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January 13, 2014

VIA EMAIL (ra-PWHealthyPA1115@pa.gov)
Beverly Mackereth, Secretary
Department of Public Welfare
Harrisburg, PA

Re: Comments on Draft Healthy PA 1115 Application

Dear Secretary Mackereth,

We write to provide comment on Governor Corbett's Draft *Healthy Pennsylvania* Demonstration Application. As you know, the Consumer Subcommittee of the Medical Assistance Advisory Committee (Consumers) represents the Commonwealth's 2.2 million Medicaid consumers. As the Department of Public Welfare's "eyes and ears," we are part of communities whose health and well being very much depend on Medicaid. Through program monitoring and formal collaboration, our role is to ensure that state Medicaid officials understand the human impact of their policy decisions.

We share the Governor's belief that all citizens of the Commonwealth should have access to quality, affordable health care. We are encouraged by the Administration's proposal to expand coverage through Medicaid to half a million uninsured adults. At the same time, however, we are deeply disappointed by the elements of *Healthy PA* that would pose significant barriers to coverage, for both current and future consumers, and render existing Medicaid coverage less effective. We elaborate on these concerns, outlined below, in the attached comments:

1. *Demonstration Participants Must Receive the Full Scope of Benefits and Protections Required Under Medicaid Law*
2. *Healthy PA's Proposed Benefit Redesign Will Harm Consumers*
3. *Experience Shows Premiums Will Result in Significant Disenrollment*
4. *Higher Emergency Department Copays Would be Ineffective and Violate Federal Law*
5. *Healthy PA's Private Coverage Option is Unlikely to be Budget Neutral*
6. *Requiring Work Search Is Impermissible Under Medicaid Law*
7. *The Process And Criteria for Determining "Medical Frailty" Is Problematic*
8. *Medical Assistance for Workers with Disability (MAWD) Should Not be Eliminated*

In light of the tremendous need of low-income Pennsylvania residents caught in the "coverage gap" between Medicaid and Marketplace subsidies, and the fact that one-hundred percent federal match is available to cover these individuals, we urge the Department to alter its demonstration proposal in such a manner that federal approval would likely be immediate.

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

January 13, 2014

1. Demonstration Participants Must Receive the Full Scope of Benefits and Protections Required Under Medicaid Law

a. All Medicaid Appeal and Due Process Protections Should be Available to Demonstration Participants

The Consumer Subcommittee emphatically objects to *Healthy PA's* request to waive Medicaid due process protections for Private Coverage Option enrollees. While *Healthy PA* requests a waiver to implement a mandatory premium assistance model, its demonstration recipients would remain Medicaid beneficiaries entitled to the full range of Medicaid due process protections. These protections to adequate notice and fair hearing are found in the Medicaid statute and regulations, and also guaranteed by the Due Process Clause of the United States Constitution.[1] These protections cannot be waived by HHS and indeed were not waived by HHS when it recently approved section 1115 demonstrations in Arkansas and Iowa.

b. Demonstration Participants Should be Provided Point-in-time Eligibility and Retroactive Coverage

Healthy PA requests a waiver to delay Medicaid coverage for newly eligible adults ***until*** they enroll in a Private Coverage Option plan. We oppose this request. Under federal Medicaid regulations, Pennsylvania must provide point-in-time eligibility and up to three months retroactive coverage for enrollees.[2] HHS cannot approve a section 1115 demonstration to waive these requirements because such a waiver would serve no experimental purpose. The predictable results would be: (1) more low-income individuals experiencing medical debt collections and bankruptcy; (2) more providers, especially safety net hospitals, incurring losses; and (3) more individuals experiencing refusal of treatment after providers realize they will not be paid retroactively by Medicaid. Considering the significant federal match available for the expansion population, it would also be misguided health policy for the Commonwealth to fail to provide retroactive

[1] See Goldberg v. Kelly, 397 U.S. 254, 261 (1970) (Finding that the "brutal need" of low-income children and adults conferred constitutional due process protections in their receipt of public assistance.).
[2] 42 C.F.R. § 435.914 (redesignated at §435.915 in 77 Fed. Reg. 17143 (Mar. 23, 2012).

eligibility and expose its consumers and medical providers to such unnecessary financial risk.

c. Medical Transportation, Health Center Access, and Family Planning Services Should Not be Curtailed for Demonstration Participants

Non-emergency medical transportation is critical to ensuring that low-income Medicaid consumers have real access to the medical providers and services they require. It is also required under federal law.[3] Especially in rural areas, medical transportation is key part of translating Medicaid coverage in the abstract into medical treatment in reality. *Healthy PA* should extend this key Medicaid benefit to the private option participants.

