COMMONWEALTH OF PENNSYLVANIA
OFFICE OF THE GOVERNOR
HARRISBURG

THE GOVERNOR

February 19, 2014

The Honorable Kathleen Sebelius
Secretary of the U.S. Department of Health and Human Services
330 Independence Avenue, S.W., Room 4257
Washington, DC 20201

Dear Madam Secretary:

On behalf of the citizens of Pennsylvania, I am pleased to submit to the U.S Department of Health and Human Services the enclosed *Healthy Pennsylvania* Section 1115 Demonstration waiver application. The reforms and coverage options proposed in the *Healthy Pennsylvania* Demonstration waiver application align with and promote the three key health care priorities of my *Healthy Pennsylvania* plan: improving access, ensuring quality, and providing affordability.

The application outlines a reformed Medicaid program for Pennsylvania, the promotion of personal responsibility and how the commonwealth will increase access to private health insurance for more than 500,000 low-income Pennsylvanians who are uninsured. This waiver application plays a critical role in achieving the goal of increasing access to quality, affordable health care and is built upon common sense reforms that provide coverage options to our most vulnerable citizens in a flexible and sustainable way that protects taxpayers.

The waiver I submit today reflects input from state legislators, local governmental entities, providers and the general public. It also reflects consultation with your staff and staff from the Center for Medicare and Medicaid Services over the last several months. In conjunction with this waiver, Pennsylvania will also be submitting State Plan Amendments to secure federal funding.

Submission of this waiver represents the next step in placing Pennsylvania's Medicaid program on a sustainable path that will allow the commonwealth to provide increased access to private health care coverage options to more Pennsylvanians. We appreciate the assistance your department has offered to date and I respectfully request that your agency review and provide timely approval of the entire waiver I submit today. I look forward to your continued support of Pennsylvania as we implement the *Healthy Pennsylvania* Demonstration.

Sincerely,

Tom Corbett

TOM CORBETT
Governor

pennsylvania
DEPARTMENT OF PUBLIC WELFARE

Healthy PA
ACCESS • AFFORDABILITY • QUALITY

Healthy Pennsylvania
1115 Demonstration Application

February 2014

CONTENTS

TABLES

FIGURES

1. Executive Summary

Healthy Pennsylvania is Governor Tom Corbett's plan to ensure that Pennsylvanians have increased access to quality, affordable health care. Governor Corbett's *Healthy Pennsylvania* plan focuses on three key priorities: improving access, ensuring quality, and providing affordability. It touches all areas of health care to encourage better care coordination for patients, providers, and insurers. It is built upon common sense reforms that provide coverage options to our most vulnerable citizens in a flexible and sustainable way that protects taxpayers. The Medicaid reforms and the Private Coverage Option encompassed in the *Healthy Pennsylvania* plan will:

1. Increase health care access for more than 500,000 Pennsylvanians.
2. Promote healthy behaviors, improve health outcomes and increase personal responsibility.
3. Provide benefits that match health care needs.
4. Implement a strategy for sustainability by reforming the current Medicaid program to align it with private health care coverage.

Pennsylvania is home to a robust, world-class health care delivery system that has led the way nationally from covering children in the Children's Health Insurance Program (CHIP) to providing access to top physicians and hospitals. Additionally, the Commonwealth has been a national leader in successfully accessing commercial market innovation, which was demonstrated when it implemented statewide managed care through the HealthChoices program. Pennsylvania seeks to continue to be a leader through its pursuit of innovative reforms that prove to the nation that the best solutions are developed at the state and local level.

To implement the Medicaid reforms and *Healthy Pennsylvania* Private Coverage Option within the *Healthy Pennsylvania* plan, various Federal Medicaid waivers and State Plan Amendment approvals are necessary.

As it stands today, Pennsylvania taxpayers and the federal government spend approximately $24 billion annually on Medicaid programs that play a critical role in serving approximately 2.2 million Pennsylvanians. The Medicaid population includes low income parents and families, children, pregnant women, persons with disabilities, and older Pennsylvanians.

Unfortunately, economic shifts and market factors threaten the sustainability of the program. Currently, one in six Pennsylvanians receive Medicaid benefits. The costs of the Medicaid program account for almost 30% of the Commonwealth's entire general fund budget and continue to grow by hundreds of millions of dollars each year. Pennsylvania's Medicaid program faces an additional challenge in light of the notification late last year of a significant drop in the federal Medicaid matching rate (FMAP). This unplanned federal reduction resulted in the Commonwealth losing over $320 million of funding in fiscal year 2014-2015. Program innovations and reforms are necessary to improve health outcomes and ensure sustainability so that an adequate and appropriate health care safety net can be provided for those who need it.

The Department of Public Welfare (Department) anticipates the following additional objectives to be met through the 1115 Demonstration (Demonstration) application:

- Promoting access to health insurance through the private insurance marketplace and increasing access to employer-sponsored coverage (ESC).
- Encouraging healthy behaviors and appropriate care, including early intervention, prevention, and wellness.
- Increasing quality of care and efficiency of the health care delivery system.

Pennsylvania relies on several funding sources to draw down additional federal revenues to support our existing programs. Our ability to provide quality health care coverage to low income Pennsylvanians will rely on a commitment from the federal government to maintain, without change or disruption, all the existing funding sources.

This Demonstration request is also predicated on enhanced federal funding under the Affordable Care Act. If these enhanced funds and the existing federal funding sources are not available, Pennsylvania will withdraw its request and cease the Demonstration program operations as further described in section 2.6.

Approval for this initial Demonstration is requested for five years (2015 through 2019).

2. Program Description

2.1. 1115 Demonstration Overview

1) Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act).

Pennsylvanians should have increased access to quality, affordable health care. Under this Demonstration, the Commonwealth will continue to be a leader through its pursuit of innovative reforms that prove to the nation that the best solutions are developed at the state and local levels. With approval of this Demonstration application (and a set of Medicaid State Plan Amendments), the Department is seeking to improve access to quality, affordable health care by:

- Increasing access to private market coverage through the *Healthy Pennsylvania* Private Coverage Option for Pennsylvanians 21 years of age or older but under 65 years of age with incomes up to 133% of the Federal Poverty Level (FPL).
- Reforming the existing Medicaid benefit plan designs to align with the commercial market but provide a safety net when individuals are in their greatest need to assure long term sustainability of the program.
- Promoting healthy behaviors and improved health outcomes through a cost sharing design and by encouraging employment.

The Commonwealth can accomplish these goals through common sense reforms that provide coverage options to our most vulnerable citizens in a sustainable way. Pennsylvania is committed to providing a pathway to prosperity for all Pennsylvanians and creating health care choices for consumers.

Medicaid Reforms

Pennsylvania and the federal government currently spend approximately $24 billion annually on Medicaid programs that play a critical role in serving approximately 2.2 million Pennsylvanians. The Medicaid program includes low income parents and families, children, pregnant women, persons with disabilities, and older Pennsylvanians. As such, this Demonstration is critical to ensure the sustainability of the Medicaid program and its ability to maintain a safety net for those vulnerable populations through sustainable reforms into the 21st century.

The Commonwealth seeks to reform its existing Medicaid program through reforming the existing adult benefit designs to provide the health care coverage that Medicaid eligible individuals need through two simplified, private market-like adult benefit packages. These redesigned benefit packages are consistent with national standards pertaining to essential health benefits, mental health parity and preventive services, including drug and alcohol services. The Commonwealth aims to move away from a 'one size fits all' approach and focus on the needs of individuals. Most adults, 21 through 64 years of age, eligible under the current Medicaid eligibility levels, will be enrolled in the Medicaid Low Risk Benefit Plan (Low Risk Benefit Plan). Both the Low Risk Benefit Plan and the Medicaid High Risk Alternative Benefit Plan (High Risk Benefit Plan) will be offered in the Fee-for-Service (FFS) program and by managed care plans through the current HealthChoices program. The HealthChoices program is a mandatory managed care program that provides both physical health services and behavioral health services. The benefit package for individuals under 21 years of age will not change.

Additional activities include:

- Promoting personal responsibility and healthy behaviors through a cost sharing design and by encouraging employment.
- Improving access and quality of care within the existing Medicaid program.
- The future creation of *a Healthy Pennsylvania* Safety Net Pool (*HPA*-SNP) to make specific payments to providers implementing health care reforms. These reforms will embody the goals of Governor Corbett's *Healthy Pennsylvania* plan and are consistent with and support Pennsylvania's State Innovation Model (SIM).

These Medicaid reforms will apply to the entire program and are designed to work with the *Healthy Pennsylvania* Private Coverage Option.

Increase Access to Coverage – The *Healthy Pennsylvania* Private Coverage Option

The Department seeks to use premium assistance to purchase a private market health insurance plan offered in the Federally-Facilitated Marketplace (FFM), the private health insurance market, or through ESC for individuals deemed newly eligible under Title XIX of the Social Security Act who are:

1. Childless adults (who are not entitled to Medicare coverage), 21 years of age or older, but under 65 years of age, with incomes up to 133% FPL.
2. Adult parents/caretaker relatives (who are not entitled to Medicare coverage), 21 years of age or older but under 65 years of age, with incomes greater than 33% FPL (Pennsylvania's current income limit of this group), but not greater than 133% FPL.

These participants include individuals who are currently covered through Pennsylvania's General Assistance (GA) Medical Assistance, the State Blind Pension medical program, the Medical Assistance for Workers with Disabilities (MAWD) (under the Medicaid category added through the Ticket to Work and Work Incentives Improvement Act), the medically needy program (except for certain spend down categories), and the SelectPlan for Women Program (a demonstration project to provide family planning services to women of childbearing age). Pennsylvania will transition income eligible adults into the newly eligible group. In addition, Pennsylvania intends to extend the SelectPlan program until the Demonstration is in place.

The participants in this option, known throughout this application as the *Healthy Pennsylvania* Private Coverage Option, will receive Essential Health Benefits (EHB) through a private health plan and will have cost sharing obligations consistent with the reformed cost sharing approach described in *Section 4: 1115 Demonstration Benefits and Cost Sharing Requirements*. Participants who are not dually eligible for Medicare and Medicaid and are determined medically frail will be covered through the new High Risk Benefit Plan provided through Pennsylvania's HealthChoices program. The medically frail will be determined using the same health screening and criteria used to identify high risk participants.

This Demonstration aims to reduce the amount of churn that will occur when newly eligible individuals move between Medicaid and private coverage plans. By providing individuals with consistent health plan access through private market health insurance plans and providing opportunities for increased personal responsibility, this Demonstration will produce improved health outcomes.

The Demonstration will further the objectives of Title XIX by promoting continuity of coverage for adults, improving access to providers, allowing for more coordinated care, and furthering quality improvement and delivery system reform initiatives. Ultimately, the Demonstration will provide truly integrated coverage for low income Pennsylvanians

by leveraging the efficiencies of the private market to improve continuity, access, and quality for *Healthy Pennsylvania* Private Coverage Option participants resulting in improved health outcomes and lowered health care costs for all Pennsylvanians.

Through the inclusion of more than 500,000 Pennsylvanians in the private health insurance market, the Department will improve affordability by driving more competitive premium pricing and reducing the overall federal burden for those eligible to receive an advanced premium tax credit (APTC).

2) Include the rationale for the 1115 Demonstration

In order to provide quality, affordable health care services to Pennsylvania's most vulnerable citizens, Pennsylvania must transform its Medicaid program. Pennsylvania's current Medicaid program continues to grow and requires substantial new state revenue on an ongoing basis. As in years past, these costs are projected to grow by more than $400 million in fiscal year 2014-2015. This cost growth does not include additional costs that the Commonwealth may incur as a result of the mandatory provisions of the Affordable Care Act (ACA), nor does it include the projected 1.7 percentage point reduction in FMAP for Pennsylvania during federal fiscal year 2015.

While Medicaid provides critical health care to millions of Pennsylvanians, its continued annual growth places an increased burden on the taxpayers of Pennsylvania and makes it increasingly difficult to fund other critical program areas, such as education. Pennsylvania is committed to providing a program that meets the needs of Pennsylvanians into the future.

Pennsylvania's approach to Medicaid reform is based on a comprehensive benefit and cost sharing design that encourages healthy behaviors and increased independence and personal responsibility by encouraging employment. This design will assist Pennsylvanians currently receiving Medical Assistance to move to the *Healthy Pennsylvania* Private Coverage Option and, ultimately, to private ESC.

By using premium assistance available through the *Healthy Pennsylvania* Private Coverage Option to purchase a private market health insurance plan, the Department will promote continuity of coverage, reduce churn between Medicaid and private market health insurance, increase provider access, and lower health care costs for all Pennsylvanians.

- **Churn Reduction and Continuity of Coverage** – The *Healthy Pennsylvania* Private Coverage Option is expected to decrease the amount of insurance coverage churn for participants, which will result in greater continuity of care. Because of the frequent income fluctuations at higher FPL percentages, Pennsylvanians closer to 133% FPL are more likely to move between Medicaid eligibility and a private coverage plan, either through an employer or the use of the APTC available through the FFM. As currently designed, the *Healthy Pennsylvania* Private Coverage Option offers a mechanism for households to stay enrolled in the same plan regardless of whether their coverage is subsidized through Medicaid or APTCs. This approach results in greater coverage stability for individuals and their families, increased continuity of care, and improved health outcomes.

- **Increased Provider Access** – Pennsylvania Medicaid provides payment rates for some services that are lower than Medicare or private market payers, causing some providers to forego participation in the program. Through the use of private market health insurers, this Demonstration will seek to increase provider access.

- **Lower Health Care Costs for All Pennsylvanians** – Pennsylvania's approach brings more than 500,000 individuals into the private health insurance market, which should increase competition and result in lower premiums and costs for Pennsylvanians who are expected to be purchasing private market health insurance with the assistance of an APTC. Bringing more competition into the private health insurance market will result in more choices and lower costs for Pennsylvania consumers.

- **Personal Responsibility –** The Department wants to ensure that Medicaid remains a transitional benefit available to vulnerable, low income Pennsylvanians. To encourage personal responsibility, while still maintaining a safety-net program for our most vulnerable citizens, a three part approach is being proposed:

  Premium Requirement: In Demonstration Year 1, participants will only be required to pay existing copayments as outlined in the state plan.

Starting in Demonstration Year 2 (CY 2016), individuals with incomes greater than 100% FPL will be required to pay a nominal payment toward a monthly premium. This requirement provides a mechanism for participants to engage in their health care which will encourage them to make healthier choices, both in their daily lives and when making decisions about their health care. Additionally it will prepare these individuals for health care coverage financial obligations that will become their responsibility when their income increases and they move into private health care coverage either through APTC subsidized coverage via the FFM, the private health insurance market, or ESC. In Demonstration Year 2, for those with income no greater than 100% FPL, the Department will evaluate data on participant copayment obligations from Demonstration Year 1 and consider changes to support incentives and personal responsibility. This could include changes in copayment amounts, implementing a nominal premium, and participating in *Encouraging Employment* as a condition of eligibility.

Healthy Behaviors Incentives: Reducing the cost of health care coverage needs to be the responsibility of both the health care provider and the individuals receiving care. In the past, Pennsylvania has implemented payment reforms to incentivize providers to improve the quality and cost of care. Following the lead of private market health insurance plans, Pennsylvania will address the participant side of the equation by offering reductions in the monthly premium amount and other cost sharing obligations as individuals practice healthy behaviors.

In Demonstration Year 1, participants will be encouraged to pay copayments on time and receive an annual wellness visit. In Demonstration Year 2, individuals will be incentivized to complete a Health Risk Assessment, pay applicable copayments and monthly premiums on time, and have an annual wellness visit. The Department will use compliance with paying copayments and having an annual wellness visit in Demonstration Year 1 to establish initial cost sharing reductions in Demonstration Year 2.

Encouraging Employment: The goal of the *Encouraging Employment* program is to better enable low-income, able bodied Pennsylvanians to

move out of poverty while also gaining access to health care coverage. The program will create an opportunity for unemployed and under-employed individuals to connect with potential employers. Adults, 21 through 64 years of age, who are able to work and working an average of less than 20 hours per week, will be asked to engage in job training and employment-related activities as part of an integrated approach to improving their health and helping them move out of poverty through employment. The Department is seeking a waiver to require adults working less than 20 hours a week to participate in the *Encouraging Employment* program as a condition of eligibility. Additionally, in Demonstration Year 2 for those individuals who are working more than an average of 20 hours per week or are engaging in the required job training and employment-related activities, the Commonwealth will reduce the amount of their monthly premiums or other cost sharing obligations or implement other incentives for these activities.

2.2. 1115 Demonstration Hypotheses

3) Describe the hypotheses that will be tested and evaluated during the 1115 Demonstration's approval period and the plan by which the State will use to test them.

The Demonstration provides reforms to the existing Medicaid program, increases access to health care coverage and stabilizes financing by delivering private market health insurance benefits to a new group of low income adults through the use of the *Healthy Pennsylvania* Private Coverage Option. As described above, some of the core innovations in the Demonstration include:

1. **Increasing access to health care coverage through the *Healthy Pennsylvania* Private Coverage Option.** Premium assistance will be used to purchase private market health insurance plans for individuals with income up to 133% FPL. The *Healthy Pennsylvania* Private Coverage Option will increase access to private market health insurance plans and their network providers, reduce churn, maintain administrative costs, and reduce both premium costs in the Commonwealth and average per-capita uncompensated care costs.

2. **Implementing the *Encouraging Employment* program to improve health outcomes and move individuals out of poverty.** Published research shows that being employed results in improved physical and mental health.[1] In order to promote improved health conditions, as well as help individuals move out of poverty, Demonstration participants who are able to work and working an average of less than 20 hours per week will be required to participate in the *Encouraging Employment* program, which includes employment-related activities, available through JobGateway℠, participating in job training programs and engaging in ongoing activities that connect them with employment opportunities.

3. **Implementing a unique incentive plan to encourage personal accountability, incentivize healthy behaviors, and develop cost-conscious consumer behaviors in the consumption of health care services.** As explained in section 2.1, the Demonstration will establish cost sharing and encourage employment. Fulfilling healthy behaviors (having an annual wellness visit, paying copayments, and completing job training or employment-related activities) in Demonstration Year 1 may result in cost sharing reductions in Demonstration Year 2. Similar incentives will continue throughout the life of the Demonstration.

4. **Utilizing a health screening tool for all adult participants, both initially and periodically, will help identify the benefit plan that best serves their needs.** Most adult participants will be screened initially and annually thereafter to align health care needs to the appropriate health care plan while still maintaining continued coverage and a safety net for the Commonwealth's vulnerable populations.

The core hypotheses in the Demonstration include:

[1] F. M. McKee-Ryan, Z. Song, C. R. Wanberg, and A. J. Kinicki, "Psychological and physical well-being during unemployment: a meta-analytic study," Journal of Applied Psychology, vol. 90, no. 1, pp. 53–76, 2005. K. I. Paul, E. Geithner, and K. Moser, "Latent deprivation among people who are employed, unemployed, or out of the labor force," Journal of Psychology, vol. 143, no. 5, pp. 477–491, 2009.

1.) Increasing access to health care coverage through the *Healthy Pennsylvania* Private Coverage Option.

#	Hypothesis	Potential Methodology, Metrics, and Data Sources
1.1	*Healthy Pennsylvania* Private Coverage Option participants will have adequate provider access.	1. Conduct a survey of *Healthy Pennsylvania* Private Coverage Option participants related to timeliness of care and other provider access issues. Possible metrics include: 1) percent of participants who report getting care quickly; 2) reported travel times/distance to Primary Care Physicians (PCP) and other providers; 3) size of network/ availability of PCPs and other providers. 2. Alternatively, conduct a comparison of *Healthy Pennsylvania* Private Coverage Option provider networks to private market provider networks. Comparisons made on a regional basis to account for differences in network size. Plan is to collect data from *Healthy Pennsylvania* Private Coverage Option plans and other non-*Healthy Pennsylvania* Private Coverage Option private market health plans. May also use NCQA HEDIS/CAHPS data, if appropriate.
1.2	*Healthy Pennsylvania* Private Coverage Option participants will have continuous insurance coverage.	1. Analysis of the number of participants that stay in the same plan as their income increases above 133% FPL. Possible metrics include: 1) percent of individuals that stay in the same plan over time; 2) percent of individuals with any period of being uninsured during the year (i.e., a coverage gap). Determine baseline data and analyze changes in that data over time. Plan is to use *Healthy Pennsylvania* Private Coverage Option enrollment data in the analysis. 2. Alternatively, a hypothetical analysis of *Healthy Pennsylvania* Private Coverage Option participant transfers to APTC coverage. Measure the percent of *Healthy Pennsylvania* Private Coverage Option participants who would have otherwise had to change coverage if not in the *Healthy Pennsylvania* Private Coverage Option. Test *Healthy Pennsylvania* Private Coverage Option participants against a hypothetical control group (those who would have potentially churned between Medicaid and APTC coverage).

#	Hypothesis	Potential Methodology, Metrics, and Data Sources
1.3	Per capita administrative costs will be maintained through the use of the *Healthy Pennsylvania* Private Coverage Option.	Comparison of per capita administrative costs expended for the *Healthy Pennsylvania* Private Coverage Option and how those costs change over time. Determine Demonstration group and compare the administrative costs of that group to the group's administrative costs in previous years. Alternatively, compare to the administrative costs of a non-Demonstration control group.
1.4	*Healthy Pennsylvania* Private Coverage Option will reduce overall premium costs in the Commonwealth.	Analysis of the impact of increased volume and competitive pricing requirements for plans offered to *Healthy Pennsylvania* Private Coverage Option participants. Compare aggregate-level private market premium costs with the inclusion of the *Healthy Pennsylvania* Private Coverage Option to historical costs and/or a non-Demonstration sample. Determine baseline data and analyze changes in that data over time. Plan to use aggregate level *Healthy Pennsylvania* Private Coverage Option/private market premium cost information.
1.5	Average per capita uncompensated care costs will decrease as a result of fewer numbers of uninsured.	Comparison of average per capita uncompensated costs before and after implementation of the Demonstration. Determine baseline data and analyze changes in that data over time. Data sources may include CMS data, hospital-level data, or an analysis of Disproportionate Share Hospital Payments.

2.) Implementing the *Encouraging Employment* program to improve health outcomes and move individuals out of poverty.

#	Hypothesis	Potential Methodology, Metrics, and Data Sources
2.1	Implementation of the *Encouraging Employment* program will result in increased employment for the Demonstration population (which will ultimately lead to improved health outcomes—see 2.2 below).	Measure the change in the employment rate of individuals who participate in the *Encouraging Employment* program. Compare the employment rate of those required to participate in the program to the same group's historical employment rate. Or compare to a non-Demonstration control group with similar income levels and other demographic characteristics (who do not participate in the program). Data sources may include state employment data (Labor & Industry work/wages data), census data, measuring the number of individuals moving from the *Healthy Pennsylvania* Private Coverage Option to the private market, and/or survey results.
2.2	The *Encouraging Employment* program will promote employment, which will result in better physical and mental health outcomes.	Based upon published research being employed results in improved physical and mental health. To test whether this holds true for the Demonstration population, changes in physical and mental health outcomes of participants who are required to participate in the *Encouraging Employment* program will be measured over time (analysis will occur in Demonstration Year 3 or 4). Possible metrics include: 1) specific behavioral health/physical health diagnoses (reduced depression and anxiety, improved functional health status, etc.); 2) service utilization (e.g., less hospitalization, reduced use of ED, etc.). Data sources may include claims data, survey results, and/or Behavioral Risk Factor Surveillance System (BRFSS) data.

Implementing a unique incentive plan to encourage personal accountability, incentivize healthy behaviors and develop cost-conscious consumer behaviors in the consumption of health care services.

#	Hypothesis	Potential Methodology, Metrics, and Data Sources
3.1	Reductions in monthly premiums and copayment amounts will promote healthy behaviors and improve physical and mental health outcomes.	Analysis of the number of individuals who pay a premium/copayment amount and engage in healthy behaviors and activities. Metrics may include: 1) consistently paying premiums; 2) completing a health risk assessment; 3) completing an annual wellness visit. Determine baseline data and analyze changes in that data over time. Data sources may include claims data, survey results, and/or Behavioral Risk Factor Surveillance System (BRFSS) data. Analysis related to completing a Health Risk Assessment will begin in Demonstration Year 2.

3.) Utilizing a health screening for all adult participants, both initially and periodically, will help identify the benefit plan that best serves their needs.

#	Hypothesis	Potential Methodology, Metrics, and Data Sources
4.1	The Low Risk Benefit Plan sufficiently meets the needs of the participants placed in it by the health screening.	Analyze the number of exception requests from the Low Risk Benefit Plan over a predetermined time period. Determine appropriate baseline percentage of exceptions (e.g., 5%) and compare to actual percentage. Examine aggregate level results.
4.2	The High Risk Benefit Plan sufficiently meets the needs of the participants placed in it by the health screening.	Analyze the number of exception requests from the High Risk Benefit Plan over a predetermined time period. Determine appropriate baseline percentage of exceptions (e.g., 5%) and compare to actual percentage. Examine aggregate level results.

2.3. 1115 Demonstration Area

4) Describe where the 1115 Demonstration will operate, i.e., statewide, or in specific regions within the State. If the 1115 Demonstration will not operate statewide, please indicate the geographic areas/regions of the State where the 1115 Demonstration will operate.

The Demonstration will operate statewide.

2.4. 1115 Demonstration Timeframe

5) Include the proposed timeframe for the 1115 Demonstration

The Demonstration will operate five years beginning on January 1, 2015 and lasting until December 31, 2019.

2.5. 1115 Demonstration Impact to Medicaid and CHIP

6) Describe whether the 1115 Demonstration will affect and/or modify other components of the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems

This Demonstration will change current Medicaid eligibility, benefits, cost sharing, and delivery systems, as detailed in the sections identified below. With respect to the current Medicaid program in Pennsylvania, outside of eligibility, benefits, cost sharing, and delivery systems, this Demonstration makes changes to:

- Payment Rates, as described in *Section 5: Delivery System and Payment Rates for Services.*
- Financing, as described in *Section 5: Delivery System and Payment Rates for Services,* and *Section 7: 1115 Demonstration Financing and Budget Neutrality.*
- Administration, to the extent needed by the Demonstration itself, as described in *Section 10: 1115 Demonstration Administration.*

This waiver will not impact CHIP.

2.6. CONTINGENCY FOR REDUCTION IN FEDERAL FINANCIAL PARTICIPATION:

Implementation and operation of this Demonstration, in particular the *Healthy Pennsylvania* Private Coverage Option, is dependent on the FMAP for the newly eligible adult group under the ACA, as provided in section 1905(y) of the Social Security Act (42 U.S.C. § 1396d(y)). Therefore, in the event any of the following occur, the Department shall discontinue the proposal:

- The methodology for calculating the FMAP for individuals in the *Healthy Pennsylvania* Demonstration is modified through federal law, regulation, or sub-regulatory guidance in a manner that reduces the percentage of federal assistance to Pennsylvania in a manner inconsistent with section 1905(y) of the Social Security Act (42 U.S.C. § 1396d(y)), as enacted March 23, 2010.
- The amount of federal financial participation for this Demonstration under ACA is reduced through a modification or restriction in the federal Medicaid appropriation in a manner that reduces the percentage of federal assistance to Pennsylvania in a manner inconsistent with section 1905(y) of the Social Security Act (42 U.S.C. § 1396d(y)), as enacted March 23, 2010.
- The ability to provide quality health care to low income Pennsylvanians under this Demonstration and the current Medicaid program relies on a commitment from the federal government to maintain without change or disruption to existing federal funding and revenue sources. Should changes be required or use of these existing federal funding and revenue sources become unavailable for the current Medicaid program or newly eligible populations under this Demonstration, it may necessitate discontinuance of this proposal.
- Federal law, regulation, or sub-regulatory guidance affecting eligibility, benefits, payment, delivery systems, financing, administration, health insurance exchanges, or qualified health plans is modified in a manner that conflicts with or materially hinders the operation or financing of this Demonstration as described herein.

3. 1115 Demonstration Eligibility

3.1. Eligibility Groups

1) Include a chart identifying any populations whose eligibility will be affected by the 1115 Demonstration.

The *Healthy Pennsylvania* Demonstration will provide access to basic health care coverage for uninsured Pennsylvanians, and creates incentives and opportunities for low income individuals to engage in more healthy behaviors, and to connect with prospective employers by encouraging employment. The plan will affect the newly eligible populations and other adults in existing categories of assistance who may be subject to two additional conditions of eligibility related to paying premiums and participation in the *Encouraging Employment* program.

The addition of the premium requirement will initially affect only those with incomes at or above 100% FPL beginning in Demonstration Year 2. This includes both newly eligible adults and some existing adult groups.

In Demonstration Year 2, the Department will evaluate data on participant copayment compliance from Demonstration Year 1 and consider changes to support incentives and personal responsibility. This could include changes in copayment amounts and implementing a nominal premium.

Required participation in the *Encouraging Employment* program will affect newly eligible adults, adults in low income families, and other groups as depicted in Table 1 and Table 2. Additionally, most non-institutional adult categories will be affected by the $10 copayment for the non-emergent use of the emergency room. (See Appendix 1 for a list of these categories.)

Individuals who qualify and enroll in the *Healthy Pennsylvania* Private Coverage Option will be required to receive coverage through a private market health insurance plan. Individuals who are not medically frail and decline coverage through the private market health insurance plans will not be permitted to receive benefits through the Medicaid program.

The Demonstration does not impact the eligibility of pregnant women or children less than 21 years of age. It also does not affect the eligibility of Pennsylvanians who are institutionalized, and those in categories limited to Medicare cost sharing programs such as Qualified Medicare Beneficiaries. Throughout this application, the term 'institutionalized' means that an individual is likely to reside or has already resided in a medical institution for more than 30 continuous days.

The adult eligibility categories set forth in the state plan that will be affected by the $10 copayment for non-emergent use of the ER starting in Demonstration Year 2 are identified in Appendix 1.

Groups will be affected by the 1115 Demonstration by premiums and activities to encourage employment as indicated in Tables 1 and 2 below: 1115 Demonstration Eligibility Group – Demonstration Year 1 and 1115 Demonstration Eligibility Group – Demonstration Years 2-5:

Table 1. 1115 Demonstration Eligibility Group – Demonstration Year 1

Eligibility Group Name Social Security and CFR Citations	**Brief Description of Population**	**Maximum Income Limit Single/Couple Asset Limit**	**Premium Applies if above 100% FPL**	***Encouraging Employment* Applies**
Low Income Families 1931	Low income parents and caretaker relatives based on income and family size.	33% FPL No asset test	NO	YES, unless otherwise exempt
Extended Medicaid due to Child or Spousal Support Collections 408(a)(11)(B), 42 CFR 435.115, 1931(c)(1)	Individuals who lose eligibility under Section 1931 due to spousal support.	N/A No asset test	NO	YES, unless otherwise exempt
Transitional Medical Assistance 408(a)(11)(A) 1931(c)(2), 1925, 1902(a)(25)	12-month continued medical assistance due to increased earnings or hours of employment	185% FPL N/A	NO	YES, unless otherwise exempt

Eligibility Group Name Social Security and CFR Citations	**Brief Description of Population**	**Maximum Income Limit Single/Couple Asset Limit**	**Premium Applies if above 100% FPL**	***Encouraging Employment* Applies**
Individuals Receiving Mandatory State Supplement 42 CFR 435.130[2]	Low income seniors or an adult with a severe disability. State increases SSI payment by $22.10.	76% FPL[3] $2,000/$3,000	NO	NO
Individuals Who Are Essential Spouses 42 CFR 435.131 1905(a)	Spouse of aged, blind, disabled individual who was grandfathered into program at time of SSI implementation.	74% FPL $2,000/$3,000	NO	NO
Blind or Disabled Individuals Eligible in 1973 42 CFR 435.133	Continuously eligible based on 1973 requirements.	Meet 1973 requirements	NO	NO
Individuals Who Lost Eligibility for SSI/SSP Due to an Increase in OASDI Benefits in 1972 42 CFR 435.134	Low income seniors or an adult with a severe disability with incomes slightly above 74% FPL.	>74% FPL $2,000/$3,000	NO	NO
Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA increases since April, 1977 1939(a)(5)(E), 42 CFR 435.135, Section 503 of P.L. 94-566	Adult with a severe disability. Had been receiving SSI but lost it due to Social Security Administration (SSA) income increases from Cost Of Living Adjustments (COLA).	>74% FPL, but low income	NO	NO
Disabled Widows and	Adult with a severe	>74% FPL, but	NO	NO

[2] Many of the federally defined categories include individuals age 65 and older as part of the definition. A waiver of comparability will be requested, so individuals age 65 and older will not be affected by the waiver.
[3] Poverty level income limits for SSI groups are approximate and based on the 2013 Federal Benefit Rate (FBR) for SSI/2013 Federal Poverty Level (FPL). Individuals in SSI protected groups will have different incomes based on their individual circumstances.

Eligibility Group Name Social Security and CFR Citations	**Brief Description of Population**	**Maximum Income Limit Single/Couple Asset Limit**	**Premium Applies if above 100% FPL**	***Encouraging Employment* Applies**
Widowers Ineligible for SSI due to Increase in OASDI 1634(b), 42 CFR 435.137	disability. Not eligible for SSI because the increased amount of widow's or widower's insurance benefits which resulted from eliminating the additional reduction factor for disabled widows and widowers under age 60.	likely low income		
Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security 42 CFR 435.138,1634(d)	Disabled widows and widowers who are at least age 60; not entitled to Medicare Part A; and become ineligible for SSI or a State Supplement because of mandatory receipt of widow's or widower's social security disability benefits.	>74% FPL $2,000, $3,000	NO	NO
Working Disabled under 1619(b) 1902(a)(10)(A)(i)(II), 1905(q),1619(b)	Would receive SSI but for earnings. Blind or disabled individual whose earnings from employment make the individual ineligible for an SSI cash payment. The SSA makes the determination for Special SSI Recipient Status.	N/A	NO	NO
Disabled Adult Children (DAC) 1634(c)	Individual who became disabled before age 22, and receives Title II Social Security benefits as dependent on parent's claim. Benefits received upon disability, retirement,	N/A	NO	NO

Eligibility Group Name Social Security and CFR Citations	**Brief Description of Population**	**Maximum Income Limit Single/Couple Asset Limit**	**Premium Applies if above 100% FPL**	***Encouraging Employment* Applies**
	death of the parent. When SSI benefits are terminated due to receipt of or increase in Social Security benefits, a DAC may be eligible for continued Medical Assistance (MA) coverage under SSI Extended Non-Money Payment Coverage – Special Circumstances.			
Individuals Eligible for Cash except for Child Care Subsidy 1902(a)(10)(A)(ii)(II), 42 CFR435.220	Low income caretakers.	33% FPL $1,000/$1,000 asset test	NO	YES, unless otherwise exempt
Individuals Eligible for but not Receiving Cash 42 CFR 435.210, 1902(a)(10)(A)(ii)(I), 1905(a), 1902(v)(1)	Have the same characteristics as an SSI recipient or Aid to Families with Dependent Children (AFDC) (Temporary Assistance for Needy Families (TANF)) recipient, but are not receiving payments from the program.	33% and 74% FPL $2,000/$3,000	NO	YES, if TANF related; NO, if SSI related
Individuals Receiving Home and Community Based Services under Institutional Rules 42 CFR 435.217 1902(a)(10)(A)(ii)(VI)	Special income level group, with gross income that does not exceed 300% of the SSI income standard; receives Long Term Services and Supports (LTSS) in the community.	222% FPL $2,000 with 6,000 disregard	NO	YES, unless otherwise exempt
Optional State Supplement Recipients - 1634 States, and SSI	Low income seniors or an adult with a severe disability. Receives a	76% FPL $2,000	NO	NO

Eligibility Group Name Social Security and CFR Citations	**Brief Description of Population**	**Maximum Income Limit Single/Couple Asset Limit**	**Premium Applies if above 100% FPL**	***Encouraging Employment* Applies**
Criteria States with 1616 Agreements 1902(a)(10)(A)(ii)(IV) 42 CFR 435.232	$22.10 state supplement.			
Poverty Level Aged or Disabled 1902(a)(10)(A)(ii)(X), 1902(m)(1)	Low income senior or an adult with a severe disability. (Note: does not affect those age 65 and older)	100% FPL $2,000/$3,000	NO	YES, unless otherwise exempt
Individuals at or below 133% FPL Age 19 through 20 1902(a)(10)(A)(i) (VIII)[4]	Newly eligible singles and couples**. Only those with incomes greater than 44% FPL will be affected by the waiver.**	Income between 44% FPL and 133% FPL No asset test	NO	NO
Individuals at or below 133% FPL, 21 through 64 years of age 1902(a)(10)(A)(i) (VIII) NOTE: Those individuals who are receiving coverage through Medical Assistance for Workers with Disabilities, SelectPlan for Women, Medically Needy for parents, caretakers, persons with disabilities and the blind, and through General Assistance and State Blind Pension participation will move to this group.	Newly eligible singles and couples.	133% FPL No asset test	NO	YES, unless otherwise exempt

[4] This group is separated from the rest of the newly eligible to clarify that they will be treated differently.

