FINDINGS AND RECOMMENDATIONS OF THE ACCESS AND ENROLLMENT SUBCOMMITTEE

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) will greatly expand access to affordable health insurance when it is fully implemented in 2014, through:

Expanding Medicaid eligibility. Currently Pennsylvania adults with significant and long-lasting disabilities or illnesses qualify for Medicaid if they have income below 77% of the Federal Poverty Level (FPL). Parents raising a minor child qualify with income at 47% of the FPL. Healthy adults without children do not qualify even if they have no income. The ACA will extend Medicaid coverage to all Pennsylvanians with income below 133% of the FPL1 – covering an estimated 483,000 additional individuals, including:

- 97,000 individuals currently eligible for existing health insurance programs but not enrolled;
- 245,375 individuals on the adultBasic waiting list3;
- 8,817 young adults who have aged out of foster care; and
- 135,917 other adults currently uninsured.4

Helping to pay for health insurance premiums. In addition to expanding Medicaid eligibility, an estimated 723,000 Pennsylvanians5 with income between 133% and 400%6 of the FPL will qualify for premium assistance to help them purchase insurance through the exchange.7 About 200,000 of this subsidy-eligible group are currently uninsured, 317,000 are insured through their employer and 206,000 have non-group coverage.

Making it easier to purchase insurance. Individuals who don’t qualify for subsidy can take advantage of the marketplace established by the state health insurance exchange to compare and purchase “qualified” insurance plans that meet federal and state standards. An estimated 219,000 individuals in the individual market who would previously have had to purchase insurance on their own will be able to do comparative shopping and take advantage of lower prices possible due to new rating rules that will put individuals in a single pool (or potentially merge the individual and small group

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1 In 2010, 133% of the federal poverty level equated to $14,404 in annual income for a single individual and $24,842 for a family of three.
2 The new law will also make 55,860 children now covered by the Children’s Health Insurance Program (CHIP) eligible for Medicaid.
3 The 42,000 individuals now covered by adultBasic would also be eligible for Medicaid under the expansion.
4 Potential new Medical Assistance eligibles estimated by the Department of Public Welfare (DPW) Budget Office.
5 Based on national estimates from the Lewin Group’s Health Benefits Simulation Model.
6 In 2010 figures, this would mean individuals would qualify for a tax credit with annual income between $14,404 and $43,320. A family of 3 would qualify with annual income between $24,842 and $73,240.
7 About 200,000 of this subsidy-eligible group are currently uninsured; 317,000 are insured through their employer; and, 206,000 have non-group coverage. (These numbers are extrapolated from the Lewin Group’s Health Benefits Simulation Model.)
The law will make it easier for the 232,000 employers with fewer than 100 employees in the Commonwealth to access coverage at a lower cost and take advantage of tax credits through the exchange.

In all, it is expected that between 1.3 and 2.1 million Pennsylvanians will potentially use the exchange to obtain health insurance. But achieving these goals depends largely on the Commonwealth’s ability to enroll people in the new and existing coverage options. Many implementation decisions are left to states. Some of these decisions will create the foundation for how Pennsylvania connects people to coverage and the extent to which the ACA’s goals of expanding insurance coverage and reducing the number of uninsured are met. The Access and Enrollment Subcommittee of the Commonwealth’s Health Care Reform Advisory Committee identified eligibly and enrollment options for Pennsylvania to consider in its approach of entry into coverage.

**Much Federal Guidance Still to Come, but the Development of Eligibility and Enrollment Systems Will Take Significant Time**

This report notes the relevant statutory requirements of the ACA; however federal regulatory guidance is pending on several issues important to Pennsylvania’s implementation efforts. For example, federal regulations on eligibility issues were expected by the fall of 2010, but have not been released to date. Until regulations are released, states do not know the essential requirements of the new systems. Federal policy makers are also considering the possibility of providing either standards for eligibility system development or possibly components of an eligibility system to states through the use of open source software or common systems. The data exchange standards and details of how verifications will be streamlined through connections to the IRS and other federal databases have also yet to be determined. A simplified common application form across health programs that states can use is yet to be developed by the federal government. Although there are a number of uncertainties about implementation, the development of eligibility and enrollment systems will take significant lead time and state implementation efforts must begin immediately.

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9 Approximately 139,000 employers with fewer than 50 employees have between 1 and 4 employees – an unknown portion of which are single proprietorships or self-employed individuals. While self-employed individuals without other employees are not eligible for the small business tax credits, they would be eligible to purchase individual insurance through the exchange and if income is below 400% of the FPL, qualify for premium subsidy and reduced cost-sharing.
MAJOR FINDINGS AND RECOMMENDATIONS

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, 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 six 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

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10 By January 1, 2013, HHS must determine whether a state will have an operational exchange ready by January 1, 2014. If not, HHS will establish and operate an exchange for the state either directly or through contract with a non-profit entity.
Commonwealth’s COMPASS application has a screening function that helps consumers determine eligibility for Medicaid, CHIP or other income based services.

