

Legal Assistance Resource Center

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Cindy Mann

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Department Of Health & Human Services

Centers for Medicare & Medicaid Services

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Richard McGreal, Associate Regional Administrator

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Re: Connecticut's Section 1115 Demonstration Authority Concept Paper Regarding the Low-Income Adult Medicaid Population

Dear Ms. Mann and Mr. McGreal:

We are a broad coalition of health advocates in Connecticut who have long supported Medicaid expansion. We write to urge you to reject the proposals in the Connecticut Department of Social Services' Section 1115 Demonstration Authority Concept Paper, dated October 27, 2011, relating to the Low-Income Adult Medicaid program adopted in 2010. We were pleased that Connecticut was the first state in the nation to adopt the option of including new populations in the Medicaid program, even before this is mandated in January 2014 under the Patient Protection and Affordable Care Act (ACA). Connecticut's early adoption of this opportunity, for low-income childless adults at the same income level as the elderly/disabled Medicaid population, has proven to be quite successful.

The changes proposed by DSS in its concept paper would significantly undermine the program adopted just last year, threaten access to care, and result in a program that is more limited than what was available before Medicaid was extended to this new population. In addition, it is our understanding that the basic requirements for a waiver are not satisfied by the Department's proposal aimed solely at cost savings, and it should also be rejected for this reason.

The Proposed Waiver Does Not Meet the Basic Requirements for a State Agency to Obtain a Section 1115 Waiver.

Under Section 1115, codified at 42 U.S.C. § 1315, “In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of [the Act] ... the Secretary may waive compliance with” certain Medicaid rules. In *Newton-Nations v. Betlach*, 2011 WL 5084839 at *9 (9th Cir. Oct. 27, 2011), the Ninth Circuit Court of Appeals made clear that, for states requesting a Medicaid waiver, “[t]he Secretary’s obligation under § 1315 to ‘make some judgment that the project has a research or demonstration value’ cannot be satisfied by ‘[a] simple benefits cut, which might save money but has no research or experimental goal.’” (quoting *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994)).

By its own terms, the Department’s proposed waiver seeks to test no hypothesis. Rather, as its cover letter states, because “the strain on the state’s budget is considerable” from the growth in the Low Income Adult program, the state is seeking approval for its waiver concept because the other options it has explored are not legally permissible or are “unlikely to result in significant mitigation of program costs,” and it believes its proposal would allow it to continue providing care under this program “in a manner which is financially sustainable.” In November 14th prepared testimony before the Connecticut General Assembly, DSS Commissioner Roderick Bremby was clear: the alternative benefits package approved by the legislature “is unlikely to result in significant mitigation of program costs;” “[f]or that reason, we have submitted a concept paper to [CMS] regarding potential options the state may pursue to better control expenditures.”

The Department is not proposing to research or demonstrate a new way to reach the goals of Medicaid, as required under the waiver statute. Putting aside the problematic nature of its proposal from a policy perspective, as discussed below, its proposed waiver cannot meet the requirement of serving some “research or experimental goal.” Rather, it will inflict harm on a vulnerable Medicaid population merely to save money. The concept should therefore be rejected for this reason.

High Enrollment Demonstrates the Importance of this Medicaid Coverage.

In June of 2010, Connecticut became “the first state in the nation to permanently add low-income adults to its Medicaid program under the new Affordable Care Act.” (June 21, 2010 Joint News Release, at <http://www.hhs.gov/news/press/2010pres/06/20100621a.html>). At the time Connecticut adopted the LIA program, DSS estimated that about 45,000 individuals would enroll in this new Medicaid program. In fact, it has been more successful than that: latest figures indicate that about 73,000 are enrolled.

We assume that a significant portion of this increase is due to the poor state of the economy, with many individuals losing their jobs and the health insurance that went along with these jobs. Medicaid LIA coverage offers a critical safety net and has limited the number of uninsured in the state, a primary goal of the passage of the ACA. And for those previously on SAGA, the broader Medicaid benefit package, coupled with the prohibition on capping provider payments, has meant more meaningful coverage, consistent with the ACA’s goal of reducing

underinsurance. This success confirms the wisdom of the ACA in ending the arbitrary eligibility classifications which have always characterized the Medicaid program.

The Proposed Changes Violate the Goals of the ACA and the Principles of Medicaid, While Going Beyond the Remedies Needed by the State.

The Department's concept paper proposes to depart radically from this positive early adoption of Medicaid coverage for low-income adults by setting up a substantially diminished second-tier health care program that would still be called "Medicaid", although the proposals violate both the established principles of Medicaid and the goals of the ACA, as discussed below. The rationale for these changes appears to be simply that the early adoption has been successful, having met a great need, and therefore, for the next two years until 100% federal match is available under the ACA, has cost more than anticipated. Although all substantial Medicaid eligibility groups, including LIA, are currently reimbursed by the federal government at the same rate of 50%, DSS proposes to single out the LIA Medicaid group, which has income eligibility which is as low as the lowest income guideline of any other group (about 56 % of the poverty level), for this restrictive treatment.