Eligibility Group Name Social Security and CFR Citations	**Brief Description of Population**	**Maximum Income Limit Single/Couple Asset Limit**	**Premium Applies if above 100% FPL**	***Encouraging Employment* Applies**
Former Foster Care Children 1902(a)(10)(A)(i)(IX)	Individuals who were receiving Foster Care and Medicaid at age 18 and aged out of the foster care program. The changes included in this waiver will only apply to those in this group who are age 21 to 25 years.	Not otherwise categorically or income eligible	NO	NO, if less than 21 years of age YES for 21 years and older

Table 2. 1115 Demonstration Eligibility Group – Demonstration Year 2-5

Eligibility Group Name Social Security and CFR Citations	**Brief Description of Population, if needed**	**Maximum Income Limit Single/couple asset limit**	**Premium Applies**	***Encouraging Employment* Applies**
Low Income Families 1931	Low income parents and caretaker relative based on income and family size.	33% FPL No asset test	NO	YES, unless otherwise exempt
Extended Medicaid due to Child or Spousal Support Collections 408(a)(11)(B), 42 CFR 435.115, 1931(c)(1)	Individuals who lose eligibility under Section 1931 due to spousal support.	N/A No asset test	YES, unless otherwise exempt	YES, unless otherwise exempt
Transitional Medical Assistance 408(a)(11)(A) 1931(c)(2), 1925, 1902(a)(25)	12-month continued medical assistance due to increased earnings or hours of employment	185% FPL N/A	YES unless otherwise exempt	YES, unless otherwise exempt

Eligibility Group Name Social Security and CFR Citations	**Brief Description of Population, if needed**	**Maximum Income Limit Single/couple asset limit**	**Premium Applies**	***Encouraging Employment* Applies**
Individuals Receiving Mandatory State Supplement 42 CFR 435.130[5]	Low income seniors or an adult with a severe disability. State increases SSI payment by $22.10.	76% FPL[6] $2,000/$3,000	NO	NO
Individuals Who Are Essential Spouses 42 CFR 435.131 1905(a)	Spouse of aged, blind, disabled individual who was grandfathered into program at time of SSI implementation.	74% FPL $2,000/$3,000	NO	NO
Blind or Disabled Individuals Eligible in 1973 42 CFR 435.133	Continuously eligible based on 1973 requirements.	Meet 1973 requirements	NO	NO
Individuals Who Lost Eligibility for SSI/SSP Due to an Increase in OASDI Benefits in 1972 42 CFR 435.134	Low income seniors or an adult with a severe disability with incomes slightly above 74% FPL.	>74% FPL $2,000/$3,000	NO	NO
Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA increases since April, 1977 1939(a)(5)(E), 42 CFR 435.135, Section 503 of P.L. 94-566	Adult with a severe disability. Had been receiving SSI but lost it due to Social Security Administration (SSA) income increases from Cost Of Living Adjustments (COLA).	>74% FPL, but low income	NO	NO

[5] Many of the federally defined categories include individuals age 65 and older as part of the definition. A waiver of comparability will be requested, so individuals age 65 and older will not be affected by the waiver.
[6] Poverty level income limits for SSI groups are approximate and based on the 2013 Federal Benefit Rate (FBR) for SSI/2013 Federal Poverty Level (FPL). Individuals in SSI protected groups will have different incomes based on their individual circumstances.

Eligibility Group Name Social Security and CFR Citations	**Brief Description of Population, if needed**	**Maximum Income Limit Single/couple asset limit**	**Premium Applies**	***Encouraging Employment* Applies**
Disabled Widows and Widowers Ineligible for SSI due to Increase in OASDI 1634(b), 42 CFR 435.137	Adult with a severe disability. Not eligible for SSI because the increased amount of widow's or widower's insurance benefits which resulted from eliminating the additional reduction factor for disabled widows and widowers under age 60.	>74% FPL, but likely low income	NO	NO
Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security 42 CFR 435.138,1634(d)	Disabled widows and widowers who are at least age 60; not entitled to Medicare Part A; and become ineligible for SSI or a State Supplement because of mandatory receipt of widow's or widower's social security disability benefits.	>74% FPL $2,000, $3,000	NO	NO
Working Disabled under 1619(b) 1902(a)(10)(A)(i)(II), 1905(q),1619(b)	Would receive SSI but for earnings. Blind or disabled individual whose earnings from employment make the individual ineligible for an SSI cash payment. The SSA makes the determination for Special SSI Recipient Status.	N/A	NO	NO

Eligibility Group Name Social Security and CFR Citations	**Brief Description of Population, if needed**	**Maximum Income Limit Single/couple asset limit**	**Premium Applies**	***Encouraging Employment* Applies**
Disabled Adult Children (DAC) 1634(c)	Individual who became disabled before age 22, and receives Title II Social Security benefits as dependent on parent's claim. Benefits received upon disability, retirement, death of the parent. When SSI benefits are terminated due to receipt of or increase in Social Security benefits, a DAC may be eligible for continued Medical Assistance (MA) coverage under SSI Extended Non-Money Payment Coverage – Special Circumstances.	N/A	NO	NO
Individuals Eligible for Cash except for Child Care Subsidy 1902(a)(10)(A)(ii)(II), 42 CFR435.220	Low income caretakers.	33% FPL $1,000/$1,000 asset test	NO	YES, unless otherwise exempt
Individuals Eligible for but not Receiving Cash 42 CFR 435.210, 1902(a)(10)(A)(ii)(I), 1905(a), 1902(v)(1)	Have the same characteristics as an SSI recipient or Aid to Families with Dependent Children (AFDC) (Temporary Assistance for Needy Families (TANF)) recipient, but are not receiving payments from the program.	33% and 74% FPL $2,000/$3,000	NO	YES, if TANF related; NO, if SSI related

Eligibility Group Name Social Security and CFR Citations	**Brief Description of Population, if needed**	**Maximum Income Limit Single/couple asset limit**	**Premium Applies**	***Encouraging Employment* Applies**
Individuals Receiving Home and Community Based Services under Institutional Rules 42 CFR 435.217 1902(a)(10)(A)(ii)(VI)	Special income level group, with gross income that does not exceed 300% of the SSI income standard; receives Long Term Services and Supports (LTSS) in the community.	222% FPL $2,000 with 6,000 disregard	YES, unless otherwise exempt	YES, unless otherwise exempt
Optional State Supplement Recipients - 1634 States, and SSI Criteria States with 1616 Agreements 1902(a)(10)(A)(ii)(IV) 42 CFR 435.232	Low income seniors or an adult with a severe disability. Receives a $22.10 state supplement.	76% FPL $2,000	NO	NO
Poverty Level Aged or Disabled 1902(a)(10)(A)(ii)(X), 1902(m)(1)	Low income senior or an adult with a severe disability. (Note: does not affect those age 65 and older)	100% FPL $2,000/$3,000	NO	YES, unless otherwise exempt
Individuals at or below 133% FPL Age 19 through 20 1902(a)(10)(A)(i) (VIII)[7]	Newly eligible singles and couples**. Only those with incomes greater than 44% FPL will be affected by the waiver.**	Income between 44% FPL and 133% FPL No asset test	NO	NO

[7] This group is separated from the rest of the newly eligible to clarify that they will be treated differently.

Eligibility Group Name Social Security and CFR Citations	**Brief Description of Population, if needed**	**Maximum Income Limit Single/couple asset limit**	**Premium Applies**	***Encouraging Employment* Applies**
Individuals at or below 133% FPL, 21 through 64 years of age 1902(a)(10)(A)(i) (VIII) NOTE: Those individuals who are receiving coverage through Medical Assistance for Workers with Disabilities, SelectPlan for Women, Medically Needy for parents, caretakers, persons with disabilities and the blind, and through General Assistance and State Blind Pension participation will move to this group.	Newly eligible singles and couples.	133% FPL No asset test	YES, unless otherwise exempt	YES, unless otherwise exempt
Former Foster Care Children 1902(a)(10)(A)(i)(IX)	Individuals who were receiving Foster Care and Medicaid at age 18 and aged out of the foster care program. The changes included in this waiver will only apply to those in this group who are age 21 to 25 years.	Not otherwise categorically or income eligible	NO, if less than 21 years of age YES for 21 years and older unless otherwise exempt	NO, if less than 21 years of age YES for 21 years and older

3.2. Eligibility Standards and Methodologies

2) Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the 1115 Demonstration, to the extent those standards or methodologies differ from the State plan.

When determining whether an individual is eligible for the *Healthy Pennsylvania* Private Coverage Option, the Department will use the same process and system as well as apply the same financial eligibility standards and methodologies as in the Medicaid state plan.

Retroactive coverage will not be provided to those who enroll in the *Healthy Pennsylvania* Private Coverage Option. For those who enroll in the *Healthy Pennsylvania* Private Coverage Option, eligibility will be effective on the first day of private coverage plan enrollment. However, PCO enrollees determined presumptively eligible (PE) by a hospital provider will be eligible from the date of the PE application. FFS coverage will be provided from the date of application until the effective date of the PCO enrollment.

Because retroactive coverage will not be available under the Private Coverage Option, the Commonwealth would like to provide a transition period for new applicants who apply for and are eligible only for a category of assistance that is being eliminated under the *Healthy Pennsylvania* plan effective December 31, 2014. The Department will make every effort to assure appropriate coverage to individuals in categories being eliminated. This may mean eligible individuals may need to remain in a current eligibility category until they are transitioned to the Demonstration.

Premium Requirement

Currently, the Medicaid cost sharing structure does not provide positive incentives for healthy choices or personal responsibility. The *Healthy Pennsylvania* Medicaid reforms emphasize individual responsibility and improved health outcomes for the existing Medicaid adult population, similar to insurance coverage through the private health insurance market.

No premiums will be required in Demonstration Year 1.

Beginning in Demonstration Year 2, unless exempt, all adults with incomes greater than 100% FPL, age 21 and older and less than 65 years of age, will be required to pay a

monthly premium as a condition of continuing eligibility. These monthly premiums will replace the current copayments applicable in the Medicaid program. Premium changes based upon fluctuations in income or household composition will be adjusted at the annual redetermination, except if income decreases to a level that is below 100% FPL or increases above the eligibility income limit. The premiums are $25 (one adult) or $35 (household with more than one adult). The premiums required are described in *Section 4.9: Cost Sharing*. The following individuals are exempt from paying the premium:

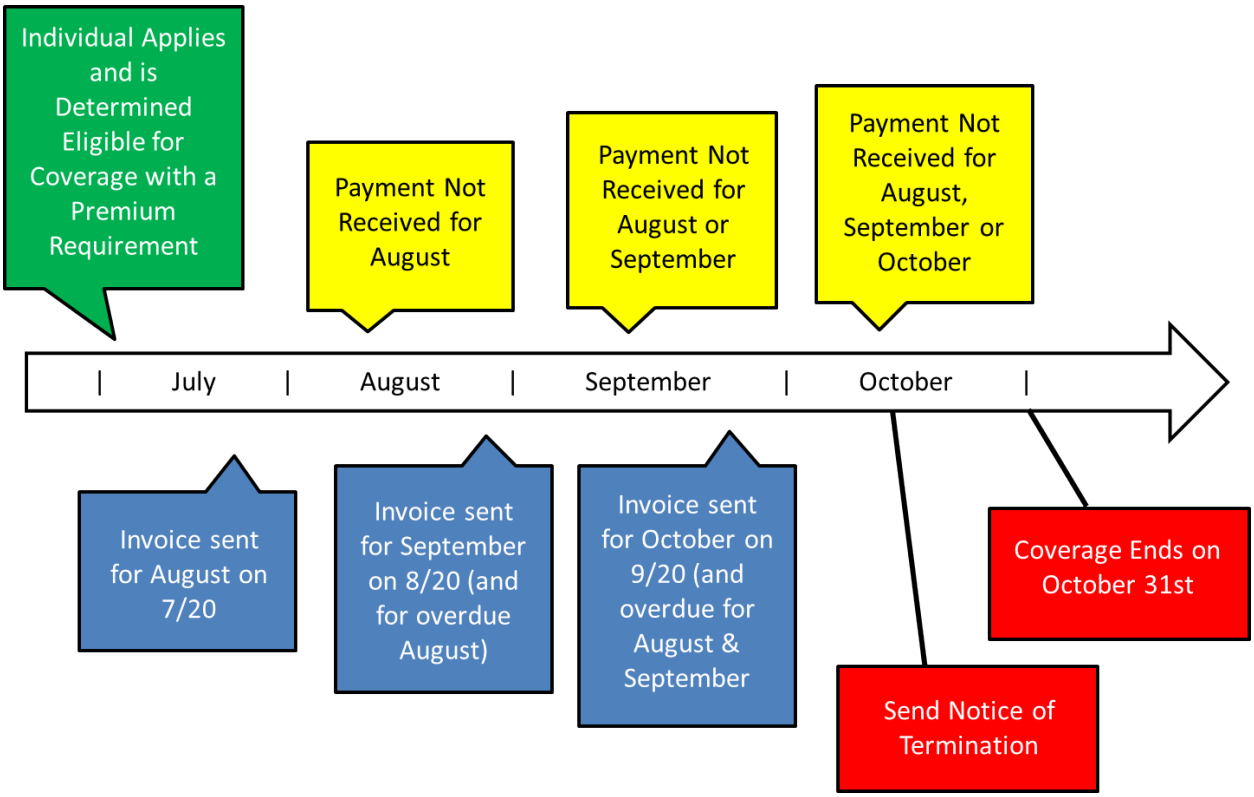
- Individuals with household income that does not exceed 100% FPL,
- Pregnant women (including the postpartum period),
- Individuals 65 years of age and older,
- Individuals under 21 years of age,
- SSI recipients and individuals deemed SSI eligible for purposes of Medicaid eligibility,
- Individuals who are dually eligible for Medicare and Medicaid, and
- Individuals who are institutionalized.

Premiums will be required to be paid a month in advance. Upon implementation of premiums, a new applicant subject to a premium will not be charged the first month's premium. Monthly premium invoices will be sent to participants.

Participants will be required to pay their premium by the date printed on the invoice. There will be a grace period after that date where the premium can still be accepted without affecting eligibility, except in situations described below.

Ineligibility for an adult or household will occur whenever an individual or household fails to pay the premium in full for three consecutive months by the end of the third month. For a new applicant, the first eligibility month will not require a premium, but if the eligible adult or household fails to pay their premium for the three subsequent months, the eligibility for the adult or adults will be terminated (see Figure 1 – Initial Premium Payment (Medicaid).

Figure 1. Initial Premium Payment (Medicaid)



In an ongoing case, if the individual whose eligibility has been reestablished fails to pay the premium for three consecutive months, there will be progressively longer periods of ineligibility.

The first time that an adult or the household fails to pay their premium for three consecutive months and eligibility is terminated, the adult or adults in the household will be ineligible for three months. After eligibility is reestablished, a second failure to pay the premium for three consecutive months will result in a six-month period of ineligibility. A third such failure will result in a nine-month period of ineligibility. Previously ineligible individuals who subsequently become exempt from premium payment due to a change in circumstances will be allowed to immediately re-enroll in the Medicaid program. Participants who pay premium arrears in full will regain eligibility on a prospective basis.

Encouraging Employment

Research has demonstrated that employed individuals are both physically and mentally healthier, as well as more financially stable. Under the Demonstration, the Department will require able-bodied adults to participate in the *Encouraging Employment* program as part of an integrated approach to improving their health and helping them move out of poverty. The *Encouraging Employment* program will begin in Demonstration Year 1.

- **Requirements**

  Unless exempt, all adults 21 years of age or older, who are working less than 20 hours per week, will be required to participate in the *Encouraging Employment* program as a condition of initial and continuing eligibility. The program includes registering with JobGateway[sm], the online system currently used for Pennsylvania's Unemployment Compensation program, and engaging in specified job training and employment-related activities on a monthly basis.

  As part of the application process, non-exempt Medicaid and *Healthy Pennsylvania* Private Coverage Option participants who are working, on average, less than 20 hours per week must register with JobGateway[sm]. Following application approval, participants must be actively engaged in either employment-related or job training activities on a monthly basis. Non-exempt participants who successfully complete, on average, 12 approved job training or employment-related activities per month during their first 12 months will continue to be eligible for health care coverage after the first year. The Department will leverage JobGateway[SM] and PA CareerLink® to connect these participants to employment opportunities and job training resources necessary for them to meet the requirements of the *Encouraging Employment* program.

  JobGateway[sm] provides participants with access to current job openings, the ability to create and upload a resume, and the ability to view job opening recommendations based on their preferences. JobGateway[SM] includes a mobile application allowing easy use for participants seeking jobs using a smart phone and a career exploration tool providing real time labor statistics for existing jobs. Participants will have access to training for job interviews and the ability to put that training into practice with virtual mock interviews. Participants may also wish to participate in job training and employment-related activities provided by PA CareerLink®, with core services being accessible either online or in person at 66 locations. Services include the ability to look for employment opportunities by

career, employer, and geography. Referrals are also available to other programs that may be capable of helping participants become gainfully employed.

Job training activities that can substitute for the employment engagement activities include participation in a federal workforce development program, on-the-job training, a full-time internship, and other activities approved by the Department.

- **Exemptions and Other Special Conditions**
  The following individuals are exempt from required participation in the *Encouraging Employment* program:

  - SSI recipients and individuals deemed SSI eligible for purposes of Medicaid eligibility,
  - Pregnant women (including the postpartum period),
  - Individuals 65 years of age and older,
  - Individuals under 21 years of age,
  - Individuals who are institutionalized, and
  - Individuals who are dually eligible for Medicare and Medicaid.

  Full-time and part-time students who work less than an average of 20 hours per week are required to complete the JobGateway[sm] registration portion of the *Encouraging Employment* program, but are exempt from participating in the job training and employment-related activities portion for each year they are enrolled in a postsecondary education institution or technical school. The Department will annually review a student's status. Registration with JobGateway[sm] and use of JobGateway[sm] will benefit students as they transition into the workforce.

  Due to the requirements of Temporary Assistance for Needy Families (TANF), individuals who are receiving TANF payments and completing their required work activities under the TANF program are deemed to have met their obligations under the *Encouraging Employment* program, if they are required to participate.

  Individuals may request from the Department an exemption from the required participation in the *Encouraging Employment* program if they are experiencing a crisis, serious medical condition, or temporary condition or situation that prevents

them from searching for work, such as domestic abuse or substance use disorder treatment.

- **Sanctions**
  JobGateway[sm] registration must be completed and will affect eligibility in Demonstration Year 1 and throughout the remainder of the Demonstration. The Department will require compliance with other aspects of the *Encouraging Employment* program requirements in Demonstration Year 1 to determine eligibility starting in Demonstration Year 2.

  Failure to meet the requirements of the *Encouraging Employment* program will result in a three-month period of ineligibility for Medicaid and *Healthy Pennsylvania* Private Coverage Option participants. However, although employment engagement activities will be required during Demonstration Year 1, except for failure to register with JobGateway[sm] , eligibility will not be terminated for failure to meet the requirements of the *Encouraging Employment* program during the first Demonstration Year. If during Demonstration Year 1, an individual completes an average of 12 job training and employment-related activities per month, eligibility can continue into Demonstration Year 2. If the participant does not complete the required employment engagement activities in Demonstration Year 1, then eligibility would cease at the start of Demonstration Year 2. Evaluation of on-going compliance will then occur at 6 month intervals thereafter.

  For an adult who re-establishes eligibility for Medicaid or the *Healthy Pennsylvania* Private Coverage Option and fails to meet the requirements of the *Encouraging Employment* program again, eligibility will be terminated for six months. If the individual fails to meet the requirements of the *Encouraging Employment* program a third time, eligibility will be terminated for a period of nine months.

  Previously ineligible individuals who subsequently become exempt from required participation in the *Encouraging Employment* program due to a change in circumstances will be allowed to immediately re-enroll in the *Healthy Pennsylvania* Private Coverage Option or the Medicaid program. Participants will receive reminders about the requirements of the *Encouraging Employment* program every three months. Beginning in Demonstration Year 2, the Department will review participant activities at the end of every six months, and if the activities are not completed, the participant will receive a notice of ineligibility.

3) **Specify any enrollment limits that apply for expansion populations under the 1115 Demonstration.**

There are no caps on enrollment in the Demonstration.

3.3. Projected Eligibility and Enrollment

1) **Provide the projected number of individuals who would be eligible for the 1115 Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid State plan, or populations covered using other waiver authority, such as 1915(c)). If applicable, please specify the size of the populations currently served in those programs.**

The Demonstration will cover all adults currently in the Medicaid program and newly eligible adults.

- Current adult populations: 1,091,000
- Newly eligible adults: More than 500,000

2) **To the extent that long term services and supports are furnished (either in institutions or the community), describe how the 1115 Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the 1115 Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State) (if additional space is needed, please supplement your answer with a Word attachment).**

Not Applicable

3) **Describe any changes in eligibility procedures the state will use for populations under the 1115 Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013) (if additional space is needed, please supplement your answer with a Word attachment).**

The State will utilize modified adjusted gross income (MAGI) methodologies for the newly eligible adult populations with incomes up to 133% FPL.

4) **If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014 (if additional space is needed, please supplement your answer with a Word attachment).**

The State will utilize modified adjusted gross income (MAGI) methodologies for the newly eligible adult populations with incomes up to 133% FPL.

4. 1115 Demonstration Benefits and Cost Sharing Requirements

1) **Indicate whether the benefits provided under the 1115 Demonstration differ from those provided under the Medicaid and/or CHIP State plan:**

__X__ Yes ____ No

2) **Indicate whether the cost sharing requirements under the 1115 Demonstration differ from those provided under the Medicaid and/or CHIP State plan:**

__X_ Yes ___ No

No for Demonstration Year 1 and Yes for Demonstration Year 2 through 5

4.1. Benefit Chart

3) **If changes are proposed, or if different benefit packages will apply to different eligibility groups affected by the 1115 Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the 1115 Demonstration:**

An integral part of the Demonstration is simplifying the outdated and complex existing benefit designs to two risk-tiered benefit plans for adults. The two adult Medicaid benefit plans, the Low Risk Benefit Plan and the High Risk Benefit Plan, will be offered through managed care plans delivered through the HealthChoices Program (populations excluded from HealthChoices participation will receive care through the traditional FFS program). For some limited populations, such as the dual eligible population, the physical health benefits will be delivered through the Department's FFS program.

The Demonstration population enrolled in the *Healthy Pennsylvania* Private Coverage Option will have access to private coverage plans which must provide the essential health benefits as required by the ACA.

The Department understands that those individuals who are currently eligible for Medicaid have varying health care needs. *Healthy Pennsylvania* benefits are designed based upon those needs and not a "one-size fits all" approach. Our current program has various benefit designs and the Department aims to simplify our approach and reduce

the complexity for our participants and for our providers. For these reasons, under this Demonstration:

- Children under 21 years of age and newly eligible adults ages 19 and 20 will be covered by the current health care package for children.
- Eligible individuals within the current Medicaid eligibility limits will receive coverage under a base benefit plan tailored to those with lower health care needs. This plan is referred to as the Low Risk Benefit Plan, which will be the benefits under the state plan.
- Those adults, 21 through 64 years of age, who are eligible under the current Medicaid eligibility limits and have more complex health care needs, when measured using the health screening or Department claims data, will be enrolled in the High Risk Benefit Plan.
- All SSI beneficiaries, pregnant women, individuals who are dually eligible for Medicare and Medicaid, residents of institutions, and individuals receiving home and community based services will be enrolled into the High Risk Benefit Plan.
- Those adults who are newly eligible, but are not determined to be medically frail, will only be eligible for the *Healthy Pennsylvania* Private Coverage Option and will be enrolled into a private market health insurance plan. *Healthy Pennsylvania* Private Coverage Option will pay for their monthly premiums and cost sharing for services provided by contracted providers as described in *Section 4.9: Cost Sharing*.
- Those adults who are newly eligible and determined through the health screening to be medically frail will be enrolled into the High Risk Benefit Plan with the option of selecting the Low Risk Benefit Plan.

Individuals enrolled in the *Healthy Pennsylvania* Private Coverage Option will receive the EHB package through their private coverage plan. The minimum EHB package for Pennsylvania is the benchmark package of covered services specified under 45 CFR §156.100(c) and 45 CFR §156.110, based on the package provided under the small group plan with the largest enrollment. Details on the EHB package in Pennsylvania are available on the web at: http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/pennsylvania-ehb-benchmark-plan.pdf

4.2. Social Security Act Section 1937 Alternative Benefit Plans

4) If electing benchmark-equivalent coverage for a population, please indicate which standard is being used:

___ Federal Employees Health Benefit Package
___ State Employee Coverage
___ Commercial Health Maintenance Organization
_X_ Secretary Approved

As described in *Section 4.1: Benefit Chart*, adults, 21 through 64 years of age, who are eligible under the current eligibility requirements of the Pennsylvania Medicaid program will have their health condition assessed using a health screening or Department's claim data. The outcome of that assessment will determine if they are provided with the Low Risk Benefit Plan or the High Risk Benefit Plan. All who qualify as high risk will be enrolled into the High Risk Benefit Plan, but will be given the choice of opting into the Low Risk Plan. The following adults will always be enrolled into the High Risk Benefit Plan:

- Individuals who are institutionalized,
- SSI recipients and individuals deemed SSI eligible for purposes of Medicaid eligibility,
- Enrolled in a home and community-based services program,
- Participating in Pennsylvania's PACE program LIFE (Living Independence for the Elderly), PACENET, and PACE Plus Medicare programs.
- Individuals who are dually eligible for Medicare and Medicaid, or
- Pregnant women (including post-partum period).

4.3. Covered Benefits

5) In addition to the Benefit Specifications and Qualifications form: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Benefit-Specifications-and-Provider-Qualifications.pdf, please complete the following chart if the 1115 Demonstration will provide benefits that differ from the Medicaid or CHIP State plan.

Table 3. Benefit Plan Comparison

Current Medical Assistance vs. Proposed Low Risk / High Risk

Services	Current Medical Assistance State Plan	Low Risk MA	High Risk MA
		Proposed	Proposed
Category 1: Ambulatory Services			
Primary Care Provider Visits / Immunizations	No limit	No limit	No limit
Routine Adult Visits*	18 visits per year (Combined with *)	12 visits per year (Combined with *)	18 visits per year (Combined with *)
Specialists Visits*			
Certified Registered Nurse Practitioner *			
Federally Qualified Health Center/Rural Health Clinic*			
Outpatient Clinic/Independent Clinic*			
Hearing Screening*			
Optometrist Services*		**NOT COVERED**	**NOT COVERED**
Podiatrist Services*		**NOT COVERED**	**NOT COVERED**
Chiropractor Services*		**NOT COVERED**	**NOT COVERED**

Services	Current Medical Assistance State Plan	Low Risk MA	High Risk MA
		Proposed	Proposed
Hospice Care	The only key limitation is related to respite care, which may not exceed a total of 5 days in a 60-day certification period.	The only key limitation is related to respite care, which may not exceed a total of 5 days in a 60-day certification period.	The only key limitation is related to respite care, which may not exceed a total of 5 days in a 60-day certification period.
Radiology (for example: X-Rays, MRIs, CTs)	No limits	6 tests	8 tests
Dentists	Diagnostic, preventive, restorative, and surgical dental procedures, prosthodontics and sedation. Key Limitations: Dentures 1 per lifetime, Exams/prophylaxis 1 per 180 days, Crowns, Periodontics and Endodontics only via approved benefit limit exception	Diagnostic, preventive, restorative, and surgical dental procedures, prosthodontics and sedation. Key Limitations: Dentures 1 per lifetime, Exams/prophylaxis 1 per 180 days, Crowns, Periodontics and Endodontics only via approved benefit limit exception	Diagnostic, preventive, restorative, and surgical dental procedures, prosthodontics and sedation. Key Limitations: Dentures 1 per lifetime, Exams/prophylaxis 1 per 180 days, Crowns, Periodontics and Endodontics only via approved benefit limit exception
Outpatient Surgery (SPU/ASC)	No limits	2 visits per year	4 visits per year
Non-Emergency Medical Transport	Only to and from MA covered services.	Only to and from MA covered services.	Only to and from MA covered services.
Family Planning Clinic	Current limits	Current limits	Current limits

Services	Current Medical Assistance State Plan	Low Risk MA	High Risk MA
		Proposed	Proposed
Renal Dialysis	Initial training for home dialysis is limited to 24 sessions per patient. Backup visits to the facility limited to no more than 15 per calendar year	Initial training for home dialysis is limited to 24 sessions per patient. Backup visits to the facility limited to no more than 15 per calendar year	Initial training for home dialysis is limited to 24 sessions per patient. Backup visits to the facility limited to no more than 15 per calendar year
Category 2: Emergency Services			
Emergency Room	No limits	No limits	No limits
Ambulance	No limits	No limits	No limits
Category 3: Hospitalization			
Inpatient Acute Hospital	No limits	2 non-emergency admits per year	3 non-emergency admits per year
Inpatient Rehab Hospital	1 admit per year	1 admit per year	2 admits per year
Inpatient Psychiatric Hospital	30 days per year	30 days per year	45 days per year
Inpatient Drug & Alcohol	No limits	30 days per year	45 days per year
Category 4: Maternity and Newborn			
Maternity – Physician, Certified Nurse Midwives, Birth Centers	No limits	No limits	No limits

Services	Current Medical Assistance State Plan	Low Risk MA Proposed	High Risk MA Proposed
Category 5: Mental Health and Substance Abuse (Behavioral Health)			
Outpatient Mental Health Treatment (Clinic): Includes Mobile Mental Health Treatment and Psych Clinic	Five hours or 10 one-half hour sessions of psychotherapy per recipient per 30 consecutive days.	30 visits per year	60 visits per year
Outpatient Drug and Alcohol Treatment	42 opiate detox visits per 365 days; three chemotherapy or drug-free visits per 30 days; eight hours total psychotherapy per 30 days.	• Opiate Detox: 42 visits per 365 days • Psychotherapy: 30 visits per year • Chemotherapy/Drug-free visits: 3 visits per 30 days	• Opiate Detox: 42 visits per 365 days • Psychotherapy: 60 visits per year • Chemotherapy/Drug-free visits: 3 visits per 30 days
Methadone Maintenance	One visit per day / 7 visits per week	One visit per day / 7 visits per week	One visit per day / 7 visits per week
Clozapine	Limited to persons with Schizophrenia	Limited to persons with Schizophrenia	Limited to persons with Schizophrenia
Psychiatric Partial Hospital	540 hours per year	540 hours per year	540 hours per year
Peer Support	No limits	4 hours per day / 900 hours per year	4 hours per day / 900 hours per year
Crisis	No limits	No limits	No limits
Targeted Case Management – Behavioral Health Only	Limited to persons with SMI diagnoses	**NOT COVERED**	Limited to persons with SMI diagnoses

Services	Current Medical Assistance State Plan	Low Risk MA	High Risk MA
		Proposed	Proposed
Category 6: Prescription Drugs			
Prescription Drugs	6 per month	6 per month	6 per month
Nutritional Supplements	No limits	No limits	No limits
Category 7: Rehabilitation and Habilitation Services and Devices			
Skilled Nursing Facility	No limits	120 days per year	365 days per year
Home Health Care	28 days unlimited; 15 days per month thereafter.	60 visits per year	Unlimited visits for 1st 28 days, Limited to 15 days per month thereafter
ICF/ID and ICF/ORC	No limits	**NOT COVERED**	365 days per year
Durable Medical Equipment (includes Orthotics and Prosthetics)	Orthotic devices limited to one pair every three years.	$1,000 per year	$2,500 per year
Medical Supplies	No limits	$1,000 per year	$2,500 per year
Therapy (Speech, Language, Hearing)	Only when provided by a hospital, outpatient clinic, or home health provider	Only when provided by a hospital, outpatient clinic, or home health provider	Only when provided by a hospital, outpatient clinic, or home health provider
Category 8: Laboratory Services			
Laboratory	No limits	$350 per year	$450 per year

Services	Current Medical Assistance State Plan	Low Risk MA	High Risk MA
		Proposed	Proposed
Category 9: Preventative / Wellness Services and Chronic Care			
Tobacco Cessation	70 per year	70 per year	70 per year

The Department will grant exceptions to the limits specified above when it determines that one of the following criteria applies:

- The participant has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of or result in the serious deterioration of the health of the recipient.
- Granting the exception is a cost effective alternative for the MA Program.
- Granting the exception is necessary in order to comply with federal law.

4.4. HEALTH SCREENING

Enrollment in the Medicaid benefit plans is based on a health screening of the individual or as determined based on analysis of Department claims data. The health screening for adults will be completed as part of an online application process in the Commonwealth's COMPASS system. Health screening will be part of a seamless continuation of the eligibility process. Paper questionnaires will be available in cases where electronic application submittal is not possible. The Consumer Service Center will be used to facilitate the health screening process for those needing assistance.

The health screening will consist of a self-administered questionnaire that is completed by the individual, family member, guardian, or with the assistance of a COMPASS community partner. The questionnaire includes questions about an individual's health care needs and conditions. The questions are specifically designed to identify an individual's medical and behavioral health needs that align with the two Medicaid benefit plans—particularly any presence of complex medical conditions. The responses will be analyzed by an algorithmic process, which will allow the Department to match the applicant's health care needs to the benefit plan that best serves those needs.

Participants eligible for traditional Medicaid will be enrolled in the Low Risk Benefit Plan or the High Risk Benefit Plan based on the results of the health screening and eligibility status. For individuals eligible for the *Healthy Pennsylvania* Private Coverage Option, the health screening will be used to determine if they are medically frail.

The goal of this health screening is to align health care needs to the appropriate health care plan while still maintaining continued coverage and a safety net for the Commonwealth's vulnerable populations. The health screening aligns benefit plans to actual participant health care needs rather than using a system that bases benefit decisions on broad categories of eligibility. It also ensures provision of critical care to Pennsylvanians most in need, while still increasing the financial stability of the Medicaid program.

Completion of the health screening is not a condition of eligibility. If applicants eligible for the *Healthy Pennsylvania* Private Coverage Option fail to complete the health screening, they will be enrolled into a *Healthy Pennsylvania* Private Coverage Option plan. If individuals who are eligible under the current Medicaid eligibility rules fail to complete the health screening, they will be enrolled into the Low Risk Benefit Plan.

Most adult participants will be screened at initial application and at their annual redetermination. Where possible, the Department will use claims data to assist in determining the appropriate benefit plan for current eligible individuals.

All requirements set forth in Section 1937 of the Social Security Act will be met in this Demonstration, including, but not limited to, ensuring that all individuals determined to be medically frail, as well as individuals in other Alternative Benefit Plan-exempt populations identified in Section 1937 of the Social Security Act, will be given the option to receive services through the Low Risk Benefit Plan. SSI and deemed SSI individuals do not need to be screened for the High Risk Benefit Plan, because they are deemed by their category to be High Risk. As such they are enrolled into the High Risk Benefit Plan.

Once an individual is determined to be eligible for *Healthy Pennsylvania* and their health screening results are determined, they will receive a notice indicating whether they qualify for the Low Risk Benefit Plan, the High Risk Benefit Plan, or the *Healthy Pennsylvania* Private Coverage Option. (Refer to Appendix 2, Enrollment Flow Chart)

4.5. Medically Frail

Under the *Healthy Pennsylvania* Private Coverage Option, newly eligible individuals who are determined to be medically frail will be enrolled in the High Risk Benefit Plan with the ability to choose the Low Risk Benefit Plan, both offered through HealthChoices managed care plans.

Individuals will be determined to be medically frail if they have a condition based upon one or more of the following:

- A disabling mental disorder.
- An active chronic substance use disorder.
- A serious and complex medical condition.
- A physical, intellectual, or developmental disability that significantly impairs their functioning.
- A determination of disability based on Social Security Administration criteria.

Appendix 3 contains more detailed criteria that will be used in the determination of who meets the definition of medically frail.

Medically frail adults who do not otherwise meet exemption criteria are subject to premium and other cost sharing obligations and participation in the *Encouraging Employment* program as described in *Section 3.2 Eligibility Standards and Methodology* and in *Section 4.9 Cost Sharing*.

4.6. Appeals

For appeals relating to determinations of eligibility decisions and plan placement, *Healthy Pennsylvania* Private Coverage Option participants must use the Department's appeal process. For appeals relating to coverage determinations and provider access decisions, *Healthy Pennsylvania* Private Coverage Option participants must go through their private coverage plans appeals process. Private coverage plans must comply with all ACA and Commonwealth standards governing review of insurance coverage appeals. Unless and until the Commonwealth is determined by the federal Department of Health and Human Services (HHS) to have a satisfactory external appeal process, appeals of adverse benefit determinations will be processed as outlined in the July 29, 2011 letter from HHS to Pennsylvania Insurance Commissioner Consedine and the joint notice of

the Pennsylvania Insurance Department and Department of Health, Notice 11/2254, 41 Pa. B. 7041 (12/31/11). Both of these documents may be accessed at http://www.portal.state.pa.us/portal/server.pt/community/health_insurance/9189/federal_health_reform_-_2011_key_dates/1070488 . Insofar as any plan is subject to the standards in Act 1998-68, the requirements of that act are found in Appendix 4.

4.7. Long Term Services and Supports Coverage

6) Indicate whether Long Term Services and Supports will be provided.

___ Yes (if yes, please check the services that are being offered) _X_ No

No long term services and supports or personal care will change under the Demonstration. Pennsylvania will continue to provide long term services and supports, including the LIFE program (Pennsylvania's PACE program) under the existing approved §1915(c) or §1934 authorities.

The provisions of the *Healthy Pennsylvania* plan articulated in this Demonstration are built on three core objectives – reform Medicaid, increase access, and stabilize funding. As part of meeting these objectives, Pennsylvania is looking to improve its current long term care system, which is not easy for older adults and individuals with physical disabilities to navigate. Governor Corbett has issued an Executive Order to convene the Pennsylvania Long-Term Care Commission to review and make recommendations to the Governor on how to improve the current system – these recommendations will be in alignment with the Demonstration's core objectives. Pennsylvania will seek any necessary federal approvals to address changes necessary to implement recommendations.

In addition, please complete the: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-LTSS-Benefits.pdf, and the: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Long-Term-Services-Benefit-Specifications-and-Provider-Qualifications.pdf

- ☐ **Homemaker**
- ☐ **Case Management**
- ☐ **Adult Day Health Services**

- ☐ **Habilitation – Supported Employment**
- ☐ **Habilitation – Day Habilitation**
- ☐ **Habilitation – Other Habilitative**
- ☐ **Respite**
- ☐ **Psychosocial Rehabilitation**
- ☐ **Environmental Modifications (Home Accessibility Adaptations)**
- ☐ **Non-Medical Transportation**
- ☐ **Home Delivered Meals Personal**
- ☐ **Emergency Response**
- ☐ **Community Transition Services**
- ☐ **Day Supports (non-habilitative)**
- ☐ **Supported Living Arrangements**
- ☐ **Assisted Living**
- ☐ **Home Health Aide**
- ☐ **Personal Care Services**
- ☐ **Habilitation – Residential Habilitation**
- ☐ **Habilitation – Pre-Vocational**
- ☐ **Habilitation – Education (non-IDEA Services)**
- ☐ **Day Treatment (mental health service)**
- ☐ **Clinic Services**
- ☐ **Vehicle Modifications**
- ☐ **Special Medical Equipment (minor assistive devices)**
- ☐ **Assistive Technology**
- ☐ **Nursing Services**
- ☐ **Adult Foster Care**
- ☐ **Supported Employment**
- ☐ **Private Duty Nursing**
- ☐ **Adult Companion Services**
- ☐ **Supports for Consumer Direction/Participant Directed Goods and Services**
- ☐ **Other (please describe)**

4.8. Premium Assistance for Employer-Sponsored Coverage

7) Indicate whether premium assistance for employer-sponsored coverage will be available through the 1115 Demonstration.

_X_ Yes (if yes, please address the questions below)

__ No (if no, please skip this question)

a) Describe whether the state currently operates a premium assistance program and under which authority, and whether the state is modifying its existing program or creating a new program.

Pennsylvania currently operates a successful premium assistance program, the Health Insurance Premium Payment (HIPP) program. It is operated under section 1906 of the Social Security Act. The Commonwealth is seeking to modify its current program for the newly eligible population, minus all Medicaid wraparound coverage.

b) Include the minimum employer contribution amount.

