November 1, 2013

VIA E-MAIL (RA-PWHealthyPA@pa.gov)
Pennsylvania Department of Public Welfare
c/o Healthy PA
625 Forster Street, Suite 333
Harrisburg, PA 17120

RE: Healthy Pennsylvania: Reforming Medicaid

Dear Sir/Madam:

Community Legal Services (CLS) was pleased to learn that Governor Corbett seeks to provide health care access to low-income Pennsylvanians, and we anticipated the release of the Healthy Pennsylvania plan with some eagerness. We thank you for sharing the plan with us, and for providing us with an opportunity to submit comments.

Each year, CLS helps more than 18,000 Philadelphians. We assist clients in establishing and maintaining eligibility for public benefits, including public health insurance programs, and we engage in systemic advocacy on our clients' behalves to ensure that public benefits programs are accessible, transparent, and effective. CLS also fights consumer fraud and predatory lending; prevents homelessness; ensures fair treatment in the workplace; and protects women, children, and the elderly. We submit these comments on behalf of our uninsured and underinsured clients.

CLS believes that implementation of the Affordable Care Act (ACA) creates an unprecedented opportunity to provide comprehensive health insurance coverage to uninsured Pennsylvanians while addressing systemic barriers to public health insurance access. We are therefore enthusiastic proponents of Medicaid expansion in Pennsylvania.

Our understanding is that the Medicaid component to the Healthy Pennsylvania plan is a precursor to an eventual Medicaid Demonstration Waiver under Section 1115 of the Social Security Act. While the plan provides an interesting overview of the direction that the Corbett Administration seeks to move Pennsylvania's Medicaid program, it is not sufficiently detailed to provide in-depth, meaningful comments to the extent that we would prefer. Accordingly, we look forward to reviewing additional details about the plan, as well as the actual waiver application, and to providing comments to both the Department of Public Welfare (DPW) and the federal Centers for Medicare & Medicaid Services (CMS).

In the meantime, we note that the Healthy Pennsylvania plan constitutes a significant break with most states' approaches to Medicaid expansion. As such, we fear that receiving final CMS approval on a Section 1115 Waiver application will take many months. We also fear that, if and when the waiver is approved, it will take additional time to "operationalize" it so that eligible individuals are able to enroll in coverage, particularly because Pennsylvania will be unable to

draw from other states' experiences and best practices. A delay of many months means that hundreds of thousands of eligible Pennsylvanians will remain uninsured unnecessarily, and that millions of dollars in federal funding will not flow into the Commonwealth for that time. For these reasons, we urge Pennsylvania to adopt traditional Medicaid expansion immediately and implement the expansion as close to January 1, 2014 as possible while it seeks federal approval for the Healthy Pennsylvania plan.

In addition, we offer the following five recommendations, based on an initial analysis of the Healthy Pennsylvania Medicaid framework.

1. Pennsylvania Should Maintain Medicaid Benefits Packages that Meet the Needs of Vulnerable Medicaid Enrollees.

The Healthy Pennsylvania plan provides that existing Medicaid benefits plans will be consolidated and scaled back. While children's coverage will not – and indeed cannot – be changed because the ACA requires states to maintain existing Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits for children, the Healthy Pennsylvania plan proposes to create two adult benefits packages that "will be similar to those provided in the commercial market for working Pennsylvanians through their employers." Based on recent conversations between DPW and advocates, we understand that one benefits package may be available to individuals with significant health care needs, such as pregnant women and individuals with disabilities, and one benefits package will be available for all other Medicaid eligible adults. The Healthy Pennsylvania plan itself, however, does not indicate that pregnant women and/or all individuals with disabilities will qualify for more robust coverage, and it does not specify what that coverage will entail. It also does not outline what coverage, precisely, will be available to the remainder of the Medicaid eligible population.

The existing federal and state requirements for Medicaid benefits packages for adults are based on the unique needs of Medicaid enrollees. Many Medicaid enrollees have very significant health care needs and very few financial resources with which to pay for services that are not covered. That is because, by definition, many Medicaid enrollees are very poor, and are either very sick or are at retirement age. Limiting the Medicaid benefits package(s) for these populations would leave many Medicaid-eligible individuals without adequate coverage.

