Access and Enrollment

Strategic Goals adopted by Health Care Reform Advisory Committee:

- To facilitate and encourage the purchase and provision of affordable health care coverage.
- To provide a one-stop, easy-to-use, accessible portal for consumers and businesses to learn about and compare options for coverage.
- To provide a unified and integrated approach for consumer application and enrollment in all health care coverage that is publicly subsidized, with linkages to existing access points for other health and human services for which people may be eligible.
- To assure administrative efficiency and maximize the leveraging of administrative funding.

1. Consumers must be able to obtain information and assistance to enroll in a health plan through a website and over the phone as well as through alternative means and sites. The system should facilitate enrollment and retention of all eligible applicants who provide the needed information.

ACA Provisions

The exchange must maintain an Internet website that:

- allows individuals and employers to determine whether they are eligible to participate in the exchange;
- directs qualified individuals and qualified employers to qualified health plans;
- assists individuals and employers in determining whether they are eligible for a premium tax credit or cost sharing reduction;
- presents standardized information (including quality ratings) regarding qualified plans, to assist consumers in making a choice; and
- provides an automatic calculator that allows users to determine the actual cost of coverage after accounting for any premium tax credit and cost sharing reduction.

(HHS will develop a web portal template that states may use.)

The exchange must also provide for operation of a toll-free telephone hotline to respond to requests for information and to assist with the application process. The state is obligated to demonstrate an implementation plan for establishing an exchange by January 1, 2013. The exchange must begin to accept applications in July, 2013. (If the state chooses not to establish an exchange or fails to establish an exchange by January 1, 2014, the federal government will set up and run a state exchange, either directly or through an agreement with a non-profit entity.)
As It Is Today: Federal Website Launched

HHS is required to create and operate an Internet portal to help consumers identify and compare affordable coverage options, including Medicaid and CHIP. This website, found at [www.healthcare.gov](http://www.healthcare.gov), is a “forerunner” of the kind of portal that exchanges are expected to operate. State websites must be operational by January 2014—but states must begin accepting applications in July 2013, so in effect the deadline is 6 months earlier. Pennsylvania has an Internet portal for application for Medicaid, CHIP and other social services programs, but other functions of the portal required by the ACA are not established. The Commonwealth’s COMPASS application has a screening function that helps consumers figure out if they would likely qualify for Medicaid, CHIP or other services that are income based.

Recommendations

- The exchange must support the needs of all individuals who are required to obtain insurance, including those who are eligible for subsidy.
- The exchange must also meet the needs of small groups/businesses to enroll in affordable health plans for their employees and obtain tax credits to help pay for it, choose their employees in qualified health plans for their employees.
- The exchange should operate a robust, state-of-the-art web portal for individuals and businesses to provide clear and understandable information about coverage available through the exchange, to enable them individuals and employees to enroll in qualified health care insurance plans and to apply for subsidy (individuals) or tax credits (businesses).
  - The web portal should maximize technology, utilize smart prompts, and retain information once an application has been started. Assistance should be immediately available over the telephone and through a robust “help” function for individuals and small businesses that have difficulty completing the electronic application process, to ensure that applicants can find out their options for coverage (whether unsubsidized or subsidized) and complete the process of obtaining insurance.
  - The portal should utilize a standardized format to provide information needed to help consumers and small business to select a plan, including the provider network, quality ratings, cost-sharing obligations, and any additional benefits included in plans offered on the exchange. This would include supporting the plan selection and enrollment process for individuals eligible for Medicaid.
  - Work should begin now to plan the web portal, in order to assure that it is operational in advance by July of January 2014 2013.
- The exchange should also operate a full-service toll-free customer service hotline to answer questions, assist in the enrollment process and help individuals to apply for subsidies and reduced cost sharing.
o Work should begin now to identify the requirements, procurement strategy, staffing plan and opportunities for leveraging existing customer service assistance resources for the exchange’s customer service call center.

o The staffing plan must accommodate the need to respond to a large initial volume of inquiries and applications for assistance from small businesses and the uninsured.

• The exchange should also provide information regarding options for assistance to find coverage for individuals and businesses not eligible to purchase insurance through the exchange. This should include information about federally qualified health centers and free clinics, free and reduced cost dental clinics, and county-based state health centers. The Exchange should also provide information about free or discounted care offered as a community benefit by non-profit hospitals to individuals in need in return for local state and federal tax exemptions.

