Statement of Gary Alexander
Secretary of Public Welfare for the Commonwealth of Pennsylvania
Before the Committee on Energy and Commerce, Subcommittee on Health
December 13, 2012

The Challenges Facing Pennsylvania in Implementing the Health-Care Reform Law

Introductory Remarks

Chairman Pitts, Ranking Member Pallone, and members of the committee, I thank you for and appreciate this opportunity to discuss the impact of the Patient and Protection and Affordable Care Act (PPACA), as amended, on the Commonwealth of Pennsylvania.

Throughout this testimony, I refer to PPACA, as amended, as the Affordable Care Act, ACA, or the health-care reform law, and I will use all these terms interchangeably.

General Observations

In all my years of public service, I have yet to witness a law so vast with such breathtaking scope, demands on state resources, and lack of federal guidance. I am not even referring to the optional expansion of Medicaid or the establishment of the insurance exchange. I am speaking of the myriad of mandates and onerous procedural requirements that have escaped public attention, but with which Pennsylvania must, by law, comply. Moreover, Pennsylvania's Governor, Tom Corbett, and I are both concerned with the economic changes that will impact the Commonwealth, although we do not fully know the full extent of what those changes will be. Even the federal government has not determined what each of the law's provisions mean,

and we at the state level still do not know in a definitive way the full scope of their impact in terms of finances, staffing requirements, system changes, and operations. Furthermore, the federal government lacks the necessary resources to implement its own law. We also know that Congress will have to make changes to the law, which creates additional uncertainty for states and the citizenry.

The media has ignored the majority of challenges facing states. I have hundreds of policy, operational, and technical staffers working to implement this health-care reform law, and yet, we realized early on that we do not have the capacity or the financial resources to address all of the provisions and requirements of this complicated law. We have had to prioritize these requirements because we cannot do it all. Now, layer on top of this the fact that the U.S. Department of Health and Human Services (HHS) has not been timely or explicit in giving instructions to the states. Not that I blame HHS; it, too, is dealing with the enormity of the law. We had sent a letter to Secretary Kathleen Sebelius with twenty-one enumerated questions, and we are still awaiting answers to six of those questions. Thus, we do not have enough information and lack federal guidance regarding many aspects of the law. But there's more. Some of the timelines in the law are unrealistic. Some of the mandates impose unnecessary duplication of efforts, adding to our costs. Other mandates impose solutions we no longer use because we have adopted more advanced processes. Others are disconnected from the operational realities we face. Some mandates require access to federal systems that are beyond their technological capabilities. More generally, as mandates often are, they impose a one-size-fits-all approach and actually make our processes less efficient, not more efficient.

These costs are not simply high, but overwhelming. We are told that the federal government will pay 90 percent of the cost, making this a good deal because states only have to pay the remaining 10 percent. But this simple formula minimizes the magnitude of the total costs. Ten percent of a huge unknown number is still a very large number, and you still must come up with the 10 percent. A sale of 90 percent off the price of an item does a consumer no good if he cannot come up with the 10 percent. It is actually worse because these are not one-time costs, but ongoing costs. Given the magnitude of the ongoing federal deficits, I have doubts that the federal government will be able to fulfill its end of the bargain.

A major weakness of the health-care reform law is that it fails to engage the states, the laboratories of democracy, as true partners. The law shows little faith in this important feature of the American federal system. The terms of the law are inflexible and heavy handed, with the federal government dictating to the states how things ought to be. Instead of trusting the states, the law creates a host of boards and commissions that serve to create even more rules and further removes decisions from the people by centralizing rulemaking by federal bureaucrats. If the federal government wants to set all of the rules and parameters, then why involve the states at all? Why not have the federal government run the entire Medicaid program, as it does with Medicare? Short of that option, I encourage members of Congress to treat the states as partners, and look to them for innovation and new ideas. That type of relationship would lead to better outcomes, lower costs and a more robust economy.

Medicaid and State Budgets

Medicaid is the most significant budget cost for the states. One third of Pennsylvania's entire state budget is spent on Medicaid. We spend more on Medicaid than we spend on any other state priority, supplanting other important priorities including education and transportation. Medicaid is considered, rightly or wrongly, a "mandatory entitlement." Most other funding is discretionary. So there is less money for other state functions, which adversely impacts our schools, judicial systems, correctional institutions, and transportation infrastructure. We recently had to cut back state funding for higher education. We would not have been forced to make that choice had Medicaid expenditures not experienced exponential growth over the past ten years. Nationally, according to the HHS Office of the Actuary, Medicaid expenditures nearly doubled between federal fiscal years 2000 and 2010.

