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PENNSYLVANIA Health Law PROJECT

April 10, 2014

VIA ELECTRONIC SUBMISSION
Centers for Medicare & Medicaid Services
Department of Health & Human Services
7500 Security Boulevard, Mailstop: S2-01-16
Baltimore, MD 21244-8016

Re: Pennsylvania's Section 1115 Demonstration Application

Dear Sir/Madam,

Thank you for the opportunity to comment on Pennsylvania's Section 1115 Demonstration Application. As part of the state's federally-mandated advisory body, the Consumer Subcommittee of the Medical Assistance Advisory Committee represents Pennsylvania's 2.2 million Medicaid consumers. As the state agency's "eyes and ears," we are part of the communities whose health and well-being very much depend on Medicaid.

To protect Pennsylvania's current and future Medicaid consumers, we respectfully request that CMS approve Pennsylvania's demonstration application only after addressing the concerns listed below. To be clear, we very much support coverage expansion. However, we believe elements of Pennsylvania's Demonstration will profound harm current Medicaid consumers. We fear that Pennsylvania's requests, if granted, will erode key Medicaid protections and erect wholly unnecessary barriers to care. We elaborate on these concerns, outlined below, in the attached comments:

1. Pennsylvania's Request to Waive the Full Scope of Benefits and Protections Required Under Medicaid Law for the Newly Eligible Should be Rejected

2. Eliminating the MAWD Program is Bad Policy and Risks Institutionalization For Many MAWD Consumers

3. Pennsylvania's Proposed Benefit Changes are Harmful and Inappropriate

4. Experience Shows Premiums Result in Significant Disenrollment

5. Higher Emergency Department Copays Are Ineffective and Violate Federal Law

6. Pennsylvania's Private Coverage Option is Unlikely to be Cost-effective

7. Pennsylvania's Proposal to Tie Work-Related Activities to Medicaid Should be Rejected

8. Pennsylvania's Demonstration Hypotheses Are Incomplete and Overly Broad

Thank you for the opportunity to provide comment, and for your commitment to strengthening the Medicaid program. If you have any questions, please feel free to contact Laval Miller-Wilson by email at LMiller-Wilson@phlp.org or phone at (215) 625-3874.

Sincerely,

Consumer Subcommittee of the MAAC
Yvette Long, Chair

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

COMMENTS OF THE CONSUMER SUBCOMMITTEE OF THE MEDICAL ASSISTANCE ADVISORY COMMITTEE ON PENNSYLVANIA'S SECTION 1115 DEMONSTRATION APPLICATION

April 10, 2014

1. Pennsylvania's Request to Waive the Full Scope of Benefits and Protections Required Under Medicaid Law for the Newly Eligible Should be Rejected

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

The Consumer Subcommittee emphatically objects to Pennsylvania's request to waive Medicaid due process protections for Private Coverage Option enrollees. While Pennsylvania requests a waiver to implement a mandatory premium assistance model, its demonstration recipients are entitled to full Medicaid due process protections. As made explicit in CMS's 2013 guidance, premium assistance enrollees "remain Medicaid beneficiaries and continue to be entitled to all benefits and cost-sharing protections."[1] Moreover, the due process protections to adequate notice and fair hearing are found in the Medicaid statute and guaranteed by the Due Process Clause of the United States Constitution.[2] There can be no doubt that Constitutional protections fall outside of scope of the Secretary's authority to approve demonstration projects under Section 1115 of the Social Security Act.