• Both the website and the call center must meet the needs of individuals with limited English language proficiency. The exchange should also assure access for individuals with sensory, motor, intellectual or other impairments that might restrict their ability to use the phone or the portal.

• Pennsylvania’s Web portal environment should present CHIP, Medicaid and other subsidized health benefits as a subset of the many products available for health insurance coverage for qualified applicants.

• The exchange should provide avenues for feedback from consumers on the quality of customer service experienced from the exchange, as well as on the quality of the plans offered, should be created.

• The exchange should publicly report wait times for service through the call center, length of time for application processing and other indicators of quality customer service.

• The portal should allow for access by a COMPASS partner or other advocate on behalf of a consumer, when that is the consumer’s preference.

• The portal should provide information about advocacy resources for individuals, such as the Pennsylvania Health Law Project.

2. Pennsylvania should have a single application for all insurance programs accessible through the exchange, including those which are subsidized and those which are not.

ACA Provisions
The law requires that a single, streamlined, user-friendly form for use for all applying for all forms of state subsidy, state subsidized coverage, must be in use. (HHS will develop a template, or states can develop their own, but it must meet federal standards). Application can be filed online, in person, by mail or by telephone.

As It Is Today: COMPASS Web Portal
Pennsylvania has developed COMPASS, which is a web portal through which consumers can apply for Medicaid, CHIP, adultBasic, and the new PA Fair Care Program over the Internet. COMPASS can also be used to apply for a wide menu of health and social services programs, including Supplemental Nutrition Assistance Program, Temporary Assistance to Needy Families, Child Care, Low Income Heating Assistance Program and waiver programs for individuals with intellectual disabilities. It has been adopted by a number of other states, and has been nationally recognized. The Website can be found at: https://www.humanservices.state.pa.us/compass.web/CMHOM.aspx

Currently, about 18% of Medicaid applications (18,000 a month) and 9% of renewals (4500 a month) are completed through COMPASS.

Recommendations

• Pennsylvania should have a single, streamlined, consumer-friendly application that is used for all forms of state and federal subsidy for health care. Renewal of eligibility should be accomplished through a single form as well.
• Electronic applications and renewals should be promoted as the “preferred” means of application, though paper forms must also be accepted.
• The Commonwealth should assess whether COMPASS can provide the vehicle for a single application for all subsidized health care programs, with special focus on errors or limitations already identified by COMPASS users.

3. The eligibility process for all subsidized and unsubsidized insurance programs should be integrated.

ACA Provisions

The law requires that states establish streamlined and integrated application and renewal procedures so that there is no wrong door into coverage. States must enable individuals to apply for, be enrolled in or renew Medicaid coverage through an Internet website that is linked to the exchange website. The eligibility process must enable individuals identified by the exchange to be eligible for CHIP or Medicaid to be enrolled, without any further need for information. In addition states must ensure that individuals found ineligible for CHIP or Medicaid are screened for the exchange and any applicable premium assistance and enrolled without an additional or separate application.

As It Is Today: Eligibility Process Integration

CHIP and Medicaid eligibility processes are already nearly completely integrated. Applications for Medicaid that appear to meet income requirements for CHIP or adultBasic are transmitted electronically to the Insurance Department for action through COMPASS. Applications for CHIP that appear to meet income guidelines for
Medicaid are transmitted electronically to DPW for action. However, this process still has some imperfections that can cause delays in authorization of insurance.

The eligibility process for coverage through the high risk pool recently created by the Commonwealth (PA Fair Care) has been added to COMPASS.

Medical Assistance Eligibility Determination Automation (MEDA), built in to the DPW Client Information System, applies a complex set of rules to determine which eligibility criteria for the many different types of state health care coverage are met by the applicant. MEDA may provide a backbone for achieving eligibility integration. The Department of Public Welfare is in the middle of a multi-year project to modernize the eligibility technology supporting this important function. While the foundation for program integration is established, significant work is likely needed to upgrade the system and build in the new rules for Medicaid eligibility enacted in the ACA.