Keep in mind that when the Affordable Care Act was signed into law, states were already struggling to keep up with the runaway costs of Medicaid that have been slowly, but surely, crowding out other state funding priorities. The additional costs that the ACA adds to Medicaid are costs the states cannot afford.

The Hidden Cost of Expansion

Governor Corbett very much wants to address the problems of health-care coverage in Pennsylvania. We have innovative ideas on how to attain greater health coverage at sustainable costs. But the health-care reform law does not give us such flexibility; it only imposes a one-size-fits-all program that prevents innovation. If we expand Medicaid under the current rules,

we would lock ourselves into an unforgiving system, making innovation impossible or difficult. Who would suffer? Pennsylvania's most needy and vulnerable citizens.

Until we have the flexibility to build a program that increases affordable and cost-effective coverage, Pennsylvania will delay the decision about expanding Medicaid for adults. Under the constraints of the health-care reform law, I do not think we can afford the expansion. After viewing Monday's letter from HHS, it is disappointing to see that the Obama Administration continues to show little interest in working with states by not allowing enhanced matching funds for states that choose a partial expansion. This decision, as noted by other governors this week, is shortsighted and will hinder the decision-making process.

Pennsylvania already has 2.2 million people on Medicaid, 2.4 million counting the Children's Health Insurance Program (CHIP). Our forecasts estimate the ACA would add 800,000 to 1,000,000 more persons onto Medicaid. This means that the ACA would boost the proportion of our population on Medicaid or CHIP from the current 19 percent to more than 25 percent. If we add the 15 percent of Pennsylvania's population on Medicare, after subtracting for persons on both Medicaid and Medicare, we would end up with more than 40 percent of our population on a federal health-care program. This number would approach the total employment numbers in our state. We have 5.7 million employed persons. But after the ACA expansion, we would have approximately 5.4 million residents on Medicaid, CHIP, or Medicare.

The federal government is supposed to pay 100 percent of the cost for the newly eligible persons on Medicaid pursuant to the ACA for the first three years of the expansion. Yet we will

still incur costs: an estimated $222 million in the first state fiscal year of the expansion, $378 million in the second, and $364 million in the third. For the next four years, the Federal Medical Assistance Percentages (FMAP) rate slowly drops to 90 percent, and we estimate a cost of $883 million by state fiscal year 2020-21 as a consequence. Moreover, the Centers for Medicare and Medicaid Services (CMS) has yet to confirm that Pennsylvania would be eligible for the 100 percent reimbursement of costs, which leaves open the possibility that our FMAP rate would be lower. If this assumption is wrong, then our estimated costs are too low.

Furthermore, for the out years, our cost estimates may very well be overly optimistic, especially when we consider the fiscal situation of the federal government. It is not just that the federal government has been unable to balance its own budget since 2001. The problem is better explained by the sheer magnitude of the annual federal deficits and the enormous national debt. Over the past four years, the magnitude of the federal deficit has been, on average, larger than the entire annual Gross Domestic Products of all but twelve countries of the world.[1] Moreover, counting the total national debt, including that held by governmental entities, our debt exceeds our own Gross Domestic Product. In short, the federal government lacks a good track record when it comes to fiscal responsibility. Consequently, we see the FMAP rates as teaser rates that are unsustainable and will have to be lowered, pushing more of the costs onto the states in the near future.

---

1. For Federal Fiscal Year 2012, it is likely that Mexico's Gross Domestic Product exceeded the U.S. federal budget deficit, thus making it thirteen countries for FFY 2012. Data source: Central Intelligence Agency, *The World Fact Book*.

Insurance Exchange

Although my department has not been tasked with implementing an insurance exchange, this does not mean we will not be affected. My department will need to communicate with the federal hub in order to exchange information to determine Medicaid eligibility based upon current and new federal rules, including provisions related to federal tax credits.