There is no minimum employer contribution.

c) Describe whether the Demonstration will provide wrap-around benefits and cost- sharing.

Under the Demonstration for newly eligible individuals, Pennsylvania will not provide wraparound benefits beyond what is provided by the private market health insurance plans or Qualified Health Plans (QHP) consistent with the Essential Health Benefits package. As in-network covered services, the private market health insurance plans or QHPs will be required to provide participants access to Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) as described in subparagraphs (B) and (C) of section 1905(a).

Healthy Pennsylvania Private Coverage Option will cover the cost sharing for in-network services. In-network services are those obtained from providers who have a contract with the private market health insurers offering the private market health plans or QHPs. Providers without a contract with the private market health insurer offering the private market health insurance plan or QHP serving the participant are considered out-of-network.

In accordance with federal and state law, private market health insurance plans, which include QHPs, must cover emergency services and out-of-network care when Act 1998-68 access standards are not met. Some private market health insurance plans and QHPs may cover additional out-of-network services. In

these instances, *Healthy Pennsylvania* Private Coverage Option will not cover cost sharing for other services provided by out-of-network providers.

d) Indicate how the cost effectiveness test will be met.

When the Department identifies that a participant has ESC, the following calculation will be completed:

1. Identify participants covered by employer sponsored coverage according to age (in years):
   - Under age 1 year,
   - Age 1 through 20 years, and
   - Age 21 through 64 years.

2. Retrieve the plan rates for *Healthy Pennsylvania* Private Coverage Option comparison or the physical and behavioral health managed care organization (MCO) rates for the medically frail.
3. Validate the Medicaid costs via the plan respectively for the participant.
4. Adjust rates, if applicable, based upon age group.
5. Calculate annual premium amount by multiplying the premium amount by a factor based on premium frequency.
6. Calculate policy deductible and copayment amount.
7. Validate the final calculation (for newly eligible participant).
   - Total private market health insurance plans or QHP cost is equal to private market health insurance plans or QHP costs for selected recipient plus deductible and copayment amounts[8].
   - Total ESC cost is equal to the ESC annual premium, the policy deductible and the supplemental cost.
   - Annual cost effectiveness amount is equal to the total private market health insurance plans or QHP cost minus the total ESC cost.

[8] Note. For medically frail, the calculation would be similar using the existing HIPP cost effectiveness tests against the MCO costs less wraparound services

4.9. COST SHARING

In Demonstration Year 1, participant cost sharing obligations under the Demonstration will be identical to those under the state plan for all Medicaid eligible adults and *Healthy Pennsylvania* Private Coverage Option participants who are not exempt from copayments under the state plan.

During Demonstration Year 1, all copayments will be paid to the provider. The provider may deny service for participants with incomes greater than 100% FPL for failure to pay the copayment.

Starting in Demonstration Year 2, a $10 copayment for non-emergent use of the ER will be implemented for all Medicaid eligible adults and *Healthy Pennsylvania* Private Coverage Option participants without regard to income.

In Demonstration Year 2, the Department will evaluate data on participant copayment compliance and consider changes to support incentives and personal responsibility. This could include changes in copayment amounts, implementing a nominal premium, and/or making premium or copayment payments and participating in *Encouraging Employment* as a condition of eligibility.

Starting in Demonstration Year 2, copayments will not be paid to the provider. The copayments will be billed monthly and paid to the Commonwealth.

Beginning in Demonstration Year 2, Medicaid eligible adults and *Healthy Pennsylvania* Private Coverage Option participants with incomes greater than 100% FPL will not be required to pay copayments, with the exception of the $10 copayment required for the non-emergent use of the ER. These Medicaid eligible adults and *Healthy Pennsylvania* Private Coverage Option participants will be required to pay a nominal monthly premium.

Healthy Pennsylvania Private Coverage Option will cover the cost sharing for in-network services beyond what non-exempt participants are required to pay in accordance with the state plan. In-network services are those obtained from providers who have a contract with the private market health insurers offering the private market health plans or QHPs. Providers without a contract with the private market health insurer offering

the private market health insurance plan or QHP serving the participant are considered out-of-network.

In accordance with federal and state law, private market health insurance plans, which include QHPs, must cover emergency services and out-of-network care when Act 1998-68 access standards are not met. Some private market health insurance plans may cover additional out-of-network services. In these instances, *Healthy Pennsylvania* Private Coverage Option will not cover cost sharing for other services provided by out-of-network providers.

Premium payments and other cost sharing will be limited to 5% of income for all Demonstration households for all years.

Premium and Copayment Reductions

The Demonstration looks to incentivize healthy behaviors, including providing an opportunity for individuals who engage in healthy behaviors and employment engagement activities, by offering the opportunity to reduce the monthly premium and potentially copayments or receive other positive incentives developed by the Department. Fulfilling healthy behaviors (having an annual wellness visit, paying copayments, and completing employment engagement activities) in Demonstration Year 1 may result in cost sharing reductions in Demonstration Year 2. Similar incentives will continue throughout the life of the Demonstration.

During Demonstration Year 1, participants with incomes no greater than 100% FPL will have financial contributions limited to copayments as currently outlined in the state plan. Starting in Demonstration Year 2, these participants will continue to be subject to a financial contribution, unless exempt. However, based on information gathered in the first year of the Demonstration, the Commonwealth will consider establishing a different cost sharing structure and a list of key activities in which a participant may participate during their enrollment period, such as completing health risk assessments, preventive services, annual wellness visits, meet premium or cost sharing obligations, or other activities related to employment or health promotion and disease prevention that may influence the level of cost sharing required. Successful completion of healthy behavior activities can reduce the premium or copayment obligation and employment engagement activities can also reduce the premium or copayment obligation.

The Commonwealth may evaluate Health Risk Assessment (HRA) data and determine additional healthy behaviors that could be used, such as cholesterol testing. The Demonstration application seeks flexibility and authority to change or expand the list of healthy behaviors for which premium and copayment reductions are available.

Premium amounts and other cost sharing obligations will be set annually, but evaluated for revision every 6 months starting in Demonstration Year 2. If the participant successfully completes the required activities in the first 6-month period, then the premium and other cost sharing obligations will be reduced in the second 6-month period. These 6-month cycles will continue throughout the span of enrollment. Credit for timely payment of the full premium and other cost sharing obligations will be applied when a participant's change in income results in moving above or below 100% FPL.

8) If different from the State plan, provide the premium amounts by eligibility group and income level.

The premiums are structured as $25 (one adult) or $35 (household with more than one adult) at the maximum threshold of 133% FPL as follows:

Table 4. *Healthy Pennsylvania* Premiums

Federal Poverty Level	Monthly Premium for Household with One Adult	Monthly premium for Household with More Than One Adult
0%-100%	Not Applicable	Not Applicable
>100%–133%	$ 25	$ 35

These FPL figures are for calendar year 2014. The FPL is adjusted annually; therefore, the eligibility income levels will be updated each year for that year's applicable FPL, with annual incomes determined using the Modified Adjusted Gross Income (MAGI) methodology. The premiums will be adjusted annually by the inflationary increase in the medical care component of the Consumer Price Index (CPI-U).

4.10.

PARTICIPANT COPAYMENTS AND DEDUCTIBLES

9) Include a table if the Demonstration will require copayments, coinsurance and/or deductibles that differ from the Medicaid State plan (an example is provided):

In Demonstration Year 1, all adults, who are at least 18 years old and enrolled in the Low Risk Benefit Plan or High Risk Benefit Plan or the *Healthy Pennsylvania* Private Coverage Option, will pay copayments as described in the state plan.

Beginning in Demonstration Year 2, all adults, who are at least 21 years old and enrolled in the Low Risk Benefit Plan or High Risk Benefit Plan or the *Healthy Pennsylvania* Private Coverage Option, and whose income is greater than 100% FPL will pay a monthly premium, unless they meet one of the specified exemptions as described in *Section 4.11: Participant Exemptions*.

In Demonstration Year 2, the Department will evaluate data on participant copayment compliance and consider changes to support incentives and personal responsibility. This could include changes in copayment amounts, implementing a nominal premium, and/or making premium payment and participating in *Encouraging Employment* as a condition of eligibility.

Beginning in Demonstration Year 2 all adults, who are at least age 18, will be responsible for a $10 copayment for non-emergent use of an emergency room, except as described in *Section 4.11: Participant Exemptions*.

Table 5. *Healthy Pennsylvania* Copayments that Differ from the State Plan

Service	Copayment
Non-emergent Use of Emergency Room	**$10 per visit**

4.11. PARTICIPANT EXEMPTIONS

10) Indicate if there are any exemptions from the proposed cost sharing.

All Medicaid recipients under the age of 18 and those residing in an institution are exempt from the $10 copayment for non-emergent use of the emergency room.

In all demonstration years, all adults who are at least 18 years old and enrolled in the Low Risk Benefit Plan or High Risk Benefit Plan or the *Healthy Pennsylvania* Private Coverage Option will be responsible for copayments unless they meet an exemption as described in the state plan.

Beginning in Demonstration Year 2, the following individuals are exempt from paying the premium:

- Individuals with household income that does not exceed 100% FPL,
- Pregnant women (including the postpartum period),
- Individuals 65 years of age and older,
- Individuals under 21 years of age,
- SSI recipients and individuals deemed SSI eligible for purposes of Medicaid eligibility,
- Individuals who are dually eligible for Medicare and Medicaid, and
- Individuals who are institutionalized.

5. Delivery System and Payment Rates for Services

5.1. Delivery System Reforms

1) **Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan:**

   _X_ Yes

   ___ No

2) **Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system. Specifically, include information on the proposed Demonstration's expected impact on quality, access, cost of care and potential to improve the health status of the populations covered by the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms.**

   The delivery system reforms that will occur as a result of the Demonstration will improve access, ensure quality, and create increased affordability in Pennsylvania's health care system.

   In terms of access, the *Healthy Pennsylvania* Private Coverage Option program will increase health care coverage access to uninsured adult Pennsylvanians with incomes up to 133% FPL by using premium assistance to purchase a private market health insurance plan offered in the FFM, the private health insurance market or through ESC. Purchase of private health insurance coverage may allow *Healthy Pennsylvania* Private Coverage Option participants to maintain their same health plan and providers as their income fluctuates, promoting continuity of coverage, and reducing churn between Medicaid and private market health insurance.

   The Demonstration will also improve *Healthy Pennsylvania* Private Coverage Option participants' access to care by increasing the number of in-network providers. Pennsylvania Medicaid provides payment rates for some services that are lower than Medicare or private market payers, causing some providers to forego participation in the program. Through use of private market health insurers, this Demonstration will seek to increase provider access.

In terms of quality, the *Healthy Pennsylvania* Private Coverage Option participants will be enrolled in private plans, which are held to federal and state required quality, benefit, and network standards. This ensures Demonstration participants will have access to quality care and robust provider networks. In addition, by adding over half a million individuals to private market health plans' enrollment rosters, the Demonstration dramatically expands the number of individuals who have access to primary care providers. Coupled with incentives to improve personal responsibility, this will improve health status and patient satisfaction, increase the use of preventive and appropriate care, and reduce uncompensated care costs.

The Demonstration is expected to encourage carrier entry, competitive pricing in the private market, and expand service areas. This in turn enables the private health plans to better leverage economies of scale to drive down premium pricing, which increases value in the health care system for all Pennsylvanians.

Taken together, the factors described above will improve quality, promote access, and reduce costs statewide. As a result, all Pennsylvanians will benefit from improved quality and reduced costs.

Information on which populations and geographic areas will be affected by the reforms is detailed in the sections below.

5.2. Delivery System Type

3) Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes:

- ☐ **Managed care**
  - ☐ **Managed Care Organization (MCO)**
  - ☐ **Prepaid Inpatient Health Plans (PIHP)**
  - ☐ **Prepaid Ambulatory Health Plans (PAHP)**
- ☐ **Fee-for-service (including Integrated Care Models) Primary Care Case Management (PCCM)**
- ☐ **Health Homes**
- ☒ **Other (please describe)**

For *Healthy Pennsylvania* Private Coverage Option participants, the Commonwealth will use premium assistance to purchase private health insurance coverage offered in the FFM, the private health insurance market, or through ESC. As explained in earlier sections, this approach will help reduce churn, improve access to providers, improve health outcomes, and stabilize financing for Pennsylvania taxpayers.

Each *Healthy Pennsylvania* Private Coverage Option participant will choose between at least two health plans offered in the private market or, if available, receive coverage from an ESC plan. Pennsylvania's existing private health insurance market and private coverage plans through the FFM together provide a broad variety of private market delivery system options and robust benefit packages. This approach is consistent with *Healthy Pennsylvania's* goal of using the Private Coverage Option to help reduce churn and increase continuity of care. *Healthy Pennsylvania* Private Coverage Option participants will have cost sharing obligations consistent with the reformed cost sharing approach proposed in this Demonstration (see *Section 4.9 – Cost Sharing*).

While not part of the waiver request, Pennsylvania will concurrently operate its HealthChoices program that uses a managed care delivery system. The HealthChoices benefit offering will be modified as described in *Section 4.3: Covered Benefits*, but there are no plans to modify the delivery system as part of this project. Certain populations will also continue to be served through the traditional FFS delivery system.

4) If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration (an example is provided). Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently authorized under the State plan, section 1915(a) option, section 1915(b) or section 1932 option:

Table 6. Delivery System Chart

Eligibility Group	Delivery System	Authority
New adults, who are not parents or caretaker relatives, 21 through 64 years of age, who are not medically frail with income up to 133% FPL.	*Healthy Pennsylvania* Private Coverage Option through (a) Qualified Health Plans (QHPs) in the Individual Market in Federal Facilitated Marketplace (FFM), (b) private health insurance market, or (c) private health plans in ESC	s. 1115 Waiver
New adults, who are parents or caretaker relatives, 21 through 64 years of age, who are not medically frail, who have income greater than 33% FPL, but no greater than 133% FPL.		
Adults, who are parents or caretaker relatives, individuals 21 through 64 years of age, who are qualified as medically frail or are currently covered by the current Pennsylvania Medicaid program (excluding MAWD, SelectPlan, and GA)	HealthChoices Physical and Behavioral Health Managed Care (MCO)	s. 1915(b)
Children, ages 19 and 20, who are newly eligible with incomes greater than 44% FPL but no greater than 133% FPL		

5.3. Managed Care Delivery System

5) If the Demonstration will utilize a managed care delivery system:

The Demonstration uses premium assistance to purchase private health insurance coverage from (a) private market health insurance plans offered in the FFM, or (b) other

private plans in the private health insurance market, or (c) ESC. The delivery systems, including robust provider networks, serving *Healthy Pennsylvania* Private Coverage Option participants will, therefore, be the same serving these plans' other members.

Medicaid managed care plans and pre-paid inpatient health plans will continue to be used to provide physical health and behavioral health services for the HealthChoices populations under the mandatory managed care authority provided through the current HealthChoices Section 1915(b) waiver.

While the Department does not initially foresee the need to use Medicaid managed care regulations, it is evaluating the applicability of the regulations for the Demonstration.

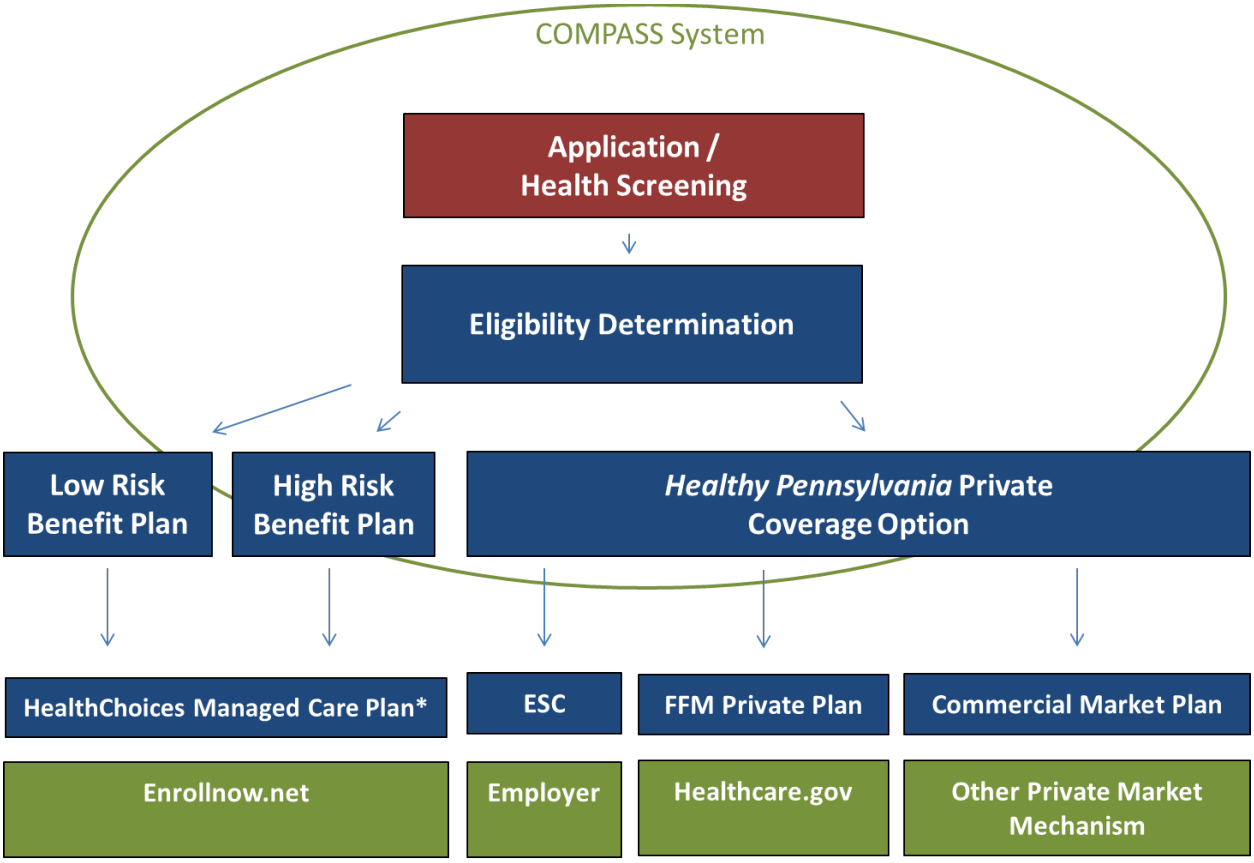
Responses are offered to the questions below to provide additional detail and context for the proposal and how it intersects with the Commonwealth's existing Medicaid managed care programs.

a. Indicate whether enrollment be voluntary or mandatory. If mandatory, is the state proposing to exempt and/or exclude populations?

Enrollment into the *Healthy Pennsylvania* Private Coverage Option will be mandatory for individuals eligible for the *Healthy Pennsylvania* Private Coverage Option, except for those who are determined to be medically frail and other exempt groups. Medically frail newly eligible adults will be enrolled in the High Risk Benefit Plan and may choose to receive services through the Low Risk Plan. Both the High Risk Benefit Plan and the Low Risk Plan will be delivered through the Commonwealth's FFS and HealthChoices Program.

If eligible for the *Healthy Pennsylvania* Private Coverage Option, the individual will enroll with a private market health insurance plan. The enrollment may be through (a) the FFM's eligibility and enrollment system, or (b) other private market enrollment mechanism, or (c) through the purchase of ESC. Eligible individuals will be informed of their private coverage plan choices and instructed on how to select their private market health insurance plan. Pennsylvania will also remind participants of their choices via their renewal notice and provide them the opportunity to change their private market health insurance plan at re-enrollment.

Figure 2. Benefit Plan Enrollment Process



*Populations excluded from HealthChoices participation will receive care through the traditional Medicaid FFS program.

a) Indicate whether managed care will be statewide, or will operate in specific areas of the state.

The Demonstration will be statewide.

b) Indicate whether there will be a phased-in rollout of managed care (if managed care is not currently in operation or in specific geographic areas of the state).

There will not be a phased-in rollout. It is proposed that the Demonstration will begin statewide on January 1, 2015.

c) Describe how the state will assure choice of MCOs, access to care and provider network adequacy.

The *Healthy Pennsylvania* Private Coverage Option participants will be able to choose from at least two health plans offered in the private health insurance market or, if available, from ESC offered by the participant's employer. *Healthy Pennsylvania* Private Coverage Option participants without access to ESC will be permitted to choose among all private plans offered in their geographic area, with the choice of at least two private market health plans.

All private market health insurance plans must meet Act 68 network adequacy and access to care standards (see Appendix 4). In addition, for private market health insurance plans that are certified as a QHP, Pennsylvania will rely on the FFM to evaluate network adequacy as part of the federal private health insurance coverage plan certification process, which includes assuring compliance with Essential Community Provider network requirements. The inclusion of FQHCs/RHCs in *Healthy Pennsylvania* Private Coverage Option networks will help to assure compliance. As a result, *Healthy Pennsylvania* Private Coverage Option participants will have access to the same networks as other Pennsylvanians who purchase coverage in the private health insurance market. This complies with the requirement under section 1902(a)(30)(A) of the Social Security Act that Medicaid eligible individuals have access to care comparable to the care of the general population in the same geographic area.

Under the *Healthy Pennsylvania* Private Coverage Option, participants will use the private market health insurance plan's appeals process for all coverage and provider access decisions, consistent with existing federal and state requirements. Pennsylvania's Medicaid appeals process will be used for all eligibility decisions, including decisions related to the payment of required financial contributions. For more information on the appeals process and Act 68, see *Section 4.6 Appeals* and Appendix 4.

HealthChoices managed care plans that provide services to Demonstration participants will be governed by the same choice, access, and provider network rules and policies established in that program.

d) Describe how the managed care providers will be selected/procured

Private market health insurance plans offered through the FFM will be selected through the FFM's regular certification process. As needed to ensure choice and competition, health plans offered through the private health insurance market that are not already participating in the FFM will be selected through a procurement process consistent with the Commonwealth Procurement Code, 62 Pa.C.S, to evaluate their qualifications. As noted above, *Healthy Pennsylvania* Private Coverage Option participants who do not have access to an ESC plan will be able to choose among private market health insurance plans available in their geographic region.

In future years of the Demonstration, the Commonwealth will review private market health insurer competition and premiums. The Commonwealth may develop more selective criteria for private market health insurance plan participation for the *Healthy Pennsylvania* Private Coverage Option to ensure both participant choice and cost effective purchasing that meets the terms and conditions of this waiver.

HealthChoices managed care plans that provide services to Demonstration participants will be governed by the same selection and procurement policies and rules established in that program.

Agreements with Healthy Pennsylvania Private Coverage Option Health Plans

To facilitate the administration of the *Healthy Pennsylvania* Private Coverage Option and the provision of health care services by the private plans, the Department will enter into agreements with: (a) the FFM and private market health insurance plans offered through the FFM, (b) other private market plans, or (c) employers covering participants enrolled through ESC. The following describes each of these agreements:

Private Market Health Insurance Plans in the FFM:

- CMS and the Center for Consumer Information and Insurance Oversight (CCIIO), in its capacity as the operator of the FFM in Pennsylvania, will exercise its authority at 42 USC § 18021(a)(1)(C)(iv) to establish an

additional requirement for selected QHPs participating in the FFM to execute the necessary agreement with the Department.

- FFM/CMS/CCIIO and the Department will agree on the language outlining the standards, responsibilities, and requirements of each party within 60 days following waiver approval.
- The agreement between the Department and each private market health insurance plan will address, for example:
    - Enrollment and disenrollment of individuals in populations covered by the Demonstration;
    - Premium assistance payments and cost sharing reductions;
    - Collection of participants' share of premiums;
    - Data and reporting requirements necessary for federal claiming;
    - Data and reporting requirements necessary to monitor and evaluate the *Healthy Pennsylvania* Private Coverage Option;
    - Handling of participant rights, grievances, and appeals;
    - Program integrity and auditing requirements; and
    - Coordination with the Department and other requirements to facilitate the *Healthy Pennsylvania* Private Coverage Option.

Private Market Health Insurance Plans:

- After selecting private market health insurance plans through a procurement process consistent with the Commonwealth Procurement Code, 62 Pa.C.S, the Department will execute an agreement with each private market health insurer.
- The agreement between the Department and each private market health insurer will address, for example:
    - Enrollment and disenrollment of individuals in populations covered by the Demonstration;
    - Premium assistance payment and cost sharing reductions;
    - Collection of participants' share of premiums;
    - Data and reporting requirements necessary for federal claiming;
    - Data and reporting requirements necessary to monitor and evaluate the *Healthy Pennsylvania* Private Coverage Option;
    - Handling of participant rights, grievances, and appeals;
    - Program integrity and auditing requirements; and

- Coordination with the Department and other requirements to facilitate the *Healthy Pennsylvania* Private Coverage Option.

Employer Sponsored Coverage:

- The Department will execute agreements with employers covering ESC participants. The agreement between the Department and each employer will address, for example:
  - Enrollment and disenrollment of employees covered by the Demonstration;
  - Premium assistance payment and cost sharing reductions; and
  - Other provisions relevant to operation and monitoring of the ESC.

***Healthy Pennsylvania* Private Coverage Option Selection and Payment**

The Department will determine individuals' eligibility for premium assistance under the *Healthy Pennsylvania* Private Coverage Option and notify the FFM, private market health insurance plan, or employer covering an ESC participant. The Department will administer annual re-determinations. FFM applicants will be pre-screened for *Healthy Pennsylvania* Private Coverage Option eligibility in the same way as potential Medicaid/CHIP eligible individuals and referred to the Department for eligibility determination.

Eligible adults will go directly to the FFM website, or Plan Selection Entity to assist with private health insurance market, or employer for ESC participants to arrange for health insurance coverage using their approved premium assistance amount. To be enrolled in a *Healthy Pennsylvania* Private Coverage Option and become eligible for premium assistance, an affirmative choice of a private market health insurance plan must be made.

For individuals who select a private market health insurance plan through the FFM or private health insurance market between the first and fifteenth day of a month, private market health insurance coverage will become effective as of the first day of the month following plan selection. For individuals who select a plan between the sixteenth and last day of a month, coverage will become effective no later than the first day of the second month following plan selection. These rules are consistent with the current HealthChoices managed care and coverage

rules and the process used by the FFM. The effective date of the ESC plan will be determined by the employer and the employer's health plan.

5.4. Services Outside the Proposed Delivery System

6) Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion.

Wrap-Around Benefits

With the exception of FQHC/RHC services, Medicaid wraparound benefits will not be provided for individuals receiving premium assistance to purchase coverage under the *Healthy Pennsylvania* Private Coverage Option. The Department has requested waivers for all wraparound services, including non-emergency transportation and family planning services (to the extent such services are not covered under the private plan). However, as noted above, private health plans in the Private Coverage Option will be required to cover the services of FQHCs/RHCs on an in-network basis, with reimbursement at the Medicaid determined Prospective Payment System (PPS) rate. Due to the federal EHB requirement, it is assumed that all other benefits potentially subject to wrap-around services are provided sufficiently through *Healthy Pennsylvania* Private Coverage Option plans.

Medically frail new adults will be enrolled into the High Risk Benefit Plan. Individuals who are 19 or 20 years of age will be able to obtain coverage in the current children's plan and will receive all medically necessary services in accordance with the Medicaid Early and Periodic, Screening, Diagnosis and Treatment provisions, even though they are included in the Demonstration.

Retroactive Coverage

Pennsylvania will not provide retroactive coverage for the *Healthy Pennsylvania* Private Coverage Option. The coverage effective date will be determined by the enrollment date in the private market health insurance plan with the exception of PCO enrollees determined presumptively eligible (PE) by a hospital provider. Eligible PE PCO participants will be eligible from the date of the PE application. Fee-for-service coverage will be provided from the date of application until the effective date of the PCO enrollment.

Out-of-Network Services

Healthy Pennsylvania Private Coverage Option will cover the cost sharing for in-network services. In-network services are those obtained from providers who have a contract with the private market health insurers offering the private market health insurance plans or QHPs. Providers without a contract with the private market health insurer offering the private market health insurance plan or QHP serving the participant are considered out-of-network.

Similar to the current HealthChoices program, private market health insurance plans must cover emergency services and services provided by out-of-network providers when required under 31 Pa. Code §§ 154.14 and 154.15 (relating to emergency services and continuity of care). Some private market health insurance plans may cover additional out-of-network services. In these instances, *Healthy Pennsylvania* Private Coverage Option will not cover cost sharing for other services provided by out-of-network providers. All out-of-network deductibles, copayments, coinsurance, penalties, and the difference between the out-of-network provider's charge and the amount paid by the private market health insurance plan will be the individual's responsibility.

5.5. Provision for Long Term Services and Supports

7) If the Demonstration will provide personal care and/or long term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available, and also provide additional information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration

___ Yes
_X_ No

The Demonstration will not change current long term services and supports or personal care.

The provisions of the *Healthy Pennsylvania* plan articulated in this Demonstration are built on three core objectives – reform Medicaid, increase access, and stabilize funding. As part of meeting these objectives, Pennsylvania is looking to improve its current long term care system, which is fragmented and not easy for older adults and

individuals with physical disabilities to navigate. Governor Corbett has issued an Executive Order to convene the Pennsylvania Long Term Care Commission to review and make recommendations to the Governor on how to improve the current system – these recommendations will be in alignment with the Demonstration's core objectives. Pennsylvania will seek any necessary federal approvals to address changes necessary to implement recommendations.

5.6. Fee-For-Service

8) If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under the State plan, please specify the rate methodology.

With the exception of FQHCs/RHCs being reimbursed at their Medicaid PPS rate, providers will be reimbursed for covered services provided to *Healthy Pennsylvania* Private Coverage Option participants at the rates providers negotiate with the respective private market health insurer. Any payment for a participant under the Medicaid program will be made in accordance with Pennsylvania's approved state plan.

5.7. Capitation Payments

9) If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438.

The rate setting methodology for private market health insurance plans serving *Healthy Pennsylvania* Private Coverage Option participants in the Demonstration will be the same used for other populations served in the private health insurance market. Private market health insurance plans serving *Healthy Pennsylvania* Private Coverage Option participants in the Demonstration will be paid premium assistance for the private market health insurance plan in an amount equal to the premium and eligible cost sharing components combined with the private market health insurance plan's Essential Health Benefit (EHB) package, less the amount of the participant's own copayments in Demonstration Year 1. The Department will collect the cost sharing obligations in Demonstration Year 2 and beyond, therefore, in Demonstration Year 2, there will be no reduction in capitation rates for the plans based on the participant's copayments.

Payment to employers for ESC will be made in accordance with the existing ESC program, which is based on the employer's commercial insurance cost, included benefits, and deductible amounts.

Any impact to cost sharing or benefits for HealthChoices participants will be addressed via modification to HealthChoices capitation rates. The Department will continue to use its existing HealthChoices rate setting process.

5.8. Quality-Based Supplemental Payments

10) If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected.

Recognizing that health care will continue to evolve, the Department will seek to promote an environment that permits the development of innovative payment models. This direction continues to reinforce Governor Corbett's *Healthy Pennsylvania* plan of increasing access to quality, affordable health care for all Pennsylvanians.

As part of the *Healthy Pennsylvania* plan, the Commonwealth submitted a State Innovation Plan to CMS in December 2013. This proposed State Healthcare Innovation Plan (Innovation Plan) puts Pennsylvania on a strong path to reform Pennsylvania's health care payment and delivery system in a way that will encourage quality health care practice and promote healthy living among Pennsylvanians, while taking quantitative measures to lower health care costs.

The Commonwealth will work with stakeholders and CMS to implement the Innovation Plan and will submit a waiver amendment as necessary. Funding and operational protocols will be developed and are subject to CMS review and approval.

The Innovation Plan seeks to:

Implement payment reform. Consistent with the direction of commercial insurers, the plan proposes a shift from a current inflationary payment system that rewards volume to one that rewards efficiency and quality. Two priority payment models, Accountable Provider Organizations (APOs) and Patient-Centered Medical Homes (PCMHs), with a

specific focus on providing intensive care management services to high-risk consumers, and a third pilot model, Episodes of Care (EOCs), are recommended in the plan.

Support providers to transform care delivery. A Healthcare Transformation Support Center (Transformation Support Center) will be created to provide training courses, offer on-site technical assistance and link practices with community resources. The Transformation Support Center's formation will allow for the dissemination of best practices throughout the state and provide instruction on how to engage in practice transformation.

Improve health information technology and data usage. Quality measurement is imperative to promoting accountability and informing consumer choice. The proposed plan calls for APOs and PCMHs to report common quality measures from their electronic health records to the Pennsylvania Health Care Cost Containment Council (PHC4), which will aggregate the data and make the information available to providers, insurers and consumers. Providers will use the data to inform performance improvement; insurers will use the data for accountability and to modify payment, as needed; consumers will use the data to inform provider choice.

Expand telemedicine. Telemedicine plays a critical role in bringing high quality health care to underserved and rural areas by bringing patients and specialists from our world-class health networks closer together through the use of technology, while lowering costs. An expansion of telemedicine "spokes" will provide additional specialty consultation services in outpatient (e.g., telepsychiatry) and inpatient settings (e.g., burn and stroke assessment services) throughout the state. The plan also proposes more extensive educational and training programs for clinicians and providers.

Develop a stronger work force. Innovations in care delivery and an expansion of coverage require an adequate supply of primary care and behavioral health providers as well as new workforce skills. To help meet these goals, the plan proposes an enhanced loan forgiveness program for primary care and behavioral health clinicians (physician and non-physician) and for dentists; more robust medical home training through the Transformation Support Center; a redesign of medical school curriculum to train providers in evidence-based, team-based delivery models; and the creation of the Pennsylvania Health Learning Network using the telemedicine infrastructure.

Strengthen public health programs. Improving the health of Pennsylvania starts in our communities. The proposed plan supports health efforts that engage individuals in their communities and promote healthy choices through initiatives such as the development

of a community health improvement plan and implementation of improvements through the state's ten county and municipal-based health departments and local health improvement coalitions; supporting the *Healthy Pennsylvania* health literacy initiative through Pennsylvania's Family Place Libraries, and utilizing technology to map chronic disease incidence to improve prevention and self-management of chronic conditions.

In addition to the innovation plan, Pennsylvania Medicaid proposes development of a *Healthy Pennsylvania* Safety Net Pool (*HPA*-SNP). The Commonwealth will work with stakeholders and CMS to develop the *HPA*-SNP and will submit a waiver amendment to implement *HPA*-SNP. Funding and operational protocols will be developed and are subject to CMS review and approval.

Conceptually, the *HPA*-SNP will include an Uncompensated Care Pool (*HPA*-UCP) and/or Delivery System Reform Incentive Pool (*HPA*-DSRIP) to make specific payments to providers implementing health care reforms that embody the goals of Governor Corbett's *Healthy Pennsylvania* plan and are consistent with and support the innovation plan.

Federal funds, unspent DSH allotment funds, DSH funds discontinued under the Demonstration, provider tax revenue, and additional savings that may be realized from moving the newly eligible population to the *Healthy Pennsylvania* Private Coverage Option may be used to fund the pools. The *HPA*-DSRIP program will be developed in consideration of Pennsylvania's State Innovation Model (SIM) grant application, but will not duplicate payments made under the State Innovation Model (SIM) grant program.

HPA-DSRIP pool funds may also be awarded to guarantee that safety net hospitals, physician practice plans in underserved areas, and other providers provide sufficient access to Medicaid eligible individuals and the newly insured population.

6. Implementation of Demonstration

6.1. Implementation Schedule

1) Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone.

Contingent on federal approval, the *Healthy Pennsylvania* Demonstration will begin January 1, 2015.

6.2. Enrollment

2) Describe how potential Demonstration participants will be notified/enrolled into the Demonstration.

Notices

Upon determination of eligibility for Medicaid or the *Healthy Pennsylvania* Private Coverage Option, participants will receive a notice from the Department advising them of the following:

- *Premiums and Cost Sharing:* For Demonstration Year 1, the notice will advise participants with incomes over 100% FPL that providers can refuse to provide treatment for non-payment of copayments and a description of financial responsibility for out-of-network services. For Demonstration Year 2, the notice will include a description of the premium requirement and process for those with income over 100% FPL, a description of the $10 copayment for non-emergent use of an emergency room, and a description of financial responsibility for out-of-network services and any changes to cost sharing for those under 100% FPL.

- *Healthy Behavior Incentives:* The notice will include a description of the incentives for healthy behaviors that are expected from the participant in order to reduce the monthly premium.

- *Encouraging Employment.* The notice will include a description of the *Encouraging Employment* program (See *Section 3.2 Eligibility Standards and Methodology*) in which participation is required to maintain eligibility, unless otherwise exempt, and how participants receive the incentives offered under the program.

- *Appeals.* The notice will also include information regarding the grievance and appeals process. Specifically, the notice will inform *Healthy Pennsylvania* Private Coverage Option participants that, for all services covered by the private market health insurance plan or ESC plan, the participant should begin by filing a grievance or appeal pursuant to the private market health insurance plan's or ESC's grievance and appeals process. This is described in greater detail in *Section 4.6 Appeals*.

For *Healthy Pennsylvania* Private Coverage Option participants, the following additional language will be included:

- *Private Coverage Plan Selection.* The notice will include information regarding how *Healthy Pennsylvania* Private Coverage Option participants can select a private market health insurance plan, including information on the Department's auto-enrollment process in the event that the participant does not select a plan.

- *Exemption from the* Healthy Pennsylvania *Private Coverage Option.* The notice will include information describing how *Healthy Pennsylvania* Private Coverage Option participants who believe they may be exempt from premium assistance provided through the private market health insurance plan, including pregnant women (including the postpartum period), and the medically frail, can request a determination of whether they are eligible for the High Risk Benefit Plan or Low Risk Benefit Plan. Participants determined exempt from the Healthy Pennsylvania Private Coverage Option are placed in the High Risk Benefit Plan or may choose to select the Low Risk Benefit Plan. The notice will include information on the difference in benefits under the High Risk Benefit Plan as compared to the Low Risk Benefit Plan. The exemption process is described in *Section 4.5: Medically Frail*.

For Low Risk Benefit Plan and High Risk Benefit Plan participants, the following additional language will be included:

- *Low Risk Benefit Plan participants only.* The notice will include information regarding their eligibility for the Low Risk Benefit Plan, as well as enrollment information.

- *High Risk Benefit Plan participants only.* The notice will include information regarding their eligibility for the High Risk Benefit Plan, as well as their option in selecting the Low Risk Benefit Plan.

