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September 29, 1999

VIA FACSIMILIE AND US MAIL

John Jewitt
Independent Regulatory Review Commission
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Dear John:

Enclosed please find the Pennsylvania Health Law Project's comments filed on behalf of the Armstrong County Low-Income Rights Organization to the Department of Public Welfare's Final Regulations entitled "Revisions to the Aid to Families with Dependent children (AFDC), General Assistance (GA), and Medical Assistance (MA) Programs mandated by Act 49, Act 20, Act 35 and permitted under the Personal responsibility and Work Opportunity Act (PRWORA) of 1996.

Respectfully Submitted,

Ann S. Torregrossa, Esq.
Mike Campbell, Esq.
Fran Chervenak, Esq.
David Gates, Esq.
Alissa Eden Halperin, J.D.
Attorneys for the Armstrong County Low Income Rights Organization

The Pennsylvania Health Law Project's Comments on Behalf of the Armstrong County Low Income Rights Organization to the Department of Public Welfare's Final Regulations entitled "Revisions to the Aid to Families with Dependent children (AFDC), General Assistance (GA), and Medical Assistance (MA) Programs mandated by Act 49, Act 20, Act 35 and permitted under the Personal responsibility and Work Opportunity Act (PRWORA) of 1996

The Pennsylvania Health Law Project files these comments on behalf of the Armstrong County Low Income Rights Organization. Mrs. Shirley Beer, the Chairperson of the Armstrong County Low Income Rights Organization, is also a member of the Consumer Subcommittee of the Medical Assistance Advisory Committee ("MAAC"), a member of the MAAC, and a member of the Income Maintenance Advisory Committee. Mrs. Beer wishes the Independent Regulatory Review Committee to know that the Department never solicited any input on these proposed regulations from either the MAAC or the IMAC contrary to the statement on p. 3 of the Regulatory Analysis Form.

As for the specific provisions proposed in pursuant to Act 49, Act 20, Act 35 and the Personal responsibility and Work Opportunity Act (PRWORA) of 1996, the Consumer Subcommittee's comments are set forth below.

1. Section 125.21 (b)(1) impermissibly exceeds the requirements of the statute in requiring a completed, signed application.

   A. **This provision limits that which the statute provides.** This provision requires that the application must be completed and signed before the 30 days begins to run. Such a requirement appears nowhere in the statute. 62 P.S. §432.19 states only that initial authorization of cash assistance shall not be delayed more than 30 calendar days from the date of application. This 30 day period is designed for completion of the application. The applicant could not possibly know all that might be required for their completed application at the time he/she submits the application. It would be unreasonable to expect this of an applicant.

   B. **This provision contradicts federal law.** The Medicaid program dates its promptness standards from the date of the filing of an application and not from the date of completion of the application. See 42 C.F.R. §435.911.

   C. **This provision is ambiguous and open to multiple interpretations.** The Department is imposing a requirement that the application be completed and signed but yet these terms are not defined. County Assistance Offices

already vary in their interpretation of the requirements for GA and other public benefits eligibility. Some, for example, insist that an application that would appear completed and signed by many people's standards is not in fact "completed" until the applicant has come into the office for a face to face meeting, which may be impossible if the applicant is in the hospital.

D. **This provision contradicts the statute.** The first sentence of this provision comes directly from the statute, that, in essence, if an applicant has cooperated in getting necessary verification from a third party but that verification has not yet been received, the application will not be delayed due to the non-receipt of the verification. This portion of the statute prohibits applications from being held-up as a result of incompleteness where the incompleteness is not the applicant's fault. For the Department to require a complete application is contrary to the statute.

2. Section 141.61(d)(1)(ii) impermissibly limits the GA eligibility of parents of disabled individuals.

A. **This provision limits that which the statute provides.** The statute does not impose a maximum age for the disabled child. The Department has selected 21, where the statute imposes no such limit. See 62 P.S. §432(3)(i)(B).

B. **This provision contradicts the statute.** Through 62 P.S. §432(3)(i)(D), a non-parental caregiver of a child under 13 or a disabled individual is eligible for GA if they live in the home and must remain in the home to give care to the disabled child. The General Assembly did not intend to deny parental caregivers of disabled children that which they were affording for non-parental caregivers. Clearly, the General Assembly used the term "child" in 62 P.S. §432(3)(i)(B) in the "parent-child" way and not in the "under the age of 21" way. For the Department to impose a limit on parents' eligibility for which there is no rational basis given and that is not imposed by the statute, would be contrary to law.

3. Section 141.61(d)(1)(iii) impermissibly ignores the statute's protections for cooperative applicants.

A. **The provisions in which the Department lays out what documentation will be acceptable for verification of a disability fails to reflect the requirements of 62 P.S. 432.19.** 62 P.S. §432.19 provides that if an applicant has cooperated in getting necessary verification from a third party but that verification has not yet been received, the application will not be delayed due to the non-

receipt of the verification. This section's protections for cooperating applicants apply to all elements of eligibility for assistance, which includes verification of a disability.

B. **The failure to include the requirements of 62 P.S. §432.19 is especially egregious in the redetermination context.** Section 141.61(d)(1)(iii)(C) provides that a recipient who does not have the proper documentation within 30 days of the redetermination shall be deemed ineligible for GA until such documentation is presented to the CAO. As provided in 62 P.S. §432.19, allowance must be made for circumstances in which recipients have been cooperative but yet, documentation is pending from third parties.

C. **The regulations fail to define reasonable accommodations in subsection (C).** In 141.61(d)(1)(iii)(C), the regulations provide that reasonable accommodations will be made to assist individuals with disabilities in securing documentation of their disability. Reasonable accommodation is not defined. It should, at a minimum, be defined by reference to the standards set forth in the Americans with Disabilities Act.

4. Section 141.61(d)(1)(vii) unduly burdens and inadequately protects victims of domestic violence or another abusive living situation.

A. **The regulations define what constitutes receiving protective services but do not specify how one will prove receipt of those services.** The Department has repeatedly taken the approach that, when dealing with allegations of domestic violence that the normal rules that require paper verification of eligibility factors will be modified in recognition of the sensitive nature of the underlying problem and the danger that can be inadvertently created by insisting upon documentation of abuse. Such consideration must be given here; especially in light of the reality that people in such situations often have to flee with none of their possessions or paperwork, it is much more sensible to allow assertions of domestic violence to be made by self-declaration. Additionally, documentation of services may be difficult to acquire.

B. **The regulations do not provide adequate indication of how the privacy of victims will be protected.** The general reference in Section 141.61(d)(1)(vii)(G) to confidentiality must be set off as a separate section and must be expanded to reflect the importance of insuring confidentiality. There is a particular need to keep this information confidential, even within the Department. We therefore recommend that the Department amend the regulation to make it clear that the information

gathered about domestic violence be kept confidential within the Department and available only on a need to know basis. Such a policy is crucial to giving people the security that they often need to feel safe.