Yesterday, Governor Corbett announced that Pennsylvania would not be pursuing a state-based exchange at this time. The Commonwealth, through our Insurance Department, had spent two years trying to understand the impact an insurance exchange would have on Pennsylvania and its insurance market. The governor continues to have strong concerns that "state authority" to run a health insurance exchange is illusory—when in reality, Pennsylvania would end up shouldering all of the costs by 2015, but have no authority to govern the program. With regulations still to be finalized and with more forthcoming, too many unknowns remain for Pennsylvania to move forward with a state-based exchange at this time.

The Many Other Mandates: A Heavy Lift

When my department first began analyzing the ACA, we enumerated 76 program changes—some optional, many mandatory. Nearly all changes require regulatory specifications and clarifications from federal agencies, mostly from CMS. It became obvious from the beginning that we did not have the staff resources to implement all of the changes. Therefore, we prioritized and focused on the ones we believed were the most important, did not require federal guidance on implementation, or were due first.

Like the federal government, we have limited human resources. The state employees needed to implement the provisions of the ACA are the same employees we depend on to administer the many other Medicaid mandates we follow on a day-to-day basis, as well as to maintain an efficient and accurate program. Additionally, this impacts non-Medicaid programs because these same resources must support other welfare programs administered by the Commonwealth. State governments have been faced with limited resources since the last recession; we do have not have resources to hire additional staff or contractors. Although the health-care reform law would provide 90-percent funding, we have to muster together the resources first—and the process to apply for the 90-percent federal match is itself a bureaucratic ordeal that involves staff time, which is not part of the 90-percent deal.

We attempted to estimate the total costs of implementing the health-care reform law, not including the expansion issue and the insurance exchange. This turned out to be a nearly impossible task. We don't have specifications from the federal government to estimate program costs and staff needs for many of the changes. Nor do we have the staff resources to work through in sufficient detail all the 76 major changes. Nonetheless, our fiscal office chose to estimate some of the larger items. My fiscal office estimated a cost of $134 million in state funds for state fiscal year (SFY) 2013-14. This cost nearly doubles to $267 million for SFY 2014-15. These are not the costs to expand Medicaid eligibility or to set up an insurance exchange. These are costs that are above and beyond expansion and the insurance exchange, and these are costs that we must incur to comply with the health-care reform law. Keep in mind that

these costs are only what we were able to quantify. We anticipate many other costs that we do not yet have enough specificity to quantify.

These state costs in the hundreds of millions of dollars may seem small to the federal government, but they are not small to the Commonwealth of Pennsylvania. They are larger than the total State General Fund budgets of many of our agencies. We had to cut back on many of our programs, and now we must allocate scarce resources to fund federal mandates instead of investing in education, highways, and other state priorities. Pennsylvania is also struggling to address a pension crisis. The combination of ACA mandates and the pension crisis will mean lean times for other state priorities going forward for the foreseeable future, severely restricting the decision-making options of our state legislature and its ability to make needed investments in infrastructure, projects that would create good-paying jobs and facilitate economic growth.

Permit me to specify ways in which the new law, as currently written, imposes huge costs and burdens on Pennsylvania.

Modified Adjusted-Gross Income (MAGI)

States are required to implement the Modified Adjusted Gross Income (MAGI) methodology to determine Medicaid eligibility, effective January 1, 2014. This mandate requires extensive eligibility system updates, changes, and enhancements including the following: income methodology to determine Medicaid; no asset test or income disregards (other than the required 5 percent disregard); incorporation of Internal Revenue Code rules for household-

composition and income-eligibility rules; and Medicaid net-income standards converted to equivalent MAGI standards. Those determined ineligible under MAGI rules must still have eligibility determined under the current Medicaid-income rules creating multiple methodologies that must be maintained. In addition, the MAGI methodology requires new written policies and procedures to be developed and implemented and will require staff training.

MAGI rules are a challenge, to say the least, for our information technology (IT) systems. The cost for the changes needed to current systems is estimated to be more than $250 million, given the various delays in receiving guidance.

Further, due to the short timeframes to implement MAGI, many shortcuts will be needed in the development, testing, and training processes. Accordingly, in many cases we may have to incur additional costs to fix any errors after implementation. The January 2014 deadline will require Pennsylvania to implement the MAGI changes in a big-bang approach.