Enrollment

Individuals eligible for private market health insurance plan enrollment through the *Healthy Pennsylvania* Private Coverage Option will begin to enroll through the following process:

- Individuals will submit a single application for insurance affordability programs—Medicaid and the *Healthy Pennsylvania* Private Coverage Option— through the web portal, via phone, by mail, or in-person.

- The individual will then complete the participant health screening.

- An eligibility determination will be made.

- Individuals who are determined eligible to receive coverage through the *Healthy Pennsylvania* Private Coverage Option will enter an eligibility/enrollment system to shop among private market health insurance plans available to *Healthy Pennsylvania* Private Coverage Option eligible individuals and to select a plan.

- The Medicaid Management Information System (MMIS) will capture the plan selection information and will transmit the 834 enrollment transactions to the private market health insurance plans.

- Private market health insurance plans will issue insurance cards to *Healthy Pennsylvania* Private Coverage Option participants

- MMIS will pay premiums on behalf of participants directly to the private market health insurance plans.

- MMIS premium payments will continue until the individual is determined to no longer be eligible, the individual selects different private market health insurance coverage during the next open enrollment period, or the individual is determined to be medically frail and is enrolled in the High Risk Benefit Plan.

- In the event that an individual is determined eligible for coverage through the *Healthy Pennsylvania* Private Coverage Option, but does not select a plan, the Department will auto-assign the individual to one of the private market health insurance plans available in that individual's geographic area.

- Individuals who are required to pay a premium will be sent invoices as described in *Section 3.2 Eligibility Standards and Methodology*.

- Individuals who are required to participate in the *Encouraging Employment* program will be monitored as described in *Section 3.2 Eligibility Standards and Methodology*.

6.3. MANAGED CARE

3) If applicable, describe how the state will contract with managed care organizations to provide Demonstration benefits, including whether the state needs to conduct a procurement action.

Private market health insurance plans offered through the FFM will be selected through the FFM's regular certification process. As needed to ensure choice and competition, health plans offered through the private health insurance market that are not already participating in the FFM will be selected through a procurement process consistent with the Commonwealth Procurement Code, 62 Pa.C.S. to evaluate their qualifications.

Pennsylvania Medicaid will enter into an agreement with the plans to outline functions such as, but not limited to, the process for verifying plan enrollment and paying premiums. Under the terms of the agreement, the QHP or private market health insurance plan will be provided a roster of its participants who are *Healthy Pennsylvania* Private Coverage Option participants. The Commonwealth will verify that the individuals listed on the roster are *Healthy Pennsylvania* Private Coverage Option participants. The MMIS will then transmit payment for premiums to the QHP or private market health insurance plan. See *Section 5.3: Managed Care Delivery System* for more detail.

7. Demonstration Financing and Budget Neutrality

This section presents the Commonwealth's approach for showing budget neutrality, including the data and assumptions used in the development of the cost and caseload estimates supporting this 1115 waiver request. The ability to show budget neutrality is important to the Commonwealth as a major tenet in the Healthy Pennsylvania demonstration is to develop a program that provides affordable access to quality healthcare for Pennsylvanians that has long-term sustainability. Initiatives that succeed in creating both effective and efficient programs allow for more effective management while pursuing innovations to enhance access to quality care in Medicaid and to pursue delivery options that utilize evolving market-based solutions in care delivery.

7.1. Demonstration Time Period

The Healthy Pennsylvania demonstration is proposed to begin on January 1, 2015 and operate for a five-year demonstration term. The five-year term of the demonstration project would cover Calendar Years (CYs) 2015 through 2019 (a portion of Federal Fiscal Year 2015 (FFY 2015) through a portion of FFY 2020). The time periods for the five-year demonstration period are detailed in the table below:

Table 7. Demonstration Year (DY) Time Periods

	DY 1	DY 2	DY 3	DY 4	DY 5
Time Period	1/1/15 – 12/31/15	1/1/16 – 12/31/16	1/1/17 – 12/31/17	1/1/18 – 12/31/18	1/1/19 – 12/31/19

7.2. Historical Medicaid Expenditures

The most recent and complete data available to support the development of cost and caseload projections was State Fiscal Year (SFY) 07/08 (July 1, 2007 – June 30, 2008) through SFY 11/12 (July 1, 2011 – June 30, 2012). SFY 11/12 was chosen as the base year throughout the cost and caseload projections. The following table presents historical program funding and caseload for SFY 07/08 through SFY 11/12.

Table 8. Historical Data - Total Computable

	SFY 07/08 (7/1/2007-6/30/2008)	SFY 08/09 (7/1/2008-6/30/2009)	SFY 09/10 (7/1/2009-6/30/2010)	SFY 10/11 (7/1/2010-6/30/2011)	SFY 11/12 (7/1/2011-6/30/2012)	3-Years
TANF Adults						
TOTAL EXPENDITURES						
Eligible Member Months	2,759,582	2,781,399	2,808,391	2,928,333	2,946,167	
Total Cost per Eligible	$ 328.69	$ 327.20	$ 315.68	$ 353.69	$ 344.23	
Total Expenditure	$ 907,051,899	$ 910,061,968	$ 886,557,350	$ 1,035,727,706	$ 1,014,153,791	$ 2,936,438,846
						3-YEAR
TREND RATES			ANNUAL CHANGE			AVERAGE
Eligible Member Months		0.8%	1.0%	4.3%	0.6%	2.4%
Total Cost per Eligible		-0.5%	-3.5%	12.0%	-2.7%	4.4%
Total Expenditure		0.3%	-2.6%	16.8%	-2.1%	7.0%
SSI-Like Adults						
TOTAL EXPENDITURES						
Eligible Member Months	557,605	638,272	735,949	828,857	883,031	
Total Cost per Eligible	$ 1,038.24	$ 1,047.72	$ 978.21	$ 1,110.77	$ 1,126.83	
Total Expenditure	$ 578,929,968	$ 668,732,790	$ 719,911,168	$ 920,667,125	$ 995,026,432	$ 2,635,604,725
						3-YEAR
TREND RATES			ANNUAL CHANGE			AVERAGE
Eligible Member Months		14.5%	15.3%	12.6%	6.5%	9.5%
Total Cost per Eligible		0.9%	-6.6%	13.6%	1.4%	7.3%
Total Expenditure		15.5%	7.7%	27.9%	8.1%	17.6%

All Title XIX medical expenditures (unless specifically identified within this application as being excluded) are proposed to be included under the demonstration. The following individuals are proposed to be excluded from the demonstration's budget neutrality agreement:

- Children (under age 21; including individuals in the New Adult Group ages 19-20)
- Pregnant women
- All individuals dually eligible for Medicare and Medicaid
- Individuals eligible through the Breast and Cervical Cancer Prevention and Treatment Program
- Individuals receiving Supplemental Security Income (SSI) and individuals deemed eligible for purposes of Medicaid eligibility
- Individuals who are institutionalized

The following expenditures are not included in this demonstration's budget neutrality agreement:

- Long term care supports and services, including Section 1915(c) home and community based waiver expenditures and LIFE Program (Pennsylvania's PACE program)
- Graduate Medical Education expenditures
- Administrative expenditures

Disproportionate Share Hospital (DSH) expenditures and DSRIP projections have not yet been included in the budget neutrality model.

7.3. Budget Neutrality Approach

This section provides background information about the methods and data sources used to develop the proposed 1115 waiver budget neutrality model. The Commonwealth is proposing that the budget neutrality limit for Federal Title XIX funding be determined using a per capita cost method. The risk for the per capita cost would be applicable to the individuals in the eligibility groups (EGs) described below, but the Commonwealth would not be at risk for conditions (economic or other) that may impact caseload levels in each of the EGs for the demonstration years.

The per capita cost projections for the Private Option and Medically Frail EGs were developed without historical experience data in Medicaid, as these EGs correspond to newly eligible adults. As such, the projected per capita cost may underestimate the actual costs of these participants once actual experience occurs. The Commonwealth is requesting the flexibility to adjust the per capita budget neutrality limit based on actual program experience.

7.4. ELIGIBILITY GROUPS

The proposed eligibility groups (EGs) that would be subject to per capita cost budget neutrality are identified in the table below.

Table 9. Eligibility Groups (EGs)

Eligibility Group	Description	Waiver Population Type
Private Option New Adults	Individuals eligible through the New Adult Group up to 138% FPL and enrolled in the Private Option	State Plan
Medically Frail New Adults	Individuals eligible through the New Adult Group up to 138% FPL and enrolled in HealthChoices	State Plan
TANF Adults-High Risk	Individuals 21+ who enroll in the High-Risk Benefit Plan , are subject to requirements of the Demonstration and are: • Parents/Caretaker Relatives	State Plan
TANF Adults-Low Risk	Individuals 21+ who enroll in the Low-Risk Benefit Plan, are subject to requirements of the Demonstration and are: • Parents/Caretaker Relatives	State Plan

Eligibility Group	Description	Waiver Population Type
SSI-Like Adults	Individuals described at 1902(a)(10)(A)(ii)(VI) (special income group below 300% FPL and at 1902(a)(10)(A)(ii)(X), 1902(m)(1) (low-income disabled adults unless otherwise exempt from waiver initiatives) subject to the requirements of the Demonstration	State Plan

7.5. Base Data Adjustments

SFY 11/12 was selected as the base data year for developing cost and caseload estimates. Based upon the historical capitation data and FFS claims data the following adjustments were applied to the SFY 11/12 base data year.

Adjustment to HealthChoices Physical Health Capitation Rates to Reflect Only Adults

In the historical capitation data, the HealthChoices Physical Health (PH) capitation rates for TANF and SSI were established for a combined Adult and Child population. Recently, some PH capitation rating groups were modified as a result of other eligibility changes to develop separate rating groups for Adults and Children. This change is not reflected in the historical data. Because the Healthy PA 1115 waiver only covers Adults, the most recent capitation rate development work was reviewed to adjust the SFY 11/12 PH capitation rates to represent an Adult-specific "rate."

HealthChoices SSI PH rates continue to be set across all Adults and Children. For the SSI-like Adults EG, it was determined that no adjustment to the PH SSI rate was necessary to reflect the SSI-like Adult individuals included in the 1115 waiver.

Adjustment to Health Choices TANF Capitation Rates to Reflect Low Risk and High Risk EGs

The base capitation, FFS claims and enrollment data were initially summarized in accordance with the current 1915(b) waiver eligibility groups (TANF or SSI) for Traditional State plan populations and benefits. However, the waiver proposes two

separate EGs for the TANF Adults: one for High Risk and one for Low Risk to recognize that TANF Adults will screen as either Medicaid High Risk or Medicaid Low Risk through the Commonwealth's new screening process. The results of this screening will determine which benefit package an individual receives. For the portion of the TANF Adults that screens as Medicaid High Risk, there could be a significant per capita cost difference when compared to the overall, adjusted TANF rates calculated to reflect only Adults. Based on historical utilization and expenditure data, an adjustment was made to estimate costs for the "TANF Adult-High Risk" and "TANF Adult-Low Risk" EGs.

Other Program Changes

As part of the base year development, all other program changes that were adjusted for in either the most recent 1915(b) waiver submission or recent capitation rate certifications for both the PH and BH HealthChoices programs were reviewed. Based upon this review, it was determined that no additional adjustments were necessary.

Affordable Care Act

The following provisions of the Affordable Care Act have not been incorporated into budget neutrality as described below:

- Expenditures do not include the Section 1202 Primary Care Increase as the Commonwealth does not intend to continue the PCP increase beyond CY2014.
- Expenditures do not include the impact of the Section 9010 Health Insurer Provider Fee as it is not yet possible to estimate the impact to the Commonwealth.
- Expenditures associated with additional periods of eligibility that result from implementation of Hospital Presumptive Eligibility are not included since this was implemented on January 1, 2014 and there is insufficient experience to estimate the impact to the Commonwealth.

7.6. Development of With Waiver (WW) Projections

Traditional State Plan Populations

The TANF Adults - Low Risk EG expenditures reflect all TANF-related individuals that are projected to receive the Medicaid Low Risk Benefit Plan, the TANF Adults - High Risk EG expenditures reflect all TANF-related adults that are projected to receive the new Medicaid High Risk Benefit Plan, and the SSI-Like expenditures reflect expenditures for these adults all of which are projected to receive the new Medicaid High Risk Benefit

Plan. The following adjustments were made to this base data to as part of the WW projection in order to reflect the demonstration initiatives:

- *Adjustment for Healthy Pennsylvania premiums and cost sharing:* An adjustment was made to all three Traditional State Plan EGs to account for the $10 copayment on non-emergent visits to the Emergency Department (ED). An adjustment was also made for these EGs to reflect an expectation that individuals would receive incentives for healthy behaviors and employment engagement activities and have reduced cost sharing as a result.
- *Benefit package changes:* A downward adjustment was made to the historical data for the SSI-like Adults EG to reflect the impact of the benefit package reform initiatives.

New Adult Participants

The 1115 demonstration initiatives also apply to the Private Option and Medically Frail new adult participants. Since there are no historical Medicaid expenditures for this group, the development of WW projections requires a projection of expenditures for the delivery systems proposed in the Healthy PA 1115 waiver. The following is a description of the basis for projections related to the two New Adult EGs, as well as the adjustments made for the demonstration initiatives.

Medically Frail New Adults

The base data summarized for the SSI-like Adults was used as a proxy for base data for the Medically Frail New Adults EG. The following additional adjustments were made to this assumed base data to develop the WW projection:

- *Adjustment for Healthy PA premiums and cost:* The base data for the SSI-like Adults reflects the impact of current State plan copayments and therefore, no adjustment was necessary for DY1. For DY2 and beyond, an adjustment was made to reflect the addition of a $10 copayment for non-emergent use of the ED. Starting in DY2, an adjustment was also made to reflect a shift from State plan copayments to premiums for those at or above 100% FPL. An adjustment was also made to this EG to reflect an expectation that participants would receive incentives as a result of healthy behaviors and employment engagement activities and have reduced cost sharing as a result.

- *Benefit package changes:* Consistent with the adjustment made to the SSI-like Adults EG, a downward adjustment was applied to reflect the impact of the benefit package reform initiatives.

Private Option New Adults

The base data used to develop the projection for the Private Option New Adults EG was an estimated average silver-level Qualified Health Plan (QHP) premium within the Commonwealth, as available through the Federally-Facilitated Marketplace (FFM). In addition to the QHP premium, the base data includes the participant cost sharing of these QHP products that will be the Commonwealth's responsibility. Wraparound costs reflecting the expected FQHC/RHC reimbursement to the PPS were also included. The following adjustments were applied to calculate the projections for the Private Option New Adults EG:

- *Adjustment for Healthy PA premiums and cost sharing in DY1*: While the insurance products available on the FFM would likely have various levels of copayments, coinsurance, and other cost sharing more reflective of arrangements typical to commercial insurances, participants would only be responsible for the current State plan copayments in DY1. An adjustment was made to the Private Option New Adults EG expenditures in Year 1 to account for State plan copayments.
- *Adjustment for Healthy PA premiums and cost sharing in DY2 and beyond*: It is assumed that participants under 100% FPL would continue to be responsible for the current state plan copayments, in addition to a $10 copayment for non-emergent use of the ED. Participants at or above 100% FPL would be responsible for the proposed Healthy PA premiums and the $10 copayment for non-emergent use of the ED. An adjustment was also made to this EG to reflect an expectation that participants would receive incentives for healthy behaviors and employment engagement activities and have reduced cost sharing as a result.

Table 10. With Waiver Projected Results - Total Computable

ELIGIBILITY GROUP	Demonstration Years (DY)					TOTAL
	DY 01 Final	DY 02 Final	DY 03 Final	DY 04 Final	DY 05 Final	With Waiver
TANF Adults - High Risk						
Eligible Member Months		397,942	409,880	422,176	434,842	
Total Cost Per Eligible		$ 2,918.03	$ 3,095.16	$ 3,283.03	$ 3,482.31	
Total Expenditure		$ 1,161,207,628	$ 1,268,643,719	$ 1,386,019,905	$ 1,514,255,852	$ 5,330,127,105
TANF Adults - Low Risk						
Eligible Member Months		3,638,110	3,747,253	3,859,671	3,975,461	
Total Cost Per Eligible		$ 530.12	$ 553.55	$ 578.02	$ 603.57	
Total Expenditure		$ 1,928,639,566	$ 2,074,301,998	$ 2,230,965,730	$ 2,399,461,648	$ 8,633,368,942
SSI - Like Adults						
Eligible Member Months		1,042,417	1,073,690	1,105,901	1,139,078	
Total Cost Per Eligible		$ 1,461.40	$ 1,550.10	$ 1,644.19	$ 1,744.00	
Total Expenditure		$ 1,523,384,378	$ 1,664,329,424	$ 1,818,314,847	$ 1,986,547,155	$ 6,992,575,805
Medically Frail New Adults						
Eligible Member Months	2,081,434	2,143,877	2,208,193	2,274,439	2,342,672	
Total Cost Per Eligible	$ 1,327.89	$ 1,403.34	$ 1,474.87	$ 1,550.06	$ 1,629.08	
Total Expenditure	$ 2,763,908,439	$ 3,008,585,970	$ 3,256,805,693	$ 3,525,510,989	$ 3,816,392,534	$ 16,371,203,625
Private Option New Adults						
Eligible Member Months	5,677,763	5,848,096	6,023,539	6,204,245	6,390,373	
Total Cost Per Eligible	$ 460.05	$ 483.96	$ 508.75	$ 534.81	$ 562.19	
Total Expenditure	$ 2,612,044,586	$ 2,830,248,269	$ 3,064,502,626	$ 3,318,089,995	$ 3,592,605,929	$ 15,417,491,404

7.7. The Commonwealth's Section 1915(b) HealthChoices Waiver

As noted in this application, the Commonwealth intends to maintain the current HealthChoices mandatory managed care delivery system and intends to maintain the Section 1915(b) authority for the purpose of authorizing mandatory managed care. As such, DPW is requesting to be exempt from the Section 1915(b) "cost-effectiveness" requirement (and corresponding financial reporting under the 1915(b) waiver) to the extent that the same expenditure is subject to the 1115 budget neutrality agreement. DPW proposes to work with CMS to achieve alignment between the EGs in the final 1115 budget neutrality agreement and the 1915(b) waiver in order to achieve this goal.

Summary of Budget Neutrality

The Commonwealth's proposed initiatives to expand access through market-based health care solutions and reform the current Medicaid program will result in a demonstration program that meets the federal requirement for budget neutrality and is sustainable for the future.

8. List of Proposed Waivers and Expenditure Authorities

1) Provide a list of proposed waivers and expenditure authorities.

Federal Waiver and Expenditure Authorities Requested

To the extent necessary to implement the proposal, the Demonstration application requests that CMS, under the authority of section 1115(a)(1) of the Social Security Act (42 U.S.C.A. § 1315), waive the following requirements of Title XIX of the Social Security Act (42 U.S.C.A. § 1396) to enable the Department to implement the *Healthy Pennsylvania* plan:

Table 11. Waiver Requests

Waiver Authority	Use for Waiver	Reason for Waiver Request
§ 1902(a)(10) (42U.S.C.A. § 1396a(a)(10))	To permit the Commonwealth to deny eligibility for up to nine months to otherwise eligible individuals who fail to meet the requirements of the *Encouraging Employment* program.	This waiver authority will allow the Commonwealth to instill a sense of personal responsibility into the program, encourage employment, and provide incentives for healthier behaviors.
§ 1902(a)(10) (42 U.S.C.A. § 1396a(a)(10))	To enable the Commonwealth to deny eligibility for up to 9 months to otherwise eligible individuals who fail to comply with premium payment requirements.	This waiver authority will allow the Commonwealth to instill a sense of personal responsibility into the program and reinforce incentives for healthier behaviors.
§ 1902(a)(10) (42 U.S.C.A. § 1396a(a)(10)(B))	To permit the Commonwealth to provide benefits which are different in amount, duration and scope.	This waiver authority will allow the Commonwealth to design alternate benefit packages that are more aligned with the needs of the individuals who use them across and within eligibility groups. It will also provide the medically frail options that better fit their needs.

Waiver Authority	Use for Waiver	Reason for Waiver Request
§ 1902(a)(10)(A) (42 U.S.C.A. § 1396a(a)(10)(B))	To enable the Commonwealth to provide coverage for the newly eligible population on the date of enrollment in the *Healthy Pennsylvania* Private Coverage Option.	This waiver authority will allow the Commonwealth to provide eligibility for the newly eligible population effective on the date of enrollment in a Qualified Health Plan.
§ 1902(a)(10) (42 U.S.C.A. § 1396a(a)(10)(B))	To enable the Commonwealth to provide medically needy coverage to institutionalized blind and disabled individuals.	This waiver authority will allow blind or disabled individuals with incomes above 133% FPL to be enrolled in a QHP while still providing institution coverage through Medicaid for those above the State's special income level.
1902(a)(10)(a)(i)(IX)(42 U.S.C.A. § 1396a(a)(10)(A)(i)(IX))	To permit the Commonwealth to charge premiums for non-exempt individuals and to require participation in the *Encouraging Employment* program for former Foster Care recipients 21 years of age or older but under 26 years of age.	This waiver authority, allows the Commonwealth to require premiums and job training and employment-related activities of those former Foster Care recipients, 21 years of age or older but under 26 years of age, in order to provide equitable treatment with other adults of the same age.
§ 1902(a)(10)(C) (42 U.S.C.A. § 1396a(a)(10)(C))	To enable the Commonwealth to eliminate the Medically Needy optional group for adults who are disabled or blind, but retain it for individuals who are 65 years of age and older.	This waiver authority will allow the Commonwealth to eliminate the complexity of the Medically Needy optional coverage group and the income 'spend down' and allow this group to become part of the newly eligible population.
§ 1902(a)(14) (42 U.S.C.A. § 1396a(a)(14)	To permit the Commonwealth to charge ER copayments in amount that exceeds the maximum allowed under regulation, without regard to the requirements of 1916(f).	This waiver authority, in conjunction with other incentives for healthy behaviors, will allow the Commonwealth to improve health outcomes by encouraging the use of primary care settings when appropriate.

Waiver Authority	Use for Waiver	Reason for Waiver Request
§ 1902(a)(14) (42 U.S.C.A. § 1396a(a)(14))	To permit the Commonwealth to charge premiums to individuals whose family income is below 150%.	This waiver authority will allow the Commonwealth to test the effect of combining positive and negative incentives on healthy behaviors and health outcomes.
§ 1902(a)(14) (42 U.S.C.A. § 1396a(a)(14))	To permit the Commonwealth to require prepayment of a premium.	This waiver authority will allow the Commonwealth to test the premise that payment of premiums aligns with improved patient involvement in care and better health outcomes.
§ 1902(a)(14) (42 U.S.C.A. § 1396a(a)(14))	To permit the Commonwealth to have copayments paid to the Commonwealth on a monthly basis rather than to the provider at point of service.	This waiver will allow the Commonwealth to more efficiently collect copayments, increase provider support, and provide a vehicle for creating a healthy behavior incentive program for those whose income does not exceed 100% FPL.
§ 1902(a)(14) (42 U.S.C.A. § 1396a(a)(14))	To permit the Commonwealth to make payments to reduce cost sharing, for certain individuals eligible under the approved state plan new adult group described in section 1902(a)(10)(A)(i)(XVIII).	This waiver authority will allow the Commonwealth to provide individuals enrolled in a private coverage plan cost sharing that is equivalent to that required for those enrolled in MA.

Waiver Authority	Use for Waiver	Reason for Waiver Request
§ 1902(a)(17) (42 U.S.C.A. § 1396a(a)(17))	To permit the Commonwealth to provide coverage through different delivery systems for different populations of Medicaid eligible individuals. Specifically, to permit the Commonwealth to provide coverage for *Healthy Pennsylvania* Private Coverage Option to Medicaid eligible individuals through private coverage plans.	This waiver authority will allow the Commonwealth to test using premium assistance to provide coverage through private coverage plans for a subset of Medicaid eligible individuals.
§ 1902(a)(17) (42 U.S.C.A. § 1396a(a)(17))	To permit the Commonwealth to provide different premium and copayment amounts for different populations of Medicaid eligible individuals.	This waiver authority will allow the Commonwealth to charge different levels of premiums to different individuals based on their response to employment engagement activities and healthy behavior incentives.
§ 1902(a)(17) (42 U.S.C.A. § 1396a(a)(17)	To permit the Commonwealth to provide retroactive coverage for some individuals based on the date of application and claim FMAP for individuals who are both newly eligible and also eligible for a State or optional Medicaid program that is terminated prior to the effective date of the Demonstration.	This waiver authority will allow the Commonwealth to provide continuous coverage and transition individuals who are determined eligible for a medical assistance program to be terminated as a result of the Demonstration implementation.

Waiver Authority	Use for Waiver	Reason for Waiver Request
§ 1902(a)(23) (42 U.S.C.A. § 1396a(a)(23))	To make premium assistance for private coverage plans mandatory for *Healthy Pennsylvania* Private Coverage Option participants and to permit the Commonwealth to limit participants' freedom of choice among providers to the providers participating in the network of the private coverage plan.	This waiver authority will allow the Commonwealth to require that *Healthy Pennsylvania* Private Coverage Option eligible individuals receive coverage through ta private coverage plan if they are not medically frail, and not through the state plan. This waiver authority will also allow the Commonwealth to align the network available to *Healthy Pennsylvania* Private Coverage Option participants with the network offered to other private coverage plan participants who are not Medicaid eligible individuals.
– § 1902(k) (42 U.S.C.A. § 1396a(k))	To permit the Commonwealth to automatically enroll groups other than those described in sub-clause VIII of 1902(a)(10)(A)(i) into the Commonwealth's benchmark plan, including those otherwise exempt from enrollment into a benchmark plan.	This waiver will allow the Commonwealth to more efficiently enroll higher need individuals into the benefit plan most likely to meet their needs while still providing these individuals a choice of state plan benefits.
§ 1902(a)(34) (42 U.S.C.A. § 1396a(a)(34))	To enable the Commonwealth to eliminate retroactive coverage for the newly eligible population enrolled in *the Healthy Pennsylvania* Private Coverage Option.	This waiver will allow the Commonwealth to efficiently enroll newly eligible adults in private market plans, aligning with private market processes.

Waiver Authority	Use for Waiver	Reason for Waiver Request
§ 1902(a)(54) (42 U.S.C.A. § 1396a(a)(54)(A))	To permit the Commonwealth to limit a *Healthy Pennsylvania* Private Coverage Option participant to receive coverage for drugs on the formulary of the participant's private coverage plan.	This waiver authority will allow the Commonwealth to align the prescription drug benefit for *Healthy Pennsylvania* Private Coverage Option participants with the prescription drug benefit offered to private coverage plan participants who are not Medicaid eligible individuals.
§ 1902(a)(54) (42 U.S.C.A. § 1396a(a)(54)(A))	To permit the Commonwealth to require that requests for prior authorization for drugs be addressed within 72 hours, rather than 24 hours for Private Coverage Option participants. A 72-hour supply of the requested medication will be provided in the event of an emergency.	This waiver authority will allow the Commonwealth to align prior authorization standards for *Healthy Pennsylvania* Private Coverage Option participants with standards in the private coverage plans.
§ 1902(a)(10)(A) §1902(k) (42 U.S.C.A. § 1396a(a)(10)(A)) and § 1902(k) (42 U.S.C.A. § 1396a(k))	To permit the Commonwealth not to cover wraparound services in the *Healthy Pennsylvania* Private Coverage Option.	This waiver authority will allow the Commonwealth and private coverage plans to align the benefits offered to non-frail *Healthy Pennsylvania* Private Coverage Option participants with individuals who are not Medicaid individuals.
§1902(a)(4) (42CFR431.53) (42 U.S.C.A. § 1396a(a)(4) and 42 CFR 431.53))	To permit the Commonwealth not to cover non-emergency transportation for the newly eligible enrolled in the *Healthy Pennsylvania* Public Coverage Option.	This waiver authority will allow the Commonwealth to meet its goal of aligning the program and delivery of services for the healthier newly eligible population with common private coverage plan practices.

Waiver Authority	Use for Waiver	Reason for Waiver Request
§1902(a)(10)(A) and §1902(k) (42 U.S.C.A. § 1396a(a)(10)(A)) and § 1902(k) (42 U.S.C.A. § 1396a(k))	To permit the Commonwealth not to cover all family planning providers for individuals 21 years of age or older but under 65 years of age and who are enrolled in the *Healthy Pennsylvania* Private Coverage Option.	This waiver authority will allow the Commonwealth to meet its goal of aligning the program and delivery of services for the healthier newly eligible population with common private coverage plan practices.
§ 1902(a)(2) (42 U.S.C.A. 1396a(a)(2))	To provide federal financial participation on delivery system reform incentive payments, which are not reimbursement for health care services and which do not apply for determining DSH spending or federal upper payment limits.	This waiver will allow incentive payments to providers who carry out specific delivery system reforms and improve care delivery.

2) Describe why the state is requesting the waiver or expenditure authority, and how it will be used.

Reference *Table 7*: *Waiver Requests* above.

9. Public Comment and Stakeholder Input

1) Start and end dates of the state's public comment period.

Pennsylvania provided an open comment period for public comments from December 6, 2013 through January 13, 2014.

2) Certification that the state provided public notice of the application, along with a link to the state's web site and a notice in the state's Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS.

Pennsylvania certifies that it published a Public Notice in our *Pennsylvania Bulletin* on December 7, 2013. The notice may be found in the *Pennsylvania Bulletin* is 43 Pa.B. 7186. The notice is available at the following link:

http://www.pabulletin.com/secure/data/vol43/43-49/2284.html

The Public Notice was posted on-line on December 6, 2013 and is found at the following web address:

http://www.dpw.state.pa.us/healthypa/index.htm

3) Certification that the state convened at least 2 public hearings, of which one hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted.

Pennsylvania certifies that seven public hearings were held at six different locations within the Commonwealth. The public hearings provided a forum for individuals to hear a presentation given by Secretary Bev Mackereth, Department of Public Welfare, to give oral testimony and/or to submit written testimony. Individuals who registered to speak, presented their testimony following the secretary's presentation and, as time permitted, remaining attendees were given an opportunity to present oral testimony.

The hearings were well attended. In fact, due to the large response, the hearing scheduled in Philadelphia was expanded into separate morning and afternoon sessions.

Following are the dates and locations of the public hearings:
Thursday, December 19, 2013, in Erie, PA
Time: 10 a.m. to 1 p.m.
Bayfront Convention Center
1 Sassafras Pier
Erie, PA 16507

Friday, December 20, 2013, in Pittsburgh, PA
Time: 10 a.m. to 1 p.m.
Allegheny County Courthouse
436 Grant Street
Pittsburgh, PA 15219

Friday, January 3, 2014, in Philadelphia, PA
Time: 10 a.m. to 1 p.m.
National Constitution Center
525 Arch Street
Philadelphia, PA 19106

Friday, January 3, 2014, in Philadelphia, PA
Time: 1:30 p.m. to 4:30 p.m.
National Constitution Center
525 Arch Street
Philadelphia, PA 19106

Monday, January 6, 2014, in Scranton, PA
Time: 10 a.m. to 1 p.m.
Hilton Scranton and Conference Center
100 Adams Avenue
Scranton, PA 18503

Tuesday, January 7, 2014, in Altoona, PA
Time: 10 a.m. to 1 p.m.
Blair County Convention Center
1 Convention Center Drive
Altoona, PA 16602

Thursday, January 9, 2014, in Harrisburg, PA
Time: 10 a.m. to 1 p.m.
The State Museum of Pennsylvania
300 North Street
Harrisburg, PA 17120

Two webinars also offered an opportunity to listen to the secretary's presentation and to speak after the presentation. Webinars were held on:

Monday, December 16, 2013
Time: 9 a.m. to 11 a.m.

and

Wednesday, January 8, 2014
Time: 9 a.m. to 11 a.m.

Following is the link to the Secretary's presentation:

http://www.dpw.state.pa.us/cs/groups/webcontent/documents/document/p_039778.pdf

4) Certification that the state used an electronic mailing list or similar mechanism to notify the public. (If not an electronic mailing list, please describe the mechanism that was used.

Pennsylvania certifies that an electronic mailing list as well as focused outreach to additional stakeholders, legislators and other interested entities was used. Following are the dates and persons or entities engaged by the department.

December 4, 2013

- Meeting held with Hospital and Healthsystem Association of Pennsylvania (HAP)
- Meeting held with PA Medical Society
- Meeting held with PA Health Care Association (PHCA)
- Meeting held with Managed Care Coalition
- Conference call with Aetna Medicaid

- Conference call Gateway Health Plan
- Meeting held with insurance trade association and insurers: Insurance Federation, Highmark, Independence BlueCross, Capital BlueCross, BlueCross of Northeastern PA, United Healthcare, UPMC Health Plan, HealthAmerica and Geisinger Health Plan.

December 5, 2013

- Meeting held with PA Pharmacists Association
- Meeting held with PA Health Law Project
- Meeting held with Pharmaceutical Research and Manufacturers of America (PhRMA)
- Meeting held with LeadingAge PA
- Meeting held with Business Groups
- Conference call with PA Community Providers Association (PCPA)
- Conference call with County Commissioners of PA (CCAP)
- Conference call with PA Partnerships for Children
- Conference call with PA Nurses Association
- Conference call with Pennsylvania Association of Community Health Centers (PACHC)

December 6, 2013

- Stakeholder Meeting held by Secretary Wolf at the Hilton, Harrisburg, PA
- Conference call with State House & Senate Democratic Leadership

December 10, 2013

- Meeting held with the Long Term Care Subcommittee of the Medical Assistance Advisory Committee (MAAC)

December 31, 2013

- Conference call with Pennsylvania Recovery Organizations Alliance (PRO-A),

January 2, 2014

- Meeting held with Pennsylvania's Medicaid MCOs

January 7, 2014

- Conference call with We Work for Health PA

January 10, 2014

- Meeting held with Gateway Health Plan
- Webinar with the Rehabilitation and Community Provider Association
- Meeting held with Magellan Behavioral Health Organization

January 13, 2014

- Meeting held with ADAPT

January 16, 2014

- Meeting held with PA Medical Society

January 17, 2014

- Conference call with Gaudenzia
- Meeting held with Temple University Health System

January 30, 2014

- Conference call with The Philadelphia Alliance

January 31, 2014

- Meeting held with United Health Group

February 5, 2014

- Meeting held with Drug & Alcohol Service Providers Organization
- Meeting held with HAP

5) Comments received by the state during the 30-day public notice period.

See Appendix 5 for the summary of comments received by the Commonwealth and the Commonwealth's responses to the comments.

6) **Summary of the state's responses to submitted comments, and whether or how the state incorporated them into the final application.**

See Appendix 5 for the summary of the Commonwealth's responses to submitted comments and how the Commonwealth incorporated them into the final application.

7) **Certification that the state conducted tribal consultation in accordance with the consultation process outlined in the state's approved Medicaid State plan, or at least 60 days prior to submitting this Demonstration application if the Demonstration has or would have a direct effect on Indians, tribes, on Indian health programs, or on urban Indian health organizations, including dates and method of consultation.**

Pennsylvania contains no federally recognized tribes or Indian health programs. As a result, tribal consultation was not required.

10. DEMONSTRATION ADMINISTRATION

Please provide the contact information for the state's point of contact for the Demonstration application.