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

Medicaid requires states to provide up to three months of retroactive coverage and point-in-time eligibility for enrollees.[3] We oppose Pennsylvania's request to delay Medicaid coverage for newly eligible adults until they enroll in a Private Coverage Option plan. Waiving these requirements serves no experimental purpose. As a policy-matter, the predictable results would be: (1) more low-income individuals experiencing medical debt collections and bankruptcy; (2) more providers incurring losses; and (3) more individuals experiencing refusal of treatment after providers realize they will not be paid retroactively by Medicaid. The availability of hospital presumptive eligibility is not a cure since that pathway fails to protect newly eligible adults who incur non-hospital

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[1] Ctrs. for Medicare & Medicaid Servs., Medicaid and the Affordable Care Act: Premium Assistance (March 2013).
[2] 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.).
[3] Social Security Act § 1902(a)(34); 42 C.F.R. § 435.914 (redesignated at §435.915 in 77 Fed. Reg. 17143).

medical debt, or those whose hospital chooses not to participate in presumptive eligibility. Creating a waiting period serves no health policy goal. CMS should require Pennsylvania to provide an interim period of fee-for-service Medicaid coverage for new eligibles in the same manner that it currently provides such coverage for enrollees in its Medicaid managed care program.

c. Medical Transportation and Family Planning Services Should Not be Curtailed

Non-emergency medical transportation (NEMT) is critical to ensuring that low-income Medicaid consumers have real access to the providers and services they require. It is also required by federal regulation.[4] Pennsylvania's change to require Private Coverage Option plans to reimburse all Federally Qualified Health Centers and Rural Health Centers on an in-network basis, while welcome, does not relieve the state of its obligation to "make arrangements with the [Qualified Health Plans] QHPs to provide any necessary wrap around benefits and cost sharing."[5] NEMT and family planning services are necessary wrap around benefits that CMS should require Pennsylvania to cover.

Especially in rural areas, medical transportation is a key part of translating Medicaid coverage in the abstract into medical treatment in reality. We understand that CMS granted Iowa a one-year waiver of NEMT for its private option participants, to be followed by a period of evaluation. Unlike Iowa, however, which is using a private option only for new eligibles over 100 percent of the Federal Poverty Level (FPL), Pennsylvania's request for waiver of medical transportation would apply to private option enrollees with incomes between 0-133 percent FPL. This request affects an estimated 600,000 newly-eligible adults, many of whom have income and geographic circumstances that necessitate transportation assistance. Waiving this key Medicaid benefit will leave many consumers with no means to get to their appointments. We urge CMS to not allow Pennsylvania to jeopardize access to care for the newly eligible population.

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.[6] Pennsylvania's request to limit family planning freedom of choice, which has been demonstrated to help women manage their pregnancies and reduce preterm births,[7] is both contrary to federal protections and misguided policy.

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[4] *See* 42 C.F.R. § 431.53.
[5] Ctrs for Medicare and Medicaid Servs, Medicaid and the Affordable Care Act: Premium Assistance (March 2013).
[6] 42 U.S.C. § 1396a(a)(23)(B); 42 C.F.R. § 431.51(a)(3).
[7] *See, e.g.*, Adam Sonfield & Rachel Benson Gold, *"Medicaid and Family Planning Expansions: Lessons Learned and Implications for the Future."* (2011), available at http://www.guttmacher.org/pubs/Medicaid-Expansions.pdf

d. Medicaid Managed Care Protections Regarding Plan Choice and Marketing Abuses Should Apply to Pennsylvania's Private Coverage Option

Currently, Pennsylvania's Medicaid managed care program (HealthChoices) 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 Pennsylvania'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.

Pennsylvania's Private Coverage Option should also be required to adopt the Medicaid protections against managed care marketing abuses.[8] 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. Especially if Pennsylvania is permitted to operate the private option outside of the Federally-Facilitated Marketplace, CMS should require the state to apply the Medicaid managed care protections to its Private Coverage Option.[9]

2. Eliminating the MAWD Program is Bad Policy and Puts Dozens of MAWD Consumers at Risk of Institutionalization

CMS should not permit Pennsylvania to eliminate the Medical Assistance for Workers with Disabilities (MAWD) program. Approximately 34,000 Pennsylvanians who are working despite having significant, long-term disabilities rely on this program. For MAWD recipients below 138 percent FPL, Pennsylvania intends to keep those that it deems "medically frail" in its traditional Medicaid delivery system, and to move the others into the private coverage option. For MAWD recipients above 138 percent FPL, the state intends to terminate coverage. These individuals would be advised to purchase

[8] *See* 42 C.F.R. § 438.104(b)(2).