5. Section 141.61(d)(4) erroneously states that GA recipients are only eligible for Medically Needy Only level of MA.

   A. **This is inaccurate and misleading.** General Assistance recipients who do not qualify for federally assisted Medicaid are only eligible for the Medically Needy Only level of MA. Pregnant women, children under 21, people over 65, are all examples of individuals who may be GA recipients but are also eligible for federally assisted Medicaid. The regulations must be revised to clarify that GA recipients are eligible for MNO-MA only if they are not also eligible for federally assisted Medicaid. In fact, the Medical Assistance Eligibility Handbook clearly states that GA recipients with "a federal program status code" are eligible for a wider array of services than those available for the medically needy only. See MAEH §338 App. A-1

6. Section 141.81(a)(1)(vii) imposes improper conditions for eligibility for MA-MNO on persons to verify employment of at least 100 hours per month.

   A. **This provision requires evaluation of past, present, and continuing employment, which is not required by the statute and unnecessary.** 62 P.S. 442.1(G) requires only that a person verify employment of at least one hundred hours per month. The regulation complicates this plain language by requiring inclusion of information of past, present, and continuing employment. These terms are unclear and open to unfavorable interpretation. Requiring information on "continuing" employing might well imply to a county assistance officer that they are required to verify that the individual still holds the given job and will continue to hold it. Additionally, where, for example, someone was working 40 hours a week for the first 100 hours of a month and then suffers a disabling stroke that person must be eligible for MA-MNO for the month by virtue of having completed 100 hours of work, regardless of whether the work will be continuing. All the statute requires is 100 hours per month. Past, present, and continuing implies that the hours must be staggered on a weekly basis, which may well be impracticable.

7. Section 177.21(a)(11) and (12) impermissibly limits the statutory exemption for monies set aside for educational expenses.

A. **The regulations improperly limit the exemption to eligibility for GA where it should be an exemption for eligibility for any assistance.** 62 P.S. §408.2 provides that educational savings accounts should be exempt "for any assistance program administered by the department." This includes TANF and all categories of MA. The Department has no legal authority to limit that which the statute explicitly provides. Accordingly, this regulation must be revised to reflect that the exemption applies for any assistance program administered by the department.

B. **The regulations must define the verification fairly and so as not to exceed the scope of the statute.** The regulations add to the statutory allowance of having such an account that the ownership, balance, and fact that the account is restricted for payment of educational expenses only must be verified by written documentation. The regulations do not define what documentation will be sufficient to verify the purpose, balance, and ownership. All the statute requires is that the money has been placed in an interest bearing savings account at a bank or other financial institution for education purposes. Whatever written verification is to be required, it must be defined broadly to be fair. It is unreasonable to expect that all parents would know about setting up an Educational Trust Fund or some other complicated mechanism for segregating the money. The mere existence of a separate account and the parent's statement of the purpose of the account should be sufficient to establish the purpose.

C. **The Department can monitor and insure that the money is for education purposes only.** It is unfair to retroactively impose on applicants requirements that the money have been allocated, designated, and labeled in specific ways. The Department will not be without means of monitoring and insuring that the money remains solely for educational purposes. The Department has already established a mechanism for sanctioning those who use the money for non-educational purposes, the inclusion in income of amounts withdrawn.

8. Section 181.12 fails to reflect recent changes in the law.

A. The regulations do not comport with federal law. This regulation describes the general working of the Medically Needy spend down program. Under this program, those whose income is too high to qualify are allowed to

"spend down" their excess income; once their income minus expenses is less than the eligibility level, they qualify for assistance for the remainder of the 6 month spend down period. Recently, federal lawmakers revised the laws governing spend down to insure that those who received free care for their medical needs could deduct the value of the free care in computing the spend down and establishing eligibility. See 42 U.S.C.§ 1396a(a)(17)(D); 42 C.F.R. § 435.831(c)(iii). The federal law governing MA requires this and as such, this must be included in the regulations that relate to the spend down process.

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REVIEW COMMISSION

Dear John:

I write to inform you that Louise Brookins, Chair of the Philadelphia Welfare Rights Organization, Chair of the Consumer Subcommittee of the MAAC, Chair of the IMAC, and member of the MAAC also wishes to support and have the comments we just filed be made on behalf of her. Accordingly, please read those comments as being made on behalf of the Philadelphia Welfare Rights Organization, the Consumer Subcommittee of the MAAC and the Armstrong County Low-Income Rights Organization.

Respectfully Submitted,

Ann S. Torregrossa, Esq.
Mike Campbell, Esq.
Fran Chervenak, Esq.
David Gates, Esq.
Alissa Eden Halperin, J.D.
Attorneys for the Philadelphia Welfare Rights Organization, the Consumer Subcommittee of the MAAC, and the Armstrong County Low Income Rights Organization

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Procedural posture

As a preliminary matter, we must take issue with the manner of the promulgation of these regulations. There simply is no reason that these regulations be published as final form omitted given that they implement statutes enacted as long as 5 years ago and NOREs have been in effect since that time. Approving these regulations as final form omitted will only confirm the Department's long-standing hostility to public participation in the rulemaking process and thwart the salutary purposes of the Regulatory Review Act.

There simply is no reason to proceed with these regulations under the final omitted procedure; the reason that DPW advances, that "failure to conform State regulations with federal requirements will seriously jeopardize Federal grant monies" is untrue. There is absolutely no federal initiative to deny Pennsylvania even one penny of federal money based on the delay in promulgation of these regulations. While Pennsylvania must comply with federal and state law, there is simply no crisis that would require the rush to push these regulations through at this time. Moreover, both Act 20, § 12 and Act 35, § 21, specifically allowed a speeded up process for the implementation of particular sections of both Acts, but that authority only lasted for a short period of time, which has now expired. Having failed to act in the prescribed period, DPW is now violating the spirit, if not the letter of those laws in promulgating these regulations in final omitted form, long after the expiration of the emergency time frame afforded it by the General Assembly.

These comments are filed by Community Legal Services and the Community Justice Project on behalf its many individual clients who have been or will be effected by these regulations and on behalf of Louise Brookins, chair of the Income Maintenance Advisory Committee that DPW purports to have consulted, but who in fact were never consulted in the development of these regulations. These comments are also filed on behalf of the following organizations: the Philadelphia Welfare Rights Organization, Success Against All Odds, the Kensington Welfare Rights Union and others.

Summary of Argument

Substantively, we object to the adoption of these regulations in that, at a number of points, DPW has contravened the welfare code and adopted regulations for which there is no statutory authority. While some of these points of conflict with the statute may be inadvertent, they nonetheless will have

serious consequences if adopted. For example, the regulations setting out the Medical Assistance coverage of General Assistance recipients, § 141.61(d)(4), has the potential to deny needed health care services to thousands of individuals in contravention with federal and state law. Similarly, the failure to allow applicants to use Community Service to satisfy at least part of their hundred hour work obligation to qualify for Medical Assistance is contrary to the legislative intent, as set forth herein. Finally, the failure to exempt money in educational savings accounts from TANF resource restrictions is directly contrary to the statute authorizing such accounts.