Similarly, access to federally qualified health centers (FQHCs) and Rural Health Centers (RHCs) are important Medicaid protections that cannot be denied through the premium assistance model.[4] Health centers are a key source of primary and preventive care for low-income consumers. We can think of no good reason for *Healthy PA* to marginalize FQHCs and RHCs by 1) permitting health plans that cover the Medicaid expansion population to exclude these essential providers from their network, and 2) by eliminating the Prospective Payment System (PPS) reimbursement that provides them enhanced reimbursement for *newly eligible* Medicaid patients. Permitting health insurers to exclude FQHCs and RHCs from their provider networks significantly reduces health care access for low income Pennsylvanians who rely on the health centers for medically necessary care. These centers exist to serve medically underserved areas; without their participation many Pennsylvanians will be denied access to care. *Healthy PA's* elimination of the inclusion requirement and reimbursement arrangement for these providers will severely limit their ability to treat patients and reduce access to care.

Federal law also protects the ability of Medicaid beneficiaries to receive family planning services from the provider of their choice – even if the provider is outside of their Medicaid managed care network. *Healthy PA's* request to limit family planning freedom of choice is both misguided policy and contrary to these federal protections.

d. Robust Provider Networks are Critical

Regardless of whether *Healthy PA's* premium assistance model uses the Federally-Facilitated Marketplace or alternative commercial marketplace, the private option

[3] *See* 42 C.F.R. § 431.53.

[4] See 42 C.F.R. § 435.1015(a)(2) (requiring the agency to furnish "all benefits for which the individual is covered under the State plan that are not available through the individual health plan"); see also "Medicaid and the Affordable Care Act: Premium Assistance," HHS FAQ, March 29 2013 ("HHS will only consider proposals that … [m]ake arrangements with the QHPs to provide any necessary wrap around benefits and cost sharing.").

insurers must be required to have robust provider networks. The draft application could satisfy this concern by importing the current Medicaid managed care (HealthChoices) network adequacy requirements. As the Consumers and DPW have seen repeatedly over years of collaboration, mandating that insurers have both enough providers and providers located throughout their service areas is an essential element of ensuring meaningful access to care.

e. Healthy PA Should Incorporate the Medicaid Managed Care Protections Regarding Plan Choice and Marketing Abuses

Currently, the HealthChoices program allows consumers to change physical health managed care organizations (MCOs) monthly. There are approximately 82,000 voluntary plan changes annually. The Consumers believe their ability to promptly disenroll is a powerful tool for Medicaid program management, and strongly oppose *Healthy PA*'s proposal to remove this protection for Private Coverage Option enrollees. Like consumers in HealthChoices, demonstration participants should have the ability to change Marketplace insurance plans monthly.

Healthy PA should also explicitly adopt the Medicaid protections against managed care marketing abuses. In the early days of managed care in Pennsylvania, there were abusive marketing practices including giveaways (notably frozen turkeys at holiday times), enrollment forms masquerading as raffle sign-up sheets, and door to door sales. The outcomes of these dubious practices were that patients changed plans without their understanding or direct consent leaving them without their regular source of care and forcing them to engage in a prolonged effort to disenroll and return to their original plan.

2. Healthy PA's Proposed Benefit Redesign Will Harm Consumers

The Commonwealth's proposal to redesign adult Medicaid benefits will result in severe harm to consumers and is unlikely to 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.[5] In contrast, its spending on children, parents, and individuals with disabilities is near or below national averages. Altering the benefit package available to adult consumers will do little to change these realities or control costs. The Consumers strongly urge the Commonwealth to abandon this element of the proposal.

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

a. Both Proposed Benefit Packages Amount to Significant Benefit Cuts and are Contrary to Federal Law

Under the proposal, both the low-risk plan and the high-risk alternative benefit plan are much more limited than the current adult benefit package. Both proposed packages impose new and severe annual limits based on usage and dollar amount caps. For example, the proposed "high risk alternative plan" would limit supplies and durable medical equipment to a combined $2,500 per year; the "low risk plan" would limit such services to a combined $1,000 limit. These limits, which will leave many consumers unable to obtain even a single item of durable medical equipment, such as a wheelchair, are patently unreasonable.