In addition to hiring additional programmers, the state will be required to use its limited number of business analysts and project managers to focus solely on the implementation of the ACA. The current state budget is strained, and hiring freezes are in effect. Since this is such a large implementation and will require extensive resources, many current state priorities, including cost containment activities, will need to be put on hold. In difficult budget times, initiatives that contain costs and reduce fraud, waste and abuse are critical to balancing our budget.

CMS has set up a collaborative forum for states to share best practices and code. The reality is that the timeframes don't allow states to effectively use these resources, since most states are facing the same challenges in the development process.

Pennsylvania currently has an integrated eligibility system. Although the A87 Cost Allocation waiver is helpful to allow states to leverage the ACA systems changes for non-Medicaid programs, the ACA is forcing us to build multiple processes. For example, the federal hub and its link to the Social Security Administration (SSA) can only be leveraged by the Medicaid program. For our non-Medicaid programs, we will still need to maintain separate exchanges with other federal programs. The use of Federal Tax Information (FTI) is one example. The FTI data can only be used for MAGI eligibility and cannot be used for non-MAGI programs. The inability to use FTI information across programs forces states to use and maintain multiple methodologies to capture income information for eligibility determinations.

Even though CMS has allowed for 90-percent federal funding for all systems changes, the required 10-percent state funding is burdensome. As mentioned before, Pennsylvania's conservative estimate for all systems changes including staffing, development, project management, testing, independent verification and validation, training and implementation is more than $250 million. This will require approximately $25 million in state funding. In addition, Pennsylvania has a stand-alone CHIP program, and therefore the A87 Cost Allocation waiver does not apply. The cost to integrate the CHIP program into the Medicaid systems would only

be entitled to a 66 percent federal financial participation rate, as opposed to the 90 percent for other programs.

Disproportionate Share Hospital Payments

Disproportionate share hospital (DSH) adjustment payments are another area of concern. They provide funding to hospitals that: (1) serve a significantly disproportionate number of low-income patients; or (2) are located in an urban area, have 100 or more beds, and can demonstrate that more than 30 percent of their revenues are derived from state and local government payments for the indigent and care provided to patients not covered by Medicare or Medicaid.

States receive an annual DSH allotment to cover the costs of hospitals that provide care to low-income patients that are not paid by other payers, such as Medicare, Medicaid, CHIP or other health-care insurance. This annual allotment is calculated by law and includes requirements to ensure that the DSH payments to individual DSH hospitals are not higher than their uncompensated care costs.

Pennsylvania uses DSH funds to make payments to qualifying hospitals in accordance with the federal criteria identified above. In addition, teaching hospitals (academic medical centers) receive funding to promote training and access to additional medical personnel. Pennsylvania also uses DSH funding to provide several supplemental payment programs to support hospitals that provide access to a high volume of Medicaid individuals and specialized care (e.g., obstetrical and gynecological care, burn care, trauma care) to Medicaid and uninsured

individuals. The ACA makes significant changes to DSH funding, and there is little guidance in determining the fiscal impact of any DSH reductions on the Medicaid program and the hospital-provider community.

Expanded Provider Enrollment Requirement

The health-care reform law requires my department to make burdensome system changes to our Medicaid Management Information System (MMIS) for both claims and providers. While not all-inclusive, some of the more onerous changes from an operations perspective include the following: automating some screening and database checks; adding new fields and algorithms for fee collection and revalidation; entering additional information for every owner, manager, managing employee board member, and person with more than five-percent controlling interest; and requiring a national provider identifier (NPI) on all media.

Additionally, as things stand now, staff are to enroll all prescribing, ordering, and referring providers. This is a significant change for all states. However, Pennsylvania has 67,000 unique rendering providers, and we estimate that this requirement alone will add at least 50,000 more providers to the enrollment workload. All of those providers are subject to the same screening requirements. Additionally, we have to check whether Medicare collected the institutional fee or not. If they did not, we must do so for every institutional service location and track it accordingly. There is no fee for individual providers or groups. By our estimates, the combination of all these things results in at least a seven-fold increase in the volume of work for my staff.

We already have many provider record systems and many areas of intake. It is a heavy lift for us to change the current structure in terms of creating new standardized policies and processes, and reorganizing staffing accordingly.

The technical challenges are even more daunting. We are required to connect to federal databases, some of which do not even have basic indexing features. There are others that we still have not been given access to: for example, the Death Master File. Furthermore, we have notified federal agencies that it is impossible for us to implement these changes without modifications. To get the information we need, the Medicare database can only be queried manually, one provider at a time. It is simply not possible for us to conduct more than 100,000 manual queries each month. We have been actively working with CMS to get a better system in place, but the outcome and timing remain uncertain.

