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PENNSYLVANIA Health Law PROJECT

October 22, 2013

*VIA EMAIL (*RA-PWHEALTHYPA@PA.GOV)
Beverly Mackereth, Secretary
Department of Public Welfare
Harrisburg, PA

Re: Comments on Healthy PA & Medicaid Reform

Dear Secretary Mackereth,

At your invitation, we write to provide our reactions to Governor Corbett's *Healthy PA* proposal. We share the Governor's belief that all of the Commonwealth's citizens should have access to quality, affordable health care, and we are encouraged by the Administration's proposal to expand coverage through Medicaid to half a million uninsured adults.

As representatives of the Commonwealth's 2.2 million Medicaid consumers, the Consumer Subcommittee of the Medical Assistance Advisory Committee ("Consumers") is the Department of Public Welfare's "eyes and ears." We are part of communities whose health and well being very much depend on Medicaid, and our role is to advise on and monitor program changes and ensure that state Medicaid officials understand their human impact. Given this role, we deeply appreciate your continued commitment to work closely together in expanding and reforming the Medicaid program.

Although *Healthy PA* is in concept form, we have a number of concerns (attached) about the legality and the policy merit of some of the proposed changes. As the Commonwealth crafts its proposal to the Secretary for the Department of Health and Human Services for permission to waive provisions of the Social Security Act governing Medicaid, we hope you will consider these comments. In advance of that submission (and thereafter), we will be available to provide additional information, clarification, and feedback.

These are extraordinarily busy times, and we appreciate the commitment and hard work of DPW staff to cover uninsured Pennsylvanians. We thank you for this opportunity to provide comments and for the Administration's commitment to sustaining and strengthening the Medicaid program.

Sincerely,

Consumer Subcommittee of the MAAC
Yvette Long, Chair

By Their Counsel:
Pennsylvania Health Law Project
Kyle Fisher
Laval Miller-Wilson

Cc: Vincent Gordon, Deputy Secretary Office of Medical Assistance Programs
Leesa Allen, Executive Medicaid Director

COMMENTS OF THE CONSUMER SUBCOMMITTEE OF THE MEDICAL ASSISTANCE ADVISORY COMMITTEE ON *HEALTHY PA* AND MEDICAID REFORM

October 22, 2013

1. Pennsylvania Must Ensure Demonstration Participants Receive the Benefits and Protections Required by the Medicaid Statute and Regulations

a. Although Hundreds of Thousands Will Purchase Insurance in The Private Market, The Single State Medicaid Agency (DPW) Must Continue to Make Administrative and Policy Decisions for the Program

Contingent on the federal government's approval, *Healthy PA* expands health access to individuals with incomes up to 133 percent of the Federal Poverty Level (FPL) by using Medicaid funds to purchase private health plan coverage through the Federal Health Insurance Marketplace. The federal government approved this approach in Arkansas, while maintaining a basic axiom of Medicaid law: the Medicaid state agency, which in Pennsylvania is the Department of Public Welfare (DPW), cannot delegate its Medicaid authority.

The Consumers seek more information about *how* DPW will effectively monitor and oversee the provision of services by private health plans to "private option" participants. If, for example, a private health plan fails to provide a medically necessary essential health benefit (e.g., durable medical equipment, prescription drugs, mental health counseling), how will DPW ensure that the benefit is provided?

Private health insurers in Pennsylvania's HealthChoices program are currently subject to extensive requirements regarding access to care, quality, collection of encounter data, beneficiary protection, and oversight. DPW, through its Bureau of Managed Care Operations, monitors the HealthChoices program aggressively compared to oversight of private health insurance plans in the Marketplace. Does *Healthy PA* contemplate a similar arrangement for the private health plans in the Marketplace?[1] What type of corrective action measures will the Commonwealth

[1] DPW's Bureau of Managed Care Operations has several divisions: its Division of Financial Analysis develops appropriate rates to be paid to the managed care plans, and performs the financial monitoring; its Division of Monitoring and Compliance ensures that managed care plans are meeting program requirements, and that plans respond to consumer and provider concerns and develops corrective action plans as needed; and its Division of Quality Management and Special Needs Coordination collects and reports data to monitor the quality performance

demand of private health insurance plans in the Marketplace that do not meet program requirements?