Federal law requires states to provide benefits sufficient in amount, duration, and scope to reasonably achieve their purpose.[6] Further, any Secretary-approved alternative benefit plan under section 1937 of the Social Security Act must provide coverage sufficient to "meet the needs" of the target population.[7] The benefit packages proposed by *Healthy PA* meet neither of these legal standards. The application fails to provide any analysis of (i) how the benefit limits imposed by the low risk package "reasonably achieve their purpose" or (ii) how the benefit limits imposed by the high risk alternative plan would "meet the needs" of consumers with the most complex medical needs.

For nearly every category of benefit listed in the *Healthy PA* proposal, the proposed reductions will reduce amount, duration, and scope such that the benefit cannot reasonably achieve its purpose. The high-risk and low-risk plans both include new and drastic limits on radiology, lab work, inpatient hospitalization, and mental health and behavioral health services. Not only are such limits often incomprehensible to consumers (who, for example, have no idea which radiology services cost less than the $500 annual limit), they would likely result in utilization shifts and increase program expenses. Consumers with mental health needs, for example, who require weekly counseling but reach their benefit limit of 30 or 40 outpatient visits per year may well deteriorate and require much more costly inpatient care.

b. The Benefit Limit Exception Process is Not an Adequate Safeguard

The Consumers are skeptical of the claim that a benefit limit exception (BLE) process will adequately protect consumers who need services beyond the proposed new limits. The exception process imposes a medical standard – "serious deterioration of health" – that is much more stringent than the normal medical necessity requirement. It also

[6] 42 C.F.R. § 440.230.
[7] 42 C.F.R. § 440.330(d).

imposes a process barrier: to receive a benefit limit exception, a consumer must persuade ***a medical provider*** to submit additional paperwork. From the existing BLE process, we know that doctors and dentists are often reluctant to submit an exception request. Widespread knowledge that DPW and its managed care plans approve very few of these requests only worsens the situation. Providers who know the likelihood of approval is low become more reluctant to submit future exception requests. In limited instances the BLE process may function properly, but Pennsylvania's experience with pharmacy and dental limits has shown that the exception process is not enough to fully mitigate the harm caused by benefit cuts.

c. Proposed Benefit Limits Violate the Mental Health Parity Mandate

The new proposed benefits limits do not conform to mental health parity requirements. The Mental Health Parity and Addiction Equity Act of 2008 and its implementing regulations prescribe that a plan that provides both physical and behavioral health benefits cannot apply a more restrictive treatment limitation to mental health and substance abuse services than it does to physical health services of the same classification.[8] *Healthy PA* proposes three non-emergency admissions per year for inpatient physical health hospitalization, while inpatient psychiatric hospitalization is limited to 45 days per year. The distinction between admissions and days per year does not comport with the parity requirements; even one physical health admission could last longer than the 45 day psychiatric limit.

d. The Health Risk Assessment Compromises, Inter Alia, the Importance of Determining the Appropriate Benefits Package

We question the need for a consumer administered Health Risk Assessment (HRA) given its importance in determining an appropriate benefits package. Because the Commonwealth has not proffered a reason for this requirement, other than stating its completion will result in a reduced premium, this application request seems burdensome and inefficient. We are also fearful HRA will be burdensome for consumers to complete, particularly if they are limited English proficient, have mental health or cognitive limitations, or have low levels of literacy. HRA will also be difficult for consumers who lack full information about their condition or diagnosis. Given their literacy levels, language barriers, and frequent distrust of institutional systems, it highly likely many HRAs will be incomplete or not submitted. Pennsylvania should outline the meaningful assistance that it will provide to individuals who struggle to complete the tool.