Other regulations, although not directly contrary to legislation are misguided and contrary to the public interest. For example, the regulations implementing the eligibility of victims of domestic violence, § 141.61(d)(1)(viii), fails to offer adequate protection to this vulnerable population.

Section 101.1(d)(2) -- Time limits

This provision adds language that TANF is "time-limited," a provision not authorized by the General Assembly. The PRWORA, which created the TANF program, gives the Commonwealth the option of exempting up to 20% of its TANF caseload from the 5-year time limit. So far, the General Assembly has imposed no time limit on cash assistance, and in fact has stated that certain categories of individuals -- the permanently disabled and those needed at home to care for a dependent adult or child -- may be entitled to indefinite cash assistance. 62 P.S. §§ 401(b)(1),(2). DPW may not define TANF to be time-limited in the absence of legislative authority.

Section 125.21(b)(1) -- Requiring a "completed" application

This regulation changes the time period for processing applications from 15 to 30 days, as provided in Act 35. However, the regulation goes on to state that the 30 day period begins with the date of receipt of a "signed, completed application." This additional requirement of submitting a <u>complete</u> application is not authorized by Act 35, which provides that the 30 days begin "after application," 62 P.S. § 432.19. While an application will eventually need to be completed, potential applicants should not have to surmount the hurdle of filing a complete application prior to the processing time beginning to run. After all, that's what the 30 days is presumably for -- making sure that all the factors of eligibility are adequately addressed.

In addition, the requirement to file a completed application would create a disparity with the food stamp program, which begins its application processing date with the date of filing of a signed application, and expressly permits the filing of incomplete applications so long as they contain a name, address, and signature. 7 C.F.R. § 273.2(c)(1). Similarly, the Medicaid program dates its promptness standards from the date of the filing of an application, not the date of completion. 42 C.F.R. § 435.911. The creation of such a disparity in processing dates will needlessly complicate application processing.

Section 141.61(d)(1)(viii) -- Domestic violence

The subsection providing for 9 months of lifetime eligibility for victims of domestic violence is lacking is some key protections that are crucial for this sensitive population. DPW has convened a domestic violence task force to assist in the development of policies concerning this area, particularly for the TANF program. Indeed, DPW has informed us that regulations for the TANF program will be submitted shortly, with extensive incorporation of recommendations from the task force. One of the key elements of the task force recommendations, which DPW has already indicated that they accept, is the notion that allegations of abuse should be self declared and not subject to the normal strictures of documentation that DPW normally demands. For example, DPW has already taken the approach in subregulatory materials that, when dealing with allegations of domestic violence, the normal rules that require verification of eligibility factors will be waived in recognition of the sensitive nature of the underlying problem and the danger that can be inadvertently created by insisting upon documentation of abuse. Especially given the fact that women in such situations often have to flee with none of their possessions or paperwork, it is much more sensible to allow assertions of domestic violence to be made by self-declaration. Unfortunately, these GA regulations inexplicably ignore this common sense approach and the commitment DPW has made to the domestic violence community. For the sake of uniformity and sound public policy, DPW should follow a consistent approach in dealing with a problem as serious as domestic violence.

Secondly, while the general reference to confidentiality is welcome, as is the reference to the general confidentiality regulation, there is a particular need to keep this information confidential, even within the Department. We therefore recommend that the Department amend the regulation to make it clear that the information gathered about domestic violence be kept confidential within the Department and available only on a need

to know basis. Such a policy is crucial to giving people the security that they often need to feel safe and to protect people from further harm and unnecessary invasion of their privacy.

Section 141.61(d)(4) -- MA coverage for GA recipients

The regulations as drafted state that "General Assistance recipients are eligible for the medically needy level of benefits." While it is true that General Assistance recipients who do not qualify for federally assisted Medicaid are eligible for a prescribed level of benefits, there are a considerable number of GA recipients who do qualify for the full level of Medicaid benefits, generally referred to as Categorically Needy benefits. For example, pregnant women, children under 21, people over 65, the blind and those found to be disabled, as defined by the Social Security Act are all treated as qualifying for full MA benefits. Indeed, the operating instructions contained in the Medical Assistance Eligibility Handbook are clear that GA recipients with "a federal program status code" are eligible for a wider array of services than those available for the medically needy only. See MAEH §338 App. A-1 (attached).

The reason for this differentiation is that some GA recipients have characteristics that qualify them for federally assisted Medicaid -- that they are 65 or over, blind, disabled, under 21 or pregnant. Over the last few years, DPW has identified quite a few GA recipients who qualify for federally assisted MA and has developed "program status codes" to identify those individuals whose Medicaid costs should be shared with the federal government. It is essential that the regulations accurately reflect program operations and that the entitlemnt to federal Medicaid be recognized.

Section 141.81(a)(1)(vii) -- Community Service and the 100 hour rule

Section 141.81(a)(1) amends the conditions for eligibility for Medical Assistance/Medically Needy Only ("MA-MNO"). Subsection (a)(1)(vii) provides that persons can qualify for MA-MNO by "verif[ying] employment of at least 100 hours per month earning at least the minimum wage." This regulation ignores the community service option promised by Governor Ridge to key supporters and the Department's own rulemaking on this subject to date.

In 1997, DPW published proposed regulations that set forth criteria for persons who are not able to find 100 hours per month of employment to qualify for MA-MNO by performing some or all of

their work in community service. 27 Pa. Bull. 2424 (May 17, 1997). Support for these regulations was provided by numerous commentators, including Community Legal Services. However, the IRRC staff expressed doubts about DPW's legal authority to permit community service to meet the work requirements for MA-MNO. See "Comments of Independent Regulatory Review Commission on Department of Public Welfare Regulation 14-436 - Voluntary Community Service Regulations" (July 16, 1997). Rather than responding to these doubts, DPW has abandoned the community service regulations without further discussion.

Senators Gerlach and Greenleaf, key sponsors of Act 35, have strongly supported the view that the legislature intended community service to be a way of satisfying the work requirement for MA-MNO eligibility. Indeed, the press widely reported that the community service option was key to the passage of Act 35. Moreover, the U.S. Department of Labor ("DOL") has indicated that community service or workfare is to be credited as "employment" at the minimum wage in order to satisfy the Fair Labor Standards Act ("the FLSA"). DOL, "How Workplace Laws Apply to Welfare Recipients" (May 22, 1997). As DPW has implemented DOL's directive in other work programs, an MA-MNO program that credited community service work at the minimum wage would seem to meet the requirements of both Act 35 ("employment of 100 hours per month earning at least the minimum wage") and the FLSA.[1]

The validity of the community service regulations should not be resolved indirectly by the abandonment of the regulatory process by DPW. Many potential recipients who are employed but work fewer than 100 hours could qualify for benefits by supplementing their employment with community service. The IRRC's question about the statutory authority for the community service option is well taken, but the legislative history of the provision, plus the crediting of such work at the minimum wage should resolve any doubts about the legitimacy of the community service option for at least some working individuals. Otherwise, proposed Section 141.81(a)(1)(vii) would be incomplete, as it would not address a critical option for under-employed persons who are willing to work to qualify for benefits.