We have observed that the waiver the Department of Health and Human Services (HHS) recently authorized for Arkansas requires that state's Medicaid agency and Department of Insurance to *both* enter detailed memorandums of understanding with *each* private health plan that enrolls demonstration participants about membership pathways, payment of premiums and cost-sharing reductions, reporting and data requirements necessary to evaluate private option benefits, and noticing requirements. See Section VI page 12, paragraph 28, Approval of AR Health Care Independence Program.

The Consumers expect Pennsylvania's application to HHS will be just as, if not more, detailed about its regulatory arrangements in order to ensure that services for demonstration participants are delivered in a manner that do not discriminate against Medicaid beneficiaries, gives participants a choice of (at least two) health insurance plans, and meets quality and network adequacy standards.

b. Demonstration Participants Should Be Able to Access the Medicaid Appeals System for All Medicaid Covered Services

When a demonstration participant challenges a private insurer's denial, reduction or termination of prescribed medical benefits or services, the Consumers have grave reservations if private insurance companies, rather than DPW, make the final decision on a consumer's appeal.

Medicaid applicants and recipients have rights to notice and administrative fair hearings when their claims for assistance are denied or not acted on with reasonable promptness. These rights are found in the Medicaid statute and regulations, and also are guaranteed by the Due Process Clause of the United States Constitution. In Goldberg v. Kelly, the U.S. Supreme Court found that the "brutal need" of low-income children and adults conferred due process protections in their receipt of public assistance. 397 U.S. 254, 261 (1970).

In Arkansas's recently approved waiver, appeal rights (including fair hearings) must be provided by the state in compliance with all federal and state requirements. No waiver was granted relating to appeals. See Section IX page 14, Approval of AR Health Care Independence Program. Arkansas must inform

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of managed care plans to ensure compliance with contract standards and coordination of services for all recipients. What will be the role of these agencies in evaluating private health plans?

applicants and beneficiaries of the right to request a hearing, the method to obtain a hearing, and the ability to be represented by an attorney or other representative.

The Consumers expect Pennsylvania's waiver application to HHS will describe the content of notices and the circumstances under which private plan benefits and services will continue pending appeal. *Healthy PA* must ensure that demonstration participants who challenge private plans are given both the right to an internal grievance process and the ability to be heard through testimony and witnesses by an impartial decision-maker. The Consumers welcome a discussion with the Department staff in the near future about these particular processes *and* the resources that should be available to help consumers challenge plans' denials of medically necessary services.[2]

c. Current Law Governing Prior Authorizations for Prescription Drugs Should Not Differ for Demonstration Participants

Section 1927 of the Social Security Act requires that prior authorization requests for prescription drugs be handled within 24 hours in Medicaid and that beneficiaries receive a 72 hour supply of a drug in emergency situations. The Commonwealth's policy is to provide a five-day emergency supply. These are protections that should not be waived under a private option delivery system.

d. Healthy PA Must Allow Demonstration Participants To Change Marketplace Insurers In the Same Manner and Frequency As Current HealthChoices Enrollees

Currently, the HealthChoices program allows consumers to change Physical Managed Care Organizations (MCOs) monthly. An independent Enrollment Broker (Maximus) contracted by DPW facilitates consumers' choice of MCO. This protection is not used frequently. Each month, less than one percent of consumers exercise this right to change plans. There are approximately 82,000 voluntary plan changes annually. Despite its infrequent use, the Consumers believe their ability to promptly disenroll is a powerful tool for Medicaid program management. *Healthy PA* does not suggest this protection will change, and the Consumers expect demonstration participants will have the same ability to change Marketplace insurance plans—i.e., monthly.

[2] Pennsylvania might consider establishing and adequately funding independent ombudsmen and advocates with extensive knowledge of consumers' rights to help individual consumers and to feed information about systemic problems to state officials and advisory committees.

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2. **The Process And Criteria for Determining "Medical Frailty" Should Be Clarified**

The final federal regulations defining alternative benefit plans for people in the new adult eligibility category provide that individuals who are "medically frail" as defined in the regulations must be given a choice of the traditional Medicaid benefit package and the alternative benefit plan (ABP) that would otherwise be available to that individual. Consumers who are "medically frail" must also be allowed to choose the traditional Medicaid delivery system. Thus, *Healthy PA* appears to be consistent with this portion of the regulations, but lacks detail about the ABP that would be offered as an alternative to the standard Medicaid benefit package.