- **Name and Title:** Leesa Allen, Executive Medicaid Director
- **Email Address:** RA-PWHealthyPA1115@pa.gov

APPENDIX 1: GROUPS SUBJECT TO $10 NON-EMERGENT USE OF EMERGENCY ROOM UNDER *HEALTHY PENNSYLVANIA*

Eligibility Group Name **Social Security, CFR Citations**	**Brief Description of Population, if needed**	**Maximum Income Limit Single/couple asset limit**
Low income families and children (including TANF) age 18 -20 1902(a)(10)(A)(ii)(I); 1931; 435.110	Low income parents and caretaker relatives and 18 year old children in school.	33% FPL No asset test TANF cash $1,000
Transitional Medical Assistance 408(a)(11)(A) 1931(c)(2), 1925, 1902(a)(25)	12-month continued medical assistance due to increased earnings or hours of employment	185% FPL N/A
Transitional Medical Assistance 1902(e)(1)(a), 1931(c)(2)	4-month continued medical due to increase in earnings or hours of employment.	N/A No asset test
Extended Medical due to spousal support collections 408(a)(11)(B), 42 CFR 435.115, 1931(c)(1)	Individuals who lose eligibility under 1931 due to spousal support.	N/A No asset test
Pregnant women group - consolidated under 42 CFR 435.116. Includes post-partum period for otherwise income ineligible individuals Qualified and poverty level pregnant women: 1902(a)(10)(A)(i)(III); 1905(n)(1), 1902(a)(10)(A)(i)(IV); 1902(l)(1)(A)(B). 1902(a)(10)(A)(ii)(I); 1902(a)(10)(A)(ii)(IV);1931	• Qualified Low income pregnant women 33% FPL. • Poverty level women with incomes below 133% FPL (mandatory). • Pregnant women with income between 133%-185% FPL (215% MAGI converted).	215% FPL No asset test

Eligibility Group Name **Social Security, CFR Citations**	**Brief Description of Population, if needed**	**Maximum Income Limit Single/couple asset limit**
Qualified Children, age 18 42 CFR 435.116 - old 1902(a)(10)(A)(i)(III) 1905(n)	Low income children age 18 meeting the income requirements of AFDC (TANF)	33% FPL No asset test
Poverty level children under age 19 1902(a) (10) (A) (i) (VII) and 1902(1) (1) (D)	18 year old children under 100% of the FPL.	100% FPL No asset test
Children under age 21 meeting income and resources requirements of AFDC State plan 435.222	Low income children under age 21 meeting income requirements of the AFDC (TANF) program.	18%-22% FPL No asset test
Individuals Receiving SSI 1902(a)(10)(A)(i)(II)(aa) 42 CFR 435.120	Adult with a severe disability.	74% FPL 100% FBR $2,000/$3,000
Individuals Receiving Mandatory State Supplement 42 CFR 435.130	Low income seniors or an adult with a severe disability. State increases SSI payment by $22.10.	76% FPL $2,000/$3,000
Individuals Who Are Essential Spouses 42 CFR 435.131 1905(a)	Spouse of aged, blind, disabled individual who was grandfathered into program at time of SSI implementation. Few beneficiaries remaining in program.	74% FPL 100% FBR $2,000/$3,000

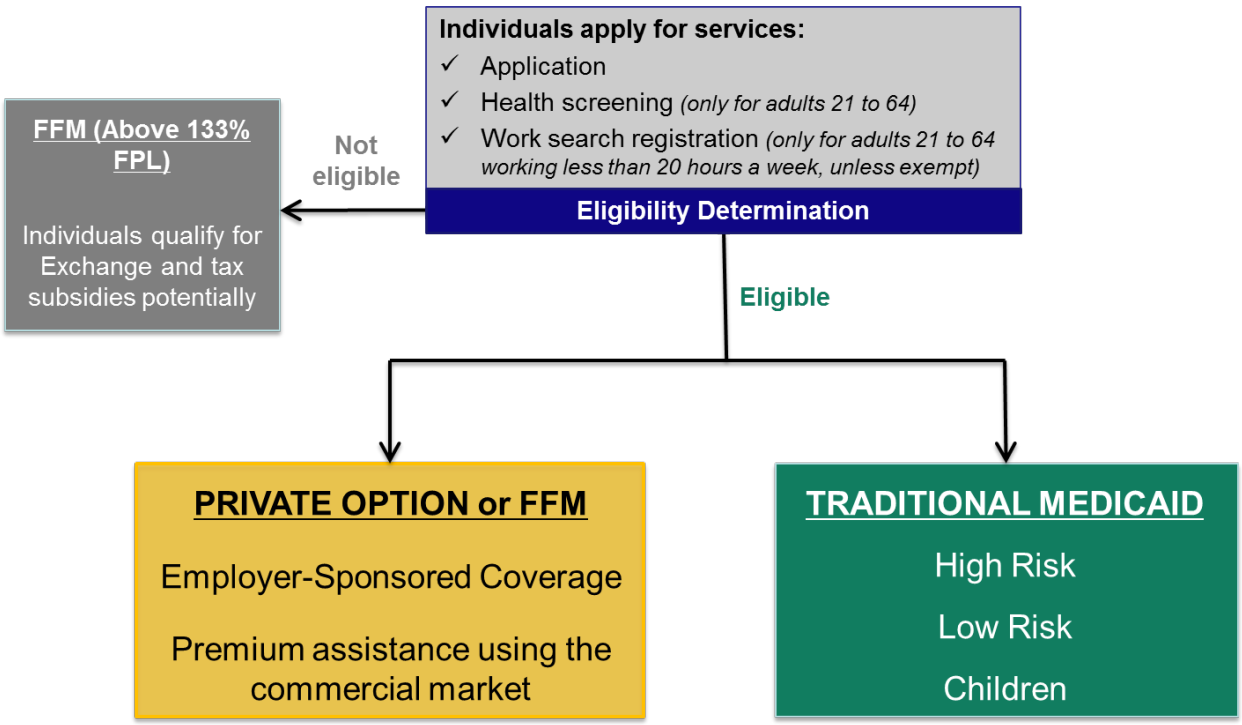
Eligibility Group Name **Social Security, CFR Citations**	**Brief Description of Population, if needed**	**Maximum Income Limit Single/couple asset limit**
Blind or Disabled Individuals Eligible in 1973 42 CFR 435.133	Continuously eligible based on 1973 requirements. Few beneficiaries remaining in program.	Meet 1973 requirements
Individuals Who Lost Eligibility for SSI/SSP Due to an Increase in OASDI Benefits in 1972 42 CFR 435.133	Low income seniors or an adult with a severe disability with incomes slightly above 74% FPL. Few beneficiaries remaining in program.	>74% FPL $2,000/$3,000
Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA increases since April, 1977 1939(a)(5)(E),42 CFR 435.135, Section 503 of P.L. 94-566	Adult with a severe disability. Had been receiving SSI but lost it due to SSA income increases from COLAs.	>74% FPL, but low income
Disabled Widows and Widowers Ineligible for SSI due to Increase in OASDI 1634(b),42 CFR 435.137	Adult with a severe disability. Not eligible for SSI because the increased amount of widow's or widower's insurance benefits which resulted from eliminating the additional reduction factor for disabled widows and widowers under age 60.	>74% FPL, but likely low income

Eligibility Group Name **Social Security, CFR Citations**	**Brief Description of Population, if needed**	**Maximum Income Limit Single/couple asset limit**
Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security 42 CFR 435.138,1634(d)	Disabled widows and widowers who are at least age 60; not entitled to Medicare Part A; and become ineligible for SSI or a State supplement because of mandatory receipt of widow's or widower's social security disability benefits.	>74% FPL $2,000, $3,000
Working Disabled under1619(b) 1902(a)(10)(A)(i)(II)1905(q),1619(b)	Low income Working adult with a severe disability. Would receive SSI but for earnings.	N/A
Disabled Adult Children 1634(c), 1935	An unmarried disabled adult, age 18 or older, with disability that started before age 22. Receives SSA based on parents benefits.	N/A
Individuals Eligible for Cash except for Child Care Subsidy 1902(a)(10)(A)(ii)(II), 42CFR435.220	Low income caretakers.	>74% FPL, but likely low income
Individuals Receiving Home and Community Based Services under Institutional Rules 42 CFR 435.217 1902(a)(10)(A)(ii)(VI)	Special income level group, with gross income that does not exceed 300% of the SSI income standard; receives LTSS in the community.	222% FPL 300%FBR $2,000 with 6,000 disregard

Eligibility Group Name **Social Security, CFR Citations**	**Brief Description of Population, if needed**	**Maximum Income Limit Single/couple asset limit**
Individuals Eligible for but not Receiving Cash 42 CFR 435.210, 1902(a)(10)(A)(ii)(I), 1905(a), 1902(v)(1)	Have the same characteristics as an SSI recipient or AFDC (TANF) recipient, but are not receiving payments from the program.	TANF 18%-22% FPL SSI 74% FPL TANF N/A SSI $2,000/$3,000
Optional State Supplement Recipients - 1634 States, and SSI **Criteria States with 1616 Agreements** 1902(a)(10)(A)(ii)(IV) 42 CFR 435.232	Low income seniors or an adult with a severe disability. Receives a $22.10 State supplement.	76% FPL $2000
Poverty Level Aged or Disabled 1902(a)(10)(A)(ii)(X), 1902(M)(1)	Low income senior or an adult with a severe disability.	100% FPL $2000/$3000
Individuals at or below 133% FPL, 18 through 64 years of age 1902(a)(10)(A)(i)(VIII), 1902(a)(10)(A)(i)(VIII)	Newly eligible adults GA population (PD, TD)/ childless adults/ parent caretakers >33% FPL.	133% FPL No asset test
Children under 21 Not Receiving Cash 1902(a)(10)(A)(ii)(I) – (IV) 1905(a)(i) 42 CFR 435.222	Low income children who meet the requirements for the family to receive a cash payment.	33% FPL No asset test
Medically Needy Children Age 18 through 20 42 CFR 435.308 1902(a)(10)(C)	Children who are eligible through spending down income to the medically needy income level.	44% FPL No asset test

Eligibility Group Name **Social Security, CFR Citations**	**Brief Description of Population, if needed**	**Maximum Income Limit Single/couple asset limit**
Special needs adoption children 1902(a)(10)(X)(A)(1)(VII)	18 year old student with special needs under a non-IV-E State adoption agreement.	N/A
Medically Needy Aged 1902(a)(10)(C) 42 CFR 435.320 and 435.330	Individuals age 65 and older who have income above categorical levels and must spend down to the medically needy income limit.	44% FPL $2,400/$3,200
Medically Needy Pregnant Women 1902(a)(10)(C)(ii)(II) 42 CFR 435.301(b)(1)(i) and (iv)	Pregnant woman with income that exceeds 185% FPL (215% FPL MAGI converted) and must spend down to the medically needy income limit.	44% FPL No asset test
Former Foster Care Children 1902(a)(10(A)(i)(IX)	Individuals who were receiving foster care at age 18 and aged out of the foster care program. The copayment waiver applies only to those in this group who are 18 to 25 years of age.	Not otherwise categorically or income eligible

APPENDIX 2: ENROLLMENT FLOW CHART



APPENDIX 3: CRITERIA FOR MEDICALLY FRAIL

DEFINITION of Medically Frail: includes individuals with disabling mental disorders (including adults with serious mental illness), individuals with chronic substance use disorders, individuals with serious and complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their functioning, or individuals with a disability determination based on Social Security criteria.

Pennsylvania has outlined the criteria for who is medically frail or otherwise has special medical needs, as set forth below:

Category	Definition
Individuals with a Disabling Mental Disorder	The individual has a diagnosis of at least one of the following: • psychotic disorder; • schizophrenia; • schizoaffective disorder; • major depression; • bipolar disorder; • delusional disorder • anxiety disorder (obsessive compulsive disorder, post-traumatic stress disorder, or severe panic disorder)
Individuals with chronic substance use disorder	The individual has a chronic substance use disorder: • The individual has a diagnosis of substance use disorder.

Category	Definition
Individuals with serious and complex medical conditions	The individual meets one of the following conditions: • Receiving chemotherapy or radiation therapy for cancer OR • Enrolled in hospice OR • A resident of LTC facility or public/private ICF OR • Has any of the following medical conditions- hemophilia, Gaucher's disease, immune deficiency, HIV/AIDS, sickle cell, cystic fibrosis or post-transplant of lung, heart, liver, pancreas, or small bowel OR • Is ventilator dependent OR • Receives Dialysis treatments OR • Has 2 or more inpatient admissions within 12 months AND o has 3 or more ER visits in 6 months AND o has 4 or more prescription medications per month.
Individuals with a physical disability	The individual has a permanent physical disability that significantly impairs his/her functioning.
Individuals with an intellectual or developmental disability	The individual has an intellectual or developmental disability and therefore exhibits: Intellectual Disability: • Significantly subnormal general intellectual functioning based on standardized testing (IQ). • Significantly subnormal adaptive functioning based on standardized testing. • Occurred in the developmental period before the 22nd birthday. Developmental Disability: • Autism spectrum disorder: The individual is diagnosed with autism and meets the ICF/ORC level of care which is an institutional level of care. The ICF level of care requires functional deficits in addition to the diagnosis.
Individuals with a disability determination	Any individual with a current disability designation by the Social Security Administration

APPENDIX 4: EXCERPTS FROM ACT 1998-68

Section 2101. Scope.—This article governs quality health care accountability and protection.

Section 2102. Definitions. - Words and phrases shall have the meanings given to them in this section:

"Active clinical practice." The practice of clinical medicine by a health care provider for an average of not less than twenty (20) hours per week.

"Ancillary service plans." Any individual or group health insurance plan, subscriber contract or certificate that provides exclusive coverage for dental services or vision services. The term also includes Medicare Supplement Policies subject to section 1882 of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1395ss) and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement.

"Clean claim." A claim for payment for a health care service which has no defect or impropriety. A defect or impropriety shall include lack of required substantiating documentation or a particular circumstance requiring special treatment which prevents timely payment from being made on the claim. The term shall not include a claim from a health care provider who is under investigation for fraud or abuse regarding that claim.

"Complaint." A dispute or objection regarding a participating health care provider or the coverage, operations or management policies of a managed care plan which has not been resolved by the managed care plan and has been filed with the plan or with the Department of Health or the Insurance Department of the Commonwealth. The term does not include a grievance.

"Concurrent utilization review." A review by a utilization review entity of all reasonably necessary supporting information which occurs during an enrollee's hospital stay or course of treatment and results in a decision to approve or deny payment for the health care service.

"Department." The Department of Health of the Commonwealth.

"Drug formulary." A listing of managed care plan preferred therapeutic drugs.

"Emergency service." Any health care service provided to an enrollee after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

(1) placing the health of the enrollee or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
(2) serious impairment to bodily functions; or
(3) serious dysfunction of any bodily organ or part.

Emergency transportation and related emergency service provided by a licensed ambulance service shall constitute an emergency service.

"Enrollee." Any policyholder, subscriber, covered person or other individual who is entitled to receive health care services under a managed care plan.

"Grievance." As provided in subdivision (i), a request by an enrollee or a health care provider, with the written consent of the enrollee, to have a managed care plan or utilization review entity reconsider a decision solely concerning the medical necessity and appropriateness of a health care service. If the managed care plan is unable to resolve the matter, a grievance may be filed regarding the decision that:

(1) disapproves full or partial payment for a requested health care service;
(2) approves the provision of a requested health care service for a lesser scope or duration than requested; or
(3) disapproves payment for the provision of a requested health care service but approves payment for the provision of an alternative health care service.
(4) The term does not include a complaint.

"Health care provider." A licensed hospital or health care facility, medical equipment supplier or person who is licensed, certified or otherwise regulated to provide health care services under the laws of this Commonwealth, including a physician, podiatrist, optometrist, psychologist, physical therapist, certified nurse practitioner, registered nurse, nurse midwife, physician's assistant, chiropractor, dentist, pharmacist or an individual accredited or certified to provide behavioral health services.

"Health care service." Any covered treatment, admission, procedure, medical supplies and equipment or other services, including behavioral health, prescribed or otherwise provided or proposed to be provided by a health care provider to an enrollee under a managed care plan contract.

"Managed care plan." A health care plan that uses a gatekeeper to manage the utilization of health care services, integrates the financing and delivery of health care services to enrollees by arrangements with health care providers selected to participate on the basis of specific standards and provides financial incentives for enrollees to use the participating health care providers in accordance with procedures established by the plan. A managed care plan includes health care arranged through an entity operating under any of the following:

(1) Section 630.
(2) The act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act."
(3) The act of December 14, 1992 (P.L.835, No.134), known as the "Fraternal Benefit Societies Code."
(4) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations).
(5) 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

The term includes an entity, including a municipality, whether licensed or unlicensed, that contracts with or functions as a managed care plan to provide health care services to enrollees. The term does not include ancillary service plans or an indemnity arrangement which is primarily fee-for-service.

"Plan." A managed care plan.

"Primary care provider." A health care provider who, within the scope of the provider's practice, supervises, coordinates, prescribes or otherwise provides or proposes to provide health care services to an enrollee, initiates enrollee referral for specialist care and maintains continuity of enrollee care.

"Prospective utilization review." A review by a utilization review entity of all reasonably necessary supporting information that occurs prior to the delivery or provision of a health care service and results in a decision to approve or deny payment for the health care service.

"Provider network." The health care providers designated by a managed care plan to provide health care services.

"Referral." A prior authorization from a managed care plan or a participating health care provider that allows an enrollee to have one or more appointments with a health care provider for a health care service.

"Retrospective utilization review." A review by a utilization review entity of all reasonably necessary supporting information which occurs following delivery or provision of a health care service and results in a decision to approve or deny payment for the health care service.

"Service area." The geographic area for which the managed care plan is licensed or has been issued a certificate of authority.

"Specialist." A health care provider whose practice is not limited to primary health care services and who has additional postgraduate or specialized training, has board certification or practices in a licensed specialized area of health care. The term includes a health care provider who is not classified by a plan solely as a primary care provider.

"Utilization review." A system of prospective, concurrent or retrospective utilization review performed by a utilization review entity of the medical necessity and appropriateness of health care services prescribed, provided or proposed to be provided to an enrollee. The term does not include any of the following:

(1) Requests for clarification of coverage, eligibility or health care service verification.
(2) A health care provider's internal quality assurance or utilization review process unless the review results in denial of payment for a health care service.

"Utilization review entity." Any entity certified pursuant to subdivision (h) that performs utilization review on behalf of a managed care plan.

Section 2111. Responsibilities of Managed Care Plans.
A managed care plan shall do all of the following:

(1) Assure availability and accessibility of adequate health care providers in a timely manner, which enables enrollees to have access to quality care and continuity of health care services.
(2) Consult with health care providers in active clinical practice regarding professional qualifications and necessary specialist to be included in the plan.
(3) Adopt and maintain a definition of medical necessity used by the plan in determining health care services.
(4) Ensure that emergency services are provided twenty-four (24) hours a day, seven (7) days a week and provide reasonable payment or reimbursement for emergency services.
(5) Adopt and maintain procedures by which an enrollee can obtain health care services outside the plan's service area.

Section 2116. Emergency Services.

If an enrollee seeks emergency services and the emergency health care provider determines that emergency services are necessary, the emergency health care provider shall initiate necessary intervention to evaluate and, if necessary, stabilize the condition of the enrollee without seeking or receiving authorization from the managed care plan. The managed care plan shall pay all reasonably necessary costs associated with the emergency services provided during the period of the emergency. When processing a reimbursement claim for emergency services, a managed care plan shall consider both the presenting symptoms and the services provided. The emergency health care provider shall notify the enrollee's managed care plan of the provisions of emergency services and the condition of the enrollee. If an enrollee's condition has stabilized and the enrollee can be transported without suffering detrimental consequences or aggravating the enrollee's condition, the enrollee may be relocated to another facility to receive continued care and treatment as necessary.

Section 2117. Continuity of Care.

(a) Except as provided under subsection (b), if a managed care plan initiates termination of its contract with a participating health care provider, an enrollee may continue an ongoing course of treatment with that health care provider at the enrollee's option for a transitional period of up to six (60) days from the date the enrollee was notified by the plan of the termination or pending termination. The managed care plan, in consultation with the enrollee and the health care provider, may extend the transition period if determined to be clinically appropriate. In the case of an enrollee in the second or third trimester of pregnancy at the time of notice of the termination or pending termination, the transitional period shall extend through postpartum care related to the delivery. Any health care service

provided under this section shall be covered by the managed care plan under the same terms and conditions as applicable for participating health care providers.

(b) If the plan terminates the contract of a participating health care provider for cause, including breach of contract, fraud, criminal activity or posing a danger to an enrollee or the health, safety or welfare of the public as determined by the plan, the plan shall not be responsible for health care services provided to the enrollee following the date of termination.

(c) If the plan terminates the contract of a participating primary care provider, the plan shall notify every enrollee served by that provider of the plan's termination of its contract and shall request that the enrollee select another primary care provider.

(d) A new enrollee may continue an ongoing course of treatment with a nonparticipating health care provider for a transition period of up to sixty (60) days from the effective date of enrollment in a managed care plan. The managed care plan, in consultation with the enrollee and the health care provider, may extend this transitional period if determined to be clinically appropriate. In the case of a new enrollee in the second or third trimester of pregnancy on the effective date of enrollment, the transitional period shall extend through postpartum care related the delivery. Any health care service provided under this section shall be covered by the managed care plan under the same terms and conditions as applicable for a participating health care provider.

(e) A plan may require a nonparticipating health care provider whose health care services are covered under this section to meet the same terms and conditions as a participating health care provider.

(f) Nothing in this section shall require a managed care plan to provide health care services that are not otherwise covered under the terms and conditions of the plan.

Section 2121. Procedures.

(a) A managed care plan shall establish a credentialing process to enroll qualified health care providers and create an adequate provider network. The process shall be approved by the department and shall include written criteria and procedures for initial enrollment, renewal, restrictions and termination of credentials for health care providers.

(b) The department shall establish credentialing standards for managed care plans. The department may adopt nationally recognized accrediting standards to establish the credentialing standards for managed care plans.

(c) A managed care plan shall submit a report to the department regarding its credentialing process at least every two (2) years or as may otherwise be required by the department.

(d) A managed care plan shall disclose relevant credentialing criteria and procedures to health care providers that apply to participate or that are participating in the plan's provider network. A managed care plan shall also disclose relevant credentialing criteria and procedures pursuant to a court order or rule. Any individual providing information during the credentialing process of a managed care plan shall have the protections set forth in the act of July 20, 1974 (P.L.564, No.193), known as the "Peer Review Protection Act."

(e) No managed care plan shall exclude or terminate a health care provider from participation in the plan due to any of the following:

(1) The health care provider engaged in any of the activities set forth in section 2113(c).
(2) The health care provider has a practice that includes a substantial number of patients with expensive medical conditions.
(3) The health care provider objects to the provision of or refuses to provide a health care service on moral or religious grounds.

(f) If a managed care plan denies enrollment or renewal of credentials to a health care provider, the managed care plan shall provide the health care provider with written notice of the decision. The notice shall include a clear rationale for the decision.

Section 2141. Internal Complaint Process.

(g) A managed care plan shall establish and maintain an internal complaint process with two levels of review by which an enrollee shall be able to file a complaint regarding a participating health care provider or the coverage, operations or management policies of the managed care plan.

(h) The complaint process shall consist of an initial review to include all of the following:

(1) A review by an initial review committee consisting of one or more employees of the managed care plan.
(2) The allowance of a written or oral complaint

(3) The allowance of written data or other information.

(4) A review or investigation of the complaint which shall be completed within thirty (30) days of receipt of the complaint.

(5) A written notification to the enrollee regarding the decision of the Initial review committee within five (5) business days of the decision. Notice shall include the basis for the decision and the procedure to file a request for a second level review of the decision of the initial review committee.

(i) The complaint process shall include a second level review that includes all of the following:

(1) A review of the decision of the initial review committee by a second level review committee consisting of three or more individuals who did not participate in the initial review. At least one third of the second level review committee shall not be employed by the managed care plan.

(2) A written notification to the enrollee of the right to appear before the second level review committee.

(3) A requirement that the second level review be completed within forty-five (45) days of receipt of a request for such review.

(4) A written notification to the enrollee regarding the decision of the second level review committee within five (5) business days of the decision. The notice shall include the basis for the decision and the procedure for appealing the decision to the department or the Insurance Department.

(6) Adopt and maintain procedure by which an enrollee with a life-threatening, degenerative or disabling disease or condition shall, upon request, receive an evaluation and, if the plan's established standard are net, be permitted to receive:

(i) A standing referral to a specialist with clinical expertise in treating the disease or condition; or

(ii) The designation of a specialist to provide and coordinate the enrollee's primary and specialty care.

The referral to or designation of a specialist shall be pursuant to a treatment plan approved by the managed care plan in consultation with the primary care provider, the enrollee and, as appropriate, the specialist. When possible, the specialist must be a health care provider participating in the plan.

(7) Provide direct access to obstetrical and gynecological services by permitting an enrollee to select a health care provider participating in the plan to obtain maternity and gynecological care, including medically necessary and appropriate follow-up care and referrals for diagnostic testing related to maternity and gynecological care, without prior

approval from a primary care provider. The health care services shall be within the scope of practice of the selected health care provider. The selected health care provider shall inform the enrollee's primary care provider of all health care services provided.

(8) Adopt and maintain a complaint process as set forth in subdivision (g).

(9) Adopt and maintain a grievance process as set forth I subdivision (i).

(10) Adopt and maintain credentialing standards for health care providers as set forth in subdivision (d).

(11) Ensure that there are participating health care providers that are physically accessible to people with disabilities and can communicate with individuals with sensory disabilities in accordance with Title III of the Americans with Disabilities Act of 1990 (Public Law 101-336, 42 U.S.C. § 12181 et seq.).

(12) Provide a list of health care providers participating in the plan to the department every two (2) years or as may otherwise be required by the department. The list shall include the extent to which health care providers in the plan are accepting new enrollees.

(13) Report to the department and the Insurance Department in accordance with the requirements of this article. Such information shall include the number, type and disposition of all complaints and grievances filed with the plan.

Section 2142. Appeal of Complaint.

(a) An enrollee shall have fifteen (15) days from receipt of the notice of the decision from the second level review committee to appeal the decision to the department or the Insurance Department, as appropriate.

(b) All records from the initial review and second level review shall be transmitted to the appropriate department in the manner prescribed. The enrollee, the health care provider or the managed care plan may submit additional materials related to the complaint.

(c) The enrollee may be represented by an attorney or other individual before the appropriate department

(d) The appropriate department shall determine whether a violation of this article has occurred and may impose any penalties authorized by this article.

Section 2143. Complaint Resolution.

Nothing in this subdivision shall prevent the department or the Insurance Department from communicating with the enrollee, the health care provider or the managed care plan as

appropriate to assist in the resolution of a complaint. Such communication may occur at any time during the complaint process.

(i) Grievances.

Section 2161. Internal Grievance Process.

(a) A managed care plan shall establish and maintain an internal grievance process with two levels of review and an expedited internal grievance process by which an enrollee or a health care provider, with the written consent of the enrollee, shall be able to file a written grievance regarding the denial of payment for a health care service. An enrollee who consents to the filing of a grievance by a health care provider under this section may not file a separate grievance.

(b) The internal grievance process shall consist of an initial review that includes all of the following:

(1) A review by one or more persons selected by the managed care plan who did not previously participate in the decision to deny payment for the health care service.
(2) The completion of the review within thirty (30) days of receipt of the grievance.
(3) A written notification to the enrollee and health care provider regarding the decision within five (5) business days of the decision. The notice shall include the basis and clinical rationale for the decision and the procedure to file a request for a second level review of the decision.

(c) The grievance process shall include a second level review that includes all of the following:

(1) A review of the decision issued pursuant to subsection (b) by a second level review committee consisting of three or more persons who did not previously participate in any decision to deny payment for the health care service.
(2) A written notification to the enrollee or the health care provider of the right to appear before the second level review committee.
(3) The completion of the second level review within forty-five (45)-days of receipt of a request for such review.
(4) A written notification to the enrollee and health care provider regarding the decision of the second level review committee within five (5) business days of the decision. The notice shall include the basis and clinical rationale for the decision and the procedure for appealing the decision.

(d) Any initial review or second level review conducted under this section shall include a licensed physician, or, where appropriate, an approved licensed psychologist, in the same or similar specialty that typically manages or consults on the health care service.

(e) Should the enrollee's life, health or ability to regain maximum function be in jeopardy, an expedited internal grievance process shall be available which shall include a requirement that a decision with appropriate notification to the enrollee and health care provider be made within forty-eight (48) hours of the filing of the expedited grievance.

Section 2162. External Grievance Process.

(a) A managed care plan shall establish and maintain an external grievance process by which an enrollee or a health care provider with the written consent of the enrollee may appeal the denial of a grievance following completion of the internal grievance process. The external grievance process shall be conducted by an independent utilization review entity not directly affiliated with the managed care plan.

(b) To conduct external grievances filed under this section:

(1) The department shall randomly assign a utilization review entity on a rotational basis from the list maintained under subsection (d) and notify the assigned utilization review entity and the managed care plan within two (2) business days of receiving the request. If the department fails to select a utilization review entity under this subsection, the managed care plan shall designate and notify a certified utilization review entity to conduct the external grievance.

(2) The managed care plan shall notify the enrollee or health care provider of the name, address and telephone number of the utilization review entity assigned under this subsection within two (2) business days.

(c) The external grievance process shall meet all of the following requirements:

(1) Any external grievance shall be filed with the managed care plan within fifteen (15) days of receipt of a notice of denial resulting from the internal grievance process. The filing of the external grievance shall include any

material justification and all reasonably necessary supporting information. Within five (5) business days of the filing of an external grievance, the managed care plan shall notify the enrollee or the health care provider, the utilization review entity that conducted the internal grievance and the department that an external grievance has been filed.

(2) The utilization review entity that conducted the internal grievance shall forward copies of all written documentation regarding the denial, including the decision, all reasonably necessary supporting information, a summary of applicable issues and the basis and clinical rationale for the decision, to the utilization review entity conducting the external grievance within fifteen (15) days of receipt of notice that the external grievance was filed. Any additional written information may be submitted by the enrollee or the health care provider within fifteen (15) days of receipt of notice that the external grievance was filed.

(3) The utilization review entity conducting the external grievance-shall review all information considered in reaching any prior decisions to deny payment for the health care service and any other written submission by the enrollee or the health care provider.

(4) An external grievance decision shall be made by:

(i) one or more licensed physicians or approved licensed psychologists in active clinical practice or in the same or similar specialty that typically manages or recommends treatment for the health care service being reviewed; or

(ii) one or more physicians currently certified by a board approved by the American Board of Medical Specialists or the American Board of Osteopathic Specialties in the same or similar specialty that typically manages or recommends treatment for the health care service being reviewed.

(5) Within sixty (60) days of the filing of the external grievance, the utilization review entity conducting the external grievance shall issue a written decision to the managed care plan, the enrollee and the health care provider, including the basis and clinical rationale for the decision. The standard of review shall be whether the health care service denied by the internal grievance process was medically necessary and appropriate under the terms of the plan. The external grievance decision shall be subject to appeal to a court of competent jurisdiction within sixty (60) days of receipt of notice of the external grievance decision. There shall be a rebuttable presumption in

favor of the decision of the utilization review entity conducting the external grievance.

(6) The managed care plan shall authorize any health care service or pay a claim determined to be medically necessary and appropriate under paragraph (5) pursuant to section 2166 whether or not an appeal to a court of competent jurisdiction has been filed.

(7) All fees and costs related to an external grievance shall be paid by the non-prevailing party if the external grievance was filed by the health care provider. The health care provider and the utilization review entity or managed care plan shall each place in escrow an amount equal to one-half of the estimated costs of the external grievance process. If the external grievance was filed by the enrollee, all fees and costs related thereto shall be paid by the managed care plan. For purposes of this paragraph, fees and costs shall not include attorney fees.

(d) The department shall compile and maintain a list of certified utilization review entities that meet the requirements of this article. The department may remove a utilization review entity from the list if such an entity is incapable of performing its responsibilities in a reasonable manner, charges excessive fees or violates this article.

(e) A fee may be imposed by a managed care plan for filing an external grievance pursuant to this article which shall not exceed twenty-five ($25) dollars.

Section 2163. Records.

Records regarding grievances filed under this subdivision that result in decisions adverse to enrollees shall-be-maintained by the plan for not less than three (3) years. These records shall be provided to the department, if requested.

APPENDIX 5: SUMMARY OF COMMENTS RECEIVED BY THE STATE AND THE STATE'S RESPONSES TO THE COMMENTS

On behalf of Governor Tom Corbett, the Department of Public Welfare has undertaken an important and transparent public comment process regarding Healthy Pennsylvania. This process has included seven public hearings in six different regions of Pennsylvania. The Department heard from 172 persons in live testimony and received more than 1,000 comments. Comments were received via the Department's website, in person, by mail, and by email. The Department also met with numerous groups and elected officials at the local, state and federal level regarding the *Healthy Pennsylvania* plan.

The purpose of this document is to catalog the comments and questions received as well as to provide a substantive response from the Department. The Commonwealth of Pennsylvania appreciates the public's input which has proved valuable to strengthening the overall proposal to provide increased access to quality affordable health care. The reforms to the Medicaid program and the establishment of a private coverage program are important upcoming steps for all Pennsylvanians.

Premiums and Cost Sharing Obligations

Comment Summary:
Several commenters expressed concerns regarding the requirement of low income individuals and persons with disabilities to pay premiums. Some felt that this requirement was unnecessary and should not be a condition of receiving health care. Many commenters perceived that premium payments were too high for individuals living below the poverty line. Some commenters felt this requirement could result in more individuals being untreated or undertreated. One commenter asked what an individual will need to pay under the Demonstration.

Response:
The Department appreciates the commenters input in the area of premiums and cost sharing obligations. The Department carefully considered this input and as a result of the comments received, the Department has made some modifications to the copayment and premium structure. In Demonstration Year 1, there will be no premium payments while the systems are brought on-line and tested toward having a smooth transition. That year will also permit education of providers and participants on the process and changes. The copayments that are

reflected in the current state plan, however, will apply in Demonstration Year 1. Service and population exclusions as set forth in the state plan will also apply in the first year. Copayments will be paid to the provider at time of service. In essence, the status quo will remain during the transition year. For those over 100% FPL, in either Medicaid or the Private Coverage Option, most providers may within their discretion, and in compliance with state and federal law, decline to provide service if the copayment is not paid in Demonstration Year 1.

Starting in Demonstration Year 2, participants with incomes from 100-133% FPL will pay premiums as outlined in the Demonstration in lieu of most other cost sharing. Premiums will be a condition of eligibility with non-compliance sanctions as outlined in the application. In Demonstration Year 2, the Department will evaluate data on the participant copayment obligations from Demonstration Year 1 for participants with income no greater than 100% FPL and consider changes to support incentives and personal responsibility. This could include changes in copayment amounts, implementing a nominal premium and/or other cost sharing payment. All participants will be responsible for the $10 copayment for non-emergent use of the emergency room.

The Department believes this premium and copayment structure provides a balance between Medicaid and private market health insurance, resulting in an affordable health insurance program for those with the lowest incomes. The Department also anticipates that the program implemented in Demonstration Year 2 will be more affordable for all income levels than the existing copayment structure, particularly with the added possibility of reducing premiums and other cost sharing obligations by engaging in healthy behaviors.

Comment Summary:
One commenter expressed a concern that the policy of eliminating copayments may not be sustainable and that people might mistakenly enroll in plans that require copayments.

Response:
The Department has developed the *Healthy Pennsylvania* Medicaid reforms and Private Coverage Option in a fashion that balances promoting healthy behaviors, improving health outcomes, and increasing personal responsibility in order to increase access to health care in a cost effective and sustainable manner. In developing the program, the Department proposes to use copayments, premiums for individuals over 100% FPL, and incentives for healthy behaviors to support the sustainability of the program. As stated above, the Department will evaluate the use of other cost sharing obligations and premiums for those under 100% for Demonstration Year 2. Demonstration Year 1 will also serve as a time period for outreach and education of changes to occur in later years.

Regardless of whether an individual receives coverage through the Medicaid program or the *Healthy Pennsylvania* Private Coverage Option, participants will not have to pay copayments

beyond what is outlined in the Demonstration application, including the $10 copayment for non-emergent use of the emergency room. Therefore, participants will not be in jeopardy enrolling in a private health insurance plan through the Private Coverage Option plan that requires them to pay additional copayments beyond what is required in the Demonstration.

Comment Summary:
Several commenters suggested that additional groups be exempted from the premium payment, including: 1) the medically frail; 2) those with a medical crisis situation; 3) individuals with HIV/AIDS; and 4) all current Medicaid eligibility groups.

Response:
Most of the individuals who would fall into the categories listed in the comments, including medically frail, individuals who have HIV/AIDS, a medical crisis situation, or are currently eligible for Medicaid will likely be exempted from having to pay a premium under the Demonstration because they generally fall into one of the exemption categories listed in the Demonstration application. The Department uses technical and statutory based definitions in the exemptions and believes that the majority of circumstances commented on will fit within the enumerate exemptions.

The revised premium exception policies will not be implemented until Demonstration Year 2 (the Department will evaluate other cost sharing obligations and policies for those under 100% for Demonstration Year 2). The Department will develop notices and systems that mitigate confusion around who is responsible for premium payments and respond to minimize any disruption in services that may arise.

Comment Summary:
Commenters objected to the proposed copayment for non-emergent use of the emergency room because there is no evidence that it is effective, they fail to see how it would reduce overall costs, and there is not a clear definition between emergent and non-emergent situations. One commenter stated that identifying non-emergent use would be difficult because diagnosis and procedure codes are not enough to distinguish the difference between emergent and non-emergent use.

Response:
Various programs, incentives and copayments are in place around the country to encourage family and primary care usage versus the emergency room when appropriate. Pennsylvania has been an outlier by not having anything in place in this area. The $10 copayment for non-emergent use of the emergency room was introduced to encourage personal responsibility for clinically appropriate use of the emergency room. The Department is seeking to incent Medicaid and Private Coverage Option participants to more effectively use their primary care

providers by providing a disincentive for utilization of the emergency room for non-emergent situations. Additionally, the Medicaid Low Risk Benefit Plan, the Medicaid High Risk Alternative Benefit Plan, and the Private Coverage Option will provide access to primary care providers alleviating the need for an individual to use the emergency room for primary care services. By combining access to primary care with the disincentive to utilize the emergency room for more routine matters, this copayment balances incentives with personal responsibility to make the best use of health care resources. Again, many states have successfully used a similar copayment policy for non-emergent use of the emergency room.

The Department does not anticipate significant problems with implementation or administration of this proposal. The Department notes the need to appropriately distinguish between emergent and non-emergent use as it determines and defines non-emergent services. HealthChoices managed care plans and many private market health insurers have developed decision logic that uses diagnosis and procedure code information to assist them in reviewing emergency room visits. There are specific diagnosis and procedures codes, assigned by hospital clinical staff to assist in this review. The Department plans to work with stakeholders as it develops its criteria. There has also been a "prudent layperson" standard in place by law in Pennsylvania since 1996 governing payments for emergency room care related to whether the care sought was emergent. Therefore, the standard is not new in law or in practice for Pennsylvania health care delivery.

Comment Summary:
One commenter proposed that a higher copayment and other incentives be used to encourage individuals to use services other than emergency rooms.

Response:
The Department agrees that both copayments and incentives should be used to encourage appropriate use of emergency rooms. The Department has developed the *Healthy Pennsylvania* Medicaid reforms and Private Coverage Option in a fashion that balances promoting healthy behaviors, improving health outcomes, and increasing personal responsibility in order to increase access to health care in a cost effective and sustainable manner. In developing the program, the Department proposes to use copayments, premiums for those over 100% FPL, and incentives for healthy behaviors to support the sustainability of the program.

The Department believes that removing the requirement that copayments be paid at the point of service as well as providing access to primary care providers, creates positive incentives that encourage the use of services other than emergency rooms. In determining copayment amounts, the Department must balance the effectiveness of the copayment in changing behavior with affordability. The Department believes the $10 copayment for non-emergent use of the emergency room is affordable, while still presenting a sufficient disincentive.

Comment Summary:
One commenter noted that in the application's *premiums* section, it states, "Ineligibility for an adult or household will occur whenever an individual or household fails to pay the premium in full for 3 consecutive months by the end of the third month." The commenter states that if the household is determined ineligible for coverage, it is unclear whether that only applies to adults or their children as well. Because the plan indicates that premiums are not applicable to children, the commenter suggests this statement needs to be rewritten to "Ineligibility for an adult or adults will occur…."

Response:
If a household becomes ineligible for coverage due to non-payment of premiums (which are implemented in Demonstration Year 2), children under 21 years of age living in the household will not be affected by the ineligibility of the adults. The Department appreciates commenter's suggested correction to clarify the language and has made changes in the application.

Comment Summary:
One commenter offered suggestions regarding the method for assessing and collecting the monthly premium paid by participants, including using a payroll deduction process.

Response:
The approach outlined in the Demonstration application is for participants' monthly premiums to be paid to the State. As the Department considers premium and other cost sharing obligation collection systems for Demonstration Year 2, various options for assessing and collecting the premiums and cost sharing obligation amounts are being considered. The goal will be to have numerous collection options for ease of use and administration. However, it is important to note that not all participants are employed and will have this as an available option.

Comment Summary:
Commenters recommended that, if a premium is imposed, the size of the family be considered, regardless of the fact that separate premiums are not assessed for children.

Response:
Premiums will be based on the Modified Adjusted Gross Income (MAGI) calculation for household composition. A household of four (2 adults and 2 children) at 100% FPL will be considered to have a family income of $23,850 when determining premiums, whereas a single adult household will have an income of $11,670. The premium cost structure is based on the private market practice of pricing premiums based on a one-person, two-person, or family amount.