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[1] This policy may not allow people to perform 100 hours of community service alone to qualify for MA-MNO, as the value of the benefits they received is probably less than 100 hours times $5.15 per hour ($515 per month). However, it would allow underemployed part-time workers with less than 100 hours of private sector employment to perform a few hours of community service employment to bring their work effort up to 100 hours per month.

Another shortcoming of the Department's rulemaking concerning the 100 hour rule is its treatment of those who have worked 100 hours but whose worked has ended just as they need medical coverage. DPW requires that such individuals show that not only have they worked 100 hours in the past month but also that the employment is continuing, that is, that the person is assured that they have a job of at least 100 hours to return to once their medical problem is treated and resolved. Such a requirement is not found in the statute and there is no justification for this additional condition of eligibility.

Section 177.21(a)(11) & (12) -- Educational Savings Accounts

The statute authorizing recipients to establish individual savings accounts without running afoul of the generally applicable strict resource limitations reads that such accounts should be exempt "for any assistance program administered by the Department." 62 P.S. § 408.2. This clearly includes TANF and all categories of MA. Despite this clear mandate, DPW has restricted the applicability of this section to GA and GA-related MNO. This is particularly inexplicable since the primary beneficiaries of such a provision are children, whose parents want to save money to provide for their education. Obviously, only a handful of children are found in the categories of assistance that DPW proposes to protect. Such a reading is clearly in contradiction to the statute.

Section 181.12 (c) - The Medically Needy Spend down program

This regulation describes the general working of the Medically Needy spend down program. Under this program, those whose income is too high to qualify are allowed to "spend down" their excess income; once their income minus expenses is less than the eligibility level, they qualify for assistance for the remainder of the 6 month spend down period. This procedure, which follows the prescription of the federal law and regulations works well to allow flexibility in the MA program. Several years ago, however, federal lawmakers noticed an anomaly in the way the law was written in that those who received free care because of their medical need could never qualify for spend down because they did not incur any liability for their medical care. This left many charitable medical care providers in a difficult situation. To fix this loophole, Congress and the regulatory agency that supervises the MA program, HCFA, changed the rules to require that the value of free care be used as a deduction in computing the spend down. 42 U.S.C.§ 1396a(a)(17)(D); 42 C.F.R.

§ 435.831(c)(iii). In fact, DPW revised the Medical Assistance Handbook, MAEH § 361.5, recently to reflect this change, but it still has not been incorporated into the regulations themselves. Given that DPW is revising the particular section of the regulations that governs this procedure, it is imperative that the regulations be accurately revised to reflect the law. It simply is not sufficient to say that the regulations will be revisited at some unspecified time in the future to reflect what is already required now.

References to any durational residency requirement are illegal

At several points throughout this rulemaking (pp. 3; 1.A, 1.C, and 3.A of the RAF), DPW has misstated the status of the litigation challenging the 60 day durational residency requirement in the General Assistance program. That provision was ruled to be unconstitutional by the district court for the Western District of Pennsylvania in a case called Warrick v. Snider, 7 F.Supp.2d 720 (W.D.Pa. 1997). That decision was recently affirmed by the Third Circuit Court of Appeals, ___ F.3d ___ (3rd Cir. August 17, 1999), following the Supreme Court's decision in Saenz v. Roe, ___ U.S. ___, 119 S.Ct. 1518 (1999), which held California's two tiered durational residency requirement to be unconstitutional. In short, the litigation is at an end and Pennsylvania's durational residency requirements are all illegal. All references to a durational residency requirement should be deleted.

Respectfully submitted,

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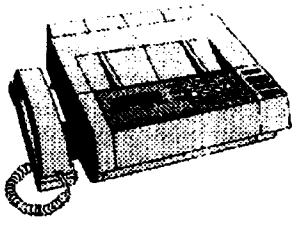

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October 14, 1999

Independent Regulatory Review Commission
Fourteenth Floor, Harristown 2
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Harrisburg, PA 17101

Re: #14-446

Dear Commissioners,

Enclosed is a final copy of our comments to the recently withdrawn rulemaking package. We are submitting this final copy to clarify our position in the hope that an amicable resolution of our differences with DPW can be achieved. We understand that DPW has committed itself to make several of the changes we had sought and we are looking forward to working with them. We have clarified our position on the domestic violence provisions of these regulations and we have corrected and expanded our comments regarding MNO spend down to provide a correct cite to the authority for crediting a potential spend down case with the value of free care provided by other governmental programs.

We are sharing our comments with the Department and look forward to a productive discussion.

Very truly yours,

Richard P. Weishaupt
Senior Attorney

c: Sherri Z. Heller, Deputy Secretary for Income Maintenance
John A. Kane, Office of legal Counsel, DPW
Legislative Committees

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Legal

BEFORE THE INDEPENDENT REGULATORY REVIEW COMMISSION

COMMENTS ON WELFARE REFORM – PRE-TANF (Combo) – 14-446

Prepared by:

Community Legal Services, Inc.

Community Justice Project

Procedural posture

As a preliminary matter, we must take issue with the manner of the promulgation of these regulations. There simply is no reason that these regulations be published as final form omitted given that they implement statutes enacted as long as 5 years ago and NORCs have been in effect since that time. Approving these regulations as final form omitted will only confirm the Department's long-standing hostility to public participation in the rulemaking process and thwart the salutary purposes of the Regulatory Review Act.

There simply is no reason to proceed with these regulations under the final omitted procedure; the reason that DPW advances, that "failure to conform State regulations with federal requirements will seriously jeopardize Federal grant monies" is untrue. There is absolutely no federal initiative to deny Pennsylvania even one penny of federal money based on the delay in promulgation of these regulations. While Pennsylvania must comply with federal and state law, there is simply no crisis that would require the rush to push these regulations through at this time. Moreover, both Act 20, § 12 and Act 35, § 21, specifically allowed a speeded up process for the implementation of particular sections of both Acts, but that authority only lasted for a short period of time, which has now expired. Having failed to act in the prescribed period, DPW is now violating the spirit, if not the letter of those laws in promulgating these regulations in final omitted form, long after the expiration of the emergency time frame afforded it by the General Assembly.

These comments are filed by Community Legal Services and the Community Justice Project on behalf its many individual clients who have been or will be effected by these regulations and on behalf of Louise Brookins, chair of the Income Maintenance Advisory Committee that DPW purports to have consulted, but who in fact were never consulted in the development of these regulations. These comments are also filed on behalf of the following organizations: the Philadelphia Welfare Rights Organization, Success Against All Odds, the Kensington Welfare Rights Union, the Mon Valley Unemployed Committee and others.