The Consumers support providing "medically frail" individuals with traditional Medicaid coverage to ensure that they receive the full scope of Medicaid benefits. We assume that most individuals who are "medically frail" will choose to receive traditional Medicaid benefits and the traditional Medicaid delivery system (the HealthChoices program).[3] Given this expected increase, does the Commonwealth contemplate making additional arrangements with HealthChoices plans to insure care for this group vulnerable group? [4]

Moreover, the *Healthy PA* proposal does not provide sufficient information regarding the process and criteria that will be used to determine whether an individual is "medically frail". It is not clear whether the approach proposed by the state will actually identify those who are "medically frail" within the definition set forth in Medicaid regulations at 42 CFR §440.315(f). The Consumers urge state officials to share as soon as possible the screening tools they are considering to determine whether an individual may be "medically frail/have exceptional needs."

[3] Although, Pennsylvania's approach of giving medically frail individuals a choice is required by federal regulations, Pennsylvania's approach might undermine the expected rationale and cost effectiveness of the demonstration. If the hypothesis of state officials is that those enrolled in the demonstration will have lower rates of preventable hospital admission than those in traditional Medicaid, can the hypothesis be truly tested if those who are the sickest remain in traditional Medicaid?

[4] This calendar year, the Department announced Keystone Mercy Health Plan (now Keystone First), the Southeast region's largest Medicaid managed-care plan, would no longer take new members, in part because of over-enrollment by medically frail individuals. The Consumers seek greater understanding about health plan enrollment and provider access if more medically frail individuals are placed in HealthChoices.

3. Cost-Effectiveness of Premium Assistance in Medicaid

All premium assistance options that will be approved by HHS require states to establish that the cost of covering an individual through premium assistance in the private Marketplace must be the same or less than providing "comparable coverage" to the individual in the traditional Medicaid program. Centers for Medicare and Medicaid Services and the Affordable Care Act: Premium Assistance (March 29, 2013). Under this standard, a state must include the cost of providing wraparound benefits that are required for an Approved Benefit Plan but not covered by private insurance on the Marketplace.

One of the most significant wraparound benefits is non-emergency medical transportation. As noted above, the consumers seek to learn more about the arrangements for accessing transportation to medical services for consumers who do not have other transportation available to them. Counties have typically provided these services at relatively low cost. How will private health insurers deliver these services, and will their costs be at amounts comparable to the current Medical Assistance Transportation Program?

Healthy PA assumes the use of expansion funds to buy private coverage for Medicaid beneficiaries through the new health insurance exchange will be more cost effective than a traditional Medicaid expansion. The Consumers seek more information about this assumption. Will Pennsylvania's demonstration application compare costs under the private option demonstration to costs that would have happened under expansion through HealthChoices or Medicaid fee-for-service?

The Congressional Budget Office estimated the per capita cost to provide Medicaid coverage to the expansion population to be $6,000 per year, whereas the cost to purchase comparable insurance through a health insurance marketplace is predicted to be $9,000 per year.[5] In Massachusetts, which has a long established health insurance marketplace, the yearly cost of Medicaid in 2009 was $2,965 whereas the cost of a comparable exchange plan was $5,143.

Whether Medicaid premium assistance programs can deliver on comparable costs remains an open and critical issue. The Consumers urge the Commonwealth to be open and transparent with all stakeholders about this matter.

[5] Congressional Budget Office, Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision (July 2012)

4. Healthy PA's Proposed Benefit Redesign is Unlikely to Achieve Significant Cost-Savings

Healthy PA proposes to reform the existing Medicaid system by simplifying the existing 14 adult benefits packages into two commercial-like alternative benefit packages: one will be for federally-protected medically frail group, and one will be more like the required essential health benefits (EHB) in the Marketplace. Adult consumers would receive a "high risk" or "low risk" benefit package based on their level of care needs. The Consumers would like to learn more about this aspect of the proposal, specifically:

- By what standard and process will DPW assess "high risk" and "low risk"?
- What will be the criteria to assign members to each set of benefit packages?
- How would the *types of services* differ between the "high risk" package, the "low risk" package, and the current benefit package for categorically-needy adults (e.g., HCB02)?
- How would *limitations on services* differ between the "high risk" package, the "low risk" package, and the current benefit package for categorically-needy adults?