[8] Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 219 (Nov. 13, 2013).

e. Care Management Alternatives and the State Innovation Model

Under *Healthy PA*, consumers will be asked to improve their health despite having benefits limits imposed that would likely thwart that outcome. Annual limits on office visits, medical supplies, lab tests and imaging, and hospitalizations run counter to evidence-based health care practices that control costs and improve the quality of care. In York and Adams Counties, team-based care management efforts to address the physical, behavioral, and social health needs of "super-utilizers" have achieved significant savings.[9]

Pennsylvania's own State Innovation Model (SIM) builds on these evidence-based strategies and tactics and takes a distinctly different approach from the benefits limits in the *Healthy PA* proposal. There are no limits on health care services. The SIM planning process addresses health care utilization issues by re-designing delivery systems and creating payment incentives for health insurers and health care providers. Key components include care management and bundled payments for episodes of care that are designed to reward tertiary care that prevents unnecessary hospitalizations. The SIM proposal recognizes that the obligation and the financial risk associated with managed care primarily rests with health care professionals, not their patients.

3. Experience Shows Premiums Will Result in Significant Disenrollment

While touted as necessary to allow incentives for healthy behavior and improved health outcomes, premiums would in fact undermine these goals. Premiums in Medicaid result in significant disenrollment. Creating a barrier that causes low-income individuals to drop their insurance would lead to worse, not better, health outcomes.

a. Medicaid Premiums Have Resulted in Steep Enrollment Declines

In the state of Oregon, even modest Medicaid premiums resulted in the disenrollment of nearly half of the affected consumers within nine months.[10] Oregon's premiums ranged from $6-$20 per month. The vast majority (82 percent) of consumers who disenrolled because of cost sharing became uninsured and did not transition to employer-sponsored insurance. This population experienced a shift in usage away from primary care and toward hospital emergency departments. Oregon consumers who lost their Medicaid

[9] In its pilot project, Wellspan Health, in York and Gettysburg reduced health care costs by 28% in the first year.
[10] 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.); *see also* Leighton Ku and Teresa Coughlin, *Sliding-Scale Premium Health Insurance Programs: Four States' Experiences*, 36 INQUIRY 471, 476 (Winter 1999-2000) (finding that premiums set to 3% of income depressed enrollment by half).

because of increased cost-sharing later experienced greater unmet health care needs, reduced use of care, and more medical debt than consumers not charged a premium.[11]

b. The Proposed Premiums Violate Statutory Cost-Sharing Protections

With limited exceptions, federal Medicaid regulations do not allow states to impose premiums on consumers with income under 150 percent of the Federal Poverty Level (FPL).[12] The federal government allowed Oregon to impose premiums on certain adults under 150 percent FPL through a section 1115 demonstration, which waives normal rules in order to allow experiments that promote the goals of the Medicaid program. Under the same authority, *Healthy PA* asks the federal government to waive the normal cost-sharing protections. The experiment of Medicaid premiums, however, has already been tried and has failed.

Moreover, there is no basis in federal law to allow *Healthy PA* to go beyond terminating coverage for nonpayment and impose "lock-out" periods of up to nine months. This punitive "lock-out" provision has no precedent in Medicaid and promotes no valid health policy goal.

c. Recent Experience Casts Doubt on DPW's Capacity to Process Premiums

Currently, only one category out of dozens within Pennsylvania's Medicaid program charges a premium. The Medical Assistance for Workers with Disabilities (MAWD) category covers higher-income adults who are working despite disabilities. It has an income limit of 250 percent FPL and a 5 percent monthly premium.

MAWD covers only 33,000 adults (1.5 percent) out of more than 2.2 million Medicaid enrollees, yet DPW has still had difficulty processing MAWD premium payments in a timely and accurate manner. DPW uses a centralized office in Harrisburg to mail premium statements and process premium payments. After widespread complaints from MAWD consumers in October 2013 that they had wrongly received payment delinquency or termination notices after paying their MAWD premium, DPW officials acknowledged a backlog in processing MAWD premiums and directed its county offices to not terminate MAWD for consumers who claim to have made payment. This recent experience does not indicate that DPW has the infrastructure needed to vastly expand its premium processing capacity.

[11] Bill Wright, et al., *"Raising Premiums And Other Costs For Oregon Health Plan Enrollees Drove Many To Drop Out,"* HEALTH AFFAIRS, Vol 29, No. 12 (Dec 2010).
[12] 42 C.F.R. § 447.51.