Summary of Argument

Substantively, we object to the adoption of these regulations in that, at a number of points, DPW has contravened the welfare code and adopted regulations for which there is no statutory authority. While some of these points of conflict with the statute may be inadvertent, they nonetheless will have

serious consequences if adopted. For example, the regulations setting out the Medical Assistance coverage of General Assistance recipients, § 141.61(d)(4), has the potential to deny needed health care services to thousands of individuals in contravention with federal and state law. Similarly, the failure to allow applicants to use Community Service to satisfy at least part of their hundred hour work obligation to qualify for Medical Assistance is contrary to the legislative intent, as set forth herein. Finally, the failure to exempt money in educational savings accounts from TANF resource restrictions is directly contrary to the statute authorizing such accounts.

Other regulations, although not directly contrary to legislation are misguided and contrary to the public interest. For example, the regulations implementing the eligibility of victims of domestic violence, § 141.61(d)(1)(viii), fail to offer adequate protection to this vulnerable population.

Section 101.1(d)(2) -- Time limits

This provision adds language that TANF is "time-limited," a provision not authorized by the General Assembly. The PRWORA, which created the TANF program, gives the Commonwealth the option of exempting up to 20% of its TANF caseload from the 5-year time limit. So far, the General Assembly has imposed no time limit on cash assistance, and in fact has stated that certain categories of individuals -- the permanently disabled and those needed at home to care for a dependent adult or child -- may be entitled to indefinite cash assistance. 62 P.S. §§ 401(b)(1),(2). DPW may not define TANF to be time-limited in the absence of legislative authority.

Section 125.21(b)(1) -- Requiring a "completed" application

This regulation changes the time period for processing applications from 15 to 30 days, as provided in Act 35. However, the regulation goes on to state that the 30 day period begins with the date of receipt of a "signed, completed application." This additional requirement of submitting a <u>complete</u> application is not authorized by Act 35, which provides that the 30 days begin "after application," 62 P.S. § 432.19. While an application will eventually need to be completed, potential applicants should not have to surmount the hurdle of filing a complete application prior to the processing time beginning to run. After all, that's what the 30 days is presumably for -- making sure that all the factors of eligibility are adequately addressed.

In addition, the requirement to file a completed application would create a disparity with the food stamp program, which begins its application processing date with the date of filing of a signed application, and expressly permits the filing of incomplete applications so long as they contain a name, address, and signature. 7 C.F.R. § 273.2(c)(1). Similarly, the Medicaid program dates its promptness standards from the date of the filing of an application, not the date of completion. 42 C.F.R. § 435.911. The creation of such a disparity in processing dates will needlessly complicate application processing.

Section 141.61(d)(1)(viii) -- Domestic violence

The subsection providing for 9 month lifetime eligibility for victims of domestic violence is lacking in some key protections that are crucial for this population and that DPW has recognized in the TANF program. In response to the difficulties and dangers faced by victims of abuse in satisfying welfare requirements, DPW made a commitment to institute more flexibility for them with respect to TANF program requirements, as the state is now encouraged to do under Federal law. To assist it in doing so, DPW appointed a Domestic Violence Task Force that has been working for over two years to develop policies and practices that appropriately respond to the needs of victims of domestic violence. The questions which the Task Force has considered and the solutions it has developed are as relevant to victims of domestic violence seeking the benefits of the GA program as they are to those seeking the assistance of the TANF program.

For example, the Task Force has studied extensively the need for flexibility with respect to verification. Victims of domestic violence do not always have documentation of abuse. Some women do not seek "official" assistance from law enforcement or other sources because they fear retaliation against themselves or their children. Others do not have documentation of their efforts to obtain assistance for a number of reasons: they were not given documentation by the authorities, the abuser destroyed the paperwork, or they were forced to flee without it. The policies developed by the Task Force, which DPW has approved, provide flexibility so that a victim of domestic violence will not be denied benefits due to inability to provide third party verification or documentation other than her own statement. Flexibility with regard to verification should be, but is not, incorporated into DPW's proposed regulation on GA benefits for victims of domestic violence.

There is also a need for flexibility in how the protective services requirement is defined. This flexibility is

not incorporated into the list of services in the regulation drafted by DPW, which is a finite list. It is very possible that a victim of domestic violence will seek services that would satisfy the purpose of the rule but might not have been contemplated by DPW. DPW appears to have recognized the need for flexibility in the protective services requirement in the Cash Assistance Handbook (CAH), where it identifies services satisfying the requirement as a non-exhaustive list, prefaced with the phrase "include, but are not limited to, the following services." CAH §105.46. This same flexibility should be incorporated into the regulations.

The Task Force has also devoted considerable attention to the confidentiality concerns of victims of domestic violence. Victims of domestic violence may divulge extremely personal information to the Department. They also divulge their location, information a victim may have deliberately withheld from the batterer from whom she has fled. It is therefore crucial that DPW policies protect the privacy and location of victims of domestic violence. The Task Force has examined DPW's confidentiality protections and has concluded that they do not adequately protect information about domestic violence or the location of the victim, either within the Department or without. While regulation 141.61(d)(1)(vii) gives recognition to the confidentiality concerns of victims of abuse by generally referring to DPW's existing regulation on safeguarding information, it fails to adequately address the particular confidentiality concerns of victims of domestic violence. We recommend that DPW seek the input of the Domestic Violence Task Force on section 141.61(d)(1)(vii) and get the benefit of their consideration and recommendation. The expertise developed by this Task Force in solving the difficulties faced by victims of domestic violence should be applied to the GA program to make it more responsive to a population which often turns to public assistance as an avenue to help them escape violence. A uniform approach in dealing with a problem as serious as domestic violence is consistent with the commitment made by the Commonwealth and DPW to respond to the needs of victims of domestic violence. We urge DPW to modify the regulation to be consistent with the flexibility contained in the Cash Assistance Handbook and to make amend the regulation to conform to policies and procedures developed by the Domestic Violence Task Force.

Section 141.61(d)(4) -- MA coverage for GA recipients

The regulations as drafted state that "General Assistance recipients are eligible for the medically needy level of

benefits." While it is true that General Assistance recipients who do not qualify for federally assisted Medicaid are eligible for a prescribed level of benefits, there are a considerable number of GA recipients who do qualify for the full level of Medicaid benefits, generally referred to as Categorically Needy benefits. For example, pregnant women, children under 21, people over 65, the blind and those found to be disabled, as defined by the Social Security Act are all treated as qualifying for full MA benefits. Indeed, the operating instructions contained in the Medical Assistance Eligibility Handbook are clear that GA recipients with "a federal program status code" are eligible for a wider array of services than those available for the medically needy only. See MAEH §338 App. A-1.

The reason for this differentiation is that some GA recipients have characteristics that qualify them for federally assisted Medicaid -- that they are 65 or over, blind, disabled, under 21 or pregnant. Over the last few years, DPW has identified quite a few GA recipients who qualify for federally assisted MA and has developed "program status codes" to identify those individuals whose Medicaid costs should be shared with the federal government. It is essential that the regulations accurately reflect program operations and that the entitlement to federal Medicaid be recognized.