[9] Pennsylvania's application is vague on information and specifics establishing that the single state Medicaid agency—i.e., the Department of Public Welfare (DPW)—will continue to make administrative and policy decisions for the Private Coverage Option plan. By law, the single state agency must be in control and accountable for developing and implementing Medicaid coverage. Thus insurance plans offering coverage through the Private Option arrangement must be subject to DPW control when it comes to benefit package details, authorization criteria, and the creation and termination of provider contracts and terms.

commercial insurance through the Health Insurance Marketplace. Notably, compared to the state's overall spending on Medicaid ($22.3 billion in FY 2014-15), the cost savings tied to eliminating MAWD ($7.2 million in FY 2014-15) are negligible.

The Marketplace will not be an option for those MAWD recipients who have Medicare in addition to Medicaid. These "dual eligible" cannot purchase Marketplace plans and will be left with only Medicare Advantage plans or Medigap policies. Insofar as these duals have already determined, by virtue of choosing MAWD, that Medicaid better suits their health care needs and their budget, this is highly problematic. Dual eligibles with behavioral health care needs, for example, choose MAWD because of the extensive array of mental health and drug and alcohol services that Medicaid provides. Additionally, licensing for behavioral health providers is more stringent under Medicare, meaning that consumers losing MAWD coverage will likely face narrower provider networks and have services such as outpatient mental health therapy disrupted. Medicare supplemental plans also have high cost sharing that, for many MAWD recipients, who by definition are high utilizers of health services, would be ruinous.

While some MAWD recipients without Medicare might find appropriate coverage through the Private Option or the Marketplace, that coverage will be insufficient for many who have significant behavioral health care needs.[10] For example, consumers on MAWD currently receiving psychiatric rehabilitation or community treatment team services will lose these supports which are integral to their recovery. Some MAWD recipients have behavioral health care needs so significant they require a Medicaid benefits package and full Medicaid protections rather than an essential health benefits package.

Additionally, dozens of MAWD recipients receive home and community based waiver services and would lose critical community supports if MAWD is eliminated. These individuals work despite having level of care needs at the institutional level. MAWD is essential to their ability to remain integrated in the community, to engage in work, and to live independently.

Cuts to existing community service programs violate the Americans with Disabilities Act and the "integration regulation" when they create a risk of institutionalization.[11] Pennsylvania's elimination of a category relied on by persons determined to be "nursing facility clinically eligible" is a textbook example of a prohibited reduction. Moreover, the cost savings from the elimination of MAWD are negligible compared to Pennsylvania's

[10] According to data supplied by the Dept. of Behavioral Health & Intellectual disAbility Services (DBHIDS), approximately 1/3 of MAWD recipients residing in Philadelphia (455 out of 1500) in 2013 obtained behavioral health services through Community Behavioral Health, the Medicaid "carve-out" BH MCO.
[11] 28 C.F.R. § 35.130(d); see also Olmstead v. L.C, 119 S.Ct. 2176 (1999).

Medicaid spending as a whole. According to the U.S. Department of Justice, in making cuts, public entities have a duty to "take all reasonable steps to avoid placing individuals at risk of institutionalization."[12]

We strongly urge CMS to make clear to Pennsylvania that the elimination of MAWD is an inappropriate component of a demonstration application focused on expanding coverage. There are no fiscal or policy justifications for so severely jeopardizing the care of those MAWD recipients for whom commercial insurance is unavailable or insufficient.