DSS's letter proposes a variety of changes only in the LIA part of the Medicaid program. The only justification appears to be that providing needed health care is expensive and the LIA enrollment keeps growing. But recent enrollment figures call even that assumption into question: they indicate that enrollment in LIA has **fallen** over the last three months, contradicting the state's estimate that the LIA caseload will continue to grow at a rate of 2% per month.

Of particular concern is DSS's request that the state be given undefined "flexibility to limit additional program enrollment if funding does not permit." This would undermine the bedrock Medicaid principle of an entitlement for all those who meet the strict eligibility requirements of the program. SAGA, the health care program that Medicaid LIA replaced, was a state-funded entitlement program. Although it offered limited benefits, there was never any cap on enrollment. Ending the entitlement to Medicaid LIA would result in a step backwards from the health care coverage that was available prior to the passage of the ACA for low-income residents of Connecticut.

The proposed benefit limitations are vague, but clearly harmful restrictions such as "Occupational, physical and speech therapy services limited to 20 visits per year" and "limits on the number of outpatient visits" are mentioned. There is no reason to provide LIA enrollees, who are at an income level at or below that of all other Medicaid enrollees, with second tier benefits or eligibility.

It also is unclear what the request to be able to "count family income when determining eligibility" would mean in practice. Clearly, the blanket inclusion of family income for purposes of establishing financial eligibility of adults for whom other family members are not financially responsible is not usual practice in Medicaid and is not appropriate.

Adoption of an asset limit would at least have the advantage of aligning the rules of Medicaid LIA with Medicaid for the Aged, Blind and Disabled (which currently has an asset

limit of \$1600 for singles and \$2400 for couples). But it would require a re-enrollment procedure for all the 73,000 individuals now in LIA, with many needy individuals likely to be inappropriately dropped in the process, or to suffer substantial delays in getting re-enrolled given the severe staffing shortages in the regional DSS offices. In 2014, the asset limit would in any event have to be removed, as it already has been for the HUSKY A population. This would presumably require another enrollment procedure and another set of outreach to individuals who were enrolled in 2010-11 and dis-enrolled because of the new asset limit in 2012. This disruption in coverage would likely undermine the effectiveness of the expansion in 2014.

Accordingly, imposing any of these changes on **any** part of the Medicaid program would exact serious harm and should be rejected. And given the equal percentage of federal reimbursement available for all Medicaid enrollees, and LIA having an income guideline which is at or below that of all other Medicaid groups, there is no legitimate reason to single out the Low Income Adult group for lower benefits or for more limited eligibility compared to any other Medicaid group. The concept paper simply declares that the costs of paying for the success of the Low Income Adults program specifically are “unsustainable.” This declaration is substantially undermined by the fact that, come January 2014, as among the current Medicaid eligibility groups, only the Low Income Adult program will be reimbursed 100% by the federal government, and this will continue for three years before a slight decline in reimbursement commences.

Conclusion

For all these reasons, Connecticut’s proposed waiver is inconsistent with the principles and history of Medicaid, and does not even satisfy the basic requirements for a Demonstration waiver. Imposing these requirements on any set of Medicaid enrollees would exact substantial harm on those individuals. A demonstration waiver which would do this must, at a bare minimum, be testing some new idea for improving the Medicaid program. Such an intention is completely lacking here.

In addition, the proposals contradict the basic goals of the ACA: broad expansion of the Medicaid program to cover low -income uninsured individuals, the ending of arbitrary distinctions among Medicaid categorical eligibility groups, and the substantial reduction of underinsurance. The fact that some of these goals cannot be fully realized until 2014 does not support granting a Medicaid waiver to substantially weaken a program that has demonstrated that it is meeting a real need and is paving the way for full implementation of the ACA in 2014.

The ACA offers real hope of finally tackling the twin problems of uninsurance and underinsurance. The Medicaid expansion, providing a guarantee of access to quality care for all non-elderly individuals below 133% of the poverty level, is a critical component of the ACA’s comprehensive solution. What this means in practice is that the arbitrary distinctions among low-income groups seeking Medicaid assistance can and should finally be put to rest. Limiting benefits and threatening the end of the entitlement for working-age adults, particularly during a period of high unemployment, would take Connecticut in exactly the wrong direction.

For all these reasons, we urge you to advise DSS officials they may not obtain a waiver to make their proposed cuts to the Low Income Adult part of the Medicaid program.

Respectfully yours,

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