FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

April 10, 2014

The Honorable Kathleen Sebelius
United States Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

By E-Mail to: Kathleen.Sebelius@hhs.gov

Re: Comments on Pennsylvania's Healthy PA Section 1115 Waiver Submission and March 5th Supplemental Proposal, "Encouraging Employment: A Pathway to Independence."

Dear Secretary Sebelius:

Families USA is grateful for the opportunity to comment on the 1115 waiver request submitted by the Commonwealth of Pennsylvania for its Healthy Pennsylvania program and the supplemental proposal, "Encouraging Employment: A Pathway to Independence." In this letter, we are commenting on both.

We are a national healthcare advocacy organization with the mission of supporting policy changes that will expand access to affordable healthcare for all Americans. We are committed to seeing Pennsylvania expand Medicaid eligibility.

While we strongly support the Commonwealth's decision to accept federal funding to extend Medicaid coverage to low-income parents and adults, we do not believe that the waiver program should be approved as submitted. The envisioned program includes components will harm Medicaid enrolles and that set extremely troubling precedents for the Medicaid program and for future Medicaid expansions. Our concerns are discussed in greater detail below. We believe that these concerns can, and should, be addressed during the waiver approval process.

Encouraging Employment

We are pleased that Pennsylvania has modified its submission and made the portion of the waiver program entitled "Encouraging Employment" a voluntary, one-year pilot. However, even with the modification, for the reasons listed below, we do not believe that portion of the waiver application should be approved.

FamiliesUSA.org
1201 New York Avenue, NW, Suite 1100
Washington, DC 20005
main 202-628-3030 / fax 202-347-2417

- ***Insufficient nexus between employment and the purpose of the Medicaid program for the proposal to meet the requirements of 42 U.S.C. 1315(a)***. The purpose of an 1115 demonstration project is to give the Secretary authority to approve pilot, experimental or demonstration projects that promote the objectives of the Medicaid program.[1] The objective of the Medicaid program is to provide medical assistance to low-income individuals. We do not believe that this aspect of the program Pennsylvania is proposing is sufficiently related to "providing medical assistance" to fall within the Secretary's authority to approve as a component of a state's Medicaid program.

- ***The mere fact of a relationship between employment and health status does not create a sufficient connection.*** In its waiver application, Pennsylvania cites research linking employment to improved mental and physical health as a rationale for linking enrollees' financial obligations under Medicaid to hours worked or participation in job search activities. The cited research may be true, but that is not relevant. The mere presence of a link between an activity, in this case employment, and health does not create a sufficient connection for the activity to promote the objectives of the Medicaid program.

  It does not matter how commendable the activities in question are, or whether those activities have been shown to promote health and well-being. Linking elements of the Medicaid program, in this case individuals' Medicaid cost-sharing or premiums, to participation in activities that are outside of the purpose of the Medicaid program changes the nature of the program itself and is outside of the Secretary's authority under Section 1115 of the Social Security Act.[2]

- ***The proposal to impose a financial penalty on individuals who do not work or participate in job search activities is punitive, discriminatory and an inappropriate use of waiver authority.*** In its application, Pennsylvania presents its "Encouraging Employment" proposal as a "copayment or premium reduction" rather than a penalty. Regardless of the state's terminology, the imposition of higher costs on individuals who do not work a certain number of hours is a penalty. Incorporating such a financial penalty in Medicaid is punitive and discriminatory.

  The proposal fails to consider the reality of low-income individuals' circumstances. There are many reasons low-income individuals may not be able to meet the weekly target hours outlined in the proposal. These can include child or elder care obligations; transportation difficulties; a poor area job market and an inability, for financial or personal reasons, to relocate to an area with better employment prospects. Additionally, many Medicaid

[1] 42 U.S.C. 1315(a).

[2] Employment is among many things that are associated with improved health but are unrelated to the Medicaid program and should not be associated with program participation or enrollee financial obligations. Other examples include things as diverse as housing quality and educational attainment. Starting down the path of linking elements of the Medicaid program to activities or conditions unrelated to Medicaid's purpose sets a precedent that could ultimately undermine the program's effectiveness in providing medical assistance to low-income people.

enrollees may engage in seasonal work and may have months in which they work very few hours per week simply because of the nature of their occupation. Likewise, there are many reasons it may be difficult for low-income individuals to participate in the Job Gateway program. Those can include lack of internet access and difficulty getting to a library or venue to conduct an internet search during opening hours.