Recommendations

- The Commonwealth should determine whether it is feasible and cost effective to build on its present technology in determining whether individuals are eligible for a premium tax credit or cost sharing reduction or another option in the exchange, or whether it should procure and implement a new technology platform.
- The Commonwealth should identify the system enhancements that would be needed to provide the seamless integration of eligibility processes required by the act.
- The Commonwealth should identify policy and practice obstacles to program integration and develop a plan for making changes needed, including recommendations for changes to the Public Welfare Code.
- Personal health information utilized to determine eligibility for subsidy must be protected.
- The eligibility system must provide a clear explanation for denials and provide a means for quick response to questions about and appeals of eligibility determinations.
- The exchange should be an entry point for other special health programs operated by the Commonwealth.
- The portal should enable applicants to apply for other assistance programs for which they may be eligible, but this should not impede the application process for health care insurance.

4. Demonstrating eligibility for subsidized health care should be as easy as possible and application and verification processes should be simplified and automated.
ACA Provisions
The law increases uniformity in income rules for all health subsidy programs, by using the modified adjusted gross income for Medicaid, with a few exceptions.\textsuperscript{1} The law standardizes the information that individual applicants must provide and requires that verifications and determinations of eligibility for participation in the exchange, premium tax credits, cost-sharing reductions, Medicaid and CHIP, as well as exemptions from the individual mandate be done electronically by checking information submitted against federal records. There are no resource limits for eligibility for premium assistance and cost-sharing reductions. Resource limits are eliminated for Medicaid except for individuals eligible due to eligibility for another assistance program, elderly individuals, medically needy individuals, and individuals eligible for Medicare cost-sharing. The new law uses the modified adjusted gross income from the federal income tax form as the basis for eligibility for both expanded Medicaid and for premium assistance.

As It Is Now: Electronic Data Exchanges
DPW has used electronic record exchanges to identify discrepancies in eligibility information for Medicaid and other programs for many years, matching applicant information with data bases operated by the Social Security Administration, U.S. Department of Labor, Immigration and Naturalization Services, PA Department of Labor and Industry, PA Department of Transportation, and PA Department of Health. Information from the exchanges is used to verify identity and citizenship, but so far, has not been used as the primary source for verifying income. The PA Insurance Department has recently made system changes needed to be able to take advantage of these exchanges for verifying citizenship for CHIP applicants. Work is underway to make exchange information more accessible and “consumable”.

Complex Eligibility Requirements for Medicaid
The Medicaid application in use today is lengthy, because there are 130 different categories of assistance, each with different eligibility criteria. The application must collect information to discern which, if any, type of assistance the applicant qualifies for.

Recommendations:
- Electronic verification processes should replace paper documentation for all public benefit programs and health insurance subsidies. Electronic verification should be done on a real-time basis to the maximum extent possible.
- By broadening the population eligible for Medicaid, the ACA provides an opportunity to greatly simplify the eligibility requirements for Medical Assistance. The Commonwealth should identify and recommend changes in existing policies

\textsuperscript{1} Exceptions include individuals eligible because of their eligibility for other aid or assistance elderly individuals, medically needy individuals, and individuals eligible for Medicare cost-sharing.
and rules for CHIP or Medicaid that add unnecessary complexity and are inconsistent with the call for a simplified eligibility process.

- The state law requiring resource limits for adults on Medicaid (with the exception of eligibility for long-term care services and Medicare cost sharing) and the requirement for eligibility redetermination every six months should be repealed to achieve consistency with federal law extending Medicaid coverage to adults with income up to 133% of the Federal Poverty Level that will go into effect in 2014.
- Presumptive eligibility for health insurance should be afforded to individuals with disabilities, pregnant women and children, as permitted by current law. Uninsured individuals who are hospitalized should be able to apply for subsidized insurance at the hospital. The state should take the option provided in the Affordable Care Act to qualify hospitals to grant presumptive eligibility to all Medicaid-eligible populations.

5. **Individuals that met the income guidelines established for Medicaid prior to ACA should have access to the essential benefits that will be covered for adults added to Medicaid under ACA.**

**ACA Provisions**
The new law requires that individuals covered by the Medicaid expansion have access to at least those services covered under a “benchmark” or benchmark-equivalent” plan as defined in Section 1937(b) of the Social Security Act. Plans used to establish the benchmark in Pennsylvania all offer some coverage of prescription drugs. In order to qualify to be offered on the exchange for purchase, private plans will be required to cover essential health services, to be further defined by the Secretary of Health and Human Services, but will definitely include prescription drugs.