In fact, our experience tells us that some Medicaid enrollees with disabilities are also enrolled in commercial, employer-based plans that do *not* meet their health care needs. As the Healthy Pennsylvania plan notes, Medicaid is a payer of last resort. Some Medicaid enrollees with disabilities have employer sponsored coverage but seek out Medicaid as secondary (or even tertiary) coverage because their private coverage does not provide for adequate care. Without Medicaid as an option for robust coverage, these individuals would either be forced to incur medical bills that they cannot pay or forgo necessary medical treatment, making them sicker and escalating the cost of their care. Either scenario hurts the Commonwealth by driving up health care costs for everyone. Pennsylvania should not take "penny wise, pound foolish" steps to undermine its social safety net by forcing Medicaid enrollees into insufficient private market plans.

Furthermore, many Medicaid enrollees who do not fit into Medicaid eligibility categories for seniors or individuals with disabilities still require robust benefits packages. By virtue of their very low incomes, many Medicaid enrollees face environmental factors that contribute to poor health, like poor nutrition and housing insecurity. Many enrollees have lacked health care access for years, and they require significant medical care as a result. These social determinants of health have prompted CMS to establish Medicaid benefits packages that are tailored to the particular needs of Medicaid enrollees. The Healthy Pennsylvania plan should not dismantle these benefits packages in the name of private market parity.

2. Pennsylvania Should Follow the ACA's Guidelines for Cost Sharing.

The Healthy Pennsylvania plan proposes to eliminate copayments, except for a $10 copayment for inappropriate emergency department (ED) visits, to encourage appropriate use of primary care. It then proposes to impose monthly premiums on a sliding scale, with all individuals over 50% of the federal poverty income guidelines (FPIGs) paying premiums, and premiums reaching a maximum threshold of $25 for individuals and $35 for couples and families at 133% of the FPIGs. The plan also suggests that premiums may be reduced if individuals participate in health and wellness appointments and/or engage in job search and training programs.

As a threshold matter, we note that a significant body of research shows that medical cost-sharing is a barrier to receiving appropriate health care coverage and services, particularly for low-income individuals with significant health care needs. As a result, cost-sharing can result in increases in uninsured individuals, unmet health care needs, and adverse health outcomes.

In light of this research, we commend the plan to eliminate copayments. We look forward to reviewing more details on the $10 copayment for inappropriate ED visits. We suggest that Pennsylvania consider delaying the ED copayment until well after the Healthy Pennsylvania plan and the ACA itself are otherwise implemented fully. It may be that the resulting near-universal coverage in Pennsylvania and other ACA reforms will reduce ED utilization to the extent that the copayments are unnecessary.

If and when the ED copayment is implemented, we hope that it will not be imposed in a manner that punishes low-income Medicaid enrollees who face insufficient primary care networks in their geographic areas. We also hope that the copayment is not threatened or applied in a manner that discourages Medicaid enrollees from seeking necessary medical treatment, resulting in enrollees eventually receiving more invasive and costly treatment.

We also look forward to learning more about the sliding scale for premiums. We note that the ACA and its implementing regulations have reaffirmed federal limits on the amounts that states can charge both traditional and expansion Medicaid enrollees for premiums. The strongest limits on cost-sharing exist for enrollees at or below 100% of the FPIGs. In light of the overwhelming research on the harm that medical cost-sharing can do, Pennsylvania must adhere to the existing federal Medicaid cost-sharing protections, especially for individuals between 50% and 100% of the FPIGs.

In addition, we urge Pennsylvania to think hard about whether the administrative burden of collecting monthly premium payments for very low-income Medicaid enrollees is worthwhile. Single enrollees at 50% of the FPIGs will have less than $500 per month in income. Many will lack computer access to make online payments and even bank accounts. Paying even very small premiums will prove financially daunting and logistically challenging. As a result, we expect that the lowest-income enrollees will "churn" on and off coverage due to premium payment delays or nonpayment, creating coverage gaps and unpaid medical bills. Meanwhile, we expect that DPW would have to shoulder at least some of the burden of monitoring repeated enrollment and disenrollment, and the additional burden on insurers will be significant as well. We are particularly troubled by DPW's capacity to monitor premium payments in light of its current backlog of Medical Assistance for Workers with Disabilities (MAWD) premium payments, which has resulted in wrongful terminations of many MAWD enrollees statewide.