The proposal is discriminatory, inconsistent with the purpose of the Medicaid program, and an inappropriate use of waiver authority.

- ***There are less punitive, and more cost-effective, ways to connect Medicaid enrollees with job search resources.*** New Hampshire's recently passed Medicaid expansion legislation includes a provision that unemployed Medicaid expansion enrollees be referred to the state's department of employment security for the purpose of helping them find employment.[3] Although the program has just passed and its exact operation has not been determined, as outlined in the legislation, the program has the same purpose as Pennsylvania's "Encouraging Employment" proposal: connecting Medicaid enrollees with job opportunities. However, it has significantly lower administrative costs than Pennsylvania's proposed approach, which will require that premiums and cost-sharing reductions be calculated on an individual basis and recalculated every six months. [4] Most importantly, for purposes of the Medicaid program's integrity and the Secretary's authority, it does not impose discriminatory conditions, requirements, or penalties on enrollees that are unrelated to the purpose of the Medicaid program.

Premiums and Cost-Sharing

We are pleased that premium payments will not be applied in the first year. However, we remain concerned about imposing premiums in Medicaid on individuals with incomes below 150 percent of poverty. Beyond that general concern, we have some additional concerns with some specifics of Pennsylvania's premium and cost-sharing proposal.

- ***Past demonstrations imposing premiums in Medicaid have shown that they limit enrollment and result in program drop-out. There is little demonstration value in adding premium payments to Pennsylvania's program.*** Past demonstrations have examined the effect of premiums on access to care and found that they limit enrollment. There is ample evidence of the effect of premium payments on Medicaid enrollees and their continued access to care. Monthly premiums proposed for the Pennsylvania programs will almost certainly cause enrollees to lose coverage, and cause newly eligible individuals to not enroll

[3] New Hampshire Senate Bill 413-FN-A, (2)(XXVI), accessed online on April 3, 2014 at http://gencourt.state.nh.us/bill_status/results.aspx?lsr=2600&sortoption=&txtsessionyear=2014&txtbillnumber=sb413.

[4] Pennsylvania's "*Encouraging Employment:* A Pathway to Independence," the March 5, 2014 supplement to the initial waiver application.

at all. There is little demonstration value in including premium payments in the Pennsylvania program.

- Premiums negatively affect coverage retention even among higher income Medicaid enrollees. In July 2012, Wisconsin added or increased premiums for some adults enrolled in its Medicaid program, BadgerCare. Enrollees with incomes between 133 and 150 of poverty who had previously had no premium costs were required to pay three percent of their income in premiums. Preliminary analysis showed that premium payments had a negative effect on the ability of these low-income enrollees to maintain coverage. From July through September 2012, there was a 24 percent enrollment reduction due to non-payment of premiums for those in the 133 to 150 percent of poverty income group. [5] While the premium levels proposed in Pennsylvania are slightly lower as a percent of income than those imposed in Wisconsin, they will affect a lower income population (individuals with incomes between 100 and 138 percent of poverty).[6] The premiums proposed would impose a significant financial burden relative to income, inevitably resulting in program drop-out.

- Premiums negatively affect enrollment. A study of multiple Medicaid programs in which premiums were imposed found that for low-income families, premiums as low as one percent of income are associated with decreased enrollment.[7] The premiums proposed in Pennsylvania's program exceed 2.5 percent of income.

- ***The premiums are higher than what individuals at the same income level would pay in the Marketplace. Imposing higher premiums in Medicaid, a low-income program, is inappropriate and should not be approved.*** Single enrollees with incomes between 100 and 138 percent of poverty will pay $300 per year in premiums and couples will pay $420 annually. Based on 2014 poverty levels, at 100 percent of poverty, the proposed premiums equal 2.6 percent of income for an individual and 2.7 percent for a couple. [8] This is higher than premium costs for individuals with comparable incomes in the Marketplace, where the maximum premium for individuals with incomes at 100 percent of poverty is 2 percent of income. While we strenuously object to Medicaid premium payments for individuals with incomes below 150 percent of poverty, at the least, premiums charged should be no more

[5] For analyses of the BadgerCare results see: "State of Wisconsin Department of Health Services Wisconsin Medicaid Premium Reforms: Preliminary Price Impact Findings," available online at: http://www.dhs.wisconsin.gov/MAreform/report12.11.12.pdf Wisconsin Council on Children and Families, "Evaluation of Last Year's BadgerCare Changes Makes Strong Case Against New Waiver," September 4, 2013, available online at: http://wccf.org/pdf/BadgerCare_changes_evaluation.pdf.