Section 141.81(a)(1)(vii) -- Community Service and the 100 hour rule

Section 141.81(a)(1) amends the conditions for eligibility for Medical Assistance/Medically Needy Only ("MA-MNO"). Subsection (a)(1)(vii) provides that persons can qualify for MA-MNO by "verif[ying] employment of at least 100 hours per month earning at least the minimum wage." This regulation ignores the community service option promised by Governor Ridge to key supporters and the Department's own rulemaking on this subject to date.

In 1997, DPW published proposed regulations that set forth criteria for persons who are not able to find 100 hours per month of employment to qualify for MA-MNO by performing some or all of their work in community service. 27 Pa. Bull. 2424 (May 17, 1997). Support for these regulations was provided by numerous commentators, including Community Legal Services. However, the IRRC staff expressed doubts about DPW's legal authority to permit community service to meet the work requirements for MA-MNO. See "Comments of Independent Regulatory Review Commission on Department of Public Welfare Regulation 14-436 - Voluntary Community Service Regulations" (July 16, 1997). Rather than

responding to these doubts, DPW has abandoned the community service regulations without further discussion.

Senators Gerlach and Greenleaf, key sponsors of Act 35, have strongly supported the view that the legislature intended community service to be a way of satisfying the work requirement for MA-MNO eligibility. Indeed, the press widely reported that the community service option was key to the passage of Act 35. Moreover, the U.S. Department of Labor ("DOL") has indicated that community service or workfare is to be credited as "employment" at the minimum wage in order to satisfy the Fair Labor Standards Act ("the FLSA"). DOL, "How Workplace Laws Apply to Welfare Recipients" (May 22, 1997). As DPW has implemented DOL's directive in other work programs, an MA-MNO program that credited community service work at the minimum wage would seem to meet the requirements of both Act 35 ("employment of 100 hours per month earning at least the minimum wage") and the FLSA.[1]

The validity of the community service regulations should not be resolved indirectly by the abandonment of the regulatory process by DPW. Many potential recipients who are employed but work fewer than 100 hours could qualify for benefits by supplementing their employment with community service. The IRRC's question about the statutory authority for the community service option is well taken, but the legislative history of the provision, plus the crediting of such work at the minimum wage should resolve any doubts about the legitimacy of the community service option for at least some working individuals. Otherwise, proposed Section 141.81(a)(1)(vii) would be incomplete, as it would not address a critical option for under-employed persons who are willing to work to qualify for benefits.

Another shortcoming of the Department's rulemaking concerning the 100 hour rule is its treatment of those who have worked 100 hours but whose worked has ended just as they need medical coverage. DPW requires that such individuals show that not only have they worked 100 hours in the past month but also that the employment is <u>continuing</u>, that is, that the person is assured that they have a job of at least 100 hours to return to

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[1] This policy may not allow people to perform 100 hours of community service alone to qualify for MA-MNO, as the value of the benefits they received is probably less than 100 hours times $5.15 per hour ($515 per month). However, it would allow underemployed part-time workers with less than 100 hours of private sector employment to perform a few hours of community service employment to bring their work effort up to 100 hours per month.

once their medical problem is treated and resolved. Such a requirement is not found in the statute and there is no justification for this additional condition of eligibility.

Section 177.21(a)(11) & (12) -- Educational Savings Accounts

The statute authorizing recipients to establish individual savings accounts without running afoul of the generally applicable strict resource limitations reads that such accounts should be exempt "for any assistance program administered by the Department." 62 P.S. § 408.2. This clearly includes TANF and all categories of MA. Despite this clear mandate, DPW has restricted the applicability of this section to GA and GA-related MNO. This is particularly inexplicable since the primary beneficiaries of such a provision are children, whose parents want to save money to provide for their education. Obviously, only a handful of children are found in the categories of assistance that DPW proposes to protect. Such a reading is clearly in contradiction to the statute.

Section 181.12 (c) - The Medically Needy Spend down program

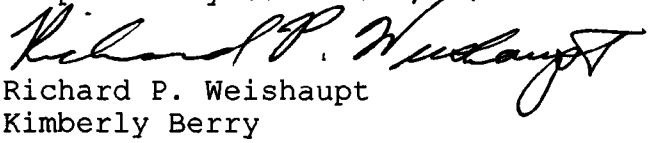
This regulation describes the general working of the Medically Needy spend down program. Under this program, those whose income is too high to qualify are allowed to "spend down" their excess income; once their income minus expenses is less than the eligibility level, they qualify for assistance for the remainder of the 6 month spend down period. This procedure, which follows the prescription of the federal law and regulations works well to allow flexibility in the MA program. Several years ago, however, federal lawmakers noticed an anomaly in the way the law was written in that those who received free care because of their medical need could never qualify for spend down because they did not incur any liability for their medical care. This left many public medical care programs in a difficult situation. To fix this loophole, Congress and the regulatory agency that supervises the MA program, HCFA, changed the rules to require that the value of free care be used as a deduction in computing the spend down. 42 U.S.C.§ 1396a(a)(17)(D); State Medicaid Manual §3628 (attached). In fact, DPW recently revised the Medical Assistance Handbook, MAEH § 361.5, to reflect this change, but it still has not been incorporated into the regulations themselves. Given that DPW is revising the particular section of the regulations that governs this procedure, it is imperative that the regulations be accurately revised to reflect the law. It simply is not sufficient to say

that the regulations will be revisited at some unspecified time in the future to reflect what is already required now.

References to any durational residency requirement are illegal

At several points throughout this rulemaking (pp. 3; 1.A, 1.C, and 3.A of the RAF), DPW has misstated the status of the litigation challenging the 60 day durational residency requirement in the General Assistance program. That provision was ruled to be unconstitutional by the district court for the Western District of Pennsylvania in a case called Warrick v. Snider, 2 F.Supp.2d 720 (W.D.Pa. 1997). That decision was recently affirmed by the Third Circuit Court of Appeals, ___ F.3d ___ (3rd Cir. August 17, 1999), following the Supreme Court's decision in Saenz v. Roe, ___ U.S. ___, 119 S.Ct. 1518 (1999), which held California's two tiered durational residency requirement to be unconstitutional. In short, the litigation is at an end and Pennsylvania's durational residency requirements are all illegal. All references to a durational residency requirement should be deleted.

Respectfully submitted,



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because the claimant is ineligible to receive SSI benefits and is not a recipient of state supplementary payments under a plan administered by the federal government.

Soc. Sec. Rul., No. 75-31 (C.B. 1975, 123). [This ruling was reported originally at NEW DEVELOPMENTS ¶ 27,622.]

.72 Social Security (FICA) tax amount as countable income.—New York Medicaid could not include the amount deducted from a claimant's income to pay his Social Security (FICA) taxes as available income in determining his Medicaid eligibility because the federal regulations require that (with respect to both the categorically and medically needy) only such income as is actually available to the applicant can be considered.

Dumbleton v. Reed, Monroe County Social Services Director, N.Y. Ct. of App., 357 N.E. 2d 363, 40 N.Y. 2d 586, 388 N.Y.S. 2d 893 (1976). [This decision was reported originally at NEW DEVELOPMENTS ¶ 28,042.]