3. Pennsylvania's Proposed Benefit Changes are Harmful and Inappropriate

a. Pennsylvania Should Not be Permitted to Cut Benefits for Current Recipients in a Demonstration Expanding Coverage

CMS should not allow Pennsylvania to couple a demonstration expanding health coverage with deep benefit cuts for current Medicaid consumers. The state's request for a broad "amount, duration, and scope" waiver so that it may fundamentally alter the state plan benefit package, and introduce a new "high risk" alternative benefit plan for current recipients, is irrelevant to the purpose of the demonstration – which is to explore new ways of providing Medicaid coverage to the newly eligible population. Until Pennsylvania has fully complied with the array of procedural and substantive requirements (discussed below) tied to state plan changes and alternative benefit plans, we ask that CMS refuse to consider the proposed benefit changes.

b. Pennsylvania's Proposed Benefit Changes 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 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 plan, ostensibly created to serve Pennsylvania's "medically frail" population, puts a $2,500 limit on durable medical equipment. Consumers will be harmed by this arrangement. Virtually all motorized wheelchairs cost more than $2,500. Every Medicaid consumer requiring such equipment will be required to navigate the benefits limit exception process or go without. Likewise, the high risk plan limit on medical supplies is $2,500 annually. However, the costs of catheterization, depending on the

[12] Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C., (July 6, 2011) available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

specific kit at issue, can vary between $220 and $1,000 per month. Under Pennsylvania's proposed limits, individuals with severe disabilities would be required to routinely navigate the benefit limit exception process, which recent experience has demonstrated is an insufficient safeguard (see Section 3.c).

We strongly oppose Pennsylvania's requested waiver of the federal "amount, duration, and scope" requirement[13] to reduce existing benefit limits for current consumers who will be transferred to a new "low risk" plan. Despite repeated requests by advocates, the state has made no showing to justify this change: it has provided neither a description of the process by which the proposed limits were designed nor the data that purportedly shows that the limits would have negligible effect on current Medicaid consumers.

Similarly, we do not believe that Pennsylvania has complied with substantive and procedural Medicaid requirements governing Alternative Benefits Packages ("ABPs").[14] Substantively, the high risk plan fails to meet federal coverage requirements because it is significantly less generous than the Essential Health Benefits plan designated in Pennsylvania's application. For example, high risk plan imposes caps on radiology, lab work, and inpatient hospitalizations that do not exist in the Essential Health Benefits context. Pennsylvania's application is also procedurally flawed because the state has not demonstrated that the high risk benefits plan is "appropriate for the proposed population".[15] CMS should require Pennsylvania to comply with federal law and provide the public with appropriate notice and opportunity to comment on a revised and complete ABP proposal.

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

The Consumers are skeptical of Pennsylvania's 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 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 the added paperwork necessary for an exception request. 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.

[13] 42 C.F.R. § 440.230.
[14] 42 C.F.R. §§ 440.300-390.
[15] 42 C.F.R. § 440.330(d).

d. Pennsylvania Provides Insufficient Detail on the Health Screening Instrument to Assess Medical Frailty.

Pennsylvania fails to provide sufficient information regarding the process and criteria that will be used to determine whether an individual is "medically frail." This process will be used both to determine (1) whether the Medicaid expansion population will enroll in the Private Coverage Option or the traditional Medicaid delivery system, and (2) whether traditional Medicaid recipients will be eligible for the high risk or low risk benefits plans. The stakes are high because we want consumers to be placed in a plan that meets their needs.

Accordingly, we are very troubled that Pennsylvania's application still has not identified a screening tool(s) to determine whether an individual may be "medically frail/have exceptional needs." Pennsylvania's proposal to rely on responses by applicants/enrollees is problematic, especially for persons with disabilities or mental illness. Some individuals will have difficulty with the questions or answer them inaccurately, and then be dangerously underinsured because their level of coverage will be less than their health status warrants. Others, such as those with mental health or substance abuse issues may not report problems either out of the stigma attached to their illness or condition or because they are in denial. We urge CMS to require Pennsylvania to produce more detail on how it intends to operationalize the definition, and to carefully review this detail, prior to approving the demonstration.