[6] Based on 2014 poverty levels, at 100 percent of poverty, the income levels where premiums initially apply, the $25/month for an individual is 2.6 percent of income; the $35 for a couple is 2.7 percent of income.

[7] Leighton Ku and Victoria Wachino, "The Effect of Increased Cost Sharing in Medicaid: A Summary of Research Findings," Center on Budget and Policy Priorities, July 2005, available online at http://www.cbpp.org/files/5-31-05health2.pdf.

[8] We recognize that premiums will not be imposed until year two, but changes in the poverty level are unlikely to significantly change the percent of income calculation.

than Marketplace premiums for individuals with comparable incomes.

- ***CMS should reject the Commonwealth's request for open-ended authority to raise cost-sharing or premiums, or impose premiums on individuals with incomes below poverty.*** In year two, the Commonwealth requests authority to change copayment amounts or impose premiums on enrollees with incomes below poverty based on "data on participant copayment compliance…" without having to obtain any separate approvals from CMS or go through a public notice or comment period.[9] Pennsylvania is also requesting authority to revise premium payment levels for many adults at all income levels starting in year two of the demonstration.

  This request to circumvent the waiver process would undermine the process itself. CMS should make clear that the Commonwealth does not have authority to make such unilateral changes to the program. Additionally, because imposition of premiums below 150 percent of poverty is inconsistent with long-standing Medicaid rules and has the potential to have a significant effect on enrollee access, we urge CMS to clearly state that the Commonwealth cannot impose premiums on individuals with incomes below the poverty level. For the same reasons, we also urge CMS to clearly state that Pennsylvania must go through the full waiver process, including public notice and comment periods at the state and federal levels, before imposing premiums on a new group, or increasing premium payments for enrollees already covered under the waiver.

- ***Pennsylvania's request for a disenrollment lock-out period is inconsistent with the goals and objectives of the Medicaid program and should be rejected.*** Pennsylvania has requested approval to exclude individuals from re-enrolling in Medicaid for progressively longer periods of time if they fail to pay premiums in the allotted time. Specifically, individuals would be barred from reenrollment for three months after the first 90 day non-payment period; six months after the second; and nine months after the third. The proposal to incorporate such "lock-out" periods should not be approved.

  It is predictable that paying the requested premiums will be a significant hardship for many enrollees, one that many will not be able to meet. Incorporating lengthy lock-out periods in response will undermine care continuity and result in potentially long periods during which enrollees will be without coverage. That is inconsistent with the purpose of the Medicaid program and should not be approved. In addition, enrollees who delay or forego care during a lock-out period may return to the program with medical conditions that have grown more serious and cost more to treat.

- ***CMS should reject Pennsylvania's request to charge cost sharing for non-emergency use of the ER that exceeds the amount allowed in regulations.*** We support strategies to discourage inappropriate use of emergency room services, provided there are adequate

[9] Pennsylvania Waiver application, page 56.

consumer protections in place. Those include providing a complete medical assessment to confirm no emergency exists and making arrangements for individuals to receive needed medical care quickly. We do not have issue with the Commonwealth's decision to apply higher cost sharing for non-emergency use of emergency room services than cost-sharing imposed on other services, provided those consumer protections are in place. However, regulations set cost sharing for non-emergency use of the ER at $8 for individuals with incomes below 150 percent of poverty.[10] The Commonwealth offers no justification for its request to charge a higher amount ($10). Absent justification that is related to goals and purpose of the Medicaid program, this request should not be approved.

Delivery System/Use of Private Option

Pennsylvania's request to purchase private coverage is vague. It is unclear that it is necessary to achieve the objectives outlined in the waiver application.