We are using Medicare requirements regarding site visits, fingerprinting, and background checks. However, we continue to await further guidance from CMS, and depending on how CMS promulgates the final requirements, we may need to implement additional enrollment steps and incur additional vendor costs to comply.

I cannot tell you the total cost of the system and personnel changes we will need to make pertaining to provider-enrollment requirements. I do not want to give you a specific number because it will not be accurate, but the cost will certainly be in the millions of dollars. We are still awaiting specifications from the federal government, and, quite frankly, the federal government's databases are not suitable for the tasks that are assigned to them. We now have

forty people across five offices working on day-to-day enrollment functions, and there is perhaps an equal number behind the scenes enabling the system to work.

Primary-Care Physicians

Another area of concern is the increased Medicaid payment rates for Primary-Care Physicians (PCP). For calendar years 2013 and 2014, the ACA requires state Medicaid payments to certain types of physicians for certain primary care services, like office visits, exams, consults, etc., to be at least 100 percent of the Medicare rate for those services. Like many states, Pennsylvania currently has Medicaid rates for these services that are below Medicare rates, so the ACA requirement will result in Medicaid fee increases. The federal government will fund the difference between the lower state Medicaid rate and the Medicare rate during 2012 and 2013. In theory, the fee increase will not impose additional Medicaid service costs on the states in those years. Absent additional federal legislation, however, the increased fee requirement and the additional federal funds only apply during the next two calendar years. Any continuation of the increased fees from that point on will involve additional state costs. It is unreasonable to expect that any state will be able to roll back those fees.

CMS has provided guidance on increased payment rates to PCPs, but it has not been timely. CMS issued the final rule only on November 6, 2012, yet it becomes effective on January 1, 2013. CMS has still not released the Medicare 2013 fees. CMS issued proposed rules back in May, and issued final rules in early November. The federal agency also issued several briefs, summaries and fact sheets over the past 12 months, and recently conducted an all-states call to discuss the final rule. CMS has promised additional managed-care-related technical assistance

from a contractor beginning in January. Additionally, the quality of the federal guidance has varied widely. The recent verbal guidance on the final rule during the all-states call seemed sufficient; however, we have requested, but not yet received, confirmation in writing. The technical assistance will not start until at least January, and the tardiness of this information necessitates late implementation and retroactive or make-up payments to providers. CMS has already acknowledged how unreasonable the timeline is by acknowledging that the states will have to implement this mandate after the required effective date.

National Correct Coding Initiative

The ACA-mandated National Correct Coding Initiative (NCCI) is an unnecessary, duplicative effort that only costs us money and diverts limited state resources. Under the ACA, states were required to implement Medicaid Procedure-to-Procedure Edits (PTP) and Medically Unlikely Edits (MUE) for practitioners, ambulatory surgery centers, outpatient hospitals and medical suppliers, beginning April 1, 2011. This implementation would prevent providers from being paid for services that were incidental or mutually exclusive and also stop the payment of services that exceeded the number of units deemed appropriate by CMS during the same date of service. These types of edits had been in effect previously for Medicare providers. Based upon the information supplied to CMS, Pennsylvania Medicaid was given approval by CMS to implement in two stages. Stage 1 pertains to the PTP edits and was implemented on December 1, 2011, and stage 2 pertains to the MUE edits and was implemented on November 1, 2012.

My department had already paid for ClaimCheck, which provided edits for mutually exclusive and incidental services. The NCCI edits now supersede the ClaimCheck edits under the

assumption that NCCI savings are much more significant, when in reality the department was already capturing these types of savings. CMS, PTP and MUE edits are at times in direct conflict with Pennsylvania Medicaid regulations, policy and billing directives. In order to prevent a claims payment conflict with the Pennsylvania Medicaid regulations, each quarterly update must be reviewed to determine when the CMS rules conflict with the Pennsylvania Medicaid rules. CMS only publishes the quarterly updates toward the end of the previous quarter, which does not leave the department sufficient time to review the new PTP pairings and MUE's before the beginning of the quarter in which they are effective. Requests for deactivation need to be forwarded to CMS in order for the department to provide claims payment that mirrors our policy, regulations and billing-guide directives. Updates to our claims-payment system (PROMISe) must be completed when the NCCI edits conflict with the department's policy, regulations and billing-guide directives. Many hours of work by two separate bureaus are dedicated to the review of the quarterly updates. In the last quarterly review, more than 250,000 PTP edits needed to be reviewed, which resulted in other work projects being set aside.

