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September 11, 2014

Cindy Mann  
Deputy Administrator and Director  
Center for Medicaid, CHIP, and Survey and Certification  
U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

Dear Cindy:

We congratulate CMS for achieving Medicaid expansion in Pennsylvania and the potential coverage of hundreds of thousands of Pennsylvanians. While we do not believe there is an adequate basis in law or policy for the § 1115 waivers of Medicaid's premium prohibition (for people below 150% FPL) and non-emergency transportation requirement, we are grateful that HHS did not further stretch the concept of flexibility beyond that granted in the Iowa demonstration. Moving forward, we urge HHS to clearly hold the lines drawn in Iowa and Pennsylvania. Every line that is blurred complicates expansion in the states that remain and risks regression in the states that have already expanded.

The primary purpose of this letter is to express our deep concern with Pennsylvania's intended "benefits approach," especially in light of the statement in CMS's approval of the demonstration that "CMS and the state have been in active consultation on the state plan amendments needed to effectuate this change and have reached agreement on the overall benefits approach."<sup>1</sup> Approving Pennsylvania's intended benefits approach (as it was described in Pennsylvania's § 1115 application) would have a catastrophic effect on coverage for Pennsylvanians and threaten the integrity of the Medicaid state plan benefit in the 50 states.

The Medicaid Act authorizes Pennsylvania to provide the expansion population with an ABP benefit which can be modeled after the state plan or any other option permitted under § 1937. However, Pennsylvania's intended "benefits approach" includes radical cuts to the existing Medicaid state plan benefit, the benefits package generally applicable to the traditional non-expansion

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<sup>1</sup> Letter from Marilyn Tavenner, Dep't Health & Human Servs., to Beverly Mackereth, Sec'y, Penn. Dep't Pub. Welfare, 2 (Aug. 28, 2014), available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/pa/pa-healthy-ca.pdf>.

population. **Under Pennsylvania’s proposed approach, hundreds of thousands of Pennsylvania’s most vulnerable individuals – including pregnant women, persons with disabilities, and seniors – will see their benefits slashed.** HHS should not approve such a “benefits approach” because it is inconsistent with Medicaid law, the process by which this proposal has been presented is in bad-faith and lacks transparency, and it will result in terrible health outcomes for real people.

### ***Pennsylvania’s Benefits Approach Is Not Legal***

Pennsylvania’s proposed cuts cannot be approved because they violate Medicaid law. The Medicaid Act requires states to cover certain Medicaid services.<sup>2</sup> Furthermore, for both mandatory services and optional services a state chooses to cover “[e]ach service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.”<sup>3</sup> At this point, there is absolutely no basis for concluding that Pennsylvania’s proposed cuts meet this legal standard for sufficiency. Reducing inpatient acute hospitalizations to 3 non-emergency admits per year will not reasonably meet the needs of the large population of seniors with advanced illness or multiple chronic conditions; reducing “radiology” to 8 tests will not reasonably cover the large population of pregnant women with diverse ranges of risk; and limiting DME and medical supplies to \$2,500 will not reasonably meet the needs of the large population of persons with disabilities who rely on those supports. These types of limits turn Pennsylvania’s Medicaid program into an insurance program that looks more like coverage for young healthy working adults – as opposed to a program created by Congress specifically to serve vulnerable individuals, low-income pregnant women and low-income people with chronic and disabling conditions.

We understand that, despite the legal requirement for reasonable coverage, HHS has signaled that it will consider an approval based on a policy of allowing cuts if the benefits package still meets the needs of 90% of the population. This “90% threshold” is mentioned nowhere in the 42 C.F.R. § 440 Subpart B regulations on Medicaid services, or anywhere else in Medicaid statute, regulations, or State Medicaid Manual. Instead, the Medicaid Act is unambiguous that “[a] State plan for medical assistance must ... include reasonable standards ... for determining the extent of medical assistance under the plan...” which must be “consistent with the objectives” of the Medicaid Act.<sup>4</sup> It is not reasonable or consistent with the objectives of Medicaid – namely, “to furnish medical assistance” for low-income seniors, pregnant women, and persons with disabilities<sup>5</sup> – to leave all of these vulnerable populations without coverage for services it is clear that they will need.

Even if the 90% threshold were legally acceptable in general terms, it would clearly be illegal as applied in the Pennsylvania proposal for two additional reasons. First, “[s]ervices cannot be arbitrarily denied based on diagnosis, type of illness, or

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<sup>2</sup> Social Security Act §§ 1902(a)(10)(A) and 1905(a).

<sup>3</sup> 42 C.F.R. § 440.230(b).

<sup>4</sup> § 1902(a)(17).

<sup>5</sup> § 1901.

condition.”<sup>6</sup> Pennsylvania’s proposal clearly discriminates on these bases. Even *if* 90% of the population did not need 8 radiology tests, this statistic would not hold true for pregnant women and numerous other groups based on their conditions. Likewise, even *if* a \$2,500 DME limit met the needs of 90% of the population, the statistic would not hold true for seniors and persons with disabilities, much less such individuals with a specific condition such as serious functional limitation, partial paralysis, quadriplegia, etc.