- ***Substantial overlap between the Marketplace and Medicaid participating managed care organizations (MCOs) makes the private option unnecessary to limit churn.*** Reducing churn is one of the main reasons that the Commonwealth gives for incorporating a private option (Marketplace coverage) in its proposal.[11] Churn is the movement between health plans when individuals move from one coverage program to another, such as from Medicaid to the Marketplace and the reverse. However, in Pennsylvania's case, the private option is likely unnecessary to reduce churn.

  There is already substantial overlap between plans available in the Marketplace and managed care plans participating in the Commonwealth's Medicaid program. A recent study found a 75 percent overlap between Pennsylvania's Marketplace plans and Medicaid managed care plans.[12] Most of Pennsylvania's existing Medicaid enrollees are already enrolled in managed care (over 80 percent).[13] Using its existing Medicaid managed care plans, Pennsylvania could address the issue of churn. Furthermore, the Commonwealth already has an established Health Insurance Premium Payment Program (HIPP) under Medicaid section 1906. Given the structure of Pennsylvania's Medicaid program, it should provide additional justification for the private option approach.

  We are concerned that Pennsylvania is merely using this approach as a way to bypass Medicaid consumer protections, such as network adequacy and access standards, grievance

[10] 42 CFR 447.54.
[11] Pennsylvania waiver application, page 13.
[12] Association for Community Affiliated Plans, "Overlap Between Medicaid Health Plans and QHPs n the Marketplace: An Examination," December 13, 2013. Accessed online at http://www.communityplans.net/Portals/0/Policy/Medicaid/ACA%20Act/ACAP%20QHP%20Analysis%20Brief.pdf.
[13] Kaiser State Health Facts, "Medicaid Managed Care Enrollees and a Percent of State Medicaid Enrollees," accessed April 7 at http://kff.org/medicaid/state-indicator/medicaid-managed-care-as-a-of-medicaid/.

processes, and quality review requirements.[14]

- ***Pennsylvania's request to purchase coverage through the Marketplace, private market, or employer plans is vague; more details are needed before approval.*** HHS's March FAQs on the use of premium assistance in the Medicaid expansion make clear that proposals should focus on providing coverage through the Marketplace.[15] The Commonwealth does not outline how private plans outside of the Marketplace would be selected or when enrollees would be placed in such plans in lieu of Marketplace plans. Those details should be required before final approval.

Benefits

We are please that Pennsylvania is planning on providing FQHC/RHC services for adults over age 21. However, the Commonwealth is requesting a waiver of other ACA required wrap-around services.[16] Additionally, it is using this waiver to make sweeping changes to benefits in its existing Medicaid program. We urge CMS to reject both of these requests.

- ***The request to waive wrap-around services for individuals in the private option should not be approved.*** Pennsylvania states that it will not provide any wrap-around benefits in its private option, with the exception of FQHCs/RHCs. It specifically asks for waivers from Medicaid alternative benefit plan requirements related to non-emergency transportation and family planning. However, no justification related to patient care or outcomes is offered for this request. It appears to be for the convenience of the contracted plans and the Commonwealth, an inappropriate rationale for a demonstration waiver. The request should not be approved.

- ***The request to waive wrap-around services is inconsistent with recent HHS guidance***. In its March FAQs, HHS stated that it will consider premium assistance proposals that, "(M)ake arrangements with the QHPs to provide any necessary wrap around benefits…."[17] Granting Pennsylvania's request to waive wrap around services would undermine HHS's own guidance and would set a very dangerous precedent for future expansions. The Medicaid alternative benefits package outlined in the Affordable Care Act is designed to meet the needs of a low-income population. Congress intended for this population to receive this comprehensive set of benefits.

---

[14] See 42 CFR 238.

[15] See HHS's FAQs "Medicaid and the Affordable Care Act: Premium Assistance," March, 2013, at http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf. The discussion of coverage through the Marketplace is covered in number 3.

[16] This excludes EPSDT services, because the waiver does not include expansion enrollees under 21. We are please with the Commonwealth's decision to omit that population.

[17] HHS, Medicaid and the Affordable Care Act: Premium Assistance at Question 3 (March 2013) available at http://medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-Implementation/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-ACA-Implementation.html.

- ***Non-emergency transportation should be a required service.*** Pennsylvania asks for a waiver of non-emergency transportation for enrollees in the Commonwealth's private option. The Commonwealth does not offer any patient care justification for this request and it should not be approved.