Administrative Simplification

Administrative simplification provisions of the ACA may seem harmless enough, but they cannot simplify a process no one is using. As some of the less-publicized provisions of the ACA, administrative simplification has the seemingly innocuous goal of decreasing the administrative burden for both payers and providers (hospitals, physicians, and allied-care practitioners). Section 1104 of the Affordable Care Act directs the HHS Secretary to implement new "operating rules" that will govern the exchange of health-data transactions, such as eligibility, claim status,

electronic funds transfers, electronic-remittance advices and new data identifiers, such as health plan IDs. These new “operating rules” will be implemented over the next three to four years, beginning January 1, 2013.

The first two transactions that require changes to be implemented are the claim-status transaction and the eligibility-verification transaction. There are two types of claims status transactions that are to be implemented on January 1, 2013: batch and interactive transactions. Both use a standardized protocol, and the information provided in the transaction is limited. Pennsylvania Medicaid has found that a majority of providers prefer to use our Internet portal to determine a claim status. Since January 2012, we have only one provider that uses the nightly batch transactions and no providers that use the interactive transaction.

When the Office of Medical Assistance Programs within my department requested enhanced funding for the implementation of these transactions, we noted that we would be requesting a waiver of the implementation of the interactive transaction. This waiver was requested in August due to the lack of return on investment, based on the fact that we do not have providers using this form of transaction. The cost to implement this transaction is estimated to be approximately $50,000. In late November, we received notification from CMS that they do not have the authority to amend statutory and regulatory requirements. We are now working on a timeline to implement a transaction that very possibly no one will use. This appears to be an area where we could have saved both state and federal financial resources.

Program Integrity

With regards to the program-integrity provisions in the ACA, Pennsylvania already has been doing most of them and has been far ahead of the game. While the provisions on program integrity are mostly good, one provision will be difficult to implement. Section 6402(h) of the ACA requires the suspension of Medicare and Medicaid payments pending investigation of credible allegations of fraud. This provision requires states to suspend payments to individuals or entities based upon credible allegations of fraud, unless HHS and the state find good cause not to do so. While this provision may be well-intended, the criteria that constitute "credible" must be defined, and the intricacies are difficult to implement and operationalize. The basis of a credible allegation for fraud-referral purposes must be detailed in a notification to the provider when payment is suspended. Documentation and reporting requirements have added complexity to the fraud-referral and tracking process. Finally, providers have raised due-process concerns because the payment is suspended one day after referral, and the state is required to notify the provider within five days of the suspension.

Other Challenges

The health-care reform law requires states to have an HHS-approved, single streamlined application. We already have one in Pennsylvania, but we are struggling with incorporating the updates, changes, and enhancements to incorporate MAGI rules and interaction with the federal data hub. CMS has not provided their final drafts of the online or paper application, has not defined all application data elements and fields, and has not provided necessary guidance on the interaction processes between the federal hub and a state's web-based applications.

Pennsylvania covers the health-care needs of children between the ages 6 and 18 living in households between 100 percent and 133 percent of the federal poverty level through CHIP. CMS, however, has said that the health-care reform law requires us to fund these children through Medicaid, not CHIP, a less costly program.

The new MAGI rule mandates that resource-limit tests, also known as asset-limit tests, be excluded for eligibility. I question the wisdom of mandating their exclusion. Although Pennsylvania currently excludes asset-limit tests for Medicaid families with children under the age 21, this was an option selected by Pennsylvania. We do, however, have asset-limit tests for other welfare populations, as the test remains an important tool to determine welfare eligibility for programs including food stamps.

Pennsylvania has an integrated eligibility system and must incorporate MAGI rules and logic into the system for Medicaid-eligibility determinations. This mandate requires incorporating into the eligibility system new rules and logic, keeping current rules and logic for non-MAGI groups and maintaining existing rules and logic for other programs, such as the Supplemental Nutrition Assistance Program (SNAP), cash assistance, and the Low Income Heating Energy Assistance Program (LIHEAP). This task is not easy. There are many complexities in designing, developing, testing and implementing all necessary system requirements. While CMS has acknowledged that many states do have an integrated eligibility system, it has not formally addressed questions, comments and concerns presented from states.