Moreover, some of the listed standards defining "medically frail" are patently absurd, and clearly contrary to the spirit if not the letter of the federal definition.[16] A person who does not have a listed diagnosis can only demonstrate a "serious and complex medical condition" if he or she has two more inpatient admissions within twelve months, and three or more emergency room visits within six months, and four or more prescription medications per month (Appendix 3, p.110). This standard is so exclusionary and so specific that very few people will be able to meet it, even if they have severe disabilities.

Where the standard is not needlessly exclusionary, it is vague. For example, it defines an "individual with a physical disability" as an individual with a permanent physical disability that "significantly impairs his/her functioning" but provides no clue as to how functional impairments will be identified. And the definition of "individuals with an intellectual or developmental disability" lists "subnormal adaptive functioning based on standardized testing" but provides no further information.

[16] 42 C.F.R. § 440.315(f).

We urge CMS to work closely with Pennsylvania's technical staff to ensure that it has the technical capacity to develop a disability screening algorithm that properly analyzes the data captured via the health screening tool, as well as existing medical claims data to the extent that that data is used for a medical frailty determination. The planned algorithm must work accurately and appropriately for all Medicaid consumers before it is implemented.

e. The Demonstration Application Does Not Adequately Address Federal Mental Health Parity Requirements.

The Mental Health Parity and Addiction Equity Act of 2008 prescribes that a plan that provides both physical and behavioral health benefits cannot apply a more restrictive treatment limitations to mental health and substance abuse services than it does to physical health services of the same classification. Pennsylvania uses a "carve out" to provide behavioral health benefits. As you know, CMS urges states who use carve out arrangements to apply principles of parity across the whole Medicaid managed care delivery system.[17]

Pennsylvania's application 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 Mental Health parity requirements: even one physical health admission could easily last longer than the 45 day psychiatric limit.

4. Experience Shows Premiums Will Result in Significant Disenrollment

While touted by Pennsylvania 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 will lead to worse, not better, health outcomes. If CMS permits Pennsylvania to impose premiums, the premium amount should be limited to the expected Marketplace contribution and the state should be required to exempt recipients of home and community based waiver programs.

[17] Ctrs for Medicare and Medicaid Servs, Appl'n of the Mental Health Parity and Addiction Equity Act to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans (SHO #13-001, ACA #24)(Jan. 2013).

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.[18] 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 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.[19]

Pennsylvania proposed copays are higher than those charged in Oregon, and also higher than the expected premium contribution required by the Health Insurance Marketplace. Pennsylvania proposes premiums of $25 per month ($300 per year) for a single adult or $35 per month ($420 per year) for households with more than one adult. On the Marketplace, individuals under 133 percent FPL have an expected premium contribution of 2 percent of their income. For someone with income of 101 percent FPL, this equals an annual premium contribution of $236, which is over $60 less than the annual premium Pennsylvania would charge. Additionally, in our experience most individuals obtain lower premiums by choosing the least expensive silver plan. If CMS permits Pennsylvania to impose premiums, the premium amount should be limited to the expected Marketplace contribution.

b. Pennsylvania's Request for Authority to Impose Premiums under the Poverty Line Should be Rejected

Granting Pennsylvania open-ended authority to alter cost-sharing or impose premiums on adults under 100 percent FPL would undermines the Medicaid statute and the waiver process; CMS should reject this request. In addition to explicitly proposing premiums for adults with income above 100 percent FPL, Pennsylvania vaguely seeks authority to evaluate cost-sharing in demonstration year two and impose premiums on adults under 100 percent FPL.

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[18] 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).

[19] 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).

Pennsylvania's request is both inconsistent with the Medicaid statute and contrary to purpose of a Section 1115 waiver. With limited exceptions, federal Medicaid regulations do not allow states to impose premiums on consumers with income under 150 percent FPL.[20] The experiment of premiums in Medicaid has already been tried in Oregon, and it failed. We urge CMS to clearly state that premiums cannot be applied under any circumstances on consumers below poverty.