Second, Pennsylvania’s benefits cuts are not approvable because the threshold is being applied wholesale to broad categories of services, while regulation in fact requires that “each service” must be provided “in sufficient amount, duration, and scope.”<sup>7</sup> Services cannot be arbitrarily lumped together, with a limitation applied to the lumps of services, and applicable to all Medicaid recipients. Pennsylvania’s plan to justify cuts through a 90% threshold applied to extremely broad categories such as “radiology,” “inpatient drug & alcohol,” or “laboratory” is not legal. On numerous past occasions, the federal Medicaid agency has refused to allow states to engage in this sort of quantitative cap bundling and now is no time to back away from that position. See, e.g., CMS Letter to Dave Goetz, Tennessee Medicaid Commissioner (Mar. 3, 2006); 58 Fed. Reg. 14477, 14578 (Mar. 18, 1993) (Notice) (disapproving Arkansas plan to impose a combined quantitative limit on six separate Medicaid services, noting that 42 C.F.R. § 440.230(d) authorizes limits but finding that the proposed gross limits did not purport to exclude any medical services on the grounds that they are not medically necessary or to be a control over the utilization of covered services “since services will be reduced even though recipients have never used them.”); 53 Fed. Reg. 8507 (Mar. 15, 1988) (Notice) (“The State may not administer a State plan which denies coverage of any medically necessary service or procedure within the five required categories even if it is also coverable as an optional service.”); see also *Bontrager v. Indiana Family and Social Services Admin.*, 697 F. 3d 604, 610-11 (7th Cir. 2012) (striking down monetary cap on optional adult service because it would exclude whole categories of medically necessary services costing above the limit and noting that categorical limits to services do not constitute permissible utilization control procedures). Notably, at least one federal court has already told Pennsylvania officials that these unreasonable limits are unacceptable. See *Jackson v. O’Bannon*, No. 80-500, Medicare & Medicaid Guide (CCH) ¶ 31, 108 (E. D. Penn. 1980) (holding “recipients have made a strong showing that limiting psychotherapy sessions to eight hours per month precluded outpatient psychiatric services from achieving its purpose”).

We also note that Pennsylvania’s proposed approach should not be approved because the State has failed to explain whether and how an exceptions process will work for individuals subject to the benefits cuts who have additional needs. Even in circumstances where states are allowed to limit access to benefits – for example in the design of “appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures”<sup>8</sup> – states should have in place a “timely” process that

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<sup>6</sup> 42 C.F.R. § 440.230(c).

<sup>7</sup> 42 C.F.R. § 440.230(b).

<sup>8</sup> See 42 C.F.R. § 230(d).

“employs reasonable and specific criteria” to judge whether an exception should be provided.<sup>9</sup> Previous HHS guidance has required a *person*-specific exceptions process that must not use a “Medicaid population as a whole” test.<sup>10</sup> Pennsylvania has provided no explanation of how individual needs will be accounted for in the broadly-applicable, strictly-limited benefits redesign that it proposes.

Finally, these proposed benefit cuts appear to violate the Americans with Disabilities Act because they will surely disproportionately affect people with chronic and disabling conditions and, without doubt, place many such individuals at great risk of institutionalization. Assuming that Pennsylvania has a comprehensive plan to ensure that people with disabilities are able to live in the most integrated setting appropriate (something that needs to be verified), CMS should require the State to explain how these cuts can possibly make that plan an effectively working plan (as CMS’s *Olmstead* letters require).

### ***Bad-faith and Poor Transparency in Pennsylvania’s Proposed Benefits Cuts***

Any state plan amendment by Pennsylvania to cut Medicaid state plan benefits based on the state’s proposed “benefits approach” should not be approved due to serious problems of bad-faith and transparency in the process.

Pennsylvania’s public process can only be described as “bait-and-switch” from the consumer perspective. While Pennsylvania is in fact pursuing drastic *cuts* to the Medicaid program, those cuts are hidden by the cuts’ placement in a Medicaid expansion proposal, and even more grievously, by Pennsylvania’s public misrepresentations about the benefits approach. Although Pennsylvania’s reform will result in a dramatic reduction in services for all adults in traditional Medicaid, the state’s proposal (and other public messaging) avers that Pennsylvania “aims to move away from a ‘one size fits all’ approach and focus on the needs of individuals.”<sup>11</sup> Many such

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<sup>9</sup> HCFA, Dear State Medicaid Director (Sept. 4, 1998), available at: <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD090498.pdf>.