Finally, we understand that the Healthy Pennsylvania plan hopes to incentivize health and wellness and economic self-sufficiency. However, we have serious concerns about the workability of tracking the incentives. We assume that participation in the job search and training activities, for example, will be monitored by DPW's County Assistance Offices (CAOs). However, CAOs will be under great stress to process new Medicaid applications timely and properly as a result of the Healthy Pennsylvania initiative. Moreover, CAOs statewide have faced staffing shortages over the past decade, resulting in long in-person wait times for CAO clients, unanswered telephones, and lost or unprocessed paperwork. In recent months, DPW has worked with CLS to begin to address some of these issues at the Philadelphia CAO. We fear that this effort will be undermined by the imposition of new administrative burdens for CAOs in the form of tracking premium reduction incentives.

Relatedly, we understand that the Jobs Gateway would be a key means of facilitating the job search and training activities. Based on CLS's experience with Jobs Gateway in the unemployment context, we believe that Jobs Gateway lacks capacity to handle hundreds of thousands – or even tens of thousands – of new users. Moreover, there are only 65 walk-in Career Link centers in Pennsylvania, fewer than one per county. For many rural Pennsylvanians who lack computer access, problems accessing job search and training assistance will be insurmountable hurdles to participation.

3. Pennsylvania Should Not Impose Additional Barriers to Eligibility for Medicaid Applicants or Enrollees, in Violation of the ACA.

The Healthy Pennsylvania plan would require work search and job training for all unemployed, working-age Medicaid enrollees, with some limited exceptions. We are very concerned about both the legality and the feasibility of this proposal.

First, we note that imposing work search requirements on Medicaid applicants and enrollees violates both the letter and the spirit of the federal Medicaid Act, as amended by the ACA. The Act does not permit states to create extraneous, additional conditions of eligibility for federal Medicaid benefits. Moreover, CMS has indicated that it is likely to reject any Section 1115

waiver application that creates barriers to eligibility for otherwise-eligible Medicaid applicants. For an overview on the legal implications of a work requirement on the Medicaid program, please see a policy brief on the topic by the National Health Law Program, also attached as Appendix A.

Beyond the illegality of the work requirement, it would be administratively unworkable. First, the Healthy Pennsylvania plan does not discuss whether individuals with disabilities would be exempt from the requirement, though we hope and expect that they would be. Even if such exemption were available, many individuals would struggle to qualify because, by virtue of being uninsured, they lack the requisite relationships with medical providers that can attest to their incapacity for work. Moreover, a similar exemption exists for individuals with disabilities who would otherwise be subject to the job search requirement while their TANF cash assistance applications are pending. CLS has represented several individuals who have been able to demonstrate disability, but have struggled to obtain the appropriate exemption because of caseworker training issues or lost or unprocessed paperwork.

More broadly, monitoring the work requirement would place an overwhelming burden on CAOs. As we note above, CAOs will be under great stress already because of an influx of new Medicaid applications due to the Healthy Pennsylvania initiative. Meanwhile, CAOs statewide are understaffed and overburdened, creating administrative barriers for public benefits applicants and enrollees, such as long in-person wait times, unanswered telephones, and lost or unprocessed paperwork. CLS and DPW have been working together to begin to address these issues in Philadelphia, but we fear that the effort will be set back by new administrative burdens. In this context, accurate, timely monitoring of ongoing work searches for hundreds of thousands of Medicaid applicants and enrollees is utterly unthinkable. By comparison, CAOs currently track job searches only for some TANF cash assistance applicants and enrollees, a comparatively small population, yet CLS and other legal advocates statewide see clients who struggle to navigate administrative red tape imposed by CAO administration of the job search requirements.

Moreover, based on the labor and employment practice at CLS and its policy work on behalf of unemployment compensation recipients statewide, we have serious concerns about the capacity of the Jobs Gateway to facilitate job search and training activities for hundreds of thousands – or even tens of thousands – of new users. Additionally, there are only 65 walk-in Career Link centers in Pennsylvania, fewer than one per county, creating particular hardship for rural Pennsylvanians who lack computer access.

Furthermore, a work search requirement will create serious "churn" on and off coverage due to work search problems like inability to obtain an appropriate exemption, inability to navigate the Jobs Gateway system, or other factors like homelessness or lack of child care or transportation. Such churn raises myriad unanswered questions such as: Will otherwise-eligible individuals face a waiting period following non-compliance? Who will bear the costs if those individuals incur medical bills while uninsured? Will insurers be compensated if individuals regain insurance but require costly care because their conditions worsened while uninsured?