Similarly, CMS should unambiguously reject Pennsylvania's request to go beyond terminating coverage for nonpayment and impose "lock-out" periods of up to nine months. A punitive "lock-out" provision has no basis in the Medicaid statute, no precedent in Medicaid practice, and no valid policy goal that it accomplishes.

c. Applying Premiums to Home and Community Based Waiver Recipients but not Individuals in Institutions Likely Violates the ADA

Pennsylvania's proposal applies premiums to current Medicaid recipients receiving home and community based waiver services, but not to individuals in institutions. This is discriminatory against disabled individuals wishing to stay in the community, and invites legal challenge under the Americans with Disabilities Act.[21]

Applying premiums to waiver recipients, but not to residents of institutions, places a financial hardship on individuals trying to stay in the community that does not exist for their institutionalized counterparts. For waiver recipients, who have already been found to meet an institution level of care standard, this approach will result in disenrollment, deterioration of health, and increased institutionalization. CMS should require an exemption from the premium requirement for all individuals receiving home and community based waiver services.

d. 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 34,000 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

[20] 42 C.F.R. § 447.51.

[21] *See* Olmstead v. L.C, 119 S.Ct. 2176 (1999); Fisher v. Oklahoma Health Care Authority, 335 F. 3d 1175 (10th Cir. 2003)(agreeing with plaintiff's assertion that benefit limits that put disabled community members at both a health disadvantage as well as a financial disadvantage compared to those in institutions raised an ADA issue.).

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 delinquent payment 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 backlog continued to at least February 2014. This recent experience illustrates DPW lacks the infrastructure needed to vastly expand its premium processing capacity.

Although not indicated in the proposal, DPW could decide to contract out the premium processing, adding yet another layer of bureaucracy for consumers. Adding a third party to the payment processing will also significantly decrease DPW's accountability for managing Medicaid funds appropriately, add further administrative costs, and reduce transparency.

e. Premium Reductions for Healthy Behaviors are Likely to be Administratively Burdensome and Ineffective

Pennsylvania's proposal to reduce premiums based on individual compliance with healthy behaviors is ill-considered. Behavioral economics research indicates that incentives should be simple, salient and provide immediate feedback.[22] Requiring immediate or early compliance with healthy behaviors but delaying the premium reduction by six months or longer is not a design that will result in improved health outcomes. Further, the administrative infrastructure necessary to collect the appropriate patient information from health care providers in a timely manner and utilize it to set each individual's premium will be both expensive and ineffective. Engaging consumers in improving their health status is best done through the strategies Pennsylvania has proposed in its State Innovation Model, not this waiver application.

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

We urge CMS to reject Pennsylvania's proposed $10 copay for inappropriate use of emergency department (ED) services. 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.[23] Medicaid consumers disproportionately use ED services, but this is

[22] Kevin Volpe, *Key Components to Successful Financial Incentives*, British Medical Journal, April 2, 2014.
[23] 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).

driven by a higher incidence of urgent and semi-urgent care needs; Medicaid consumers are sicker than their privately insured counterparts.[24] Imposing higher copays would both violate the statutory limits on "nominality",[25] and be ineffective in reducing ED visits.[26] Again, we ask that this element of Pennsylvania's application be rejected.

6. Pennsylvania's Private Coverage Option is Unlikely to be Cost-effective

We urge CMS to scrutinize Pennsylvania's claim that its proposed Private Coverage Option arrangement will be "cost-effective." The demonstration application states that the state's historical cost data is inapplicable to cost projections for the newly eligible and requests "flexibility to adjust the per capital budget neutrality limit based on actual program experience" (p.83).

This attempt to demonstrate "cost-effectiveness" by comparing the private option's projected costs against its actual costs is misguided. The relevant comparison is to the cost that would be incurred through the traditional Medicaid delivery system. As described in CMS guidance, "Cost effective generally means that Medicaid's premium payment to private plans plus the cost of additional services and cost sharing assistance that would be required would be comparable to what it would otherwise pay for the same services."[27] The federal Medicaid statute requires that a premium assistance model be "cost-effective;" it must be "comparable" to the cost of providing coverage directly through traditional Medicaid.[28] Against these measurements, Pennsylvania's Application falls short.