Comment Summary:
One commenter stated that the Department should analyze the effects of non-payment of premiums on churn in eligibility and coverage, retracted hospital and other payments, and uncompensated care. The commenter also recommended reconsidering elimination of copayments and permitting health plans in HealthChoices and the Private Coverage Option to use copayments to control unnecessary utilization and incentivize the use of lower-cost generics drugs. The commenter suggested that the Department consider the return on investment and administrative costs of eliminating copayments. The commenter supports the copayment for non-emergent emergency room care.

Response:
Through the Demonstration's evaluation process, the Department will monitor the effects of implementing a premium, instances of non-payment, and the elimination of most copayments for those above 100% FPL. Because copayments will be paid to the provider at point of service in Demonstration Year 1, the Department will be able to assess how changing to a premium structure in Demonstration Year 2 impacts utilization. In Demonstration Year 2, the Department will evaluate data on participant copayment obligations from Demonstration Year 1 for participants with income no greater than 100% FPL and consider changes to support incentives and personal responsibility. This could include changes in copayment amounts, implementing a nominal premium and/or other cost sharing payment.

The Department agrees that the new copayment for non-emergent use of emergency room services is appropriate.

Work Search (Encouraging Employment)

Comment Summary:
Several commenters expressed concerns regarding the requirement of low income individuals and vulnerable populations (including those with disabilities and other limitations, HIV/AIDS, and veterans) to engage in work search (i.e., job training and employment-related) activities. Some commenters expressed concern that this will result in more individuals who are untreated or undertreated and increase uncompensated care. One commenter recommended fewer activities be required.

Response:
The objective of *Encouraging Employment* is to enable low-income, able bodied Pennsylvanians move out of poverty while also gaining access to health care coverage. The Department has also provided numerous and broad enumerate exceptions including some listed by the

commentator. Thus, in some circumstances the *Encouraging Employment* program does not apply. However, the job training and employment-related activities and registration encompassed in the *Encouraging Employment* program reflect an important principle of the Demonstration. Participation in the program is only for individuals working on average less than 20 hours per week who are otherwise not exempt. The program is not about creating barriers to care, but about encouraging employment as a means to improving individuals' health and providing individuals with the necessary connections and linkages to find employment and move out of poverty.

Because the Private Coverage Option will extend access to health care to many individuals who are currently uninsured, the Department disagrees that encouraging employment among certain able-bodied individuals will result in more individuals untreated or undertreated and increase uncompensated care. As a result of the Demonstration, the Department anticipates that there will be less uncompensated care and untreated or undertreated individuals.

Comment Summary:
Commenters recommended that additional groups be exempted from the work search requirements, including: 1) the parent/caretaker relative of a child under the age of 6 for whom an alternate child care arrangement is unavailable; 2) the custodial parent in a one-parent household who is caring for a child under the age of 12 months; 3) pregnant women for 6-12 months after delivery; 4) incarcerated individuals for 24 months after being released from prison; 5) individuals undergoing cancer treatment; 6) individuals age 55-64; 7) foster care participants 21-26 years of age; 8) any individual who works; 9) individuals with mental health or drug/alcohol disorders; 10) individuals who are actively participating in intensive behavioral health day treatment programs such as Community Integrated Recovery Programs, Partial Hospitalization and D&A Intensive Outpatient Programs; 11) SSDI recipients; 12) anyone enrolled in a HCBS program or on attendant care; 13) individuals participating in the PACE program (LIFE); and 14) anyone determined to be medically frail.

Response:
The Department has listed numerous broad exemptions in the Demonstration application. Based upon the current exemption criteria, many, if not most, of the individuals or category of individuals cited in the comments will be exempt. In addition, the proposal is currently structured in a way that allows for additional exemptions to be granted based upon circumstances that would make it difficult for a person to achieve the objectives of the program. For example, individuals can request an exemption if they are experiencing a crisis, serious medical condition, or temporary condition or situation that prevents them from searching for work. These exemptions should provide protection for those who are unable to engage in or meet the number of expected activities, including individuals undergoing cancer treatment. Individuals working on average more than 20 hours per week do not have to

participate in the *Encouraging Employment* program. Further, neither premium payment nor participation in the *Encouraging Employment* program applies to individuals age 65 or older.

Comment Summary:
Commenters suggested additional groups that *should be* subject to the work search requirement, including pregnant women (unless there is a medical prohibition) and young adults 18-20.5 years of age.

Response:
All pregnant women through the postpartum period will remain exempt from participating in the *Encouraging Employment* program to be consistent with current federal regulations. Young adults under age 21 will not have to participate as outlined in the Demonstration application.

Comment Summary:
Commenters have concerns regarding the lockout periods of up to nine months per year for people who have difficulty proving that they have met the work search activities or lack means to pay their premiums. Commenters believe the lockout periods would cut off necessary health insurance coverage to vulnerable Pennsylvanians, leaving hospitals to pay the bills for people who require emergency treatment while they are locked out.

Response:
The Department's goal is to have zero eligible individuals in non-compliant status. However, all must acknowledge, coverage suspensions occur in the Medical Assistance (MA) program today for individuals who do not submit the necessary information; however, the structure that the Department has developed is designed to strike a reasonable balance between personal responsibility and access to care barriers. As a result, the Department proposed a lockout period that progressively increases for adults who do not comply with the *Encouraging Employment* program or make timely premium payments. Furthermore, Demonstration Year 1 will provide time for participants to adjust to the new program. The lockout period increases from three to six to nine months for each period of non-compliance.

The Department does not agree this graduated lockout period will result in increased uncompensated care for hospitals or other providers as the *Healthy Pennsylvania* Medicaid reforms and Private Coverage Option will increase access to health care to many individuals who currently are uninsured. The Department and federal government project the net result will be significantly less uncompensated care and untreated or undertreated individuals.

The draft premium proposal has been revised to exempt individuals with incomes no greater than 100% FPL. With this change—as well the exemptions protecting individuals who may not be able to make the payment, the positive incentives for those who do comply, and the

progressive periods of ineligibility—few should ever reach the longer non-compliance sanction periods of six and nine months. Individuals who make a full payment of all outstanding premium payments will be able to re-enroll in the program. Previously ineligible individuals who subsequently become exempt from premium payment due to a change in circumstances will also be allowed to re-enroll in the Medicaid program on a prospective basis.

Given the value of taxpayer supported health care services, it is reasonable to expect higher income participants to contribute modest amounts toward their own health care coverage and all able bodied participants to become more engaged in seeking employment opportunities.

Comment Summary:
One commenter indicated that the work search requirement makes arbitrary distinctions in the amount premiums are reduced based on the number of hours worked.

Response:
The Department disagrees. The different levels of incentives reward a higher level of performance and number of hours worked.

Comment Summary:
One commenter felt that the Demonstration is not likely to enhance participants' health by requiring enrollment be based on other qualifying factors, like work search activities.

Response:
Empirical evidence shows that being employed results in improved physical and mental health.[9] In order to promote improved health conditions and help these individuals begin to move out of poverty, Demonstration participants who are able to work and working on average less than 20 hours per week will be able to participate in the *Encouraging Employment* program, including registering with JobGateway[sm] and engaging in a specified number of job training and employment-related activities every month in an effort to pursue available employment opportunities.
---

[9] F. M. McKee-Ryan, Z. Song, C. R. Wanberg, and A. J. Kinicki, "Psychological and physical well-being during unemployment: a meta-analytic study," Journal of Applied Psychology, vol. 90, no. 1, pp. 53–76, 2005. K. I. Paul, E. Geithner, and K. Moser, "Latent deprivation among people who are employed, unemployed, or out of the labor force," Journal of Psychology, vol. 143, no. 5, pp. 477–491, 2009.

Comment Summary:
One commenter expressed concern about being unable to consistently obtain 20 hours of work per week despite being highly educated and having five employers, and views the requirement as derogatory to those who are uninsured and needing public assistance.

Response:
Healthy Pennsylvania is not intended to be derogatory to individuals needing help. The Demonstration takes an existing federal requirement for some Medicaid eligible individuals and expands the concept to non-exempt populations. As a condition of enrollment in other assistance programs, like TANF, many current Medicaid eligible individuals already participate in similar work-related activities in accordance with the Deficit Reduction Act of 2005.

This proposal is about helping people move out of poverty by providing them with connections and tools to find employment or more consistent employment opportunities. The Department is proposing that individuals register with JobGateway[sm] as a way to support individuals in this endeavor. The possible variability of work hours highlights a question that was not directly addressed in the draft Demonstration application. In cases where the number of hours varies, for purposes of determining compliance hours worked per week, work hours will be averaged over a six month period preceding a compliance review.

Comment Summary:
One commenter expressed concern with being able to document hours worked and work search activities in order to qualify for the premium reductions, especially for those who are self-employed. Other commenters expressed concern with using JobGateway[sm] to track work search activities because of its complexity; it is perceived as an inadequate resource.

Response:
JobGateway[sm] will be used as the vehicle for tracking all *Encouraging Employment* program activities. JobGateway[sm] is currently used by hundreds of thousands of individuals to access current job openings, create and upload resumes, and view job opening recommendations based on preferences. Close to 2 million job applications were submitted through JobGateway[sm] last year. On average, over 200,000 job openings are available each day, with over 10,000 new jobs being posted daily.

In terms of documenting hours worked, the Department plans to leverage current processes.

Comment Summary:
Commenters stated that JobGateway℠ does not support languages other than English.

Response:
JobGateway℠ is accessible in Spanish. The Department will review specific cases where language barriers pose significant problems to using the site. Should some individuals have an English-as-a-second language barrier, they will be referred to a CareerLink® or other local opportunity to seek employment and job training. Language barriers may also be considered a temporary condition or situation that prevents an individual from searching for work, allowing the person to qualify for an exemption.

Comment Summary:
One commenter provided recommendations for alternative approaches to the work search activities outlined in the Demonstration application.

Response:
The *Encouraging Employment* program has been developed to leverage existing Pennsylvania infrastructure, programs, and processes. However, the Department may continue to review acceptable additions that encourage employment.

Comment Summary:
One commenter questioned what will happen if CMS denies the proposed work search activity requirements.

Response:
The Demonstration application includes many provisions that will be evaluated by CMS. The Department has been working with CMS over the last year and there will continue to be discussion and negotiation between CMS and the Commonwealth. If CMS ultimately denies any of the major components of the application, the Commonwealth will have to evaluate the impact of the denial on the goals of the Demonstration and then make a decision about how to proceed.

Concerns Regarding Loss of Access for Persons with Disabilities and other Chronic Conditions

Comment Summary:
Commenters expressed concern that by phasing out Medical Assistance for People with Disabilities and the Medical Assistance for Workers with Disabilities (MAWD) programs, the Demonstration does not ensure a basic safety net for people with disabilities. Other commenters stated that changes from this phase out, such as requiring copayments, may result in some people with disabilities being unable to maintain health care coverage.

Response:
While the MAWD program is transitioned, individuals currently in the MAWD program will still have coverage through a variety of options including Medicaid, the Private Coverage Option (including employer sponsored coverage), and the FFM. Most individuals will be enrolled in Medicaid moving forward because they are medically frail and below 133% FPL.

With regards to the comment on copayment obligations, the current MAWD program requires premiums and copayments. As a result, the Department does not see the premium and copayment obligation as a barrier to maintaining health care coverage as those individuals are subject to substantially similar requirements today.

Comment Summary:
Commenters expressed concerned that the *Healthy Pennsylvania* plan will change the Commonwealth's commitment to home and community based service waiver programs. One commenter was specifically concerned about the outcome of the Attendant Care Program with the elimination of the MAWD program. The commenter stated that the in-home services that waiver eligible individuals receive help people with disabilities remain in the community and are an important support for employment. Other commenters pointed out that many in the MAWD program are able to access HCBS services when their income would otherwise exceed the HCBS income limit. If these individuals lose HCBS services, they may not be able to continue working and could be forced into an institution.

Response:
The *Healthy Pennsylvania* plan does not change the Commonwealth's commitment to home and community based service programs. The Demonstration application does not change access to, dedicated resources for, or eligibility criteria for waiver services. It is not the Department's intent for individuals currently eligible for MAWD to lose access to home and community services as a result of the Demonstration. The Department is carefully evaluating its

data to ensure there are not any unintended consequences. However, no waiver criteria are being modified by this Demonstration.

Comment Summary:
Commenters expressed concern for how individuals with disabilities will be impacted by the Demonstration, feeling they could lose benefits or be discriminated against by being subject to the premium and work search requirements. One commenter expressed specific concerns about the impact of the proposed changes on individuals with Multiple Sclerosis. Other concerns included confusion individuals may have regarding program changes.

Response:
The Department recognizes the importance of providing access to good health care for persons with disabilities and, as such, the *Healthy Pennsylvania* plan includes important provisions to address this issue.

The Demonstration does not change any of the requirements or services related to the Department's HCBS waiver programs. While the adult benefit plans described in the Demonstration application will apply to current waiver participants, the additional services being provided through the HCBS waiver will continue.

One of the goals of the Demonstration is to provide all individuals with the opportunity to achieve independence and self-sufficiency, where possible. It is important to point out that there are many individuals with serious mental illness, serious and complex medical conditions, and intellectual or developmental disabilities that can and do want to work. This Demonstration is designed to offer medically frail individuals and other low income individuals that same choice.

By increasing access to private market health insurance coverage, supporting private sector choice and competition, aligning benefits with private health care coverage, and encouraging healthy behaviors and individual responsibility, the proposed Demonstration directly supports the fiscal sustainability of Medicaid and helps to ensure that Medicaid remains the safety net available for special needs populations.

Comment Summary:
One commenter stated that *Healthy Pennsylvania* will have an adverse impact on access to treatment for persons living with HIV/AIDS.

Response:
The Demonstration will not interfere with any federal or state program for the treatment and prevention of HIV/AIDS, nor will it create barriers to efforts to reduce health disparities for

persons living with HIV/AIDS. On the contrary, by increasing access to health care services for over 500,000 individuals, the Demonstration will significantly increase access to coverage for HIV/AIDS preventive services and treatment of HIV/AIDS. The Demonstration will also reduce demands on the limited resources of existing HIV/AIDS related programs as individuals who are not currently eligible for coverage will gain access to affordable health care through the Private Coverage Option.

Comment Summary:
One commenter requested that *Healthy Pennsylvania* maintain the current categorically needy and medically needy categories for adults.

Response:
Mandatory and most optional categorically needy programs will continue to be covered under *Healthy Pennsylvania*. Other individuals, such as some portions of the medically needy and other optional programs, such as MAWD, will be enrolled in the Private Coverage Option or Medicaid as appropriate. As such, these categories of eligibility are no longer needed. Low income individuals will be eligible to be enrolled in Medicaid, in private market health insurance with the assistance of an advance premium tax credits (APTCs) available through the FFM, or in other private market health insurance options.

Benefits/Services

Comment Summary:
Several commenters expressed concerns regarding the limitations on benefits in the Low Risk and High Risk Benefit Plans, feeling they were: 1) equivalent to reductions to current MA benefits; 2) do not provide adequate benefits; 3) could increase emergency room attendance; and 4) are insufficient for the covered populations—particularly those with special needs or chronic conditions, such HIV/AIDS or those who qualify as medically frail. Benefit and service limitations that were specifically mentioned by commenters include: 1) behavioral health services; 2) hospitalizations and rehabilitation visits; 3) inpatient psychiatric coverage.

Response:
Pennsylvania's MA program currently has benefit limits on hospitalizations, office and clinic visits, some mental health services, as well as other services. The benefit package for children will remain the same and the community based supports and services for older Pennsylvanians and persons with disabilities will not change.

As a result of the comments received, the Department has decided to revise some of the benefit limits outlined in the application by adding to several categories. In the Medicaid Low Risk Benefit Plan (Low Risk Benefit Plan), Radiology will be changed from a limit of $500 per year to 6 tests per year. In the Medicaid High Risk Alternative Benefit Plan (High Risk Benefit Plan), it will change from a limit of $750 per year to 8 tests per year. Outpatient Mental Health Treatment provided at clinics was specified to include both Mobile Mental Health Treatment and Psychiatric Clinics within the visit limit. In the High Risk Benefit Plan, the limit for this service changed from 40 visits per year to 60 visits per year (the limits in the Low Risk Benefit Plan remain the same). Outpatient Drug and Alcohol Treatment services were specified to include opiate detox (42 visits per 365 days in the Low Risk and High Risk Benefit Plans, which is not a change from the current benefit limits), chemotherapy/drug-free visits (3 visits per 30 days in the Low Risk and High Risk Benefit Plans, which is not a change from the current benefit limits), and psychotherapy visits (30 visits per year in the Low Risk Benefit Plan and 60 visits in the High Risk Benefit Plan).

In terms of Laboratory services, limits in the Low Risk Benefit Plan changed from a limit of $250 per year to $350 per year. In the High Risk Benefit Plan, it changed from a limit of $350 per year to $450 per year. In terms of Durable Medical Equipment and Medical Supplies, limits have been revised to $1,000 per year each in the Low Risk Benefit Plan and to $2,500 per year each for the High Risk Benefit Plan. To encourage appropriate use of the emergency room, the Department is also removing Primary Care Provider (PCP) visits from the 12 visit limit in the Low Risk Benefit Plan and the 18 visit limit in the High Risk Benefit Plan. Therefore, there are no limits on PCP visits. This is applicable to PCP visits in any location of service, including but not limited to Federally Qualified Health Centers and Rural Health Clinics. Other benefits and services were also clarified on the chart found in Section 4.3 of the Demonstration application.

One of the key components of the *Healthy Pennsylvania* plan is that it provides adult benefit plans that match health care needs rather than using the legacy one-size-fits-all Medicaid approach. The benefits and limits in the adult benefit plans align very closely to the utilization of services today and will be consistent with national standards for coverage including: Essential Health Benefits; mental health parity; and drug and alcohol services. These limits were determined based on a statistical analysis of current Medicaid eligible individuals to ensure that at least 90% of current eligible individuals would be covered, and in many areas above 90%. The packages were also compared to the minimum Essential Health Benefit standard required for Pennsylvania, i.e. Aetna's POS 3.7 plan.

The Department will grant exceptions to the limits when it determines that one of the following criteria applies: 1) The eligible individual has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize life or result in the serious deterioration of health. 2) Granting the exception is a cost-effective alternative for the MA program. 3) Granting the exception is necessary in order to comply with federal law.

These exception criteria are consistent with the current MA benefit limit exception criteria and, therefore, should not prevent eligible individuals from receiving necessary care for serious health care needs. The process for requesting a benefit limit exception will be consistent with the process that is used, and working well today.

Comment Summary:
Commenters expressed concern that the Demonstration would use an ineffective exception process for the service limits.

Response:
The Department will utilize the service limits exception process that is currently in place and will handle requests in a timely and efficient manner. Additionally, the Department intends to automate many of the new exception processes, making the process easier for eligible participants, and minimizing delays and errors.

Comment Summary:
Commenters requested that the service limits placed on home health care in the Low Risk and High Risk Benefit Plans be eliminated.

Response:
The home health care limits for Medicaid services in the Low Risk and High Risk Benefit Plans are consistent with current MA limits; however, most Medicaid eligible individuals are enrolled in HealthChoices, where they receive their services through managed care plans. These managed care plans may choose to add additional services or set different service limits as a cost effective alternative that improves health outcomes.

Comment Summary:
Commenters expressed concern that the Community First Choice Option was not included in either benefit plans.

Response:
The Community First Option is a state plan change that the Department considered outside of the waiver process. It is not part of the state plan redesign because the Community First Choice Option is focused on individuals determined to be in need of long term care services. This Demonstration waiver does not change long term care services and supports.

Comment Summary:
Commenters objected to deleting family planning from the list of covered services. Some commenters stated that federal law protects the ability of Medicaid eligible individuals to receive family planning services from the provider of their choice, even if the provider is outside of their Medicaid managed care network. Others questioned the out-of-network copayments.

Response:
The Demonstration does not remove family planning as a covered service. The proposed waiver of family planning services only applies to the Private Coverage Option. Private market health insurance plans participating in the Private Coverage Option must cover family planning services through the federal Essential Health Benefit requirement. The intent of the waiver is to let the private market health insurance plans, including employer sponsored coverage, manage their own provider networks. As such, copayments for out-of-network services are the responsibility of the participant in the Private Coverage Option.

Comment Summary:
Commenters do not want the current SelectPlan for Women replaced with the *Healthy Pennsylvania* plan, some believing that private insurance doesn't offer the same coverage of services.

Response:
The SelectPlan for Women program was intended to cover services that are related to family planning for uninsured women. However, with the changes made to the health care market under the Affordable Care Act, the SelectPlan for Women program will no longer be needed to assist individuals' access reproductive health care coverage as program participants will now have access to Essential Health Benefits that have broader coverage than the SelectPlan for Women program. Because SelectPlan only covers family planning services, the program does not meet the requirements of an Essential Health Benefits package.

The Essential Health Benefit requirement of the Affordable Care Act includes 10 categories of services: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Preventive and wellness services for women are covered without any cost sharing for in-network providers. Such services include well-woman visits, screening for gestational diabetes, human papillomavirus testing, counseling for sexually transmitted infections, counseling and screening for the human immune-deficiency virus, and contraceptive methods and counseling.

However, the Commonwealth is seeking to maintain the SelectPlan program until the *Healthy Pennsylvania* Demonstration is implemented.

Comment Summary:
One commenter asked if the women in active treatment through the Breast & Cervical Cancer Treatment program will be allowed to continue receiving their treatment services through the Department's existing program or if their benefit plan will change before their treatment ends.

Response:
This waiver does not affect the Breast & Cervical Cancer Treatment program.

Comment Summary:
One commenter recommended that *Healthy Pennsylvania* include robust mechanisms to allow women to report their pregnancy and receive care in a timely manner.

Response:
The reporting mechanisms that are currently used today will continue to exist under the Demonstration.

Comment Summary:
Commenters objected to limits placed on mental health or durable medical equipment (DME) services, since these help consumers obtain and keep work. Commenters specifically expressed concerns regarding the combined $2,500/month limit on DME and DMS.

Response:
The Department agrees that mental health and DME are necessary services that can help people with disabilities obtain and maintain employment. In response to the comments, the Department has revised the limits as noted above.

Exceptions to benefit limits can also be approved when there is a demonstrated medical need for additional services as described below. As such, the limits should not prevent eligible individuals from receiving necessary care.

The Department will follow its current benefit limit exception process. The following are the types of conditions reviewed for benefit limit exceptions. The patient has a serious chronic illness or other serious health condition and without the additional service, before the next eligibility period begins, his/her life would be in danger. The patient has chronic illness or other serious health condition, and without the additional service, before the next eligibility period begins, his/her health will get much worse. The patient would need more costly services if the

exception is not granted. The patient would have to go into a nursing home or institution if the exception is not granted.

Comment Summary:
One commenter stated that in the existing Medicaid MCO system, several MCO plans have severely restricted provider networks to certain providers of DME equipment and supplies. It is the commenter's position that patients needing DME and supplies are, in general, patients with other "expensive medical conditions," and that limiting DME suppliers creates a de facto discrimination against these high needs patients. As such, they promote any willing provider status for inclusion in MCO's and the private insurance option for all DME providers that meet the criteria for admission and participation.

Response:
Current Medicaid MCOs must meet contractual requirements around network standards and the Department has not received complaints nor identified problems with accessing DME equipment and supplies. Plans serving Private Coverage Option participants must meet state and federal network adequacy standards. The Department encourages the specific reporting of issues or complaints by participants.

Comment Summary:
One commenter made statements associated with Olmstead requirements and the impacts of *Healthy Pennsylvania,* in particular, on the DME limit.

Response:
The Governor and the Department remain committed to Olmstead and working with the disability community. The limits that are incorporated into the adult benefit plans are based on the utilization of services in the current program. Exceptions can be approved when there is a demonstrated medical need for additional services. Therefore, the limits should not prevent eligible individuals from receiving necessary care.

Comment Summary:
One commenter recommended that psychiatric rehabilitation be included as a service under the *Healthy Pennsylvania* benefit plans.

Response:
Psychiatric rehabilitation is not currently a Medicaid state plan service and the Department is not intending to add the service. It is a supplemental service offered by HealthChoices Behavioral Health plans and will still be available at the discretion of the plans.

For those enrolled in the *Healthy Pennsylvania* Private Coverage Option, private coverage plans may cover any health service they determine would improve the outcomes of their members, including psychiatric rehabilitation.

Comment Summary:
Commenters suggested that the way physical and mental health hospital limits are designed in the Demonstration will not meet federal mental health parity requirements.

Response:
The Department will ensure that all benefit plans in the *Healthy Pennsylvania* plan, including those offered under the Private Coverage Option, meet all applicable state and federal laws, including mental health parity requirements.

Comment Summary:
One commenter asked if the Demonstration would change the benefits for Pennsylvania state employees. Another commenter does not feel there is a need for additional screenings if a Pennsylvania employee maintains a relationship with a primary physician.

Response:
This proposal will not impact benefits that state employees receive under their benefit program. Only state employees who are covered under Medicaid will be impacted by the change.

Comment Summary:
One commenter felt that the two benefit plans would be costly for Medicaid managed care organizations to manage.

Response:
The Department does not agree that there would be an unwarranted increase in administrative costs for Medicaid managed care plans. In fact, the *Healthy Pennsylvania* plan will reduce the administrative burden for HealthChoices managed care plans by replacing the Medicaid program's multiple existing adult benefit designs with two simplified, private market health insurance-like adult benefit plans that are consistent with national standards.

Comment Summary:
One commenter expressed the concern that her 20 month old grandson who suffers from Juvenile Idiopathic Arthritis would be harmed by the requirements contained in the Demonstration application.

Response:
The proposed demonstration does not affect children under 21 years of age (although all adults, who are at least 18 years old and enrolled in the Low Risk Benefit Plan or High Risk Benefit Plan or Private Coverage Option will pay copayments as described in the state plan and consistent with federal policy and approved demonstration requirements).

Comment Summary:
Commenters expressed concern regarding the Department's decision to waive the mandated provision of non-emergency transportation. Other commenters suggested that all wrap around services be provided to Private Coverage Option participants, including 90 days of retroactive coverage.

Response:
Essential Health Benefits do not include non-emergency medical transportation. One of the basic goals in creating the Private Coverage Option is to utilize and stay in alignment with the private health insurance market. The Department is not seeking to impose additional mandates on the private market health insurance plans to create and administer a separate supplemental package of wrap around services that would be unique to the newly covered population or provide retroactive coverage (however, Private Coverage Option participants may be determined to be presumptively eligible by a hospital). The Department is seeking to make a sustainable program that aligns with private market health insurance and can be maintained over time. Private Coverage Option plans, including employer sponsored coverage, can offer such benefits or services should they choose to do so.

Retroactive coverage is not being eliminated for the traditional Medial Assistance program.

Comment Summary:
One commenter recommended adding retroactive coverage for the newly covered group so that coverage would be provided at the start of a hospital stay, arguing there would be an overall increase in uncompensated care if retroactive coverage was not provided.

Response:
A primary goal of implementing the Private Coverage Option is to align the new program with private health insurance market practices. Private market health insurance plans, including employer sponsored coverage, typically do not provide retroactive coverage. In addition, public

programs, like the Children's Health insurance Program, do not provide for retroactive coverage. However, with the goal to increase access across the board, the Department will be revising presumptive eligibility standards currently in place. These new standards will include the populations that are eligible for the Private Coverage Option. As outlined in the Demonstration application, the Department will provide coverage under FFS for the period between the inpatient acute care hospital presumptive eligibility application date and the effective date of the Private Coverage Option coverage.

The Department does not believe that there will be an overall increase in uncompensated care resulting from the waiver of retroactive coverage. Individuals who are enrolled in the Private Coverage Option are generally not currently insured and when enrolled will have access to coverage that includes hospital services. Finally, with coverage available and a federal mandate to obtain insurance, it is expected that many more individuals will enroll before a catastrophic health-related event occurs. While it is very likely that there will continue to be applications for new coverage that result from an unexpected hospitalization, the volume should noticeably decrease.

Comment Summary:
Commenters objected to the change in dental benefit services covered under the *Healthy Pennsylvania* benefit plans. Another commenter recommended the plans include basic dental.

Response:
The adult dental services provided in the Low Risk and High Risk Benefit Plans are the same as what is currently provided through Pennsylvania MA, which is above what is federally required to be provided by states.

For those enrolled in the *Healthy Pennsylvania* Private Coverage Option, private coverage plans may cover any health services, including dental, if the plan determines that the service would improve the health outcomes of its members.

Comment Summary:
Commenters expressed concern with ensuring coverage and funding of non-hospital residential treatment for substance use disorders and use of the Pennsylvania Client Placement Criteria for Adults (PCPC) guidelines. Some commenters also recommended that retroactive coverage be provided in such cases.

Response:
The Department understands the concern regarding continued access to non-hospital substance use disorder services and wants to assure the commenters that *Healthy Pennsylvania* will not negatively impact substance use disorder services. In fact, the Demonstration will

significantly increase access to substance use disorder treatment and mental health care for those currently without coverage today. State laws governing substance use disorder treatment facilities are unaffected.

For Medicaid eligible individuals, the use of PCPC guidelines is not affected by the Demonstration. It is also important to note that any individuals determined to be medically frail, including those with a chronic substance use disorder, will be served through the High Risk Benefit Plan.

For participants in the Private Coverage Option, private market health insurance plans may use PCPC or other evidence-based guidelines in making individual coverage decisions for residential substance use disorder treatment, including admission and length of stay. Private Coverage Option plans must provide participants with all medically necessary behavioral health care covered in the Essential Health Benefits package as well as state mandated Act 106 benefits through an adequate network of behavioral health providers. One of the basic goals in creating the Private Coverage Option is to utilize and stay in alignment with the private health insurance market. In this light, the Department is not seeking to impose additional mandates on Private Coverage Option plans, such as what clinical criteria to use. The Department is seeking to make a sustainable program that aligns with private market health insurance and can be maintained over time.

As with other private market health insurance coverage, Private Coverage Option does not provide for retroactive eligibility or coverage of services before the effective date of plan enrollment (however, Private Coverage Option participants may be determined to be presumptively eligible by a hospital). For Private Coverage Option participants, payment policies, including handling of retroactive approvals of an admission, will be determined by the patient's private market health insurance plan with rates negotiated with providers. Retroactive coverage is not being eliminated for the traditional MA program.

Comment Summary:
Commenters asked if the proposed benefit plans will meet the requirements of Pennsylvania's Act 106 of 1989.

Response:
The Department will ensure that *Healthy Pennsylvania* Private Coverage Option plans comply with all state and federal laws, including Act 106.

Comment Summary:
Commenters are concerned that the movement of the General Assistance (GA) population to the Private Coverage Option would result in the loss of substance use disorder treatment services.

Response:
The population now covered through the General Assistance Medical Program (GA-related Medical) will greatly benefit from the Private Coverage Option, which includes all of the Essential Health Benefits, including mental health and substance use disorder services. Additionally, this population will benefit from a broader benefit package than they receive today, established provider networks, care coordination, and chronic care management. The Department will ensure that participating Private Coverage Option plans comply with all state and federal laws.

It is also important to note that any individuals determined to be medically frail, including individuals with a chronic substance use disorder, will be served through the High Risk Benefit Plan.

Comment Summary:
Commenters expressed concerns related to how the Demonstration will affect behavioral health services. Other commenters stated that behavioral health services should continue to be controlled at the county level and that mental health and substance use disorder services should be the same in both the Low Risk and High Risk Benefit Plans.

Response:
Under the current Demonstration application and State Plan Amendments, behavioral health benefits for MA eligible individuals will continue to be provided in the manner they are today. All behavioral health benefits in the *Healthy Pennsylvania* Private Coverage Option plans would be equivalent to the services provided under the Essential Health Benefit benchmark plan for Pennsylvania and delivered through the Private Coverage Option plans' provider network.

Both the MA program and the Private Coverage Option plans for will comply with the federal and state parity and network adequacy requirements. Because of this, the Department does not anticipate degradation in behavioral health services. In fact, because more individuals will have access to insurance coverage, it is anticipated that more individuals will receive behavioral health services.

The Commonwealth aims to move away from the legacy one-size-fits-all Medicaid approach and focus on the individuals by implementing two different adult benefit plans; as such, mental health and substance use disorder services will vary across the two different plans to accommodate varying circumstances. However, as a result of the comments received, the

Department has decided to revise some of the benefit limits outlined in the application. In the High Risk Benefit Plan the limit for Outpatient Mental Health Treatment services changed from 40 visits per year to 60 visits per year and was specified to include both clinic-based as well as mobile mental health treatment visits within the visit limit.

Outpatient Drug and Alcohol Treatment services were specified to include opiate detox (42 visits per 365 days in the Low Risk and High Risk Benefit Plans, which is not a change from the current benefit limits), chemotherapy/drug-free visits (3 visits per 30 days in the Low Risk and High Risk Benefit Plans, which is not a change from the current benefit limits), and psychotherapy visits (30 visits per year in the Low Risk Benefit Plan and 60 visits in the High Risk Benefit Plan).

Comment Summary:
One commenter stated that the Private Coverage Option will create provider access issues, especially in terms of behavioral health services.

Response:
The Private Coverage Option will be subject to the federal Essential Health Benefits requirement, which mandates the coverage of behavioral health services. This means all Private Coverage Option plans must offer mental health and substance use disorder benefits in parity with medical and surgical benefits. Private Coverage Option plans must additionally meet all state and federal network adequacy requirements. To comply with these requirements, all private market health insurance plans, including employer sponsored coverage, will expand their networks as necessary to meet any changes in demand, mitigating provider access issues. The Department will monitor access to services, including behavioral health, and address any access limitations.

Comment Summary:
One commenter asked how substance use disorder treatment, such as methadone maintenance therapy, would be handled in the Private Coverage Option.

Response:
It is important to point out that most individuals with chronic substance use disorders will be considered medically frail and would be enrolled in the High Risk Benefit Plan that covers methadone maintenance therapy.

If an individual is not determined to be medically frail, and not currently eligible for Medicaid, they will be enrolled in the Private Coverage Option, in which private coverage plans may cover any health services, including methadone maintenance therapy, as long as the plan meets the requirement to provide Essential Health Benefits. The federal Essential Health Benefits

requirement does mandate the coverage of behavioral health services, including mental health and substance use disorder services. This includes anti-addiction/substance abuse treatment agents (opioid antagonists) on the prescription drug Essential Health Benefit, but does not specifically require methadone. All Private Coverage Option plans must additionally offer mental health and substance use disorder benefits in parity with medical and surgical benefits.

Comment Summary:
One commenter proposed working with the Administration in designing the reformed Medicaid benefit plans to ensure they include sufficient flexibility and depth of coverage.

Response:
The Department has worked with clinical staff to analyze the adult benefit plans and used the public comment process to evaluate the need to modify them. In response to comments received, the Department has revised the adult benefit plans as described in earlier responses.

Comment Summary:
One commenter is concerned that the changes included in the *Healthy Pennsylvania* plan will reduce enrollment.

Response:
The Department does not agree that that enrollment will be reduced under the *Healthy Pennsylvania* plan. A primary goal of the *Healthy Pennsylvania* plan is to increase access to health care coverage for more than 500,000 Pennsylvanians and do so in a way that is right for Pennsylvania.

Comment Summary:
One commenter disagreed with the approach of placing people with different conditions into broad benefit plans.

Response:
The adult benefit plans are comprehensive in design and allow exemptions for the limits placed on some services. This will allow individuals to receive the specific and individualized treatments they require.

Comment Summary:
One commenter expressed frustration about the inequity of the Medicaid benefit plan versus the commenter's current plan that costs $12,000 per year. The commenter prefers a single plan that would help all Pennsylvania citizens save on their health care.

Response:
The Department agrees that the current health care system needs to become more cost effective. This is the reason Governor Corbett's *Healthy Pennsylvania* plan is broader than just increasing access to health care. *Healthy Pennsylvania* seeks to increase access to primary care, increase the use of technology, ensure quality, and improve affordability. Part of the affordability strategy includes reforming the adult benefit plans in MA to help better align the plans with private market health insurance. However, there are federal statutory requirements with which the benefit plans must comply. Some of these requirements may result in a richer benefit plan in the MA program, which covers individuals with high needs and few resources to pay for the needed health care.

Comment Summary:
Commenters suggested that Pennsylvania cover nutrition counseling by registered dietitian nutritionists for health promotion and disease prevention, and not just to treat existing disease such as diabetes and kidney as it does now**.** There were also suggestions to cover Lactation Consulting services, Medication Therapy Management, and Parent Support Partners, and additional oral health services.

Response:
The benefits covered through the Demonstration comply with federal requirements, which do not require the suggested services. Most Demonstration participants will be enrolled in a private market health insurance product or a HealthChoices physical health Medicaid managed care plan. These plans may choose to cover any health services, including nutrition counseling, lactation counseling, medication therapy management and parent support partners, as long as the plan meets the requirement to provide Essential Health Benefits. While these services are not currently one of the Essential Health Benefits, a private market health insurance plan may determine that this benefit would improve the health outcomes of its members and cover the service.

The adult oral services provided in the Low Risk and High Risk Benefit Plans are the same as what is currently provided through the MA program.

Comment Summary:
Commenters recommended adding telehealth to the benefit plans.

Response:
The Department currently covers consultations provided to MA eligible individuals when rendered using telecommunication technology. In addition, the Governor's broader *Healthy*

Pennsylvania plan is pursuing additional opportunities to increase the use of telehealth technology throughout the Commonwealth.

For those enrolled in the *Healthy Pennsylvania* Private Coverage Option, private coverage plans may cover telehealth services if they determine that this benefit would improve the health outcomes of their members. Several private market health insurers currently cover telehealth while others are conducting internal evaluations as to whether to reimburse for care delivered via telehealth. The Corbett Administration will continue dialogue with all stakeholders in its effort to use technology to improve the quality of and access to health care in Pennsylvania.

Comment Summary:
One commenter asked to clarify if *Healthy Pennsylvania* participants will have access to clinical trials.

Response:
It is important to note that clinical trials are not covered services; rather the services provided during the clinical trials are assessed for coverage. For those enrolled in the *Healthy Pennsylvania* Private Coverage Option, private coverage plans may cover clinical trial services if they determine that these services would improve the health outcomes of their members.

Comment Summary:
Commenters requested that podiatry be included in the *Healthy Pennsylvania* benefit plans, since it is essential in the treatment of diabetes.

Response:
The Department currently covers podiatry services provided by licensed physicians with a Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO) degree, independent and outpatient hospital clinics and under a home health agency plan of care. Under *Healthy Pennsylvania*, these services would continue to be covered. In terms of other podiatry services, the benefits covered through the Demonstration comply with federal requirements, which do not require podiatry services. However, most Demonstration participants will be enrolled in a private market health insurance product or a HealthChoices physical health Medicaid managed care plan. These plans may choose to cover podiatry services when they determine that this benefit would improve the health outcomes of their members.