  The private option will include some very low-income individuals. Undoubtedly, many will have difficulty affording transportation to medical care. At the same time that Pennsylvania is asking to waive non-emergency transportation benefits, it is requesting to include a wellness component in its program. Premiums and cost-sharing will be reduced if enrollees engage in specified healthy behaviors. For the wellness program to be successful, it is critical to mitigate as many barriers to care as possible. Covering non-emergency transportation will lessen one barrier to care, making it easier for individuals to meet their wellness requirement. It is incongruous to omit nonemergency transportation benefits and financially penalize individuals for not need meeting wellness requirements. This request should not be approved.

- ***Coverage requirements for family planning providers should not be waived.*** Pennsylvania's waiver request would allow the Commonwealth to limit access to family planning providers to plan network providers. States have a heightened obligation regarding Medicaid enrollees' access to family planning providers. The request to waive this requirement appears to be for the convenience of participating plans, rather than based on any medical or health rationale, and should not be granted.

- ***Offering the essential health benefits to the expansion population is not a justification for not offering required Medicaid services.*** In it application, Pennsylvania states, "Due to the federal EHB requirement, it is assumed that all other benefits potentially subject to wrap-around services are provided sufficiently through (the private options plans)."[18] There is no reason for the assumption. Alternative benefit plans for the Medicaid expansion population are required to provide the essential health benefits *plus* additional services specific to the Medicaid population.[19] Providing only the essential health benefits package is not sufficient to assure that the critical health care needs of the lower-income Medicaid population are met as intended under the Medicaid statute.

- ***The Commonwealth's request to restructure its existing Medicaid program should not be considered.*** Pennsylvania is requesting approval for sweeping changes to Medicaid's "amount, duration and scope" requirements for low-risk adults in traditional Medicaid. The request is overly broad. Additionally, it is neither related to the primary purpose of this waiver application, nor does it further any of the objectives listed on application page 5. Specifically, it fails to meet objective (4), "….reforming the current Medicaid program to align it with private health care coverage." In fact, on several key variables, the coverage

[18] Pennsylvania wavier application page 71.

[19] Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medicaid Program: States Flexibility for Medicaid Benefit Packages, Final Rule, 75 *Federal Register*, 23068 (April 30, 2010).

proposed is significantly less than the essential health benefits through private plans.[20] This portion of the waiver application should not be considered.

Retroactive eligibility

In its waiver application, Pennsylvania states that it will not provide retroactive coverage for individuals enrolled in the private option.[21] The Commonwealth does not offer any rationale for this request, although it appears to be to accommodate enrollment practices of the plans participating in the private option. There is nothing to precluding Pennsylvania from providing these individuals with retroactive eligibility through its traditional Medicaid program. That would keep low-income enrollees from incurring medical bills they cannot pay and will assist the Commonwealth's safety-net providers. Waiving retroactive eligibility is a hardship on some Medicaid beneficiaries as well as on providers and should not be waived.

Thank you so much for your consideration of these comments and for your work moving Pennsylvania forward toward the Medicaid expansion in a manner that retains Medicaid's integrity as an insurance program that truly provides access to appropriate, quality care for low-income people.

If you have any questions, please contact me at 202.628.3030.

Sincerely,

Dee Mahan
Medicaid Program Director

cc: Marilyn Tavenner, Administrator, Centers for Medicare & Medicaid Services (Marilyn.Tavenner@cms.hhs.gov)
Cindy Mann, Deputy Administrator, Centers for Medicare & Medicaid Services and Director for Medicaid and CHIP Services (Cynthia.Mann@cms.hhs.gov)
Eliot Fishman, Director, Children and Adults Health Programs Group, Centers for Medicare and Medicaid Services (Eliot.Fishman@cms.hhs.gov)

[20] See Community Legal Services, "Final Healthy PA Proposal Still Includes Severe Medicaid Benefit Cuts," accessed online, April 7, 2014 at http://clsphila.org/sites/default/files/issues/DPW%27s%20Health%20Care%20Proposal%20Includes%20Severe%20Benefits%20Cuts_0.pdf.

[21] See page 71 of the Commonwealth's waiver application. An exception is made for individuals determined presumptively eligible by a hospital provider.