**As It Is Now: Lack of Uniform Benefits**
Currently, there are 14 different benefit packages in the Medicaid program. Childless adults now eligible for Medicaid are generally not eligible for prescription drugs, medical devices and vision and dental services, unless they meet the disability standard for Supplemental Security Income benefits. As Medicaid for the expansion group of low income adults will include prescription drugs, the state should consider adding this benefit for lower income adults on Medicaid as a matter of equity. The Commonwealth should consider how this benefit could interact with publicly available prescription drug coverage through low- or no-cost Rx programs offered by retailers (e.g., Wal-Mart, etc.)

**Recommendation:**
• The state should explore the feasibility of providing prescription drug coverage to benefits covered for the lowest income adults in Pennsylvania’s current Medicaid program to ensure equitable benefits by 2014.

6. Health plans that participate in the exchange should be expected to enable continuity of care for individuals and families with income below 400% of the federal poverty level.

ACA Provisions
Exchanges are responsible for implementing procedures for certifying health plans as qualified health plans that are consistent with federal guidelines. One of the criteria is that the plans ensure a sufficient choice of providers.

As It Is Now: Lack of Continuity of Care
Currently, families with children receiving health care coverage through CHIP and/or Medicaid, have difficulty maintaining continuity of care when income changes or when the child has a birthday and coverage switches from Medicaid to CHIP or vice versa. This is because CHIP and Medicaid do not have the same provider networks in some instances. This makes it difficult for families and does not support optimal care, when primary care or specialists that were providing care previously are suddenly not accessible due to the switch in coverage.

Recommendations:
• When eligibility for subsidized benefits changes in any direction, families and individuals should not have to change providers during a course of treatment and especially for those with incomes below 200% of the federal poverty level. Medicaid plans should have non-Medicaid plan partnerships that offer access to the same provider network.
• The exchange should consider how continuity of coverage can be encouraged through the process of qualifying plans for participation in the exchange.
• The commonwealth should explore a new approach to coverage changes that allows for continued relationships with care providers through eligibility changes, by making behind-the-scene adjustments to charge the correct plan for the cost of premiums.
• The state should re-assess the current requirements for Transition of Care coverage to assure maximal continuity.
• The state should explore how to require or strongly encourage the use of a uniform credentialing standard and clearinghouse for credentialing packets for all plans to facilitate continuity of care relationships, while reducing cost to payers and health care providers.
7. The exchange should provide hands-on assistance in the community to inform employers and individuals about opportunities for health coverage and to help them to select a health plan.

ACA Provisions
Exchanges are required to set up a Navigator grant program to provide fair and impartial, culturally and linguistically appropriate information concerning enrollment in qualified health plans and available subsidies through the exchange, facilitate enrollment and provide referrals for complaints. To be eligible for a grant, an entity must demonstrate to the exchange that it has existing relationships or could readily establish relationships, with employers and employees, physicians, consumers (both uninsured and underinsured), or self-employed individuals likely to be eligible to enroll in a qualified plan. Grantees may include trade, industry and professional associations, farming organizations, community and consumer-focused non-profit groups, chambers of commerce, unions, small business development centers, and other licensed insurance agents and brokers (but may not be a health insurance issuer or receive any consideration from any health insurance issuer connected to the enrollment of individuals or employers in a qualified health plan).

As It Is Now: Assistance for Consumers and Businesses
Two hundred thirty-five (235) community-based organizations and health care providers currently act as partners and provide outreach and application assistance for Medicaid, CHIP and the Supplemental Nutrition Assistance Program in the communities they serve. In August, they assisted 4500 families or individuals to make application for benefits through COMPASS.

Recommendations:
- The exchange should establish a navigator program to provide fair, impartial, culturally and linguistically appropriate information concerning enrollment in qualified health plans and available subsidies through the exchange, facilitate enrollment in qualified health plans, and provide referrals for complaints.
- Community organizations that now serve as COMPASS partners should continue to be able to assist individuals to apply for subsidized insurance through the web portal.
- Safety net providers should be encouraged to become sites that can assist consumers, with funding provided by the exchange to pay for the cost associated with such assistance.

8. Planning for the exchange should consider the needs of special populations.

ACA Provisions
States are required to conduct outreach to vulnerable and underserved populations including: children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS.

**As It Is Today: Outreach to Special Populations**

COMPASS community partners conduct outreach to many hard-to-serve populations. Currently, some Medicaid MCOs make special efforts to reach out to vulnerable group members to assist them to complete renewal processes to maintain their health benefits.