Comment Summary:
Several commenters mentioned the need to address the Commonwealth's long term care model. One commenter described the need to move towards a long term care model that balances community and institutional care. Another commenter stated that they would like the

current nursing home transition program to be less complex. Another believes that the *Healthy Pennsylvania* plan needs to include a provision that stresses the need for community based alternatives to nursing facility care in order to address "skyrocketing" Medicaid spending. Others discussed the establishment of the Long Term Care Commission. One commenter encouraged the Commonwealth to look at the manner in which long term care services are being provided in Pennsylvania Medicaid, espousing that a medically needy group with an income spenddown be added to Medicaid. Another commenter suggested creating a Medicaid Managed Long Term Services and Supports program as part of the Demonstration.

Response:
No long term services and supports or personal care will change under the Demonstration. Pennsylvania will continue to provide long term services and supports, including the LIFE program (Pennsylvania's PACE program) under the existing approved §1915(c) or §1934 authorities.

The *Healthy Pennsylvania* plan is built on three core objectives—reform Medicaid, increase access, and stabilize funding. As part of meeting these objectives, Pennsylvania is looking to improve its current long term care system, which is fragmented and not easy for older adults and individuals with physical disabilities to navigate. On January 31, 2014, Governor Corbett signed an executive order establishing the Pennsylvania Long Term Care Commission. The Commission will review and make recommendations on how to improve the current long term services and support system in ways that align with the Demonstration's core objectives. Pennsylvania may revise the Demonstration program through a future amendment to this waiver, or other necessary authorities, to address any potential changes.

Comment Summary:
One commenter suggested including the Balancing Incentive Program in the Demonstration.

Response:
No long term services and supports will change under the Demonstration. However, as announced in Governor Corbett's recent budget proposal, the Department will be submitting an application for the federal Balancing Incentive Program that will provide more resources to those in need of long term care supports.

Comment Summary:
One commenter indicated that support for treatment and recovery is not supported in the plan.

Response:
Both the Low Risk and High Risk Benefit Plans include behavioral health inpatient and outpatient benefits. Private Coverage Option plans will also cover treatment and recovery services.

In terms of the Low Risk and High Risk Benefit Plans, Outpatient Mental Health Treatment provided at clinics includes Mobile Mental Health Treatment and Psych Clinics. In the High Risk Benefit Plan, the limit for this service changed from 40 visits per year to 60 visits per year (the limits in the Low Risk Benefit Plan remain the same). Outpatient Drug and Alcohol Treatment services were specified to include opiate detox (42 visits per 365 days in the Low Risk and High Risk Benefit Plans, which is not a change from the current benefit limits), chemotherapy/drug-free visits (3 visits per 30 days in the Low Risk and High Risk Benefit Plans, which is not a change from the current benefit limits), and psychotherapy visits (30 visits per year in the Low Risk Benefit Plan and 60 visits in the High Risk Benefit Plan).

Comment Summary:
Commenters suggested that the benefit plan be expanded to include a special needs service coordination service.

Response:
Most Medicaid eligible individuals are enrolled in both physical and behavioral HealthChoices managed care plans that are responsible for providing care management and coordination. These plans have Special Needs Units to assist individuals requiring special needs assistance.

For those enrolled in the *Healthy Pennsylvania* Private Coverage Option, private coverage plans may cover special needs coordination if they determine that this benefit would improve the health outcomes of their members. As a result, some private market health insurers have established care management programs that may include assisting individuals requiring special needs assistance.

Comment Summary:
One commenter suggested that the Department cover chiropractic services under the *Healthy Pennsylvania* benefit plans.

Response:
The Department currently covers certain chiropractic services when provided by approved providers, such as licensed physicians with a Doctor of Medicine (MD) or Doctor of Osteopathic

Medicine (DO) degree, independent and outpatient hospital clinics, and under a rehabilitation plan of care. Under the *Healthy Pennsylvania* plan, these services will continue to be covered. In terms of other chiropractic services, the benefits covered through the Demonstration comply with federal requirements, which do not require chiropractic services. However, most Demonstration participants will be enrolled in a private market health insurance product or a HealthChoices physical health Medicaid managed care plan. These plans may choose to cover any health services or provider type if they determine would improve the health outcomes of their members.

Comment Summary:
Several commenters (pharmacists) requested that the Department keep pharmacists in mind when looking for help with expanding health care.

Response:
The Department of Public Welfare plans to work closely with all of its stakeholders to implement the *Healthy Pennsylvania* plan.

Comment Summary:
Commenters suggested that the benefit plans include comprehensive primary care and preventive care.

Response:
Preventive and primary care health benefits are included in both the Low Risk and High Risk Benefit Plans as well as the Private Coverage Option. Both the benefits and limits in the adult benefit plans align very closely to the utilization of services today and will be consistent with national standards for coverage including Essential Health Benefits and mental health parity. The packages were also compared to the minimum Essential Health Benefit standard required for Pennsylvania, i.e. Aetna's POS 3.7 plan.

Based on comments received, the Department is removing PCP visits from the 12 visit limit in the Low Risk Benefit Plan and the 18 visit limit in the High Risk Benefit Plan, meaning there are no limits on primary care visits. This is applicable to PCP visits in any location of service, including but not limited to Federally Qualified Health Centers and Rural Health Clinics.

Comment Summary:
One commenter suggested that the Department look closely at how it pays for services to treat mental illness and determine if there are more effective approaches.

Response:
The Department agrees the current mental health, and physical health system should be reviewed to determine if there are more effective approaches. The *Healthy Pennsylvania* plan supports this suggestion by ensuring quality and providing affordability for all Pennsylvanians. To help address these goals, Pennsylvania has developed a State Healthcare Innovation Plan (Innovation Plan). The Innovation Plan puts Pennsylvania on a strong path to reform Pennsylvania's health care payment and delivery system, including the mental health system, in a way that will encourage quality health care practice and promote healthy living among Pennsylvanians, while taking quantitative measures to lower health care costs.

Comment Summary:
One commenter urged the Department to increase the list of preventive services; another urged the Department to use this opportunity to include prevention measures.

Response:
The list of preventive services included in the waiver is not an all-inclusive list. The Department will continue to review the list of preventive services developed by the United States Preventative Services Taskforce to determine updates and future inclusions within the Medicaid program. Additionally, the Demonstration is taking steps to include preventive and primary care in the program by providing incentives for healthy behaviors, as well as providing preventive and primary care to more than 500,000 individuals who currently do not have access to health care.

Comment Summary:
One commenter believes the Demonstration should offer participants more choice of benefit designs than is currently available through traditional Medicaid or premium assistance for private market health care coverage, particularly covered services and cost sharing.

Response:
The Department agrees with the importance of choice and competition. The existing HealthChoices program and the proposed Private Coverage Option offer participants a choice of competing health plans. Health plans may also offer additional benefits to increase membership and improve care. The Department will monitor choice and competition in the Private Coverage Option and identify improvements as appropriate. In determining cost sharing amounts, the Department must balance the access, affordability and the sufficiency of the incentive with federal rules and regulations.

Comment Summary:
One commenter suggested that targeted case management should not be limited to the High Risk Benefit Plan.

Response:
Targeted case management (TCM) is appropriately included in the High Risk Benefit Plan and is available to eligible individuals with a severe mental illness. Individuals identified with severe mental illness will be determined medially frail and enrolled in the High Risk Benefit Plan. In terms of the Private Coverage Option, case management services, used to assist eligible individuals gain access to necessary care, is increasingly being integrated into private market health insurance plans' delivery systems.

Comment Summary:
Commenters recommended continuing EPSDT services for individuals, regardless of age, as long as they live with their parents or caretakers.

Response:
Under federal Medicaid law the Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program allows Medicaid programs to reimburse providers for medical services beyond those covered by the Medicaid program so long as they are medically necessary and provided to an individual younger than 21 years of age. To expand this program to cover persons with disabilities living with their parents would require a change to federal law and cannot be done by the Department through the Demonstration.

Healthy Behaviors

Comment Summary:
One commenter urged clarification that the "healthy behavior" incentive program will only include process or participation measures. The commenter discourages including outcome based incentives in the Demonstration, like being successful at quitting smoking. Additionally, the commenter strongly encourages the Department not to include premium payment and work search related incentives because the measures are not related to preventive health care and will not improve health. Another commenter stated that the plan's three "healthy behaviors": paying a premium on time, completing a Health Risk Assessment, and receiving an annual medical check-up are only the first step to health behavior change and are not actual "healthy behaviors." Commenters also stated that the incentives would be difficult to

administer and it is unclear that they will actually lead to the desired "healthy behaviors" described in the plan.

Response:
The Department appreciates the input on healthy behaviors. The initial set of healthy behaviors outlined in the waiver proposal is just a first step in an on-going process to develop and reward behaviors that lead to a healthier population. The Department will continue to refine and develop plans to reward healthy behaviors over the life of the Demonstration.

The Department disagrees with the commenter on the point about not including premium payment and job training and employment-related activities because they will not improve health. Empirical evidence shows that being employed results in improved physical and mental health.[10] The premium and copayment structure will increase the personal responsibility of participants with regards to their health care decisions.

Automated processes will primarily be used in tracking healthy behaviors, which will significantly reduce the perceived administrative burdens of the proposal.

Comment Summary:
One commenter expressed concern with participants' ability to achieve healthy behaviors given external hardships, such as working two jobs, having to travel to grocery stores that offer healthy options, and having little time to exercise.

Response:
To help individuals take steps to achieve better health, the Department is proposing to begin the healthy behavior incentives program with reasonable expectations. In Demonstration Year 1, participants will be encouraged to have an annual wellness visit. In Demonstration Year 2, individuals will be incentivized to complete a Health Risk Assessment and have an annual wellness visit through reductions in their premium payments and other cost sharing obligations. It is believed that by completing these two activities, individuals will have a better sense of their own health and will be encouraged to be more active participants in improving their health. After three years, the Commonwealth may evaluate Health Risk Assessment data and determine whether broader healthy behaviors should be used, such as cholesterol testing.
---

[10] F. M. McKee-Ryan, Z. Song, C. R. Wanberg, and A. J. Kinicki, "Psychological and physical well-being during unemployment: a meta-analytic study," Journal of Applied Psychology, vol. 90, no. 1, pp. 53–76, 2005. K. I. Paul, E. Geithner, and K. Moser, "Latent deprivation among people who are employed, unemployed, or out of the labor force," Journal of Psychology, vol. 143, no. 5, pp. 477–491, 2009.

Comment Summary:
One commenter recommended that using the term "annual wellness visit" would be a more appropriate clinical term than "annual physical." A physical exam is not always needed annually.

Response:
The Department will use the term "annual wellness visit" in place of physical exam.

Comment Summary:
One commenter urges the Department to provide incentives for low income individuals to seek and receive primary care. He suggests paying members $100 for getting a hemoglobin a1c test.

Response:
The Department agrees that incentives are a valuable tool to encourage use of primary care. *Healthy Pennsylvania* seeks to do this through the revised premium and copayment structure and the healthy behavior incentives program, which include having an annual wellness visit (beginning in Demonstration Year 1) and completing a Health Risk Assessment (beginning in Demonstration Year 2). In developing incentives, the Department must comply with federal Medicaid requirements and establish a program that is sustainable. The Department believes the proposed incentives meet both of these items.

The initial set of healthy behaviors outlined in the waiver proposal is just a first step in an on-going process to develop and reward behaviors that lead to a healthier population. The Department will continue to refine and develop plans to reward healthy behaviors over the life of the Demonstration.

Comment Summary:
One commenter offered to work with the Commonwealth in designing a program that incentivizes healthy behaviors and personal responsibility. The commenter believes that the Commonwealth should work with health plans and community-based organizations on any local, community-based outreach and education needed to successfully implement the Demonstration and support the goals for healthy behavior and personal responsibility.

Response:
The Department looks forward to working with stakeholders, including health plans experienced in serving low income populations, to ensure that healthy behaviors and personal responsibility is encouraged and supported.

Health Screening and Enrollment

Comment Summary:
Commenters asked about how risk status will be determined. Several commenters expressed concern with the accuracy of the assessment and using a self-assessment for identifying the benefit plan into which the individual would be enrolled. Commenters also questioned the ability of individuals to move between the Low Risk and High Risk Plans as their circumstances change.

Response:
One of the key components of the *Healthy Pennsylvania* plan is that it matches the correct benefit plan to individual health care needs. The Department will use claims data to assist in determining the appropriate adult benefit plan for current eligible individuals. A health screening process will also be used to identify eligible individuals' health status for enrollment in either the Low Risk or High Risk Benefit Plan. For current individuals, the health screening can supplement the results of the claims data. The health screening will consist of a self-administered questionnaire that is completed by the individual, family member, guardian, or with the assistance of a COMPASS community partner. Consumer Service Centers may be used to facilitate the health screening process, and additional assistance may be provided to individuals as needed. The health screening includes questions about an individual's health and conditions. The Department believes individuals have the best understanding of their own health; as such self-reporting process will produce the best results. The responses will be analyzed by an algorithmic process, which will allow the Department to match the applicant to the appropriate benefit plan. The Department plans to implement additional reviews to validate the results of the algorithmic process. To the extent the Department has access to recent Medicaid claims data on the individual, that data will also be used to help determine whether someone is high or low risk.

Comment Summary:
Commenters expressed concern regarding the potential of the application and enrollment process to delay care.

Response:
The Demonstration's application and enrollment process will operate under the same timelines as currently exist in the traditional MA program. The health screening for adults will be part of a seamless continuation of the eligibility process. It will not delay eligibility and completion of the health screening is not a condition of eligibility.

Comment Summary:
One commenter requested that eligibility information be timely and current. Another commenter stated that, with the implementation of premium and work search requirements, providers will need to receive timely notice of individuals whose benefits are suspended.

Response:
The Department agrees that eligibility information needs to be timely and current. As such, the Department intends to automate as much of the processes as possible and will attempt to minimize the burden on eligible individuals and providers. The Department will use existing processes, which providers are familiar with and are required to use today, to determine eligibility for services. These processes allow providers to receive timely notice of individuals whose benefits are suspended.

Comment Summary:
One commenter recommended that a health insurer notify the provider of a patient's grace period status as part of the insurance eligibility verification process.

Response:
Notification of eligibility status during the 90-day grace period will be the same as during other eligibility periods. As with any other eligible individual, the health plan or the MA program will be responsible to pay eligible claims for services rendered during the 90-day grace period.

Comment Summary:
One commenter felt that the High Risk Benefit Plan enrollment criteria are too stringent.

Response:
All SSI recipients, pregnant women, individuals who are dually eligible for Medicare and Medicaid, residents of institutions, and individuals receiving HCBS services will be automatically enrolled into the High Risk Benefit Plan. In addition, adult individuals who are identified through the health screening process or the Department's claim data as having more complex medical needs will be enrolled in the High Risk Benefit Plan. The Department believes this allows sufficient opportunity for enrollment in the most appropriate adult benefit plan.

Comment Summary:
One commenter recommended that the Commonwealth reconsider self-administration of the health screening and transition eligible individuals between the low risk and high risk benefit categories automatically upon more accurate determination by Private Coverage Option plans of members' health status.

Response:
The Department appreciates the importance of the screening process and has worked to develop a process that uses the applicant's input, automated decision making logic, and data to determine the appropriate benefit category. To clarify, the Private Coverage Option does not have low risk and high risk benefits. Only non-medically frail individuals will be covered under the Private Coverage Option.

As explained above, the Department will use claims data to help determine the appropriate benefit levels for current eligible adult individuals. The health screening can supplement the results of the claims data. The responses to the health screening will be analyzed by an algorithmic process, which will allow the Department to match the applicant to the appropriate adult benefit plan. The Department plans to implement additional reviews to validate the results of the algorithmic process. Ultimately, if the applicant or the applicant's provider disagrees with the outcome, the applicant can appeal the decision.

Through evaluation and consultation with health plans, the Department will monitor the effectiveness of the health screening and the identification of low risk and high risk eligible individuals. The Department will identify improvements to the process, as necessary, throughout the Demonstration.

Comment Summary:
One commenter suggested that presumptive eligibility program be implemented as part of the *Healthy Pennsylvania* plan.

Response:
The Department will expand the presumptive eligibility (PE) process to the Private Coverage Option. The coverage effective date will be determined by the enrollment date in the private market health insurance plan with the exception of Private Coverage Option participants determined presumptively eligible by a hospital. Eligible PE Private Coverage Option participants will be eligible from the date of the PE application. Fee-for-service (FFS) coverage will be provided from the date of application until the effective date of the Private Coverage Option enrollment.

Comment Summary:
One commenter expressed concern that the Demonstration is intruding into participants' privacy.

Response:
The Department recognizes the importance of participant privacy and has worked to develop an enrollment process that obtains the minimally necessary information to determine eligibility

and to enroll individuals into the appropriate adult benefit plan. Determining whether an individual is medically frail necessitates some form of a screening process. Under the *Healthy Pennsylvania* plan, the Department is trying to minimize paper work and process steps by using claims data to help determine the appropriate benefit levels for current eligible individuals and by automatically assigning many individuals who are easily identified by their eligibility category or residential status into the High Risk Benefit Plan. As occurs today, all information received from applicants and current consumers must follow existing state and federal rules on confidentiality, including HIPPA.

Comment Summary:
Commenters recommended that all Medicaid members be placed into the High Risk Benefit Plan until further determination can be made.

Response:
One of the key components of the *Healthy Pennsylvania* plan is that it matches the benefit plan to individual health care needs rather than using a one-size-fits-all approach. The limits that are incorporated into the adult benefit plans are based on the utilization of services in the current program. These limits were determined based on a statistical analysis of current Medicaid eligible individuals to ensure that at least 90% of current eligible individuals would be covered. Exceptions can be approved when there is a demonstrated medical need for additional services.

As a result, the Department will not make the High Risk Benefit Plan the default plan. However, the Department will monitor the effectiveness of the health screening of adults and the identification of low risk and high risk eligible individuals and make refinements as necessary throughout the Demonstration
---

Medically Frail

Comment Summary:
Commenters recommended that a better definition of medically frail needs to be established and suggested that the definition needs to adapt to the changing needs of eligible individuals. One commenter recommended that the definition of a disabling mental disorder be expanded. Another commenter suggested that the determination of medically frail be as inclusive as possible of behavioral health conditions.

Response:
In the initial waiver draft, the Department used the definition of medically frail based on federal standards. In response to comments received, the Department has decided to clarify that the

definition of medically frail includes individuals with HIV/AIDS and individuals on dialysis (see Appendix 3 of the Waiver Application).

With respect to the recommendation that the definition of disabling mental disorder be expanded, the Department has further expanded on what is a disabling mental disorder. Specifically, it provides that the individual has a diagnosis of at least one of the following: psychotic disorder; schizophrenia; major depression; bipolar disorder; delusional disorder; anxiety disorder (obsessive compulsive disorder, post-traumatic stress disorder, or severe panic disorder.

The Department will review the definition over time as necessary—particularly if it is determined that it is not accurately capturing all of those who need to be placed in the High Risk Benefit Plan (as outlined in the Demonstration application's Hypotheses section). Because the Department understands that an individual's health status could change over time, most adult participants will be screened at initial application and at their annual redetermination, or earlier if necessary, which will facilitate appropriate plan transitions as health needs change.

Comment Summary:
Commenters expressed concern with the process to determine medically frail. One commenter suggested separating the medically frail by income criteria rather than a health assessment. There was also a concern that by separating the populations by medical frailty, the risk pools would be skewed. Another commenter recommended that the Commonwealth adopt a two-part approach to serving medically frail individuals: 1) develop a list of conditions and automatically designate individuals with such conditions as medically frail and therefore eligible for more benefits; and 2) create an automatic exceptions process so such individuals can continue to receive the services they need if they reach their benefit limits in a given year (the commenter states that there is precedent for automatic exceptions in the current prescription drug program for people with specific medical conditions).

Response:
The Department has attempted to construct a system that is the least intrusive, accurate, and relatively easy to accomplish. Adult individuals who are medically frail will be identified or through the Department's claim's data or by a self-screening process that will occur at the time of application and periodically thereafter. As the Department develops and finalizes the health screening, it will ensure that the screening's questions are tested, that all procedures are validated, that established processes effectively reclassify individuals as medically frail as soon as possible after a change in status, and the health screening otherwise functions as intended. The responses to the health screening will be analyzed by an algorithmic process, which will allow the Department to match the applicant to the appropriate adult benefit plan. The Department plans to implement additional reviews to validate the results of the algorithmic process.

The definition of medically frail is based on federal requirements related to alternative benefit plans. Additionally, income divisions would not as accurately identify the service needs of different populations. Therefore, the Department cannot adopt the suggested approach of separating the medically frail by income criteria or change the definition to address the issue of risk pools being skewed.

It is also important to point out that, with some exceptions, a specific diagnosis does not necessarily lead to being medically frail. If that were the case, the federal definition would likely be structured to include a list similar to the one that commenters recommended the Department establish.

Comment Summary:
One commenter commits to working with the Department in defining the medically frail population, making sure they are placed in health plans that best meet their needs, and ensuring that Health Risk Assessments and preventive exams are a key part of the Demonstration.

Response:
The Department agrees that the medically frail population is best served by health plans experienced in meeting the needs of high needs patients as well as that Health Risk Assessments and timely preventive care are essential. The Department developed a medically frail definition using federal standards and has modified it based on comments received. It will review the definition over time as necessary. The Department plans to work closely with all of its stakeholders to implement the *Healthy Pennsylvania* plan.

Access to Services and Providers

Comment Summary:
Commenters expressed some concerns about ensuring adequate access to Medicaid primary care and specialty providers after an individual enrolls. They felt the Commonwealth needs to ensure access to physician services, adequate private payment rates for physician care, and broad provider networks. One commenter requested legislation to prohibit health plans from using all-product agreements with providers and the creation of a task force to study current network adequacy standards across all Pennsylvania health insurance markets.

Response:
One advantage of enrolling Private Coverage Option participants into private market health insurance is that the pool of participating providers is expected to expand. Under the Demonstration, *Healthy Pennsylvania* Private Coverage Option participants will have access to the full provider networks of their selected private market health insurance plan, which include many providers who do not currently participate in Medicaid. As such, the Demonstration will seek to stabilize provider payments across payers and increase provider access. Providers will be reimbursed for covered services provided to *Healthy Pennsylvania* Private Coverage Option participants at the rates providers negotiate with the respective private coverage plan. Any payment for an eligible individual under the Medicaid program will be made in accordance with Pennsylvania's approved state plan.

During the Demonstration, the Department will monitor access in Private Coverage Option plans, determine if state and federal network adequacy standards remain adequate.

In terms of limiting the negotiating power of the Pennsylvania health plans, this request is outside the Demonstration and the Department's authority.

Comment Summary:
One commenter believes that the Demonstration application should include medical student loan forgiveness and additional residency slots, particularly in primary care physician specialties, to increase physician capacity to serve the newly insured. Another commenter asked the Governor to increase funding for the medical student loan forgiveness program in the upcoming 2014 budget in order to incentivize primary health care providers to practice in rural and underserved areas of Pennsylvania.

Response:
While funding for medical student loan forgiveness and primary care residency slots are not part of this Demonstration, Governor Corbett's broader *Healthy Pennsylvania* plan supports medical student loan forgiveness and efforts to increase primary care capacity.

Comment Summary:
One commenter suggested that the Commonwealth expand the scope of nurse practitioners' practice authority to help ensure access to primary care services.

Response:
The Department agrees that building primary care capacity is critically important. However, nurse practitioners' scope of practice and related regulatory issues are matters for the Pennsylvania General Assembly and the State Board of Nursing. The Department is not able to address scope of practice or professional regulation through the Demonstration application.

Comment Summary:
In terms of evaluating whether *Healthy Pennsylvania* Private Coverage Option participants have adequate provider access, one commenter suggested that the survey or measurement instrument be expanded to include all providers of service, not just physicians.

Response:
The proposed hypothesis and methodology regarding adequate provider access are meant to capture all providers. However, because of the importance of primary care in the *Healthy Pennsylvania* plan, the Department wants to specifically measure the availability of primary care.

The final evaluation methodology will be refined after the Demonstration is approved by CMS, including the proposed methodology, metrics, and data sources.

Payment Rates for Services and Other Funding Issues

Comment Summary:
One commenter recommended the use of continuous enrollment and that all providers be paid Medicaid rates.

Response:
Healthy Pennsylvania's core concepts include developing a sustainable system that allows increased access to health care through using private market health insurance practices. The use of continuous enrollment does not support these goals and, as a result, the Department will not provide continuous enrollment for adults. *Healthy Pennsylvania's* Private Coverage Option will allow individuals who have an increase in income to continue their health care coverage with their private market health insurer and avoid churn. However, it is not fiscally responsible for Pennsylvania to allow these individuals to continue under the Demonstration if their income increases above 133% FPL, and they should transition to the Federal Facilitated Marketplace or employer sponsored coverage.

Providers will be reimbursed for covered services provided to *Healthy Pennsylvania* HealthChoices or Private Coverage Option participants at the rates providers negotiate with the respective private coverage plan. Any payment for an eligible individual under the Medicaid FFS program will be made in accordance with Pennsylvania's approved state plan.

Comment Summary:
One commenter expressed concern with the lack of clarification of the proposal's impact on provider rates and requirements.

Response:
Healthy Pennsylvania's core concepts include developing a sustainable system that allows increased access to health care through private market health insurance practices. Most Demonstration participants will be enrolled in a private market health insurance plan or a HealthChoices Medicaid managed care plan. These plans will continue to negotiate rates with providers as done today. The Department believes that utilizing private market plans will leverage networks and pricing strategies broadly available in the commercial marketplace, thus increasing access for *Healthy Pennsylvania* participants.

The Department will work with CMS to finalize the terms and conditions of the Demonstration as part of the approval process. The Department expects the Demonstration to have a positive impact on providers and has designed hypotheses to measure the impact on providers as a result of the Demonstration.

Comment Summary:
Commenters called for the Department to ensure that providers are reimbursed regardless of the failure of their patients to pay the premium.

Response:
In Demonstration Year 1, copayments will be paid to the provider at time of service; for individuals with incomes over 100% FPL, in both the Medicaid and Private Coverage Option, most providers can refuse service if the copayment is not paid, unless otherwise required to provide service under federal or state law.

Starting in Demonstration Year 2, participants with incomes from 100-133% FPL will pay premiums to the State as outlined in the Demonstration (including a $10 non-emergent use of the emergency room). In Demonstration Year 2, the Department will evaluate data on the participant copayment obligations from Demonstration Year 1 for participants with income no greater than 100% FPL and consider changes to support incentives and personal responsibility. This could include changes in copayment amounts, implementing a nominal premium and/or other cost sharing payment. These participants will also be responsible for the $10 copayment for non-emergent use of the emergency room.

Medicaid payments to providers will be made only for eligible individuals. Payment will be made for services received by eligible individuals for the three month grace period when premiums are not paid. The Department will use existing processes, which providers are familiar with and are required to use today, to determine eligibility for services. These

processes allow providers to receive timely notice of individuals whose benefits are suspended. Payments will not be made once the individual is terminated from the program; termination will be prospective.

Comment Summary:
One commenter questioned whether the premium requirements and processes will have any impact on health plans' ability to maintain adequate provider rates or participation.

Response:
The Department modified the copayment and premium structure in response to concerns raised about the premium structure. The Department does not believe that premiums will have any impact on health plans' ability to maintain adequate provider rates or participation.

Comment Summary:
One commenter asked about capitation payments for the Private Coverage Option plans.

Response:
The Department will, with the assistance and advice of its contracted actuaries, determine rates and a methodology for paying plans in the Private Coverage Option. This will be done following federal approval of the Demonstration, consistent with the waiver's terms and conditions and the federal budget neutrality requirement.

Payment Issues

Comment Summary:
Several commenters recommended that days of care and hospital service-related costs covered under the Private Coverage Option be classified as Medicaid days and costs under the *Healthy Pennsylvania* waiver request. The commenters indicated that not counting these as Medicaid days will negatively affect a hospital's eligibility for Medicaid disproportionate share (DSH) and supplemental payments; Medicare DSH payments; Medicaid DSH limits and federal §340B prescription drug discounts. The commenters further requested that the Department explicitly state in the *Healthy Pennsylvania* waiver that it is the Department's intent to continue making the current DSH and supplemental hospital payments.

Response:
Medicaid DSH payments are undergoing major changes under the Affordable Care Act and new CMS rules. The Department is moving forward under the assumption that care that flows

through the Private Coverage Option will be counted under disproportionate share calculations. However, as always and moving forward, the Department is working with CMS and will assess whether and how inpatient utilization by Private Coverage Option participants should affect Medicaid DSH calculations and any changes or clarifications will be through the regular State Plan Amendment process. The federal 340B prescription drug discount program policies, Medicare DSH payments, and Medicare critical access hospital payments are outside of the purview of the Department. As a result, the Department is unable to respond to this portion of the comment.

Comment Summary:
One commenter requested that their organization be included in any discussion of quality-based supplemental payments.

Response:
As it moves forward with the design of quality-based supplemental payments, the Department plans to work with stakeholders.

Comment Summary:
Several comments received requested that the Department explore flexible grant program options, such as Delivery System Reform Incentive Programs (DSRIP) that would promote cost effective improvements to the health care delivery system as part of the *Healthy Pennsylvania* waiver.

Response:
The Department recognizes the need to continually improve care quality and will seek to promote an environment in which innovative approaches to improving the health care delivery system are encouraged. One of the Department's objectives of the *Healthy Pennsylvania* plan is to promote a cost effective health care delivery system that results in quality health outcomes.

The Department intends to use the State Innovative Model (SIM) Design grant to explore new payment and delivery system models for health care services in the Commonwealth. While outside of this Demonstration waiver, the SIM grant submitted in December of 2013 is consistent with the overall goals of the Demonstration. The Commonwealth plans to work with stakeholders and CMS to implement the State Innovation Plan and will submit necessary waiver amendment as it is developed.

In response to the comments, the Department has added language in the Demonstration application for the opportunity for the future development of a DSRIP program.

Comment Summary:
One commenter requested that payment for observation status cases be included as part of the *Healthy Pennsylvania* plan.

Response:
The Department is currently in the process of developing a policy for observation status cases for Medicaid FFS eligible individuals. While this process and the recognition of observation status cases is not part of the *Healthy Pennsylvania* waiver process, it is the Department's expectation that the adoption of this policy will generally coincide with the anticipated implementation of the *Healthy Pennsylvania* plan. For example, most Demonstration participants will be enrolled in a private market health insurance product or a HealthChoices physical health Medicaid managed care plan—and a number of these plans already reimburse for observation status cases.

Comment Summary:
One commenter voiced the concern that the Private Coverage Option could increase hospitals' uncompensated care costs. The commenter is concerned that many applicants will continue to utilize emergency rooms as their entry point to health care because the program will not be using a FFS system.

Response:
The Department does not believe that there will be an increase in uncompensated care; it actually believes it will decrease. One of the primary goals of the *Healthy Pennsylvania* plan is to increase access to health care coverage for more than 500,000 Pennsylvanians. Many of the individuals who will be enrolled in the Private Coverage Option are not currently insured and when enrolled will have access to coverage that includes hospital services. While the Demonstration application does request a waiver of retroactive coverage, applications will be processed expeditiously (however, Private Coverage Option participants may be determined to be presumptively eligible by a hospital). Additionally, with coverage available and a federal mandate to obtain insurance, it is expected that many individuals will not defer enrollment until a catastrophic event occurs. While it is very likely that there will continue to be applications for new coverage that result from unexpected hospitalizations, the Department anticipates that the volume should decrease.

Delivery System

Comment Summary:
Commenters expressed concern about the use of the federally-facilitated marketplace (FFM) and what it means to access to health services. Other commenters stated that the Department should not use the FFM for the Private Coverage Option given its many operational problems and the difference in premiums, cost sharing, and other requirements between QHPs and Private Coverage Option plans. Some commenters expressed concern that due to the FFM's problems a full procurement process could delay the implementation date of the Demonstration. Another commenter suggested the Department create a specialized commercial marketplace to serve Private Coverage Option participants, and enter into agreements with health insurers that are familiar with low income populations and operate under other state government contracts by CMS.

Response:
In recognition of the potential challenges associated with using the FFM as the Private Coverage Option's delivery system, the *Healthy Pennsylvania* Demonstration application does not specify that the FFM will necessarily be the method through which individuals will choose their *Healthy Pennsylvania* Private Coverage Option plan (for example, some individuals will be eligible for employer sponsored coverage). The Private Coverage Option enrollment process will be an area of negotiation with CMS. The Department will seek to develop a process that works for Pennsylvanians, is consistent with *Healthy Pennsylvania* goals, and can be approved expeditiously.

Comment Summary:
Commenters suggested the Department use a streamlined process for plan selection and contracting.

Response:
The mechanism for selecting and entering into agreements with Private Coverage Option plans will be evaluated and established before federal approval of the Demonstration.

Comment Summary:
One commenter expressed the opinion that the private market health insurance plans, with their cost sharing structures, are not set up to accommodate the new population, but also points out that plans may not participate without those cost control mechanisms in place.

Response:
Considering the precedence set in other states, the Department believes that most plans will make the decision to participate in the proposed Demonstration, even with nominal cost sharing.

Comment Summary:
Commenters suggested using HealthChoices as the Demonstration's delivery system. It was thought that this approach would provide a private market approach, with plans having the needed experience and expertise of working with the Medicaid population. Other commenters suggested covering those under 100% FPL in the HealthChoices program.

Response:
Healthy Pennsylvania seeks to use premium assistance to purchase private market health insurance plans or employer sponsored coverage for those who are newly eligible. The Department encourages all types of payors to participate, including but not limited to Medicaid managed care plans and commercial entities.

Most individuals who are eligible under the traditional Medical Assistance program and the newly eligible population that are medically frail will have their care delivered through the HealthChoices Program (populations excluded from HealthChoices participation will receive care through the traditional FFS program).

Comment Summary:
Commenters expressed concern with the utilization of private insurance companies to administer the program, some feeling that it would inevitably direct taxpayer funding toward corporate profits first, and health care second.

Response:
Pennsylvania has a long and successful history of partnering with private market health plans to ensure Pennsylvanians receive quality health care. Private market health insurance plans, including employer sponsored coverage, will serve Private Coverage Option participants as they already serve most other Pennsylvanians. Private plans are also utilized widely in the federal Medicare program. Private Coverage Option participants will have a choice of private market health insurance plans that will compete for membership and be responsible for providing access to high-quality health care. A market-based system with choice and competition is the best way to ensure health needs are met.

Comment Summary:
One commenter urged the Department to place limits on the amount of profits that health plans can earn from *Healthy Pennsylvania* enrollment, both through some form of gain sharing and/or pay for performance incentives.

Response:
The Department agrees with the importance of aligning financial incentives with performance expectations. The Department has successfully used pay for performance incentives with HealthChoices managed care plans and may consider including some performance-based financial incentives when establishing the processes for selecting and entering into agreement with Private Coverage Option plans.

Comment Summary:
One commenter suggested that the *Healthy Pennsylvania* plan use the accountable care organization (ACO) model used by home care agencies to manage the health care of *Healthy Pennsylvania* members.

Response:
The Department recognizes the value that the ACO model can provide, which is why the model is included in Pennsylvania's SIM grant design. However, one of the basic goals in creating the Private Coverage Option is to utilize and stay in alignment with the private health insurance market. In this light, the Department is not seeking to impose additional mandates on the participating private market health insurance plans such as requiring they use the ACO model. However, many private market health insurance plans do currently operate ACO models.

Comment Summary:
Commenters believe Federally Qualified Health Centers (FQHCs) should be a central component of primary care delivery for low income populations, including individuals covered under the Demonstration.

Response:
The Department agrees that FQHCs play an important role in providing primary care services in many Pennsylvania communities. As such, the Department has revised the Demonstration application so that private market health insurance plans participating in the Private Coverage Option, including employer sponsored coverage, will be required to meet the Medicaid standard for including FQHC/RHC providers in their networks. The Department has also revised the application so that Private Coverage Option plans will be required to reimburse FQHC/RHC services in accordance with the prospective payment system requirements.

Comment Summary:
Commenters recommended that Medicaid managed care organizations should be encouraged to offer *Healthy Pennsylvania* Private Coverage Option plans through the Marketplace. This would ease transitions between Medicaid and Marketplace eligibility and reduce churn.

Response:
The Department will encourage all Pennsylvania health insurers, including Medicaid managed care organizations and private market health insurers, to participate in the Private Coverage Option. Given expected enrollment, the Department anticipates that private market health insurance plans will have a strong interest in serving Private Coverage Option participants. Additionally, some individuals will be eligible for employer sponsored coverage.

Comment Summary:
One commenter suggested that the *Healthy Pennsylvania* Medicaid reforms do not go far enough in reforming Medicaid and do not make the program sustainable. The commenter supports a new plan that would mirror the Florida Medicaid waiver program, which includes robust private plan options for Medicaid eligible individuals.

Response:
The Department appreciates the commenter's thoughts on reforming Medicaid. A primary goal of the *Healthy Pennsylvania* plan is to increase access to health care coverage for more than 500,000 Pennsylvanians and do so in a way that is right for Pennsylvania. At the same time, the program encourages personal responsibility for healthy behaviors and provides structured opportunities for individuals to seek and obtain employment, which will result in healthier outcomes.

Comment Summary:
Commenters inquired about whether CHIP would be included in Demonstration.

Response:
The *Healthy Pennsylvania* Demonstration waiver does not include CHIP.

Comment Summary:
One commenter objects to the movement of children with incomes under 133% FPL out of Pennsylvania's CHIP program into Medicaid as required by CMS. Another commenter urged the Governor to eliminate the waiting period for children to enroll in CHIP.

Response:
While these comments are outside the scope of the *Healthy Pennsylvania* Demonstration application and related State Plan Amendments, the Department agrees with the commenter's position on moving children from CHIP to Medicaid. Governor Corbett has reached an agreement with CMS to allow parents of impacted CHIP children the choice to either stay in CHIP until the end of 2014 or move to Medicaid now or at their child(ren)'s renewal.

On October 16, 2013, Governor Corbett signed legislation eliminating the six-month waiting period for enrollment in CHIP, which was part of his broader *Healthy Pennsylvania* plan and there is not a waiting list for the CHIP program today. The Commonwealth encourages all parents who have uninsured children to apply for CHIP.

Private Coverage Option Plan Oversight and Consumer Protections

Comment Summary:
Commenters stated that it is not clear if participants will be responsible for out-of-network cost sharing under the Private Coverage Option.

Response:
Unless out-of-network services are an emergency or are authorized by the participant's private market health insurance plan, copayments for out-of-network services are the responsibility of the participant in the Private Coverage Option.