Finally, and most importantly, we note that the work search requirement is both contrary to the philosophy of the ACA and inherently unfair. It creates a two-tier system in which individuals

with incomes at 140% of the FPIGs will qualify for affordable coverage for a year if other eligibility factors are met, while individuals at 130% of the FPIGs will face loss of coverage each month if they are unable to wade through multiple layers of bureaucracy or otherwise fail to complete the work search requirements.

4. If Pennsylvania Establishes a Private Option for Medicaid Coverage, It Should Adhere to Federal Guidance.

The Healthy Pennsylvania plan would establish a "private option program" that would require individuals covered by Medicaid expansion to purchase health insurance through the Federally Facilitated Marketplace. Only individuals deemed "medically frail" would have the option to remain in a traditional Medicaid program. This initiative would mirror a similar initiative recently approved in Arkansas, sometimes referred to as "the Arkansas model."

CLS does not take a position on the Arkansas model, though we note that the Congressional Budget Office has estimated that private insurance sold through the Marketplace will cost significantly more than Medicaid. We also note that the Arkansas model is not necessary to inject private market competition into Pennsylvania's Medicaid program, as Pennsylvania is a national leader in risk-based Medicaid managed care. In fact, Pennsylvania recently expanded the involvement of its Medicaid managed care Health Choices program.

CLS strenuously opposes any plan that does not adhere to existing standards for adoption of the Arkansas model outlined in CMS guidance. Most notably, CMS has indicated that successful Section 1115 waiver applications creating a private option must: (1) provide "wrap around" coverage to ensure that Medicaid enrollees receive the federally mandated Medicaid benefits package even if their private plans offer less and (2) limit the private option to Medicaid enrollees who qualify in the new category of coverage. Thus, we feel strongly that the Healthy Pennsylvania plan must ensure that the traditional Medicaid benefits package is available to individuals even if they choose insurance plans through the Marketplace. We also feel strongly that individuals traditionally covered by Medicaid, such as individuals with disabilities and parents and related caretakers, must not be pushed onto the Marketplace.

5. Pennsylvania Should Not Define "Medical Frailty" in a Manner that Places an Undue Burden on Individuals with Disabilities.

The Healthy Pennsylvania plan seeks input on Pennsylvania's nascent definition of "medical frailty," a new category for individuals with disabilities and other serious and complex physical health, mental health, or substance abuse problems. The plan lists several examples of individuals who would qualify as medically frail.

CLS appreciates Pennsylvania's exploration of the proper way to provide adequate coverage for individuals with disabilities. We hope that a final definition of the standard will incorporate feedback from a wide range of medical providers, beyond the usual consulting providers to

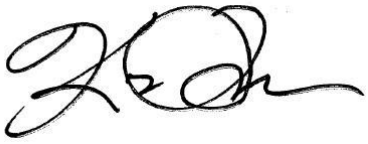
DPW, with a particular focus on feedback from providers that serve low-income individuals with disabilities, such as providers at Federally Qualified Health Centers.

We urge DPW to shy away from creating an exclusive list of medical conditions that constitute medical frailty. Defining a subset of individuals with disabilities or chronic medical conditions as medically frail is fraught with legal and policy difficulties. The number of conditions and impairments that individuals face collectively is enormous, as is the effect on function in individual patients. And the list changes swiftly and frequently – for example, in 1980, who would have listed people living with HIV/AIDS as medically frail? An exclusive list of diagnoses constituting medical frailty will surely result in anachronisms and unfairness and prove to be difficult to administer, and it will undoubtedly be subject to legal challenge.

We feel strongly that a final definition, and the related assessment tool, must not result in a rollback of coverage for the most medically needy. Historically, DPW has provided medical providers with a disability assessment tool, the PA-1663, which permits them to ascertain and indicate whether their patients meet the requisite disability standard to qualify for Medicaid coverage. While it can be argued that the assessment tool is not perfect, it is widely understood by and manageable for providers, and it ensures that individuals with disabilities are able to access the health coverage that they need. CLS would oppose any new effort to redefine medical frailty and/or implement a new evaluation tool that is more burdensome or stringent than the existing disability definition and evaluation tool for Pennsylvania Medicaid.

Thank you for the opportunity to submit comments. Should you have any questions, please feel free to contact Kristen Dama via telephone at (215) 981-3782 or e-mail at kdama@clsphila.org.

Sincerely yours,



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