The Department of Health (DoH) operates many programs to address the specific needs of individuals with specific diseases or special health care needs. The Health and Human Services Helpline supported by DoH, PID, PDA, OLT, and DPW and the DPW’s Office of Income Maintenance’s Helpline currently provide consumers with help to connect to these specialty programs.

**Recommendations:**

- The navigator program should be used to do outreach to children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS.
- The hotline and website should accommodate the needs of individuals with disabilities and those with limited English proficiency. The exchange should also assure access for individuals with sensory, motor or other impairments that might restrict their ability to use the phone or the portal.
- Information about specialized health programs offered by the DoH should be accessible through the website, and the customer service helpline should be able to provide customers with additional help to connect to these programs.
- Although the exchange is focused on providing access to insurance for adults under 65 and children, it should be able to connect senior citizens to other health care resources that are available through the Department of Aging and the Office of Long-Term Living, and CMS including:
  - APPRISE, which provides health insurance counseling to individuals over age 60 and answers questions about Medicare, Medicare Supplemental Insurance, Medicaid, and Long-Term Care Insurance
  - PACE and PACENet, which provide prescription coverage Pennsylvania to seniors
- Home and community-based programs that enable seniors to obtain the services they need to remain in their own homes or in a community setting.
- Long-Term Care Facilities
- Medicare.gov

- The Exchange should be able to route individuals with disabilities and their families to the full range of health care and other services available in Pennsylvania, including those provided through:
  - Consolidated Waiver for Individuals with Mental Retardation
  - OBRA Waiver
  - Person/Family-Directed Support Waiver for Individuals with Mental Retardation
  - Attendant Care Waiver
  - Mental Retardation Services (non-Medical Assistance)
  - Act 150 Program
  - Infants, Toddlers and Families Waiver
  - Independence Waiver
  - Michael Dallas Waiver
  - Community Care Waiver (COMMCARE)
  - Head Injury Program

- The exchange should be able to direct individuals and family members to services available to address behavioral health issues through the county-based services systems:
  - Substance Abuse Services
  - Mental Health Services

9. A comprehensive communication plan is needed to prepare for implementation of the exchange.

- The Commonwealth should develop an outreach plan and implement a marketing campaign to reach small businesses and uninsured individuals well before the exchange is operational. This campaign should include town hall, regional, and local forum to explain how the exchange will work and what assistance will be available.
- Outreach materials in multiple formats, including posters, pamphlets, and webinars, must be available for small businesses and individuals.
- Products available to consumers at reduced cost (Medicaid, CHIP and premium assistance) should be presented as health insurance products, not as “welfare programs”.
10. Pennsylvania should carefully consider establishing a Basic Health Program to individuals with income up to 200% of the FPL, rather than offering coverage through the Exchange.

ACA Provision
Section 1331 requires the federal HHS to establish a basic health program (BHP) under which a state may choose to offer, via contracts with insurers, health care coverage to individuals who:

- are not eligible for Medicaid
- lack affordable comprehensive employer-based coverage (as defined by the ACA), and
- have income at or below 200% of the FPL.

The plan(s) must cover at least the essential health benefits required for a qualified plan and would be selected through a competitive process. The state would have to ensure that the monthly premiums charged and cost sharing required did not exceed limits established in the law. Individuals offered the Basic Health Plan could not purchase health insurance through the Exchange.

The state is expected to coordinate its administration of the BHP with Medicaid, SCHIP, and other state-run health care programs, to maximize efficiency and continuity of care. In return for administering the BHP, states will receive federal payments consisting of 95% of the premium tax credits, and the amount of any reductions in enrollee cost-sharing based on the formula in section 1402, that enrollees would have received to enroll in Exchange health plans. The state must place these payments in a trust fund, and use the funds only to cover premiums and cost-sharing, or to provide additional benefits, for BHP enrollee.

As It Is Today:
Pennsylvania achieves significant cost savings and attention to quality through the DPW contracting process used to select managed care organizations (MCOs) to deliver both physical health and behavioral health services for the Medicaid Health Choices program. However, MCOs for physical health do not currently operate statewide.