Comment Summary:
Commenters recommended that the *Healthy Pennsylvania* Private Coverage Option pay for out-of-network services.

Response:
Private market health insurance plans, including employer sponsored coverage, serving Private Coverage Option participants must meet all applicable federal and state access standards, including provider network adequacy and coverage of out-of-network services for emergency and pregnancy-related care. Participants will have a choice of at least two private market health insurance plans, with plans competing for business based on provider networks, among other factors. Private market health insurance plans may also offer some out-of-network coverage. Requiring payment of out-of-network services would hinder private market health insurance plan participation, care management, and personal responsibility; interfere with provider-plan negotiations; and increase Demonstration costs. For these reasons, the Department will not impose additional mandates on the coverage of out-of-network service. In addition, the same

dynamic exists between private Healthchoices plans and providers today in the Medicaid program.

Comment Summary:
Commenters expressed concern with QHP oversight and appeals processes as well as consumer protections. Some recommended applying Medicaid standards to the Private Coverage Option plans. Commenters believe that the Private Coverage Option is attempting to strip away Medicaid protections from the newly covered group.

Response:
The Department agrees that oversight is important and will establish necessary oversight processes after final agreement is reached with CMS. Specific details on Private Coverage Option plan oversight will be negotiated during the CMS approval process and developed and described during implementation. The oversight processes and agreement language will be subject to federal review as appropriate and will be consistent with waiver terms and conditions. Performance of private market health insurance plans will also be a key component of the Demonstration's evaluation.

Under state and federal law, private market health insurance plans, including employer sponsored coverage, must now meet a wide range of consumer protections, including a grievance and appeals process (see Appendix 4 of the waiver for details of Pennsylvania's Act 68 grievance and appeals process). Participants in the Private Coverage Option will receive premium assistance to purchase coverage from private market health insurance plans. Therefore, these private plans must comply with all applicable federal and state standards governing internal coverage appeals and impartial, independent external review of private market health insurance plan service decisions, including new requirements under the Affordable Care Act. These processes provide comprehensive, strong, and precise safeguards for participants in the Private Coverage Option. In addition, participants may file complaints with the Pennsylvania Insurance Department.

Comment Summary:
One commenter recommended that the Department include service requirements in agreements with Private Coverage Option plans that reflect the demographics of the newly-covered population, including additional behavioral health features due to the prevalence of such concerns in the newly covered population.

Response:
Plans participating in the Private Coverage Option will be expected to meet national standards for coverage including: Essential Health Benefits (which includes mental health and substance use disorder services); mental health parity; and drug and alcohol services.

Comment Summary:
Commenters believe that the Private Coverage Option will be too complicated for the newly covered group.

Response:
While *Healthy Pennsylvania* participants may need assistance in navigating their Private Coverage Option choices (similar to those using the FFM), the Department believes that individuals in the newly covered group are capable of doing so. The plans available through the Private Coverage Option will be similar to other plans selected by individuals otherwise covered in the commercial market.

Comment Summary:
One commenter recommended that the Department include special needs application assisters to help enrollment brokers during implementation.

Response:
The Department's staff is available to assist individuals who require assistance, including those who require special needs application assisters.

Comment Summary:
One commenter stated that confidentiality concerns continue to exist when private market health insurers are not able or are unwilling to invest in the technology that will suppress an EOB (explanation of benefit) statement.

Response:
While this comment is outside of the scope of the Demonstration, the Department recognizes the need to protect personal health information. The Department also recognizes that some private market health insurers rely on EOBs as a tool to help identify fraudulent health care claims. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, requires that plans and providers accommodate a reasonable request for alternative communication, such as an alternative means or location, when disclosure could endanger an individual. HealthChoices and Private Coverage Option plans must comply with the HIPAA Privacy Rule.

Managed Care

Comment Summary:
One commenter suggested relying on the health plans to manage care for their members.

Response:
Healthy Pennsylvania will use private market health insurance plans, including employer sponsored coverage, as the program's delivery system. The Department agrees that health insurance plans can provide care management for their members.

Comment Summary:
One commenter recommended that the Commonwealth ensure that capitation rates for HealthChoices managed care plans reflect the financial implications of the Demonstration, including newly eligible individuals, new adult benefit designs, administrative burdens, and uncertain medical costs.

Response:
In determining future, actuarially sound capitation rates, the Department and their actuaries will consider the various effects of the Demonstration on HealthChoices managed care plans.

Comment Summary:
One commenter recommended that all Behavioral HealthChoices supplemental services, such as psych rehab, non-hospital Drug & Alcohol, Assertive Community Treatment, and Intensive Outpatient, be maintained and that current rules for access and management also be maintained.

Response:
The Department understands the concern regarding continued access to behavioral health supplemental services or substance use disorder services and wants to assure the commenter that *Healthy Pennsylvania* will not negatively impact behavioral health supplemental or substance use disorder services. In fact, the Demonstration will increase access to substance use disorder treatment and mental health care for those currently without coverage today. State laws governing drug and alcohol treatment facilities are unaffected.

The *Healthy Pennsylvania* Demonstration does not modify the HealthChoices 1915 waiver in terms of what supplemental services the HealthChoices health plans can provide or the existing access standards.

Private Coverage Option plans must provide participants with behavioral health care covered in the Essential Health Benefits package through an adequate network of behavioral health providers. Private Coverage Option plans may cover additional behavioral health services if they determine that this benefit would improve the health outcomes of their members. The Private Coverage Option plans must also provide certain parity protections between mental health and substance use disorder benefits and medical and surgical benefits.

Comment Summary:
One commenter suggested additional reforms be made to the requirements for managed care plans participating in in HealthChoices.

Response:
Any reforms to HealthChoices are outside the scope of this Demonstration and will be pursued separately from the *Healthy Pennsylvania* Demonstration application.

Comment Summary:
Commenters suggested that the current Behavioral HealthChoices program structure should be maintained. Other commenters asked if supplemental services and evidence-based practices currently used by the Behavioral HealthChoices program will be used in the Private Coverage Option.

Response:
The Demonstration does not change Behavioral HealthChoices structure or delivery system. One of the basic goals in creating the Private Coverage Option is to utilize and stay in alignment with the private health insurance market. In this light, the Department is not seeking to impose additional mandates on the private market health insurance plans, including requiring the provision of supplemental services.

In addition, Private Coverage Option plans must provide participants with all medically necessary behavioral health care covered in the Essential Health Benefits package through an adequate network of behavioral health providers. Private Coverage Option plans may cover additional behavioral health services if they determine that this benefit would improve the health outcomes of their members. The Private Coverage Option plans must also provide certain parity protections between mental health and substance use disorder benefits and medical and surgical benefits.

Comment Summary:
One commenter requested regular communication continue between the Department and HealthChoices managed care plans as it finalizes its proposal.

Response:
The Department plans to work with all of its stakeholders as it moves forward with the design and implementation of the proposal.

FQHCs, Rural Health Centers, and other Community Health Centers/ Safety Net Providers

Comment Summary:
Commenters expressed concerns related to the waiver of the mandated coverage and the prospective payment system (PPS) methodology found under the Medicaid statute and regulation. The commenters indicated that these waivers would threaten the financial viability of the Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and other safety net providers. The commenters indicated the waivers will result in a break in the continuity of care for many existing patients, threatening access to care.

Response:
The Department recognizes that community health centers, including FQHCs and RHCs are important safety net providers. As a result of the comments received, the Department has decided to retain the requirement that Private Coverage Option private coverage plans have FQHC/RHC providers in their networks. The Department has also revised the application so that Private Coverage Option plans will be required to reimburse FQHC/RHC services in accordance with the prospective payment system requirements.

Comment Summary:
Commenters stated that the limits on primary care visits with no limits on the use of emergency rooms limits the flexibility of a patient's medical home provider and conflicts with other Demonstration application components related to healthy behaviors. Some commenters suggested changing the benefit structure to encourage FQHCs and RHCs to adopt and use the patient centered medical home model of care.

Response:
In response to comments, the Department has revised the benefit limit for primary care visits. As specified in the Demonstration application, there are no limits on primary care visits. The Demonstration application also proposes a $10 copayment for the non-emergent use of the emergency room, which should help dissuade such use, especially for those who are connected to a medical home.

The Department encourages all providers, including FQHCs and RHCs, to consider innovative models of care such as patient centered medical homes. Governor Corbett's broader Healthy Pennsylvania plan and SIM grant proposal focus on such innovations. Additionally, the proposed Healthy Pennsylvania adult benefit plan structure, in combination with the flexibility afforded to HealthChoices managed care plans, should provide for the ability of safety net providers to adopt and use a medical home model.

Comment Summary:
Commenters also expressed concern that not allowing copayment exemptions for out-of-network providers will either force current patients to travel to receive care from in-network providers or result in the need to pay more out-of-pocket costs. An additional concern was expressed that this might result in conflicts with federal sliding fee requirements.

Response:
Private market health insurance plans participating in the Private Coverage Option, including employer sponsored coverage, must meet all applicable federal and state access standards, including provider network adequacy and coverage of out-of-network services for emergency and pregnancy-related care. Additionally, in response to public comments about FQHCs/RHCs, the Department has decided to maintain the mandate to include FQHC/RHC providers in Private Coverage Option plan networks. The Department believes that this will help to further ensure adequate access. The Department will continue to monitor the issue once the Demonstration is operationalized and make adjustments if necessary.

Unless out-of-network services are an emergency or are authorized by the participant's private market health insurance plan, copayments for out-of-network services are the responsibility of the participant in the Private Coverage Option. There is not a cap for out-of-network copayments.

Comment Summary:
One commenter suggested that the Department require payers to retroactively pay for services back to the date of application when credentialing new FQHC, RHC, and hospital-based employed providers.

Response:
While the credentialing issue is beyond the scope of the proposed Demonstration application, one of the basic goals in creating the Private Coverage Option is to utilize and stay in alignment with the private health insurance market. In this light, the Department is not seeking to impose additional mandates on health insurance plans such as the requirement to pay back to the date of application.

Comment Summary:
Commenters expressed concern that the proposed Demonstration would harm the safety net for pregnant women, seniors, persons with disabilities, persons with significant health issues, and other vulnerable populations. Another commenter believes the Demonstration should include rural health center services and expressed concerns with the limits placed on community health centers.

Response:
Based on comments received, the Department has modified the Demonstration to include FQHC/RHC providers as a mandatory provider type. Additionally, most pregnant women, seniors, persons with disabilities, persons with significant health issues, and other vulnerable populations will be enrolled in the High Risk Benefit Plan, which will be delivered through HealthChoices managed care plans (or the traditional FFS program for populations excluded from HealthChoices participation).

One of the primary goals of the *Healthy Pennsylvania* plan is to increase access to health care coverage for more than 500,000 Pennsylvanians. Many of the individuals who will be enrolled in the Demonstration are not currently insured. As a result, safety net providers should serve less uninsured individuals, helping to preserve the safety net.

Demonstration Timing and Costs

Comment Summary:
Several commenters were concerned about the proposed January 1, 2015 implementation date. They expressed a preference for an earlier implementation to avoid delaying care for those who are currently uninsured. Another commenter indicated that there is a January 1, 2014 deadline for an agreement with the federal government.

Response:
While the Department would like to implement the proposed Demonstration as soon as possible, January 2015 is the earliest date such a program could be implemented. The Department will work to implement the approved *Healthy Pennsylvania* plan expeditiously; however, the timing of the implementation is largely dependent on obtaining federal approval. The Administration has been in discussion with CMS over the last year and will work with CMS as quickly as possible to obtain federal approval. Many system, administrative, and Private Coverage Option agreement activities cannot be pursued until final program design is agreed

on and official federal approval is received. Early implementation using a different model is not feasible.

There is no federally imposed deadline for an agreement or implementation of the changes being proposed in the Demonstration application.

Comment Summary:
Several commenters support a more traditional Medicaid expansion approach (maintaining current benefit structures and delivery systems), rather than implementing the *Healthy Pennsylvania* plan. Other commenters also expressed support for implementing the Affordable Care Act's Medicaid expansion now and transitioning to the *Healthy Pennsylvania* plan at a later date. Another commenter asked that Pennsylvania provide immediate coverage for specific groups who lack insurance. One commenter suggested that the Governor does not intend to provide health care coverage to low income Pennsylvanians by implementing the *Healthy Pennsylvania* plan.

Response:
Because Governor Corbett recognizes the importance of health care, the Department has carefully considered how to increase access to health care for uninsured Pennsylvanians in the most sustainable manner. The goals of improving access, ensuring quality, and providing affordability were established and used in evaluating different options. Ultimately, traditional Medicaid expansion and continuing the existing Medicaid program in its current form did not appear sustainable and was not the right solution for Pennsylvania. The current growth rate of the Medicaid program could result in a loss of coverage for Pennsylvanians due to budget shortfalls. Instead, Governor Corbett proposed *Healthy Pennsylvania* as a way to increase access to health care coverage for more than 500,000 Pennsylvanians and to do so in a way that is sustainable over time.

The Department is diligently working to implement the proposed Demonstration as soon as possible with January 2015 being the earliest date such a program could be implemented. Many system, administrative and Private Coverage Option agreement activities cannot be pursued until final program design is agreed on and federal approval is received.

Comment Summary:
One commenter suggested that Pennsylvania pilot the *Healthy Pennsylvania* plan to determine its impact.

Response:
Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the

objectives of the Medicaid and CHIP programs. The *Healthy Pennsylvania* plan is a Demonstration being pursued under such authority.

Because of equity issues associated with implementing strategies to increase access to health care coverage, the Department does not intend to pursue an implementation strategy that pilots *Healthy Pennsylvania* to a small number of individuals. This would not be consistent with Governor Corbett's goal to increase access to health care coverage for more than 500,000 Pennsylvanians and do so in a way that is right for Pennsylvania.

Comment Summary:
One commenter suggested that the Commonwealth expand Medicaid under the existing system to determine a baseline for the population and then require future participation be contingent on the acceptance of being placed, in a randomized manner, in different alternate benefit plans to determine the best plans for the population.

Response:
It would be difficult to create such a large scale, approvable demonstration that would comport with federal law and regulation under the constraints of the 1115 demonstration process. However, some of what the commenter suggests is already built into the Demonstration (without the rigor of randomized assignment). Several different systems will be included in Demonstration, including the existing HealthChoices managed care model and private health insurance market approaches.

Comment Summary:
One commenter noted that the Commonwealth will lose federal funding by not enacting Medicaid expansion.

Response:
Governor Corbett is seeking to balance increased federal funding with three key priorities—improving access, ensuring quality, and providing affordability. The *Healthy Pennsylvania* plan accesses federal funding and increases access to health insurance coverage for more than 500,000 individuals, while doing so in a fiscally responsible and sustainable way. Enhanced federal funding will be accessed by the Commonwealth via the Demonstration application.

Comment Summary:
Commenters questioned whether the proposed Demonstration is more affordable than the current MA program because it includes additional requirements that are not contained in the Affordable Care Act. Another commenter does not believe that the Private Coverage Option will be deemed budget neutral by CMS.

Response:
The *Healthy Pennsylvania* Demonstration application is being submitted under the authority of section 1115 of the Social Security Act. As such, it is required to be budget neutral. This means that the program implemented under a Demonstration should not cost the federal government any more than what would have otherwise been spent absent the Demonstration (with the particulars being subject to negotiation between the Commonwealth and CMS).

Waivers approved in Iowa and Arkansas have used financial modeling approaches similar to *Healthy Pennsylvania's* Private Coverage Option to demonstrate budget neutrality. The Department is confident that CMS will determine that *Healthy Pennsylvania* will be budget neutral as well.

Comment Summary:
One commenter expressed specific concerns with affordability, including that it is not possible to achieve affordable, sustainable health care using private market health insurance plans, at least in part due to its administrative costs.

Response:
The Pennsylvania Medicaid program, as well as Medicaid programs in many other states, has been contracting with private market for-profit and not-for-profit health care plans in a cost effective manner for three decades. Waivers from Iowa and Arkansas have been approved using approaches similar to *Healthy Pennsylvania's* Private Coverage Option.

Comment Summary:
One commenter requested that the waiver application include anticipated cost savings from the *Healthy Pennsylvania* plan.

Response:
The Governor has published information on anticipated cost savings to the state budget for public review. For more information on expected state budget savings, please see Pennsylvania's 2014-15 Governor's Executive Budget.[11] The federal requirements for a Demonstration project require that the Commonwealth demonstrate that the project is budget neutral, meaning that the project will not cost the federal government more than it would have cost in the absence of the demonstration. The Department will provide the expenditure information required by CMS in the application and work with CMS to determine the detailed

[11] http://www.portal.state.pa.us/portal/server.pt/document/1393859/2014-15_budget_document_web_pdf

information necessary to support budget neutrality. The Department is confident that CMS will determine the application to be budget neutral.

Comment Summary:
One commenter questioned the cost effectiveness of the Private Coverage Option based on the Congressional Budget Office (CBO) report.[12]

Response:
The *Healthy Pennsylvania* Private Coverage Option meets federal cost effectiveness criteria and the entire *Healthy Pennsylvania* plan is budget neutral to the federal government. Newly approved waivers in Iowa and Arkansas use approaches similar to the Private Coverage Option and were found to meet the federal budget neutrality requirement. For many reasons, the CBO report is not relevant for assessing the Private Coverage Option. CBO estimated national average Medicaid costs and a national average rate differential between Medicaid and private market health insurance plans. Actual, state-specific cost differentials, payment rate differentials, and health insurance market and competitive dynamics vary widely across the United States. This makes broad, national estimates meaningless for state-level decision making or analysis of any particular waiver program.

In addition, the CBO report looked at the cost effectiveness of premium assistance in a highly narrow context, applying it as a limited, optional substitution of private coverage for Medicaid. This makes the CBO analysis inapplicable to the Private Coverage Option. CBO also did not adjust for a variety of other economic and actuarial factors. For example, the CBO report did not consider the marketplace effects of a program of the size, structure, and buying power of Private Coverage Option; the effects of Affordable Care Act policies on the private insurance market or provider reimbursement; or the fact that most of the medically frail will be served through HealthChoices managed care plans.

Comment Summary:
One commenter stated that the Governor's plan insists on cost containment at the expense of human services that actually bend the cost curve. The plan implies that cost savings will be shifted to other areas of the budget that are now under severe constraints caused by other factors. By not solving the real reasons for these cost overruns, the tradeoffs won't result in real cost containment.

[12] http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf

Response:
Changes to Medicaid are needed to create a financially sustainable program. The intent of this Demonstration is not to divert Medicaid dollars, rather to stabilize the unsustainable growth of Medicaid funding so that the Commonwealth can maintain a viable Medicaid program while simultaneously upholding its responsibilities to fund other vital State services and increase access to health care for over 500,000 individuals.

One example of how *Healthy Pennsylvania* seeks to create a sustainable program is through matching the benefit plans to individual health care needs. The limits that are incorporated into the adult benefit plans are based on the utilization of services in the current program. These limits were determined based on a statistical analysis of current Medicaid eligible individuals to ensure that at least 90% of current eligible individuals would be covered in accordance with CMS guidance. Exceptions can be approved when there is a demonstrated medical need for additional services. Therefore, the limits should not prevent eligible individuals from receiving necessary care while simultaneously providing savings to the Department.

Comment Summary:
Some commenters felt that the program would unnecessarily increase the administrative processes and costs of the program. Some commenters felt that the administrative complexity of the proposal could lead to a delayed process for granting coverage, exceptions, and/or lead to wrongful eligibility terminations. Commenters also questioned the capability of Department caseworkers to handle influx of new members.

Response:
The Department has had extensive discussions regarding the capability to support *Healthy Pennsylvania*. Information technology systems will be enhanced to ensure the efficient processing of all aspects of premium administrative processes and the reformed adult benefit plans will also lessen the administrative burden. The Department plans to ensure the adequacy of well-trained staff for the implementation of *Healthy Pennsylvania* to avoid eligibility delays.

While the Demonstration may result in some additional costs to the Commonwealth, the Department believes that the added costs will be more than offset by program savings generated by better designed adult benefit plans, improved heath, and employment for many program participants. The Department believes that the results of covering 500,000 more people and attaining a Medicaid program that is financially sustainable in the long run is worth the additional administration costs in the short run.

Comment Summary:
One commenter stated that the ability of the Department and its contractors to implement and operate the Demonstration's various administrative functions without interruption in continuity

of care will be critical to counties who have responsibility for the criminal justice system and other social services costs.

Response:
The Department agrees that effective and timely implementation of new administrative functions is critically important, and plans to work with stakeholders, including counties, to ensure administration functions are implemented without interruption and continuity of care is maintained.

Comment Summary:
One commenter stated that the Governor's plan is not likely to be approved by CMS when other state waivers using the same cost sharing and work search pre-condition proposals were rejected.

Response:
The Department has been in discussions with CMS since April of last year. CMS understands that the *Healthy Pennsylvania* plan is a Pennsylvania specific approach and will be unique compared to other state waivers. The Commonwealth has considered and made several changes to the waiver based on public comment and discussions with CMS. The Department anticipates that negotiations between the Commonwealth and CMS will result in terms and conditions that will be acceptable to both parties.

Comment Summary:
One commenter is concerned that the upper income limit for the premium assistance program is only 133% FPL in the Demonstration.

Response:
133% FPL is the income limit set by the Federal government for which it will provide enhanced federal funding. The Department will also utilize the MAGI income methodologies that provide an additional 5% income disregard.

Comment Summary:
One commenter is concerned that the *Healthy Pennsylvania* plan design will lead to more churn.

Response:
The Department disagrees with the commenter and does not expect that there will be a significant increase in eligibility churning resulting from the premium and *Encouraging Employment* program. The *Healthy Pennsylvania* plan is about helping people move out of

poverty and find employment or more consistent employment. Participants with an income of 100% of FPL and greater will not lose eligibility until premiums have not been paid for three consecutive months and, with the exception of job registration, the *Encouraging Employment* job training and employment-related activities will be verified after one year of enrollment. Additionally, there are grace periods and other processes that should help minimize the imposition of losing eligibility for non-compliance.

Ultimately, because *Healthy Pennsylvania's* Private Coverage Option uses private market health insurance plans (including employer sponsored coverage), the Demonstration will provide a path to maintaining continuity of coverage for people as their income changes. *Healthy Pennsylvania's* Private Coverage Option will allow individuals who have an increase in income to continue their health care coverage with their private market health insurer and avoid churn.

Opposition to Medicaid Expansion

Comment Summary:
Several commenters expressed a lack of support for the Affordable Care Act and expansion of health care coverage. One commenter specifically mentioned opposition to the Affordable Care Act because it penalizes employers who offer health care coverage to their employees.

Response:
The Department is submitting a Demonstration application that aligns with the goals and objectives of Governor Corbett's *Healthy Pennsylvania* plan and is not in a position to address broader concerns related to the Affordable Care Act through this Demonstration. *Healthy Pennsylvania* is a state-developed alternative to the Affordable Care Act that provides an alternate path towards increased coverage of lower income individuals and their families, while simultaneously reforming Medicaid into a more financially sustainable program.

Comment Summary:
Several commenters stated that they do not support any expansion of health care coverage because of the added expense at both the federal and state levels.

Response:
The *Healthy Pennsylvania* plan is not an expansion of Medicaid. It is a plan to increase access to private market coverage for lower income adults through the purchase of private market health insurance. The federal government will pay for the cost of this coverage, but it is important to consider that these costs will be offset by the estimated savings that will occur from the coverage of uninsured individuals. Currently, when an individual is uninsured and they are

unable to pay for medical care (hospital stays, clinic visits, etc.), those costs are shifted onto insured Pennsylvanians through increased private market health insurance plan premiums and cost sharing (copayments, co-insurance, deductibles, etc.). Additionally, the uncompensated costs of health care provided to these individuals can be substantially higher than the care received by others because uninsured individuals often do not seek or receive preventative care or wait to seek health care for a specific health condition until it worsens, substantially driving up the cost of the medical services required.

The Department agrees with the critical importance of fiscal responsibility in health care programs. By expanding access to private market health insurance, supporting private sector choice and competition, providing benefits that match health care needs, and encouraging healthy behaviors and individual responsibility, the proposed Demonstration directly supports the fiscal sustainability of Medicaid and the broader health care system of Pennsylvania.

Comment Summary:
One commenter opposes the *Healthy Pennsylvania* plan because he believes using the Medical Loss Ratio required under the Affordable Care Act of 15% to run Medicaid isn't enough funding.

Response:
The Affordable Care Act's 15% Medical Loss Ratio requirement is not applicable to Medicaid HealthChoices managed care plans. The Department develops actuarially sound capitation rates that consider the costs to provide the services under the contract, including the administrative costs and profit expected to be incurred by an efficiently and effectively operated Medicaid managed care program.

Comment Summary:
One commenter stated that Pennsylvania has taken the federal money for Medicaid expansion and is now doing a bait and switch.

Response:
Pennsylvania has not yet received any federal funding for the newly eligible population. This Demonstration application will be Pennsylvania's formal submission document to CMS. If CMS and Pennsylvania reach agreement on the *Healthy Pennsylvania* plan, then and only then, will Pennsylvania receive federal funding.

Comment Summary:
One commenter expressed support for Medicaid reforms that do not require federal approvals.

Response:
The Department supports maximum state flexibility in Medicaid policies and administration. Unfortunately, until federal law and regulations are fundamentally changed, federal waivers are required for any significant Medicaid reforms. The proposed Demonstration seeks new flexibility and includes innovative policies for a market-based, Pennsylvania-specific model that promotes efficient use of taxpayer dollars.

Comment Summary:
One commenter objected to the manner that the Affordable Care Act provides coverage for those with incomes below 133% FPL and would prefer that these individuals be provided with a subsidy with which to purchase private insurance through the FFM rather than receiving Medicaid. The commenter also recommends broadening the insurance pool to combine the large, medium, small and non-group markets into a single insurance pool to absorb the costs across the entire U.S. population not receiving Medicare.

Response:
In essence, by enrolling the newly covered population into private market health insurance plans, including employer sponsored coverage, through the Private Coverage Option, *Healthy Pennsylvania* accomplishes the same goal. The commenter's recommendation to combine all insurance markets into a single insurance pool is beyond the scope of the *Healthy Pennsylvania* Demonstration and the associated State Plan Amendments.

Application

Comment Summary:
One commenter stated that the Demonstration application was too long, "not a people friendly document," and is confusing. The commenter also disagreed with the definition of "stakeholders."

Response:
The application follows the format provided by CMS. The Public Notice that was published by the Commonwealth is shorter and addresses the core components of the Demonstration application. Additional information about Governor Corbett's *Healthy Pennsylvania* plan is also available on the *Healthy Pennsylvania* website http://www.dpw.state.pa.us/healthypa.

It is not clear which list of stakeholders is referenced by the commenter, but within the Demonstration application, consumers and the public are mentioned. These two terms are intended to include the public and people with disabilities.

Comment Summary:
The commenter indicated that there was a discrepancy in the number of people affected by the waiver.

Response:
The Department does not agree that there is a discrepancy in the number of people. The 500,000 refers to the number of new people covered under the Demonstration, the larger number references the current adult Medicaid population.

Comment Summary:
One commenter provided detailed typographical revisions to the language of the Demonstration application.

Response:
The Department appreciates the suggestions and made appropriate typographical changes to the Demonstration application.

Comment Summary:
One commenter asked what is meant by the terms 'newly eligible,' 'institutionalized' and 'medical institution.' The commenter also asks about enrolling in private coverage while in a treatment facility.

Response:
The newly eligible are individuals who are enrolled in the new adult group created by the Affordable Care Act (section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, codified at 42 C.F.R. §435.119).For the most part, the newly eligible will be covered through the Private Coverage Option.

The term institutionalized used throughout the document has the meaning given in the Social Security Act that defines who can be subject to the special institutionalized income limit. It specifically means individuals who have resided or who are likely to reside for 30 or more days in a medical institution.

The term 'medical institution' is defined at 42 CFR 435.1010. As is true for private insurance, there will be no safeguards to prevent individuals, regardless of their health condition or status in seeking treatment, from enrolling in the Private Coverage Option while in a treatment facility. Retroactive coverage will still be available in the Medicaid program and Private Coverage Option participants may be determined to be presumptively eligible by a hospital.

Comment Summary:
One commenter posed questions about the proposed income limits, the implementation date, and the application process.

Response:
The proposed income limit is 133% FPL before the application of a 5% disregard.[13] For a single person, this is approximately $15,521 per year.

While the Department would like to implement the proposed Demonstration as soon as possible, January 2015 is the earliest date such a program could be implemented.

The application process under the Demonstration will be similar to the current application process for MA. There may be some additional information required to help ensure applicants are enrolled in the appropriate adult benefit plan. The Department is committed to automating as many of the processes as possible and ensuring there is adequate staffing to quickly process applications and address people's questions.

Comment Summary:
One commenter questioned whether the Private Coverage Option has only one level of coverage and Medicaid has the Low Risk and High Risk Benefit Plans.

Response:
The standard for private market health insurance plans, including employer sponsored coverage, in the Private Coverage Option is the Essential Health Benefit standard. Coverage under the Private Coverage Option will vary by plan while meeting the Essential Health Benefit. This choice will allow participants to select the plan that is best for them. Under *Healthy Pennsylvania*, Medicaid will have two benefits plans, Low Risk and High Risk Benefit Plans.

Comment Summary:
One commenter had several concerns with the methodology described for the evaluation and hypotheses section. The commenter states there is no mention of a theoretical framework on which the research hypotheses are based.

[13] Under the Affordable Care Act, current Medicaid income disregards are replaced by a 5% income disregard, which makes the effective eligibility rate 138% FPL.

Response:
The waiver proposal indicates what areas of the demonstration will be tested, including the type of metrics that will be measured. The technical methodology will be decided upon, with input from CMS, after approval of the waiver application.

Comment Summary:
One commenter indicated that the Demonstration proposal does not meet the scientific rigor of an experiment and pointed to the Oregon example that had a control group.

Response:
The Oregon "controlled group" experiment was a very unusual set of circumstances that is unlikely, and preferably not, to be duplicated in Pennsylvania as Oregon used a lottery system to select who should be covered due to funding issues. Further, the *Healthy Pennsylvania* plan proposes covering all eligible individuals under 133% FPL so establishing a control group will be difficult. However, the Department has outlined possible research methods and control groups to use in the evaluation section in the application and will develop a more robust research method once the Demonstration is approved by CMS.

Comment Summary:
One commenter made several high level suggestions and outlined guidelines on how best to design reform efforts. The commenter suggested the need for evaluation, that science based prevention be used, that incentives and requirements should add to health, as well as others.

Response:
The Department appreciates the information and suggestions. The Department considered many of the suggestions, such as Demonstration evaluation, personal responsibility, and using incentives to improve health in developing *Healthy Pennsylvania.*

Comment Summary:
Commenters do not believe that the Demonstration, as proposed, meets the purposes of section 1115 of the federal Social Security Act. One commenter cited examples from the CMS website on possible uses of section 1115 demonstrations.

Response:
By increasing access to private market health insurance coverage, supporting choice and competition, providing benefits that match health care needs, and encouraging healthy behaviors and personal responsibility, the *Healthy Pennsylvania* plan fully meets the purposes of a section 1115 demonstration. Additionally, it furthers the objectives of Title XIX of the Social Security Act by providing for the demonstration and evaluation of unique and positive

innovations and being budget neutral to the federal government. The demonstration is well within the scope of the waiver authority of the Secretary of Health and Human Services.

The examples on possible uses of section 1115 demonstrations that are listed on the CMS website are illustrative, not all-inclusive, and phrased in a broad, general fashion. Even so, the Demonstration is consistent with the examples cited.

Comment Summary:
Commenters expressed concern with legality of the waivers the Commonwealth is requesting in this Demonstration application.

Response:
The purpose of Section 1115 of the Social Security Act (the Act) is to give the Secretary of Health and Human Services the authority to waive otherwise legal requirements of Section 1902, 1903 and other sections of the Act. There is over 30 years of precedent of approval of 1115 demonstrations. The Commonwealth intends, with the oversight of Health and Human Services, to stay within the legal boundaries of the Act. The Department has reviewed the waivers highlighted by the commenter and will work with CMS once the Demonstration application is finalized and submitted to determine which ones may be waived within the federally approved process.

Comment Summary:
One commenter wonders what changes will be required to the 1915(b) waiver.

Response:
Until the Demonstration application is finalized and approved by CMS, the Department cannot make final determinations about the impact of the Demonstration on 1915(b) waivers.

Comment Summary:
One commenter raised a series of highly technical, procedural questions regarding eligibility processes and Demonstration implementation.

Response:
A waiver application is the start of a process and is not intended as to serve as a technical implementation work plan. Technical and procedural questions regarding eligibility process and implementation will be addressed following federal approval and agreement on the terms and conditions.

Comment Summary:
One commenter asked a series of detailed questions requesting further justification for the eligibility, benefit, premium, cost sharing, and delivery system policies in the application.

Response:
The application fully addresses the merits of *Healthy Pennsylvania* plan and provides the necessary detail expected in a federal waiver application.

Comment Summary:
One commenter believes that amount of time available for comment on *Healthy Pennsylvania* was insufficient.

Response:
Federal law regarding public comment periods for 1115 demonstration applications specifies that the application be available for public comment for at least 30 calendar days. Pennsylvania exceeded this requirement and exceeded the number of public hearings required under federal guidelines.

Comment Summary:
One commenter suggested that the waivers requested related to pharmacy benefits were not required because of recent federal regulations that clarified the application of section 1927 of the Social Security Act to premium assistance approaches to coverage.

Response:
When taken as a whole the regulations cited are not without ambiguity on the issues related to pharmacy coverage. The Department will work with CMS to finalize what waiver requests will be necessary to accomplish the goals of the *Healthy Pennsylvania* plan.

Miscellaneous

Comment Summary:
One commenter requested that individuals who are paroled be covered by the Demonstration.

Response:
If meeting all other eligibility criteria, paroled individuals will qualify.

Comment Summary:
One commenter expressed support of the *Healthy Pennsylvania* plan and the belief that persons who are not legally in the United States should not receive free health care, including through a hospital emergency room.

Response:
Individuals who are not in the United States legally are not eligible for Medicaid. Neither the Affordable Care Act nor the *Healthy Pennsylvania* plan would change this requirement. Medicaid law requires that most individuals who enter the United States legally are not allowed to receive Medicaid benefits for five years. Individuals can receive the APTC under the Affordable Care Act as long as they are residing in the United States legally. The federal law that requires hospitals to provide medical treatment in an emergency is not a Medicaid requirement and is outside of the scope of this waiver request.

Comment Summary:
One commenter expressed her desire to see the minimum wage increased in Pennsylvania and the need to reform the prison system.

Response:
Since the *Healthy Pennsylvania* waiver and State Plan Amendments do not have any association with raising the minimum wage or reforming the current prison system, this is not a relevant comment
---

Comment Summary:
One commenter suggested some restructuring of state taxes.

Response:
Since the *Healthy Pennsylvania* waiver and State Plan Amendments do not have any association with reforming the state tax system, this is not a relevant comment.

Comment Summary:
One commenter expressed opposition to the denial of legal protections.

Response:
There are no changes proposed in the legal protections afforded under the MA program. Additionally, there are protections for those in the Private Coverage Option that are described in the Demonstration application.

Comment Summary:
Nurse practitioners expressed support for plan to increase primary care providers through *Healthy Pennsylvania* and urges passage of SB 1063.

Response:
Since the *Healthy Pennsylvania* waiver and State Plan Amendments do not have any association with the passage of SB 1063, this is not a relevant comment.

Comment Summary:
One commenter appears to be advocating for a specific strategy to use in the prevention of heart attacks and strokes.

Response:
Since the *Healthy Pennsylvania* waiver and State Plan Amendments do not address specific medical prevention strategies, this is not a relevant comment.

Comment Summary:
One commenter warned that drug rebates may not be available for the services received by the Private Coverage Option group.

Response:
Under section 1927 of the Social Security Act, Medicaid prescription drug rebates only apply to health plan prescription drug utilization when such utilization is through a "Medicaid managed care organization" as defined under section 1903(m)(1)(A) of the Act. However, the Department will request clarification from CMS whether private market health insurance plans in the Private Coverage Option will be considered Medicaid managed care organizations for the express purpose of the Medicaid prescription drug rebate program.

Comment Summary:
One commenter recommended recognizing pharmacists as providers and including pharmacists in the development of patient-center homes and ACOs.

Response:
Since the *Healthy Pennsylvania* waiver and State Plan Amendments do not address pharmacists' scope of practice and related regulatory issues a, this is not a relevant comment. Pharmacists' scope of practice and related regulatory issues are matters for the Pennsylvania General Assembly and the State Board of Pharmacy.

Comment Summary:
One commenter requested that the Commonwealth reconsider a decision to exclude eligible individuals from the PAWorkWear funded programs.

Response:
Since the *Healthy Pennsylvania* waiver and State Plan Amendments do not address PAWorkWear funded programs, this is not a relevant comment.

Comment Summary:
One commenter recommends reducing barriers to allow qualified non-US health care practitioners.

Response:
Since the *Healthy Pennsylvania* waiver and State Plan Amendments do not address immigration reform, this is not a relevant comment.

Comment Summary:
One commenter was appalled by the *Healthy Pennsylvania* plan, indicating that current eligible individuals will be harmed.

Response:
While the commenter does not provide enough detail to determine how best to respond to the comment that current eligible individuals will be harmed, the Department disagrees with the suggestion *Healthy Pennsylvania* will harm current or future participants.

Comment Summary:
One commenter felt the Department should rebrand the Medicaid program.

Response:
Since the *Healthy Pennsylvania* waiver and State Plan Amendments do not address rebranding, this is not a relevant comment.

Statements of Support

Comment Summary:
Commenters offered broad support for the proposed Demonstration, some specifically mentioning the Private Coverage Option, premiums, job training and employment-related

activities, rewards for healthy behaviors, and coverage of more Commonwealth residents. Other commenters believe that the proposed Demonstration is fiscally responsible and helps the sustainability of Medicaid post-acute and long term care.

Comment Summary:
Several commenters believe that *Healthy Pennsylvania* plan is a good plan, allowing Pennsylvania its own local solutions. One commenter expressed specific concern regarding participation in the federally expanded Medicaid program, believing the regulatory requirements to be too high and the risk of losing enhanced federal funds to be too great. The commenter believes that if the federal government will not allow Pennsylvania to have its own plan, the Commonwealth should still refuse to participate in theirs.

Comment Summary:
Commenters expressed support for the Demonstration, including support for maintaining the frail elderly as a priority. One commenter suggested that a more traditional Medicaid expansion would increase HCBS waiting lists.