4. Higher Emergency Department Copays Would be Ineffective and Violate Federal Law

The Consumers applaud *Healthy PA's* proposal to largely eliminate copays. The proposed $10 copay for inappropriate use of emergency department (ED) services, however, should not be advanced. 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.[13] 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.[14] Rather than imposing higher copays, which studies show to be ineffective in reducing ED visits[15] and likely violate the statutory limits on "nominality",[16] the Commonwealth should instead focus on enhancing access to primary care providers and urgent care centers.

5. Healthy PA's Private Coverage Option is Unlikely to be Budget Neutral

The Consumer Subcommittee is skeptical that *Healthy PA's* Private Coverage Option will be "budget neutral." *Healthy PA's* expenditure and enrollment projections, published in the PA Bulletin, show a calendar year 2015 capitation of $6,800 for newly eligible adults.[17] This projection is ***more than double*** the Pennsylvania Medicaid program's current per capita expenditure of $3,173 for non-disabled adults.[18] The *Healthy PA* application proposes a per capita budget neutrality model, but is entirely silent on the specifics of how providing coverage through a private option would be no more expensive than using Medicaid's current delivery system.

The federal Medicaid statute requires that a premium assistance model—like the private coverage opetion *Healthy PA* proposes—be "cost-effective;" it must be "comparable" to the cost of providing coverage directly through traditional Medicaid.[19] Similarly, section 1115 demonstrations must be "budget neutral." Against these measurements, *Healthy PA* falls short.

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[13] 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).
[14] *Id.*
[15] Mortensen, Karoline, *"Copayments Did Not Reduce Medicaid Enrollees' Nonemergency Use of Emergency Departments,"* HEALTH AFFAIRS, Vol. 29, No. 9 (September 2010).
[16] 42 C.F.R. § 447.54 (2010).
[17] 43 Pa.B. 7186 (Dec. 7, 2013)(showing per year projected enrollment and expenditures for CY 2015-19).
[18] Kaiser Family Foundation, "Medicaid Payments per Enrollee (FY 2010)," *available at*: http://kff.org/medicaid/state-indicator/medicaid-payments-per-enrollee/
[19] 42 U.S.C. § 1396e, § 1396e-1(a), § 1396d(a); see also 42 C.F.R. § 435.1015(a)(4); Centers for Medicare and Medicaid Services and the Affordable Care Act: Premium Assistance (March 29, 2013).

In Pennsylvania, unlike Arkansas, the Medicaid program already heavily uses risk-based managed care. Because the Arkansas Medicaid delivery system is almost entirely fee-for-service, premium assistance offers potential savings through managed care. In contrast, 77 percent of Pennsylvania Medicaid consumers receive coverage through a physical health MCO and 90 percent of Medicaid consumers receive coverage through a behavioral health MCO.[20] Our skepticism regarding budget neutrality is heightened by the fact that newly-eligible adults who are medically frail will be allowed to enroll in traditional Medicaid. The private option will by definition cover a healthier cohort than the traditional Medicaid program. Conversely, the existing Medicaid managed care plans will be required to absorb the portion of the expansion population with the highest utilization needs.

The Consumers strongly recommend that the final *Healthy PA* application include the following information:

- Spending base (e.g., the base Medicaid expenditure levels for non-elderly, non-disabled adults) and growth rate against which the Commonwealth proposes to measure budget neutrality;
- Percentage of the expansion population expected to be found "medically frail" and the portion of this cohort expected to enroll in traditional Medicaid;
- Projected rate adjustments to the existing Medicaid managed care plans necessary to maintain actuarial soundness following enrollment of the "medically frail"; and
- All projected administrative costs associated with: (i) procurement and state agency oversight of the private option insurers; (ii) medical frailty determinations and appeals; (iii) work search requirement compliance monitoring; (iv) benefit package health assessments and appeals; (v) premium processing and compliance monitoring.

Though not explicit in the draft application, *Healthy PA* may intend cost savings from other waiver components, such as the benefit redesign and work search requirements, to offset the increased costs associated with the private coverage option. The Consumers emphatically oppose any attempt to apply projected savings from other Medicaid reforms to the premium assistance "cost-effectiveness" analysis. To begin, this would be contrary to the Medicaid statute. Moreover, if the private coverage option is necessary to ensure the sustainability of the Medicaid program, it should not need to rely on saving from extraneous program reforms. Whether *Healthy PA's* Private Coverage Option can deliver "comparable" costs to Pennsylvania's current Medicaid arrangement is an open and critical issue.

[20] As of April 2013, according to DPW data.

