducted an analysis of the new levels of cost-shifting fees allowed under the Deficit Reduction Act of 2005. Its report found that the state would incur almost $16 million in administrative costs to collect $5.6 million in co-pays and premiums.[17] New Mexico should expect to see similar results.

V. The cost savings are minimal compared to the cost burdens for patients, healthcare providers, and the State.

By imposing these fees, New Mexico will lose federal matching funds that generate tax revenue and sustain jobs in the healthcare industry. To gain $1.5 million of "savings", the State loses $6 million of federal matching funds that would have gone into New Mexico's healthcare system. Due to healthcare reform, especially Medicaid expansion, New Mexico was on the path to making much needed investments into healthcare facilities and the workforce. These gains will be undercut by shifting more costs onto providers and patients. The savings are miniscule compared to the overall Medicaid budget that tops $5.5 billion per year. Meanwhile, co-pays can multiply into large burdens for low-income families with limited budgets and for healthcare providers that are unable to collect the fees.

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[14] 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.

[15] New Mexico Legislative Finance Committee, Health Note: Medicaid Managed Care Provider Networks and Access to Care (April 2016), *available at* http://www.nmlegis.gov/lcs/lfc/lfcdocs/health%20notes%20-%20access%20to%20care.pdf (detailing New Mexico Medicaid recipients' struggles in accessing the healthcare system).

[16] *Supra* note 6.

[17] 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 (Dec. 2006), *available at* http://www.azahcccs.gov/reporting/Downloads/CostSharing/FINAL_Cost_Sharing_Report.pdf.

VI. Any savings from shifting costs to patients and healthcare providers will be negated by administrative costs of implementation.

HSD will face significant challenges in administering new co-pays in Medicaid, which will have implementation costs and will result in improper eligibility determinations if the program is not correctly administered. HSD will need to determine co-pay amounts at the time of the initial application process for new enrollees, revise benefit eligibility for hundreds of thousands of current enrollees whose co-pays are now being altered, provide new notices to patients, designate patients according to income and other criteria in its membership and notification systems for managed care organizations and hospitals, and make revisions whenever a person has a change in circumstances with their income. These changes could occur frequently, especially for adults and children in families whose income fluctuates.

HSD must also comply with federal guidance given to the Department last year that requires the amount to be used in determining co-pay fees is the amount a Medicaid patient *attests to* – not the documentation the person provides or the outcome of income verification processes used by the Department.[18] HSD's compliance in this area will be especially problematic if it is currently using other records to determine co-pay amounts, rather than each client's attestation of income. HSD would need to search back into application records to use the proper amount.

Finally, the Department will still incur high administrative costs despite attempting to delegate its duties regarding the implementation and monitoring of cost-shifting fees to the managed care organizations and providers. It is still HSD's responsibility to account for the 11 categories of Medicaid recipients that are exempt from cost sharing under federal rules,[19] assuring that they will not be charged with co-pays for services. Ultimately, much of this will rest on the efficiency of HSD's IT system and processes for enrollment, notifications, etc. One major challenge will be to properly flag Native Americans in the enrollment, IT system, and tracking and notification systems with healthcare providers and managed care organizations to ensure none of these individuals are subject to the fees.

Additionally, HSD will need to ensure that individuals are not paying more than an aggregate cap of five percent of their income toward cost sharing fees, including co-pays, as calculated on a quarterly or monthly basis.[20] HSD will need to ensure the process to track each family's incurred costs from co-pays is effective and not reliant upon a recipient's documentation.[21] Under this process, HSD must ensure that the managed care organizations are informing all recipients and providers of the recipient's aggregate limit for co-pays.[22] HSD must also monitor the managed care organizations to ensure that they notify recipients and providers when a patient's aggregate cap limit has been met and that the recipient is no longer

[18] Centers for Medicare and Medicaid Services, Letter to NM Medical Assistance Director, Re: Deficiencies Identified by CMS in New Mexico's Medicaid Application, Verification, and Renewal Process, Table 1 (Jan. 20, 2017).
[19] 42 C.F.R. 447.56(a)(1).
[20] 42 C.F.R. 447.56(f).
[21] *See Id.*
[22] *See Id.*

responsible for co-pays the remainder of the cap period.[23] HSD must also ensure the managed care organizations have a process in place for recipients to request a reassessment of the aggregate cap if they have a change in circumstances.[24]

The monitoring and administration of co-pays will be further complicated by numerous exceptions and limitations for when these amounts may be charged. This creates additional administrative burdens in altering the IT system, notices, and rules and regulations for patients and providers, where these limitations and conditions must be clearly described and accounted for. Overall, HSD cannot simply delegate these responsibilities to the managed care organizations, and must ensure proper compliance. This will include additional administrative hours to monitor and ensure the managed care organizations are properly tracking co-pays, educating providers, and notifying patients of their co-pay obligations and limits. The complexity of monitoring this compliance will undoubtedly incur substantial costs above and beyond any expected savings from imposing cost-shifting fees.

VII. HSD has no legislative mandate to implement co-pays

Contrary to its statement in this proposal, it is misleading for HSD to continue to state that it is "required" to implement co-pays under the 2016 General Appropriations Act (GAA). That language was placed in the appropriations bill in anticipation of HSD needing to make up for a budget shortfall in the FY 17 budget. However, HSD faced uniform opposition to implementing co-pays from its Medicaid Advisory Council subcommittee of stakeholders, and was able to find savings in other ways that actually resulted in a surplus of $5 million for FY 17. Those savings were reappropiated to the Department in FY 18 budget to use for IT purposes. This negates the need for co-pays as a cost containment measure for the FY 17 budget year. HSD cannot argue that the so-called "requirement" still stands for FY 18 either as language from the General Appropriations Act only applies to the fiscal year for which it is passed and the Legislature explicitly chose not to include any language around co-pays in its FY 18 budget – indicating co-pays were no longer required as cost containment.

For all of the reasons above, we urge the Department to rescind its proposal to amend the administrative code to impose co-pay fees on Medicaid patients. Should you have any questions, please contact the Center on Law and Poverty at 505-255-2840 or email Abuko D. Estrada, abuko@nmpovertylaw.org, or Sireesha Manne, sireesha@nmpovertylaw.org.

Respectfully,

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(continued)

[23] *See Id.*
[24] *See Id.*

On behalf of the following organizations:

American Congress of Obstetricians and Gynecologists - New Mexico Chapter
Casa de Salud
Centro Savila
EleValle: South Valley Healthy Communities Collaborative
Encuentro
Health Action New Mexico
Interfaith Worker Justice - NM
Lutheran Advocacy Ministry - NM
Native Health Initiative
New Mexico Academy of Family Physicians
New Mexico Asian Families Center
New Mexico Behavioral Health Provider Alliance
New Mexico Coalition to End Homelessness
New Mexico Legal Aid
New Mexico Medical Society
New Mexico Pediatric Society
New Mexico Voices for Children
Norton Kalishman, MD
Olé
Parents Reaching Out
Partnership for Community Action
Prosperity Works
RISE Stronger-New Mexico
Southwest Women's Law Center
Strong Families New Mexico