The Consumers are skeptical that *Healthy PA's* proposed benefit redesign will achieve significant cost-savings. Long-term care costs are the primary cost driver in Pennsylvania's Medicaid program. The Commonwealth spends over $21,000 per "aged" enrollee, which is well above the national average of $13,000.[6] In contrast, its spending on children, parents, and individuals with disabilities is near or below national averages. Further, our spending on "aged" Medicaid beneficiaries, who also have Medicare, is disproportionately skewed towards long-term care services, as opposed to acute care.[7] Altering the benefit package available to adult consumers will do little to change these realities or control costs.

5. Experience Shows Premiums Will Result in Significant Disenrollment

Healthy PA proposes to overhaul the current Medicaid cost-sharing arrangement by eliminating copays and imposing a sliding scale premium structure for adults with income between 50 and 133 percent FPL. Premiums would be capped at $25 for an individual and $35 for a two-adult household. Consumers could have their premiums reduced by participating in wellness activities or job search and training programs.

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[6] Kaiser Family Foundation, "Medicaid Payments per Enrollee (FY 2009)," *available at*: http://www.statehealthfacts.org/comparetable.jsp?ind=183&cat=4

[7] In Pennsylvania, 84 percent of spending on dual-eligibles goes towards long-term care. Kaiser Family Foundation, "Distribution of Medidaid Spending for Dual-Eligibles (FY 2009)," *available at:* http://www.statehealthfacts.org/comparetable.jsp?ind=661&cat=6

As a matter of law, the Consumers question whether the proposed premiums comply with the federal Medicaid statutory protections for cost-sharing. With limited exceptions, premiums are prohibited for consumers with income under 150 percent FPL.[8] *Healthy PA* does not specify what statutory authority permits its proposed premium structure. The Consumers would like to learn more about this aspect of the proposal, specifically:

- Will the new premiums apply to all adult Medicaid recipients regardless of health status, (i.e. pregnant women, medically frail, people living in ICF-MRs, etc.)?
- How often will a premium be collected?
- What entity will collect premiums (DPW, Enrollment Broker, insurer, Exchange)?
- What will happen if an individual cannot pay the premium? Will that result in disenrollment from Medicaid?
- Could consumers be granted temporary hardship waivers if they cannot afford their premium payment?
- What is the sliding scale formula?
- Would the wellness incentive be tied to participation in particular activities or specific outcomes?
- Does DPW intend to implement new wellness programs or provide coverage for dietician or nutritionist services?

Assuming the legality of premiums for consumers earning less than 150 percent FPL, the Consumers have serious reservations about their affordability. Rather than pose a barrier to specific services, premiums pose to a barrier to enrollment and continued coverage. The imposition of sliding scale premiums by the state of Oregon ranging from $6 to $20 per month – levels similar to those proposed by *Healthy PA* – resulted in nearly half of the affected consumers disenrolling from Medicaid within nine months of implementation.[9]

For Medicaid consumers living near half the poverty level, which is considered the upper threshold for "deep poverty," virtually every dollar is needed for basic survival. Even modest premiums can result in a dramatic reduction in Medicaid enrollment, and disproportionately harm the very poor.[10]

[8] 42 CFR § 447.51 (2010).
[9] Bill Wright, et al., *"The Impact of Increased Cost Sharing on Medicaid Enrollees,"* HEALTH AFFAIRS, Vol 24, No. 4 (July 2005) (Finding a 46% decrease in covered lives between February and December 2003, the implementation period for increased cost-sharing.).
[10] *Id.*

6. Pennsylvania Should Not Adopt A Copay for Visits to the Emergency Department for Non-Emergency Services

The Consumers applaud *Healthy PA's* proposal to eliminate copays. A substantial body of research shows that copays lead low-income individuals to forego medically appropriate care, often resulting in poorer health outcomes and greater use of high-cost services like Emergency Departments (ED).[11]

However, *Healthy PA*'s proposed $10 copay for inappropriate use of emergency department services should not be advanced. The Consumers question the proposal's efficacy and its implicit premise. Research has found that non-urgent ED use by Medicaid consumers is uncommon and roughly equivalent to non-urgent ED use in the commercial context.[12] Medicaid consumers disproportionately use ED services, but this is driven by a higher incidence of urgent and semi-urgent care needs; Medicaid consumers are sicker than their privately insured counterparts.[13] Rather than imposing higher copays, which studies show to be ineffective in reducing ED visits[14] and likely violate the statutory limits on "nominality",[15] the Commonwealth should instead focus on enhancing access to primary care providers and urgent care centers.