States must maintain Medicaid eligibility standards, methodologies and procedures that are no more restrictive than those in effect on March 23, 2010, the date the ACA was enacted. These are known as Medicaid Maintenance of Effort (MOE) provisions, which for the adult population is set to expire when the HHS secretary determines that an exchange, either federal or state-based, is fully operational in a state, scheduled for January 1, 2014. The MOE provisions for children under age 19, for both Medicaid and CHIP, are effective through September 30, 2019. This MOE requirement has been a stumbling block for states to implement needed cost savings and reforms. In fact, the ACA has been effective in blocking many innovative ideas on cost containment and operational reforms that would have resulted in better-quality outcomes for recipients. Even efforts to "go green" by implementing paperless application processes are precluded by MOE requirements.

ACA also contains provisions regarding administrative "passive" renewals. This involves completing benefit renewals for ongoing eligibility using data sources and sending a notice of eligibility at renewal. If eligibility cannot be determined through the use of data sources, states are to send a pre-populated form. Renewals for individuals enrolled through MAGI-based rules could be limited to no more than once every 12 months. These requirements would necessitate substantial system changes to the current eligibility and auto renewal/semi-annual review systems to meet requirements. States would need to develop and implement new written policies and procedures. Staff training also would be necessary. CMS has not yet provided guidance and definitive clarification on these processes, nor has CMS provided necessary guidance and clarification on the interaction processes between the federal hub and a state's eligibility and enrollment system.

ACA allows a hospital to be a qualified entity to do presumptive eligibility (PE) determinations for Medicaid. It requires the establishment of policies and procedures, which will entail system updates and Medicaid-eligibility training provided by the state. CMS stated that verification is not required by the Medicaid agency to authorize presumptive eligibility for Medical Assistance. This may contradict, or possibly preempt, Pennsylvania state law because verification of income must be provided prior to Medical Assistance authorization. Moreover, states have raised program-integrity concerns because they may be financially liable for any services paid to the hospital under PE, regardless of whether an individual is later found ineligible. CMS has not provided the final guidance or definitive clarification necessary to implement this requirement.

The exchange of information to verify the income and eligibility of applicants and beneficiaries is required and must have adequate safeguards in place. It requires system updates and new written policies and procedures to be developed and implemented. States have concerns with the safeguarding and sharing of information, especially with integrated eligibility systems and with the electronic transfer of data in the verification process. CMS has, likewise, not released final guidance on this provision.

Letter to Secretary Sebelius

We have had a chronic issue with the timeliness of directions received from HHS. The poor response rate confirms the inability of HHS to cope with the magnitude of the health-care reform law. On August 23, 2012, I wrote to Secretary Kathleen Sebelius, enumerating twenty-one questions that Pennsylvania needs answers to before it can move forward with ACA

implementation. More than three months later, I have not received a direct response. We were able to glean answers to a number of those questions through various avenues, including a letter sent by Secretary Sebelius to the governors of various states just this past Monday. Even so, multiple questions in my letter remain unanswered. Of those answered, numerous responses demonstrate complete inflexibility. For example, CMS answered that we will have to run two concurrent databases and are prohibited by the health-care reform law to consolidate them into a single, more cost-effective system. Not only is this decision costly to Pennsylvania but it also could mean delays in receiving services for consumers. As another example, CMS told us that we had to change the financing of health care for children ages 6 through 18 from CHIP to Medicaid, thus costing the taxpayers additional funds and removing authority from the state.

Economic Impact on States

The challenges and costs discussed above will be worse in practice when the full weight of the health-care reform law impacts the general economy. I say this because our analyses are based on a static picture of the economy and the current configuration of business practices. The reality will be much more dynamic. We will certainly witness cost-avoidance behavior on the part of businesses that will move many more persons onto the Medicaid rolls.

Let me explain. The health-care reform law assesses a fee of $2,000 per full-time employee, excluding the first thirty employees, on employers with more than fifty employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit. Employers with more than fifty employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of $3,000 for each employee

receiving a premium credit or $2,000 for each full-time employee, excluding the first thirty employees. Penalties do not apply to employers with under fifty employees. This creates an incentive to use more part-time and less full-time employees.