**Recommendations**

- The exchange must support the needs of individuals who are required to obtain insurance, including those eligible for subsidies.
- The exchange must also meet the needs of small businesses to choose 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 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 help consumers and small business select a plan, including, but not limited to 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 to assure it is operational by July 2013.
- The exchange should 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 reduce cost sharing.
  - 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.
  - 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 up-to-date 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, nurse-managed clinics 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.
- 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, including, but not limited to the Pennsylvania Health Law Project, local legal services programs, and the Insurance Department’s Bureau of Consumer Services.

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 subsidized coverage. (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 (4,500 a month) are completed through COMPASS.

Pennsylvania has received a $1 million planning grant from CMS to develop a plan to establish a state-wide health insurance exchange. One portion of the work funded by the grant is a third-party assessment of options for building the portal needed to support insurance exchange functions, including whether it makes sense to use the Commonwealth’s existing internet-based application process (COMPASS) as the starting point for developing the more robust functionality that will be needed by the exchange. This assessment is currently underway, with a preliminary report expected in January.

**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 complete the assessment of COMPASS as the vehicle for a single application for all health care programs offered through the exchange, with special focus on errors or limitations already identified by COMPASS users.
- Following the assessment of technology options for the portal, planning and development should commence expeditiously in order to achieve HHS certification in January 2013 that the state will have a fully functioning portal ready by January 2014.  

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*

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11 Since the exchange is expected to begin to accept applications for insurance subsidy in July 2013, the portal should be operating by that time to allow sufficient lead time to have applications processed by January 2014.
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**

- First and foremost, the portal should enable applicants to complete a streamlined application for health care insurance, including any available subsidies. The portal should also make it possible for applicants to choose to be screened and apply for other assistance programs, without the need to supply the same information twice, as is possible through COMPASS now.
- 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.

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. 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, Citizen and Immigration Services (formerly Immigration and Naturalization Services), PA Department of Labor and Industry, PA Department of Transportation, and PA Department of Health. Information from these data bases 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

12 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.
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, and such databases used as the primary source of information, to the extent that accurate information needed to document eligibility is available. Electronic verification should be done on a real-time basis to the maximum extent possible. However, the verification process should be able to accommodate individuals and families who have experienced a reduction of income that is not reflected in their prior year’s income tax return.
- 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 and rules for CHIP or Medicaid that add unnecessary complexity and are inconsistent with the call for a simplified eligibility process.
- The General Assembly should review current statutory requirements for Medicaid eligibility to assess their compatibility with federal ACA and make necessary changes. An initial assessment of needed changes to the Public Welfare Code is found in Appendix __, and includes creating an eligibility group based on income below 133% of the federal poverty level and modifying provisions that govern treatment of resources and income.
- The General Assembly should consider modifying the state requirement for eligibility redetermination every six months for some categories of Medicaid recipients in order to align Medicaid with the annual eligibility determination process established in the ACA for health insurance subsidies.
- 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 ACA to qualify hospitals to make presumptive eligibility determinations for eligible individuals to the maximum extent permitted by federal law.

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. This lack of uniformity of covered benefits creates issues of equity.

Recommendation:
- The state should explore the feasibility of adding prescription drugs and other coverage included in the essential benefits package for the small group of Medicaid recipients now eligible for limited benefits to ensure equitable benefits by 2014. The enhanced federal reimbursement for the Medicaid expansion group (100% in 2014 through 2016, with gradual shift of 10% of the responsibility to the state by 2020) should make this financially feasible.
- The exchange should provided information and assistance to connect with publicly available prescription drug coverage through low or no-cost prescription programs offered by FQHC’s, community health centers, nurse-managed clinics, pharmacies, retailers and drug companies.

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 in the Medicaid Program and other health insurance programs to assure maximal continuity.
- The Commonwealth 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 and maintaining quality.

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, for example, they assisted 4,500 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.
- Special outreach efforts and enrollment efforts should be designed for small businesses.
- 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, such as FQHC’s, community health centers and nurse-managed clinics should be encouraged to become sites that can assist consumers to enroll.
- The exchange should consider providing resources where needed to community agencies to help defray the cost assisting consumers to enroll and select a plan.

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, OLTL and DPW and the DPW’s Office of Income Maintenance’s Helpline currently provide consumers with help to connect to these specialty programs.
FQHC’s provide access to comprehensive services, frequently including mental health and dental services.

