

THIS REVISED LETTER IS NOW OPEN FOR ENDORSEMENT: TO SIGN ON, PLEASE SEND EMAIL TO research@healthpolicyproject.org (in the subject line please write: "Sign on to Utah waiver recommendations")

The Honorable Kathleen Sebelius, Secretary
United States Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Sebelius:

We are concerned Utah's recent application for a demonstration waiver of Medicaid rules under Section 1115 of the Social Security Act could hinder access to medically necessary services for Medicaid consumers. After reviewing the waiver proposal, we have several concerns and specific recommendations we would like to bring to your attention.

The current proposal introduces cost sharing changes that could interfere with access to needed care. While inappropriate use of emergency rooms is a problem, and we agree that co-payments may be a valid tool for steering traffic to more appropriate settings, the waiver is missing critical details and safeguards around the health plans use of copayments for this purpose. High co-payments could potentially be used to deny patients access to expensive, but needed care.

With respect to this and other cost sharing changes, we recommend the following:

1. Any increases in cost sharing for E.R. use should be dependent on whether there is adequate access to primary care.¹ To achieve the goals of accountable care, an adequate network of providers is not enough. There should also be adequate access to after-hours care, given the peak hours of inappropriate E.R. use are 6:00-8:00 pm. The state might consider setting up an emergency department diversion program, along the lines of [Presbyterian Health System in Albuquerque, New Mexico](#).
2. Create a sliding scale, or a tiered program, acknowledging that families and individuals with different household incomes have different abilities to pay, drawing on lessons from Utah hospitals' financial assistance programs.
3. Provide cost-sharing protections for people with disabilities, children with special health care needs, and other vulnerable Medicaid communities.
4. Health plans' marketing materials should be appropriate and consistent with Federal standards for such materials. To this end, they should be approved by the Utah Department of Health before use. The waiver should have stronger rules and a transparent process for approving marketing material to prevent the ACOs from attracting the healthiest clients to their plans by marketing lower co-pays to them, and discouraging clients with persistent or chronic illness through higher co-pays.
5. Cost sharing changes should be aligned with the intent of Accountable Care Organizations and with changes in the Affordable Care Act related to coverage of preventive care. They should support the [principles of Value-Based Benefit or Insurance Design](#) (under this model, cost sharing is reduced for services that have strong evidence of clinical benefit).²
6. Children and adults on the disability waiver/waiting list should be exempt from the new cost sharing obligations.
7. The state should institute a cap on pharmaceutical co-pays to protect Medicaid consumers from being priced out of necessary prescriptions.

¹ Salt Lake Tribune (2011). Fewer Utah Doctors to Treat Medicaid Patients. <http://www.sltrib.com/sltrib/home2/52146012-183/medicaid-doctors-utah-patients.html.csp>.

² Learn more here: <http://www.sph.umich.edu/vbidcenter/>. Or here: <http://content.healthaffairs.org/content/29/11.toc>.

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The waiver request proposes giving Medicaid-eligible individuals the option to use Medicaid dollars to subsidize their portion of the premium for employer-sponsored insurance. The Congressional Budget Office has stated it is more cost effective (for all payers, including the taxpayer) to cover low-income individuals, defined as having household income less than 133% of poverty level, in Medicaid rather than in the ESI (employer sponsored insurance) or private market with subsidies.³ Further, the waiver asks that all cost sharing protections be waived under this premium subsidy program. This is an unacceptable risk and unreasonable expectation for low-income households.

We have additional concerns regarding the proposal to reduce benefits on a pre-determined schedule when Medicaid spending per member exceeds general fund growth targets. *If* such a priority list is implemented, CMS should consider the following:

1. Ensure that the process for determining what is on the priority list is aligned with evidence-based medicine, engaging local expertise, for example: The Institute for Health Care Delivery Research and/or HealthInsight as a neutral convener.
2. Create a mechanism (or entity, if needed) to bring local expertise (*see above*) to bear on benefit standards and methods for minimizing wasteful procedures.
3. Create safeguards and exceptions for dually eligible individuals or those with exceptionally high medical expenses but with income over the poverty level (the Medically Needy Program).
4. Create a transparent and accessible process for periodic review of the list.
5. Do not waive the EPSDT standards for medically necessary services. These standards exist to ensure our children's healthy growth and development.

The waiver states that medical homes will be at the core of the ACO but fails to explain what this really means. If the intent is for each ACO to formulate its own definition for "medical home," then at the very least the waiver should articulate parameters and a community input process for shaping this definition.

Based on our understanding of definitions in use around the U.S., the state should consider the following parameters for medical homes:

- Enhanced payments for medical homes that utilize chronic disease case-managers or require Medicaid ACOs to place case managers in large volume medical home sites.
- The definition should emphasize patient-centered medical homes, along the lines of the definitions used by the NCQA⁴ and the American Academy of Family Physicians. Utah's ACO medical home standards should interface with these scoring and accreditation processes.

The waiver request calls for mandatory enrollment of dual eligibles but provides no indication how the ACO will work with Medicare in order to provide specialized care that meets the unique needs of this vulnerable population. The waiver should clarify these issues.

The waiver proposal excludes services such as mental health and long term care and is unclear about whether there will be any care coordination provided to these group and if so, who will manage that coordination, the plan or the providers. Providing care coordination across the full

³ Congressional Budget Office (2009). Preliminary Analysis of the Chairman's Mark for the America's Healthy Future Act. http://www.cbo.gov/ftpdocs/106xx/doc10642/10-7-Baucus_letter.pdf

⁴ NCQA (2011). Patient-Centered Medical Home Overview. <http://www.ncqa.org/tabid/631/default.aspx>.

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spectrum of services-- preventive, acute, behavioral, and long-term care--is critical to achieving the inseparable goals of cost containment, improved quality, and better health outcomes for patients. Separating long-term care or mental health care from the broader ACO transition could easily perpetuate the institutional bias in Medicaid while limiting the potential for cost containment over the long term.

In closing, we have serious concerns about the waiver *as currently proposed*. The waiver's emphasis on cost containment is entirely appropriate, but this needs to be balanced with a commitment to quality improvement and better health outcomes for enrollees.

We urge CMS to consider these concerns while emphasizing transparency and inclusion of stakeholders' input *at every stage of the waiver negotiation process*.

Given the expertise in our medical community, Utah is uniquely positioned to create a robust ACO model for Medicaid. Please work closely with the state, on a reasonable time frame, to design a waiver that will serve as the strongest possible foundation for Medicaid ACOs.

Sincerely,

The Undersigned Organizations and Individuals

CC: Cindy Mann, Deputy Administrator, CMS
Vikki Wachino, Director, Children and Adults Health Program Group
Richard Jensen, Director, Division of State Demonstrations and Waivers