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2 The ACA sets the limit on Basic Health Plan premiums at the amount of the monthly premium the individual would have been required to pay if enrolled in the second lowest cost silver plan. Cost sharing cannot exceed that required under a platinum plan for those with income below 150% of the FPL and cannot exceed the cost sharing required under a gold plan for anyone else.
PID selects commercial health plans to provide the specified health benefit package for CHIP and adultBasic enrollees through a competitive bid process. The reimbursement rates for providers are somewhat higher under this approach.

HealthChoices MA managed care plans, CHIP insurers, and current adultBasic insurers might be interested in contracting for the new population, using the same provider networks and similar contract terms. This would make enhance continuity of care for a group of beneficiaries who experience frequent income fluctuations.

The Urban Institute estimates that for most states, the economies of purchasing coverage for this large new group with the basic health plan approach would make it possible to offer the essential benefits package with lower premiums and cost-sharing to participants. In addition, contracting for coverage for a large group would make it possible to negotiate extra services to improve health care quality outcomes, such as care coordination and care management for enrollees with chronic conditions and incentives for use of preventive services. Massachusetts has established the equivalent of a basic health plan for those eligible for subsidy under the state’s health care reform law, and has been able to keep premium and cost sharing costs low.

On the other hand, adding this large new group of purchasers to the private market will make participating on the exchange more enticing for insurers.

**Recommendation:**
- DPW and PID should do an in depth analysis of the potential benefits of providing a Basic Health Plan, once the essential benefit package has been defined and the guidelines for basic health plans are issued by HHS. Present information indicates that the State would receive 95% of premium tax credits and reduction in cost sharing that the enrollee would have received through the Exchange which would be $4,940. The average, non elderly, non disabled adult cost for those receiving care under Medicaid is $4,578. Thus, it may make sense to offer the Basic Health Care Program to those with incomes up to 200% FPL, because it saves money for the state while increasing benefits and coordination of plans and providers for consumers.

**11. Pennsylvania should take full advantage of the Long-Term Living provisions of the ACA.**

**ACA Provisions**
Three major long term living programs and funding streams were established by the act that will help to support community living assistance.

a) Community Living Assistance Services and Supports (CLASS) program
This voluntary insurance program will provide a cash benefit for eligible enrollees, which can be used to purchase community living assistance services and supports. Beginning in January, 2011, individuals 18 and older who are actively employed will be auto-enrolled. Employers as well as individuals may opt-out. Enrollee premiums will be paid through a payroll deduction. While HHS has not yet established premiums, low-income workers and employed full-time students may enroll at the minimum of $5/month. There is a five-year vesting period and individuals must have a certified functional limitation in their activities of daily living for benefits to commence. Benefits will be placed in an individualized Life Independence Account and beneficiaries will receive a debit card to access funds. The minimum daily benefit will be $50/day and is expected to average $75/day with no lifetime limit, indexed to inflation. Medicaid will be coordinated with CLASS and beneficiaries will receive half of the benefit simultaneous with Medicaid home and community-based services and five percent while in an institution.

b) State Balancing Incentive Payment Program
This is a first-ever financial incentive for states to accelerate efforts to support home and community-based services (HCBS) and reduce institutionalization in the Medicaid program. The program has a fixed term: October 1, 2011 – September 30, 2015. States spending less than 25% of on HCBS may apply for incentive payments of 5% additional federal match through the program’s term if they agree to exceed 25% spending by the program’s end date. Similarly, states between 25 and 50% spending for HCBS would qualify for a 2% incentive for meeting or exceeding the 50% threshold.

States must make the following structural changes within 6 months of application:
• “Single entry point” for information, referrals and applications for all long-term care services and supports statewide.
• “Conflict-free case management” across all affected HCBS programs that would likely separate service provision from service coordination.
• “Standardized assessment” statewide and across programs for determining needs and developing service plans.

c) Community First Choice Option
Beginning on October 1, 2011, the Community First Choice Option will offer a 6% enhancement to a state’s federal match for personal care and related services for states that:

- Offer personal care to eligible individuals over age 21 with up to 150% of FPL or the same level as a state’s home and community-based waiver programs (300% for Pennsylvania).
- Establish an Implementation Council with a majority consumer membership.
- Monitor quality through health outcomes and incorporate consumer feedback.

**As It Is Today:**

Few Pennsylvanians have individual long term care insurance or a savings program that could be relied upon to help with the cost of care in the community should they be unable to care for themselves.