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.[29] 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

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[24] *Id.*
[25] 42 C.F.R. § 447.54 (2010).
[26] Mortensen, Karoline, *"Copayments Did Not Reduce Medicaid Enrollees' Nonemergency Use of Emergency Departments,"* HEALTH AFFAIRS, Vol. 29, No. 9 (September 2010).
[27] Ctrs for Medicare and Medicaid Servs, Medicaid and the ACA: Premium Assistance (March 2013)(emphasis added).
[28] 42 U.S.C. § 1396e, § 1396e-1(a), § 1396d(a); see also 42 C.F.R. § 435.1015(a)(4); Ctrs for Medicare and Medicaid Servs, Medicaid and the Affordable Care Act: Premium Assistance (March 2013).
[29] As of April 2013, according to DPW data.

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.

Pennsylvania's expenditure and enrollment projections, published in the PA Bulletin, show a calendar year 2015 capitation, in the aggregate, of $6,800 for newly eligible adults.[30] This projection is more than double the Pennsylvania Medicaid program's current per capita expenditure of $3,173 for non-disabled, non-elderly adults.[31]

The projected "with waiver" costs provided in Pennsylvania's application invite disbelief. For example, without explanation, Pennsylvania projects 2016 costs for low risk Temporary Aid to Needy Families (TANF) adults to be $530 per month and for high risk TANF adults to be $2,918 per month (p.89). These projections are extremely high, compared to either the estimate of $484 per month for private option adults or the actual 2010 expenditure of $264 per month ($3,173 per year) for TANF adults. We urge CMS to carefully review these estimates and require Pennsylvania to fully satisfy its burden of demonstrating "cost-effectiveness." Whether Pennsylvania's proposed Private Coverage Option can deliver "comparable" costs to Pennsylvania's current Medicaid arrangement is an open and critical issue.

7. Pennsylvania's Proposal to Tie Work-Related Activities to Medicaid Should be Rejected

We urge CMS to reject Pennsylvania's proposal to reduce premiums based on whether a consumer is engaged in a work-related requirement. While this proposal is clearly less problematic than the state's initial proposal to make work search a condition of eligibility, it should still be rejected as being outside the scope of the Secretary's authority to approve demonstration projects under Section 1115.

Demonstration projects must assist in promoting the objectives of the Medicaid program. The core purpose of the Medicaid program is to provide health care services to low-income and vulnerable people. Programs designed to support employment have no connection to the purpose of the Medicaid program, and should be rejected on this basis.

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[30] 43 Pa.B. 7186 (Dec. 7, 2013)(showing per year projected enrollment and expenditures for CY 2015-19).
[31] Kaiser Family Foundation, "Medicaid Payments per Enrollee (FY 2010)," *available at*: http://kff.org/medicaid/state-indicator/medicaid-payments-per-enrollee/

8. Pennsylvania's Demonstration Hypotheses Are Incomplete and Overly Broad

A Section 1115 waiver is a research and demonstration project to test new or existing approaches to financing and delivering Medicaid and CHIP services. The hypotheses set out in the proposal are poorly defined at best. As just one example, the state hypothesizes that using the private option model will reduce overall premium costs in the Commonwealth, and proposes to measure success by comparing aggregate premium costs with the private option to historical costs. This is both overly broad, insofar as it extends well beyond the Medicaid program, and analytically lacking, insofar as it fails to include any mechanism for measuring causality.

We strongly urge CMS, as a condition for any approval, to require DPW to contract with an impartial program evaluation and policy research organization to measure the impact of the proposed changes on the full Medicaid population, including existing enrollees, as well as those newly eligible. This impartial organization should demonstrate experience with underserved populations and expertise in Medicaid programs as well as data collection and methodologies for analysis.