We are already seeing this shift, according to data from the Bureau of Labor Statistics. The recent drop in the unemployment rate has been because companies are hiring more part-time workers, not because of full-time hiring. This trend will become institutionalized; already companies have been changing their business models to utilize part-time help at low wages and no benefits. This trend will only increase over time as businesses look for ways to cut costs.

The economic impact extends beyond the trend toward business relying more and more on part-time help, as opposed to full-time help. The taxes on the health-care industry contained in the ACA, such as the tax on medical devices and insurance companies, will increase the cost of providing health care, making the name of the law a misnomer. In combination with the anticipated cuts to Medicare providers because of the ACA, these same providers will be looking to offset their losses. Consequently, health care will become even more expensive in the private market and for the federal government. As health-care insurance costs rise, this will increase the amount of federal dollars needed for the tax credit and cost-sharing reductions.

What this means is that even more people will become eligible for Medicaid or will be forced into government health care than our original estimates predicted.

Recommendations

My first recommendation is to upgrade the federal information technology systems before you mandate states to create interchanges with them. Federal agencies lack resources and sophistication to fully implement the health-care reform law. Congress ought to alter deadlines or suspend requirements for those areas where federal agencies are inadequately prepared.

Second, there are too many mandates imposed upon the states all at once. We cannot handle them all within the expected timeframe on top of the already burdensome mandates from Washington that we must follow. Not only do states lack the resources to comply with all these mandates, but the federal government also lacks the resources to adequately offer guidance. Furthermore, the implementation of the ACA needs to be a partnership, not a top-down relationship where the federal government dictates each and every term to the states.

Third, allow states to innovate and come up with solutions better suited to their specific circumstances. One way to accomplish this would be to grant waivers to the states from ACA requirements. Also, draft the waiver authority broadly to increase flexibility in favor of the states and allow for an expedited federal approval process with streamlined reporting requirements that are understandable to the taxpayers. Waivers mean nothing if they cannot be implemented for several months.

Fourth, provide the ability for states to seek a “superwaiver” for demonstration projects, whereby a state could devise a system to integrate and coordinate better outcomes across all welfare programs that would empower recipients and improve outcomes. I would include all

welfare-related programs: health care, food stamps, housing, child-care, cash assistance, and social security disability.

Fifth, keep a close eye on DSH payments. Like the Commonwealth, Pennsylvania's providers continue to face fiscal strains that over time will result in less access and poorer quality of health care for our residents. DSH payments are designed to compensate them for uncompensated care. The ACA cuts DSH payments even though the ACA does not guarantee a commensurate reduction in uncompensated costs. If uncompensated costs remain high even after the ACA is fully enacted, Congress must work with the states to reform this program and ensure that reform takes into account the unique programs different states have.

Sixth, it is much more preferable that we allow for innovation by the states, but if the federal government insists on mandating system changes, then the federal government should pay for them all. If this is unacceptable, then at the very least, there should be a 90/10 split, which ought to be extended beyond the December 2014 termination date.

Closing

The choices you make as national legislators on the implementation of the ACA will exert consequences on the states and our nation for years to come. Like many of my counterparts in other states, I have strong concerns about the unfunded and inflexible mandates as well as the timeframes associated with the national health-care reform law. The mandates have costs for the states that will have to be paid for by state and federal taxpayers and supplant other

funding priorities, including education and infrastructure. Also keep in mind that every $100 spent on Medicaid benefits incurs $5.50 in administrative costs. Pennsylvania pays roughly $2.48 of that amount. So whenever the federal government increases spending on programs like this and pays 100 percent of the increased costs, administrative costs will also increase for the states.

Finally, the ACA invites bureaucratic gridlock that works against its desirable goal of securing greater affordable health care coverage for more Americans. If we want a system that will work efficiently and effectively, states and localities must be engaged and viewed as partners to create innovative solutions to provide opportunity for our citizenry. The health-care reform law as it stands is not only beyond the capacity of state governments to fully comply with, it is also beyond the resources of the federal government. There is a great deal of work to be done to make this law more reasonable and less burdensome for states, businesses and all Americans.

Thank you for taking the time to hear my testimony. I look forward to any questions that you may have.