<sup>10</sup> *Id.*

<sup>11</sup> Healthy Pennsylvania 1115 Demonstration Application, 8 (Feb. 19, 2014) available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/pa/Healthy-Pennsylvania-Private-Coverage-Option-Demonstration/pa-healthy-demonstration-app-022014.pdf>. Governor Corbett’s press release upon approval of the demonstration, currently available on the Pennsylvania government website, states that the plan will “increase access” to health care, “focuses on ... benefits to match health care needs,” and says the benefits redesign “will better tailor health care benefits to the needs of the different populations served in the program.” Press Release, Office of Governor Thomas Corbett, Corbett Announces Historic Approval of New Healthy Pennsylvania Program, (Aug. 28, 2014), available at: <http://www.pa.gov/Pages/NewsDetails.aspx?agency=governors%20office&item=15963#.VAd8wWPQrD8>. Most recently, Medicaid agency Secretary, Beverly Mackereth, who filed the demonstration application with HHS, wrote in a newspaper op-ed article that the Pennsylvania administration “knew there was a better way to tailor Medicaid benefits to the actual needs of recipients” and that a “healthy young person does not need the same benefits as an older Pennsylvanian or someone with a chronic illness.” She added that “[b]y basing our plans on actual needs, we can make better use of taxpayers’ money, while still ensuring eligible individuals get the care they need. Our plan will screen eligible individuals to determine whether they need a high-risk benefit plan or a low-risk one.” Most shockingly, she states that

individuals may not realize that the new “focus” is in fact two new options that are both worse than the Medicaid Act’s existing coverage package. Efforts to cut Pennsylvania’s Medicaid program are not new, and over the past decades have been repeatedly attempted through the state’s normal budgetary process, with consumers often able to unite and block the most extreme proposals. Regardless of the outcome, the process has been through the appropriate open and public political channels. However, the current state government is exploiting and leveraging the Medicaid expansion process to furtively achieve results that opponents of Medicaid have not been able to achieve by openly attempting to cut Medicaid through the political process. HHS should not aid or abet such a bad-faith process.

There are other problems. The state has provided absolutely no data or evidence to the public that supports the proposition that the proposed cuts are reasonable under the Medicaid Act (we assume HHS will not waive the requirement that states have reasonable standards), or even that the cutbacks would meet a 90% threshold test. Should HHS approve the state’s proposed state plan amendments without any public access to the data underlying the action, it would be a serious betrayal of transparency and accountability and raise questions about the federal agency’s actions under the Administrative Procedures Act. Hundreds of thousands of consumers have a right to see, understand and identify problems with data that ultimately is the basis for serious cuts to their health benefits. HHS must require Pennsylvania to publicly explain the basis of its conclusions and should not approve any SPA based on data that have not been subjected to public scrutiny.

### ***Pennsylvania’s Proposal is Bad Policy***

Pennsylvania’s proposed policy approach is bad health policy. The benefits cuts proposed by Pennsylvania will impact the state’s most vulnerable populations, including pregnant women, seniors, persons with disabilities, and persons so limited in function that they need home care or have been placed in a nursing home or similar facility. These populations have high rates of advanced illness, multiple chronic conditions, and frailty, and as a result need a robust package of benefits. Indeed, the provision of these services to vulnerable populations is one of the core purposes of the Medicaid program, see § 1901. The cuts proposed by Pennsylvania will leave many of these individuals without treatment. The all-too-predictable result is that many individuals will live sicker and die earlier.

Some examples of the significant cuts in the Pennsylvania proposal include:

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the new program will allow Pennsylvania “to save our funding for those who will most need public assistance in the future, such as individuals with disabilities [and] seniors,” despite the fact their services are actually proposed to be cut in the same proposal. Beverly Mackareth, Letter to the Editor, *A Pennsylvania solution to health care (letter)*, York Daily Record, Sept. 2, 2014, available at: [http://www.ydr.com/letters/ci\\_26453050/bev-mackereth-pennsylvania-solution-health-care-letter](http://www.ydr.com/letters/ci_26453050/bev-mackereth-pennsylvania-solution-health-care-letter).


- Limits on “radiology” – an extremely broad range of services – to a maximum of 8 visits, often not enough for a pregnant woman with even a middle-risk pregnancy or a senior with moderately complex multiple conditions;
- Limits on inpatient acute hospitalization – a service low-income individuals cannot afford – to a maximum of 3 visits, frequently not enough for a person with a disability or an older adult, or any individual who suffers a serious medical event;
- Limits on outpatient mental health treatment to a maximum of 60 visits, potentially cutting in half the number of visits available even to individuals with serious and persistent mental illness; and
- Limits on DME and medical supplies to a maximum of \$2,500, well below the amount needed by many persons with disabilities and older adults.

We note that some individuals who are not eligible for the “high risk” plan (or whom Pennsylvania fails to identify and enroll in that plan) will face even steeper cuts, since they will not qualify for the new maximum benefit.

### ***Conclusion***

Pennsylvania’s proposed cuts are not legal, have been pursued deceptively, and will have horrible impacts on Pennsylvania’s most vulnerable residents. For the reasons described above, we respectfully request that HHS refuse to approve any state plan amendment that cuts Pennsylvania’s Medicaid state plan benefit. Doing so would harm beneficiaries in Pennsylvania, and opens the door to similar damage in every other state. If you have any questions or need any further information, please contact Leonardo Cuello ([cuello@healthlaw.org](mailto:cuello@healthlaw.org)), Health Policy Director, or Jane Perkins ([perkins@healthlaw.org](mailto:perkins@healthlaw.org)), Legal Director, at the National Health Law Program.

Sincerely,



Elizabeth G. Taylor,  
Executive Director

Cc:

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