**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.
- The exchange should maximize the ability of technology to guide individuals with special health care needs and concerns to appropriate services. To the extent possible application processes for special services should be integrated with or linked to the application process for health insurance – with information from the health insurance application populating the application for other health services.
- Information about specialized health programs offered by the Department of Health should be accessible through the website, and the customer service helpline should be able to provide applicants 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, but not limited to:
  - 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, but not limited to, 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
- Community Care Waiver (COMMERCARE)
- 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 and FQHC’s, community health centers and nurse-managed clinics.
  - Substance Abuse Services
  - Mental Health Services

9. **A comprehensive communication plan is needed to prepare for implementation of the exchange.**
   - The commonwealth should conduct outreach and marketing to explain the importance of preventive care, how the purchase of health insurance permits and encourages access to health care, and the potential outcomes of receiving regular checkups, immunizations, etc.
   - 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 halls, regional and local forums 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 for 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. If the state opts to offer a basic health plan, eligible individuals would be offered only the plan (or plans) that the state had selected to provide coverage for this group, instead of being eligible for a federal subsidy that they would use to purchase health insurance through the exchange.

The state is expected to coordinate its administration of the basic health plan with Medicaid, CHIP, and other state-run health care programs, to maximize efficiency and continuity of care. In return for administering the basic health plan, 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 basic health plan enrollees.

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. 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 Medicaid 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. If a managed care

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13 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.
approach is desired, Pennsylvania would need to expand managed care to all
regions of the state. This would 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 could have
important benefits to consumers. First, this approach could achieve lower out-of-
pocket costs for consumers – economies of scale achieved could make it possible
to offer the essential benefits package with lower premiums and cost-sharing to
participants. In addition, states may be able 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.
Furthermore, this approach could enhance the continuity of care for a group of
consumers that is prone to frequent income fluctuations. Other states that have
purchased services for Medicaid expansion groups have achieved lower costs
and enhanced quality through this approach.

On the other hand, the basic health plan approach limits consumer choice and
potentially removes an incentive for insurance companies to offer plans on the
exchange. Adding this large new group of purchasers to the private market would
make participating on the exchange more enticing for insurers. Including this large
group in the new consumer pool for insurers via the exchange may also help to
hold down premium costs.

Recommendation:

- DPW and PID should do an in-depth analysis of the potential benefits of
  providing a basic health plan and the potential impact on insurers’ willingness
to participate in the exchange, once the essential benefit package has
been defined and the guidelines for basic health plans are issued by HHS and
this analysis should be made available to the public and the Legislature for
consideration. Present information indicates that the State would receive
95% of the premium tax credit and reduction in cost sharing that the enrollee
would have received through the exchange which is estimated to be $4,940.
The average, non-elderly, non-disabled adult cost for those receiving care
under Medicaid for most states will be less than that. Thus, it may make sense
to establish a Basic Health Care Program for those with incomes up to 200% 
FPL, if the state can leverage its buying power to purchase services at or
below the amount the enrollee would have received for a premium tax
credit and reduced cost sharing reduction, reduce the out-of-pocket costs
for consumers, improve benefits and increase 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 long term care expenditures 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 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 300% of the Federal Poverty Level in Pennsylvania (the same income level as the state’s home and community-based waiver programs).
- Establish an Implementation Council with a majority consumer membership.
- Monitor quality through health outcomes and incorporate consumer feedback.

As It Is Today:

Pennsylvania ranks third in the nation for share of the population age 65 and older. Pennsylvanians do not tend to differ significantly from the national average for this age group on characteristics such as marital status, poverty status, and prevalence of disability and certain chronic health conditions. This means that a similar proportion of Pennsylvania’s elderly population requires long term care services. The ability of states to offer a wide range of to those needing long term care has a profound impact on the choices individuals are able to make and the costs incurred by the individual, their families and state and federal government. Staying at home or in the community generally costs far less than seeking services in a long term care facility, and is the preferred option for many consumers. As the baby boom generation reaches old age, the need for long-term care services will grow significantly, as will the costs to the Medicaid program. With spending for long-term care in the Medicaid budget expected to exceed $3 billion in 2010-11, developing alternatives to nursing homes will be critical- not only to provide consumers with real choices, but also to reduce the rate of growth of government spending on long term care.

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. With only limited funding available through the Medicare program, a majority of those who need long-term care find themselves quickly spending their resources, and eventually turning to Medicaid.

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.

Nationally, states spend an average of 40 percent of their Medicaid long-term care budgets on home and community-based alternatives. That number is growing every year. Pennsylvania needs to continue to invest in home and community-based services in order to keep pace with the rest of the nation. When the state achieves the same level of balance as the average US state, Pennsylvania will save $520 million annually.

As explained above, the ACA provides enhanced match to states who have not 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 million from the additional federal match. However, if CMS includes services for individuals with intellectual disabilities, 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 persons with intellectual disabilities. 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.
- Pennsylvania should continue its rebalancing initiative and should maximize federal funds available to do so. Because states have developed 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 ACA 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 be defined by HHS to include at least the following general categories and the items and services covered within these 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 health and vision care

As It Is Today

Pennsylvania’s Department of Health 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 are 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.