Since FY 02-03, when only 21 percent of Medicaid recipients of long-term living services received their care in home and community-based settings, Pennsylvania has focused intently on increasing families’ options as to where and how they receive services. That percentage has steadily risen over these last eight years and now approximately 35,000 people, or 40 percent of Pennsylvanians receiving Medicaid long-term living services, will receive those services in their homes and communities.

This change in investment can also be seen in spending. In FY 02-03, Pennsylvania devoted only 8 percent of all Medical Assistance long-term living expenditures on home and community-based services – ranking us next-to-last in the nation. By way of contrast in the current fiscal year, Pennsylvania will likely increase that figure to nearly 24 percent. This dramatic shift is a result of our increased investment for home and community-based waivers by over $600 million during that time. Despite a surge in the number of older adults in the commonwealth, that investment has played a major role in reducing Medicaid-paid days in nursing facilities by two million over a decade.

As explained above, the ACA provides would provide enhanced match to states who have yet achieved a 25% benchmark in their spending dedicated to home and community-based services. Because Pennsylvania would likely meet the criteria, the commonwealth could benefit from the higher matching rates for states to move to the 50% target in the State Balancing Incentive Program. The Office of Long-Term Living estimates a best case scenario of four year savings of over $200 m from the additional federal match. However, if CMS includes services

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³ It is likely that the date for starting this program will be delayed.
for the developmentally disabled, Pennsylvania would qualify for a smaller 2% incentive, and need a much greater investment to reach the 50% threshold.

Pennsylvania does not offer this personal care assistance as a state plan service under Medicaid. However, qualified individuals may receive personal care through home and community-based waiver programs that serve as alternatives to nursing facilities and intermediate care facilities for the mentally retarded. The waivers operated by the Office of Long-Term Living will spend nearly $800 million in total funds this fiscal year. Personal care and related services account for over 80% of waiver costs in each program and is often much higher. It is estimated that the additional 6% FMAP through Community First could save over $200 million in 5 years. However, the commonwealth must balance creating a state plan entitlement with maximizing the additional match on existing expenditures.

**Recommendation:**

- **CLASS** should be promoted by the commonwealth as an opportunity for working adults to save for their future needs and assure control over their long-term services and supports in the setting they choose. Today, 68% of nursing home residents are on Medicaid. **CLASS** offers a real alternative for Pennsylvanians to take control of their future, direct their own care, and reduce Medicaid expenditures.
- Because states have developed a higher proportion of home and community based services for some populations than for others, but still have significant unmet needs, Pennsylvania should work to persuade HHS to take a flexible approach to implementation of the State Balancing Incentive Payment Program, providing incentives for states to develop additional resources for populations that have fewer options.
- Pennsylvania should consider defining personal assistance as a state plan service available to all who qualify for it, and implementing the other changes required to qualify for enhanced match for these essential services under the ACA.

**12. Planning for implementation of federal health care reform should assure appropriate program integration to reflect coverage of most Pennsylvanians by health plans with essential benefits.**

**ACA Provisions**

The Act greatly expands the population in Pennsylvania covered by health insurance. In addition, the new law establishes an essential benefits package that
must be provided by all qualified health plans. Essential benefits will include at least the following general categories and the items and services covered within the categories:

a) Ambulatory patient services  
b) Emergency services  
c) Hospitalization  
d) Maternity and newborn care  
e) Mental health and substance use disorder services, including behavioral health treatment  
f) Prescription drugs  
g) Rehabilitative and habilitative services and devices  
h) Laboratory services  
i) Preventive and wellness services and chronic disease management  
j) Pediatric services, including oral and vision care

As It Is Today

Pennsylvania’s DoH operates many small programs designed to take care of the needs of special populations with serious diseases. A chart in Appendix provides details about these special health care programs. Some pay for care for individuals with particular serious conditions who are uninsured; some pay for discrete services which are in short supply or are very expensive, still others help to pay for infrastructure needed to adequately treat a particular condition.

Some of these programs are funded entirely by federal dollars. Federal program guidance could change to make the programs line up with the new health care reform structure. There may be services that now paid for within special health programs that may be considered essential benefits and paid for under all qualified health insurance plans.

Recommendation:

• The Commonwealth should conduct a systematic review of programs for special target populations operated by the Department of Health to assess the impact of federal health care reform and recommend appropriate changes in program design.