.73 Spenddown—Guidelines.—The following guidelines have been issued concerning attainment of Medicaid eligibility by spending down to a state's eligibility level.

GUIDELINES

Guidelines in HCFA's *State Medicaid Manual* are reproduced below in the following order:

3628. DEDUCTION OF INCURRED MEDICAL AND REMEDIAL CARE EXPENSES (SPENDDOWN)

3628.1. Expenses That Must Be Deducted

3628.2. Optional Deductions and Limitations on Incurred Medical Expenses

3628.3. Projection of Expenses

3628.4. Projection of Institutional Care Expenses

3628.5. Date of Eligibility

3628.6. Application of Post-Eligibility Rules When Projection of Institutional Care Expenses Is Used

3628.7. Order of Deduction

3645. PAY-IN SPENDDOWN OPTION

3645.1. Pay-in Spenddown Requirements

3645.2. Application of Expenses Incurred in Prior Months

3645.3. Application of Amounts Paid In Toward Spenddown

3645.4. Federal Financial Participation

3645.5. State Plan Requirements

3645.6 Administrative Requirements

3628. *Deduction of Incurred Medical and Remedial Care Expenses (Spenddown)*

The following definitions are used for purposes of this section.

Financially Responsible Relative—A spouse or parent (including a stepparent who is legally liable for support of stepchildren under a state law of general applicability) whose income is actually used in determining eligibility.

Incurred Expenses—Expenses for medical or remedial services:

- recognized under State law,
- rendered to an individual, family, or financially responsible relative, and
- for which the individual is liable in the current accounting period or was liable in the 3-month retroactive period described in 42 CFR 435.914.

An expense as described above is an incurred expense from the beginning of the accounting period in which the liability arises until the end of the accounting period in which the liability is satisfied. The expense is deductible from the income in any accounting period in which it meets the definition of an incurred expense but only to the extent that the amount has not been deducted previously. (See § 3628.1.)

Liable Third Party—Any individual, entity or program that is or may be liable to pay all or part of the cost of medical or remedial treatment for injury, disease, or disability of an applicant or recipient of Medicaid.

NOTE: There is no Federal financial participation (FFP) in expenses used to reduce spenddown liability.

Projected Expenses—Expenses for services that have not yet been incurred but are reasonably expected to be.

Spenddown Liability—Amounts by which countable income exceeds the MNIL for the budget period.

State or Territorial Public Program—A program that is operated (i.e., administratively controlled) by a State or territory (including a political subdivision thereof).

State or Territorially-Financed Program—A State or territorial public program whose funding, except for deductibles and coinsurance amounts required from program beneficiaries, is either:

- appropriated by the State or territory directly to the administering agency, or
- transferred from another State or territorial public agency to the administering agency.

State Medicaid Manual, HCFA-Pub. 45-3, § 3628, Transmittal No. 48 (November 1990).

When countable income exceeds the MNIL for the budget period, the state's Medicaid agency deducts from that income certain medical and remedial care expenses incurred by an individual, family or financially responsible relative that are not subject to payment by a third party unless the third party is a public program of a state (or territory) or political subdivision of a state (or territory). The agency must deduct incurred medical and remedial care expenses paid by a public program (other than a Medicaid program) of a state (or territory). Once countable income is reduced (by applying these deductions) to an amount equal to the MNIL, the individual or family is income eligible.

MAEH
cf 361.5

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OCT 05 1999

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Dear Mr. Nyce:

Thank you for your comments and suggestions, discussed at the meeting of September 27, 1999, regarding the Department of Public Welfare's (DPW's) Regulation #14-446 (#2062-Omnibus Amendments). This is to inform you, pursuant to discussion at that meeting, that DPW is withdrawing the regulation so we can make several changes we discussed.

We will delete language in §177.21 that exempts educational savings accounts as a resource only when determining eligibility for General Assistance (GA). By removing the qualifier "for GA only," this resource exemption will apply to both the GA and Temporary Assistance for Needy Families (TANF) categories. As we explained to IRRC staff, when these regulations were prepared, TANF was not yet in place, and the predecessor program, Aid to Families with Dependent Children (AFDC) did not permit this exemption for AFDC without a Federal waiver, which Pennsylvania did not receive. The Notices of Rule Change (NORCs) which announced the policy changes that Regulation 14-446 places into the Pa. Code implemented State law changes that predate TANF. The revision to §177.21 will reflect a change implemented with the TANF program in 1997 and implemented via the NORC that implemented the TANF program. By adding a TANF change to this pre-TANF regulation, we are also adding another effective date for one component of these regulations.

In addition, we will revise §141.61 to add a cross-reference to sections of the Pa. Code that indicate that notwithstanding 62 P.S. §442.1(a)(3)(i) (which provides that GA cash recipients receive medically needy benefits), individuals who receive or qualify for GA cash receive categorically needy medical assistance (a larger benefit package) if they qualify for Federally-funded medical assistance on any basis. This includes children, pregnant women, persons with disabilities or awaiting a determination of eligibility for disability benefits under Title II or Title XVI of the Social Security Act.

We also will make a revision to the Regulatory Analysis Form and preamble of the regulations to reflect the conclusion of litigation in Warrick et al. v. Snider, Nos. 98-3010 and 98-3011, U.S. Ct. of Appeals, 3d Cir., which concluded (on the merits) after the regulations were submitted.

Our final reason for withdrawing these regulations is to address a concern raised regarding §181.12(c). Advocates requested that §181.12(c) be revised to add a provision that applicants for retroactive medical assistance on a spend-down basis be permitted an income deduction for the value of medical care they received that was paid for by a public program other than Medicaid. As was discussed with IRRC staff, the Federal regulation cited by advocates does not exist, but there is a provision in the Medical Assistance Eligibility Handbook that could be interpreted this way. We are exploring the basis for this provision of the handbook and any Federal provision or guidance that may have generated it, after which we will determine what language is appropriate in this section.

It is our understanding that the changes outlined above would address the Commission's concerns, and that DPW can reasonably anticipate the approval of this regulation package when resubmitted.

Sincerely,

Sherri Z. Heller

cc: The Honorable Harold F. Mowery
The Honorable Vincent J. Hughes
The Honorable Dennis M. O'Brien
The Honorable Frank L. Oliver
David J. DeVries, Chief Deputy Attorney General
Howard Burde, Deputy General Counsel
John Nanorta, IRRC

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DEPARTMENT OF PUBLIC WELFARE

OFFICE OF INCOME MAINTENANCE
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Dear Mr. Nyce:

The Department of Public Welfare's (DPW's) Regulation #14-467, formerly #14-446 (#2062-Omnibus Amendments), withdrawn on October 5, 1999, is now making its way through the approval process. Although we do not ordinarily write to IRRC on the substance of a regulation before resubmission, we thought it appropriate in this situation to alert you to two slight changes in our approach from what we had discussed with your staff in the process of withdrawing this regulation. Our understanding after discussion with your staff in September and October was that we could anticipate approval of this regulation after the Department made the changes we discussed. While we have made all the changes we discussed, with respect to two of them, the resolution of the concern turned out to be slightly more complicated than we anticipated. We are writing to you now not only to alert you to this change, but also to encourage you to contact us now, in advance of the formal resubmission, if you have any questions about this approach.