7. Requiring Work Search Is Impermissible Under Traditional Medicaid Rules

Under *Healthy PA*, all unemployed, working age Medicaid consumers would be required to engage in work search or job training. An online "JobGateway" would facilitate work search requirements similar to those required to receive unemployment compensation.

As a matter of law, work requirements are impermissible under traditional Medicaid rules. Federal law clearly enumerates Medicaid eligibility criteria. Although states have flexibility in designing and administering their Medicaid programs, the Medicaid Act requires that they provide assistance to all individuals who qualify under federal law. Thus, for example, a court struck down a state's attempt to add eligibility requirements beyond those contained in federal law, including ensuring childhood immunizations, wellness check-ups, school attendance and refraining from substance abuse.[16] The court

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[11] Leighton Ku & Victoria Wachino, *"The Effect of Increased Cost Sharing in Medicaid: A Summary of Research Findings"* (2005), *available at* http://www.cbpp.org/cms/?fa=view&id=321..
[12] Anna S. Sommers et al., "*Dispelling Myths About Emergency Department Use: Majority of Medicaid Visits Are For Urgent or More Serious Symptoms,"* Ctr. For Studying Health System Change, Research Brief No. 23 (2012).
[13] *Id.*
[14] Mortensen, Karoline, *"Copayments Did Not Reduce Medicaid Enrollees' Nonemergency Use of Emergency Departments,"* HEALTH AFFAIRS, Vol. 29, No. 9 (September 2010).
[15] 42 CFR § 447.54 (2010).
[16] Camacho v. Texas Workforce Comm'n, 408 F.3d 229 (5th Cir. 2005), aff'g, 326 F. Supp. 2d 803 (W.D. Tex. 2004).

reasoned that since the Medicaid Act contains no such requirements, the state restrictions were inconsistent with and therefore preempted by federal law. A state "cannot add additional requirements for Medicaid eligibility." [17]

Notably, Congress has allowed only one group of Medicaid recipients to be terminated for failure to meet work requirements. These individuals receive Medicaid because they would have qualified under rules governing the former AFDC program (now called Temporary Assistance to Needy Families, or TANF). Under federal law, most TANF recipients must engage in work activities to receive TANF benefits. If those recipients lose their TANF benefits for failure to meet those requirements, federal law permits (but does not require) states to terminate their related Medicaid coverage as well.[18] Congress had the opportunity to create a similar requirement for ACA Expansion individuals, but did not do so, nor did it extend the TANF work requirement to ACA Expansion individuals.

Congress' objective in passing the Medicaid expansion is also clear: it is intended to provide nearly universal coverage for all qualifying adults with incomes below 138 percent of the poverty line. Federal health reform also emphasizes access to care, particularly preventive care, and provides an efficient, streamlined system for determining eligibility and reducing "churning," the inefficient movement of people between programs and eligibility statuses. Work requirements would require time-consuming and costly verification procedures, increase of churning, and reduce the number of people accessing preventive and other necessary care. None of those outcomes are consistent with the goals of the Medicaid Act or the Affordable Care Act.

CMS has already addressed questions regarding its willingness to permit states to bar otherwise eligible members of the Expansion group from coverage, and has stated that it "does not anticipate" approving any 1115 waivers that impose enrollment caps or periods of ineligibility for the Expansion group because such barriers do not further the objectives of the Medicaid program. A work requirement would be impermissible for the same reason.

For additional background about the impermissibly of work search requirements see Medicaid Expansion Work Requirements, National Health Law Program (October 4, 2013).

[17] Id. at 235.
[18] 42 U.S.C. § 1396u–1(b)(3)(A). Pregnant women, infants, and minors who are not head of household may not have their Medicaid terminated. Id. at (A), (B).

CONCLUSION

The Consumers and their counsel appreciate the Commonwealth's intent to accept federal funding to expand coverage and this opportunity to express our concerns. We will provide additional information upon request. Please direct questions to Kyle Fisher (KFisher@phlp.org) and Laval Miller-Wilson (LMiller-Wilson@phlp.org), counsel for the Consumer Subcommittee.