6. Requiring Work Search Is Impermissible Under Medicaid Law

a. Work Search Requirements Have No Basis in Federal Law and Do Not Promote the Objectives of the Medicaid Program

The Consumers categorically oppose *Healthy PA's* work search requirement and punitive "lock-out" periods. Work requirements unambiguously go beyond the enumerated eligibility criteria allowed by the Medicaid statute.[21] 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. Courts have struck down state attempts to add eligibility requirements beyond those contained in federal law.[22] A state "cannot add additional requirements for Medicaid eligibility."[23]

Congress' objective in passing the Medicaid expansion is also clear: to provide universal coverage for all adults with incomes below 133 percent of the poverty line. Not only would work search requirements require time-consuming and costly verification procedures and increase churn, they would impose a significant barrier to coverage. None of these outcomes are consistent with the goals of the Medicaid Act or the Affordable Care Act.

b. The County Assistance Offices Do Not Have the Administrative Capacity Needed for Additional Work Search Requirements

The administrative capacity of DPW's County Assistance Offices (CAOs) to take on any additional function is lacking. As described by the excerpt below of an October 2013 report issued by the anti-hunger program Just Harvest, CAOs across the state are already overtasked. From the report:

> "When calling the local office, 82 percent of survey participants reported that they have experienced disconnections or full voicemails and 43 percent stated they were more likely to be disconnected than to be able to talk to someone. When they were able to leave a message, 48 percent reported never having their calls returned. . . . The persistent inability of the CAO system to manage its workload – whether it be answering the phone, processing documents or returning voicemail messages – indicates that the department is understaffed and/or lacks the basic resources necessary to enable community members to access vital public benefits."

[21] See generally 42 U.S.C. § 1396a.
[22] See, e.g., Camacho v. Texas Workforce Comm'n, 408 F.3d 229 (5th Cir. 2005).
[23] Id. at 235.

7. **The Process And Criteria for Determining "Medical Frailty" Is Problematic**

While *Healthy PA* purports to incorporate the definition of "medically frail" set forth in federal Medicaid regulations, it defines a key elements of that definition in a manner so restrictive manner that it undermines the spirit of the federal definition.[24] The draft application defines "individuals with serious and complex medical conditions" as an individual with certain diagnoses or who has had:

> "2 or more inpatient admissions within 12 months AND has 3 or more ED visits in 6 months AND 4 or more prescription medications per month."

Draft Application, Appendix 3. This definition would penalize consumers who appropriately manage their disability and do not require emergency or inpatient care. With these excessive utilization requirements, it would also fail to identify as "medically frail" many consumers with serious and complex medical needs, such as someone who is post-cardiac arrest who was admitted for only one inpatient stay. There can be little doubt that someone with a recent history of heart attack has a "serious and complex medical condition," and yet this person would not be considered "medically frail" under *Healthy PA*'s proposed definition. *Healthy PA* also fails to provide sufficient information regarding the process that will be used to determine whether an individual is "medically frail".

8. Medical Assistance for Workers with Disability (MAWD) Should Not be Eliminated

The *Healthy PA* proposal would eliminate the Medical Assistance for Workers with Disabilities (MAWD) program. Persons with incomes above 133 percent federal poverty would be referred to the Marketplace. This is harmful for at least two reasons. First, a significant number of MAWD enrollees qualify for Home and Community Based Services (waiver) services, even if their income exceeds waiver income limits. The individuals who qualify for waiver services, like attendant care, through MAWD are all individuals with disabilities who are employed (as employment is a requirement for MAWD). For most of these individuals, the services they receive through the waivers are essential to maintaining their employment as well as their ability to remain in the community. For these individuals, loss of MAWD will mean loss of waiver services; which will in turn result in unemployment. This is directly contrary to the Commonwealth's goal of expanding employment for persons with disabilities. Second, MAWD recipients, who by definition have disabilities, have significant utilization needs and many will not be able to afford the higher levels of cost-sharing required in the Marketplace.

[24] 42 C.F.R. §440.315(f).

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 remain optimistic that the Commonwealth's final submission will exclude the barriers discussed above. Please direct questions to Kyle Fisher (KFisher@phlp.org) and Laval Miller-Wilson (LMiller-Wilson@phlp.org), counsel for the Consumer Subcommittee.