In our withdrawal letter dated October 5, 1999 we indicated that a cross-reference would be added to 55 Pa. Code §141.61 to identify General Assistance (GA) cash recipients who qualify for Federally-funded Medicaid, which provides more comprehensive Medicaid coverage than is provided under State law. Upon further analysis, we determined that we needed to expand the regulations and that a simple cross-reference was not possible. The number of cross-references that would have been needed was so extensive that it would have made the resulting regulation too complicated and confusing. Instead of numerous cross-references, text has been added to §§141.61(d)(4), 141.71(c)(2) and 141.81(c)(3)(v)(A) to identify individuals who qualify for Federally-funded Medicaid.

Advocates raised a concern that Medically Needy Only (MNO) Medicaid Spend-down regulations found at 55 Pa. Code §181.12(c) are inconsistent with the Medical Assistance Eligibility Handbook (MAEH) used by DPW staff. For an individual whose income exceeds the limits for Medicaid eligibility, medical expenses can be deducted to "spend down" the excess income to qualify the person for MNO Medicaid. A provision added to the MAEH on February 1, 1999 instructs staff to allow the value of medical

care received by an individual and paid by a public program other than Medicaid to be used as a deduction from income, even if the individual never was financially liable for the care. Upon further analysis and Federal guidance on interpretation of Federal Medicaid law, we determined that the handbook revision was too broad in scope and the regulations were too narrow. In response to the advocates' concern and for consistency between DPW regulations and operating guidelines, 55 Pa. Code §§181.14(d)(3) and (e)(6) and the MAEH are being amended. Both will provide a deduction from income for medical expenses paid by a public program that is not financed by any Federal funds when determining eligibility for MNO Medicaid under Spend-down. The cross-reference at §181.12(c)(2) is being revised accordingly. This issue is explained in greater detail in the enclosed issue paper.

I want to thank you for the continued support you have afforded us with this regulation package, including the resolution of these issues. We are always available to discuss these issues with you at your convenience. Please contact Mr. Edward J. Zogby at (717) 787-4081 if you have any questions or concerns.

Sincerely,

Sherri Z. Heller

Sherri Z. Heller

Enclosure

ISSUE PAPER

Issue: Whether medical expenses paid by a public program are allowable medical expenses when determining eligibility for Medicaid.

Background

Under the eligibility requirements for Medically Needy Only (MNO) Medicaid, persons whose income exceeds the income limits may still qualify for Medicaid. Medical expenses can be used as a deduction from income to reduce the person's income to within the income limits to qualify for MNO Medicaid. This process of using medical expenses as a deduction from income is referred to as "Spend-down."

Advocates raised a concern that the regulations under review did not reflect a provision in the Medical Assistance Eligibility Handbook (MAEH). The MAEH was revised to allow an income deduction for medical care which never was an expense to the individual. This MAEH revision was an overly broad interpretation of the provision in the statute.

Statute: 42 U.S.C. §1396a(a)(17)(D)

The section that is relevant to the advocates' concern provides, in part: "... a State Plan for medical assistance must ... provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums, payments made to the State under Section 1396b(f)(2)(B) of this title, or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred for medical care or for any other type of remedial care recognized under State law;"

The Health Care Financing Administration (HCFA) has not promulgated any regulation that clarifies this provision in the statute regarding income deductions for medical expenses reimbursed by another public program. In the absence of regulations, states rely on the State Medicaid Manual (issued by the US Department of Health & Human Services) as guidance, with further clarification via memos and letters from HCFA.

HCFA State Medicaid Manual

The State Medicaid Manual, Part 3 – Eligibility, provides the following guidance on what are allowable medical expense deductions when determining MNO Medicaid eligibility using Spend-down:

"3268. Deduction of Incurred Medical and Remedial Care Expenses (Spend-down)

The following definitions are used for purposes of this section...

Incurred Expenses – Expenses for medical or remedial services:

- recognized under State law....
- for which the individual is liable in the current accounting period or was liable in the 3-month retroactive period described in 42 CFR §435.914...

State or Territorial Public Program – A program that is operated (i.e., administratively controlled) by a state or territory (including a political subdivision thereof).

State or Territorially-Financed Program – A state or territorial public program whose funding, except for deductibles and coinsurance amounts required from program beneficiaries, is either:

- appropriated by the state or territory directly to the administering agency; or
- transferred from another state or territorial public agency to the administering agency...

3628.1 Expenses That Must Be Deducted – Deduct from countable income the medical or remedial care expenses listed below that are not subject to payment by a third party. (Such deductions are allowable even if the expenses are paid by a public program (other than the Medicaid Program) of a state or territory if the program is financed by the state or territory.)"

These provisions are contradictory in that they provide that the deduction is for "expenses ... for which the individual is liable," and the expenses are deductible only if they are not subject to payment by a third party, but go on to say expenses are deductible if the third party paying them is a public program of a state or territory."

MAEH (Handbook Revision)

On February 1, 1999, the MAEH §361.5 was revised to include the following:

"Reminder: Federal policy states that incurred medical and remedial care expenses which are paid by a public program (other than Medicaid) of a state are to be deducted in the Spend-down computation."

HCFA Memorandum (copy attached)

In response to DPW's inquiry in November 1999, HCFA provided DPW with a memorandum that had been issued to HCFA Regional Administrators on May 31, 1994 in response to an inquiry from the State of Iowa. This memo set forth HCFA's interpretation of the meaning of this provision. The memorandum requires that states treat health care expenses paid by a state or territorially-financed public program as incurred expenses. Health care paid for by a program that receives Federal funds, which includes Pennsylvania's CHIP Program, Medicare and Medicaid, is not an expense that is deductible from the individual's income.

Discussion

Upon review of the advocates' concern, we agree that a revision to current regulations is appropriate. The reminder that was recently inserted into the handbook was too broad in scope and the current regulations were too narrow; both did not accurately reflect HCFA's interpretation of this provision in the statute. The handbook will be revised to incorporate the provisions in 42 U.S.C. §1396a(a)(17)(D) in advance of the promulgation of regulations. For your convenience, the following language is presented to illustrate the regulations that will be part of Regulation 14-467 when it is submitted:

§181.14. Eligibility under MNO-MA Spend-down.

(d) Deductible medical expenses include:

(3) Medical and remedial expenses paid by a public program if:

(i) the public program is not financed by any Federal funds;

(ii) the expenses are wholly financed by a state or a subdivision of the state; for example, county or municipality;

(iii) the expenses have been paid in the month of application, or any month in the retroactive period, or a combination of both, for which the individual is applying; and

(iv) the expenses have not been previously used as a deduction in the determination of eligibility for a prior authorization of MA.

The regulations in §§181.12(c)(2) and 181.14(e)(6) have been revised to reflect that this change also applies when determining eligibility for retroactive MNO Medicaid coverage.