FAST FACTS
House Appropriations Committee (D)
JOE MARKOSEK, DEMOCRATIC CHAIRMAN Sept. 10, 2014

Gov. Corbett's *Healthy PA* Submitted vs. Approved Plan

On August 28, the federal Centers for Medicare & Medicaid Services (CMS) and the Corbett Administration reached an agreement on *Healthy PA*, the governor's alternative to Medicaid expansion. This agreement makes Pennsylvania the third Medicaid expansion state (joining Arkansas and Iowa) approved to use federal funds to purchase private coverage for newly eligible adults with incomes up to 138 percent of federal poverty.

However, the approved *Healthy PA* plan is significantly different from what the Corbett Administration submitted. One key difference is that the newly eligible Medicaid adults participating in the Private Coverage Option will be enrolled in private managed care plans under contract with Department of Public Welfare (DPW) rather than the qualified health plans on the insurance exchange, as initially proposed. Most of these managed care plans in the Private Coverage Option are the very same private plans that currently serve nearly 1.7 million Medicaid recipients enrolled in the department's nationally-recognized *HealthChoices* program.

Beginning in 2015, the approved Private Coverage Option will serve newly eligible adults, ages 21 through 64, who are not medically frail; all other newly eligible adults will enroll in *HealthChoices*. Beginning in 2016, newly eligible adults in the Private Coverage Option who have incomes over 100 percent of the federal poverty level (FPL) will pay a monthly premium no greater than 2 percent of household income, with reduced premiums for adults who participate in healthy behaviors.

CMS did not approve many of Gov. Corbett's proposals because they were inconsistent with federal rules and regulations or exceeded the parameters and provisions in the expansion waivers CMS granted to other states. In some cases, CMS denied the governor's proposal outright. In other cases, the proposal was modified. For example, CMS rejected the governor's proposed job training/work requirement; scaled back his proposal to impose monthly premiums on current as well as newly eligible adults; and removed from the waiver his proposed changes to current Medicaid benefits.

This document provides a side-by-side comparison of the *Healthy PA* plan submitted by Gov. Corbett and the plan approved by CMS. Please note some provisions are limited to the newly eligible adult population, while other provisions are broad-based and therefore also apply to adults in Pennsylvania's current Medicaid program (i.e. *HealthChoices*). Details of the *Healthy PA* agreement are in the Special Terms and Conditions which accompanied the approval letter sent from CMS to DPW on August 28. Final approval of *Healthy PA* is subject to CMS receiving DPW's acceptance of the terms and conditions within 30 days of the date of the letter.

Under the waiver agreement, Medicaid expansion in Pennsylvania will be paid for with 100 percent federal dollars through 2016. Beginning in 2017, federal funding will gradually decline, but will never fall below 90 percent. Coverage under the agreement is scheduled to begin in January 2015. **Had Gov. Corbett opted into Medicaid expansion, as envisioned by Congress in the Affordable Care Act of 2010 (ACA), uninsured Pennsylvanians would have been covered beginning Jan. 1, 2014.**

Major Provisions	As Submitted by Gov. Corbett (2/19/14)	As Approved by CMS (8/28/14)
Medicaid Eligibility		
Groups subject to Private Coverage Option	All newly eligible adults, ages 21 through 64, who are not medically frail. This includes: > Parents with incomes between 33% and 138% Federal Poverty Level (FPL). > Childless adults with incomes between 0% and 138% FPL. *NOTE: Newly eligible adults ages 19 and 20 are exempt (see below).*	Approved
Groups exempt from the Private Coverage Option	The following are covered through DPW's Medical Assistance program: > Newly eligible adults, ages 19 and 20 . > Newly eligible adults who are medically frail (according to criteria developed by DPW). > Currently eligible children, ages 0 through 21. > Currently eligible adults (including parents with income up to 33% of FPL; pregnant women; elderly individuals, ages 65 or older; persons who are dually eligible for Medicare and Medicaid; and individuals who are institutionalized).	Approved
Medical Assistance for Workers with Disabilities (MAWD)	Eliminate MAWD, which covers working adults with disabilities who have incomes below 250% FPL and includes a 5% monthly premium. Coverage would change as follows: > Medically frail adults up to 138% FPL remain in DPW's Medical Assistance program. > Adults up to 138% FPL who are not medically frail enroll in Private Coverage Option. > Adults above 138% FPL lose Medicaid eligibility; however, they could receive subsidized coverage through the insurance exchange.	Proposal Withdrawn On July 24, 2014, the Corbett Administration announced the MAWD program would continue. However, it remains to be seen the benefits individuals will receive (i.e. high risk or low risk); which delivery system they will be enrolled in (i.e. traditional Medical Assistance or Private Coverage Option); and their cost sharing requirements.
SelectPlan for Women (Family Planning Waiver Program)	Eliminate SelectPlan for Women, which provides family planning services to women, ages 18 through 44, with incomes below 215% FPL. Coverage would change as follows: > Women below 138% FPL enroll in either the Private Coverage Option or in DPW's Medical Assistance program (if they are in a group exempt from the Private Coverage Option). > Women above 138% FPL lose Medicaid eligibility; they may obtain subsidized coverage through the insurance exchange.	Approved

Major Provisions	As Submitted by Gov. Corbett (2/19/14)	As Approved by CMS (8/28/14)
Benefits		
Benefits under Private Coverage Option	Establishes an Alternative Benefit Plan that provides the 10 essential health benefits, as required by the Affordable Care Act, for newly eligible adults in the Private Coverage Option. *NOTE: Wrap-around Medicaid benefits are addressed separately below.*	Modified CMS approved, in conjunction with requiring wrap-around benefits for non-emergency medical transportation beginning in 2016 and family planning services with free choice of provider (see below).
Wrap-around benefit: Non-emergency medical transportation	Requested CMS to waive the state's responsibility to provide non-emergency medical transportation to and from providers for newly eligible adults enrolled in the Private Coverage Option.	Modified Responsibility waived through December 2015 while DPW undertakes efforts to ensure enrollees have transportation by 2016. > DPW must provide a plan to CMS no later than March 31, 2015, detailing how the state will assure transportation by 2016. The plan must include plans to amend broker contracts, a beneficiary outreach strategy, and identification and mitigation of any anticipated capacity issues.
Wrap-around benefit: Family planning services	Requested CMS to waive the state's responsibility to cover all family planning providers for newly eligible adults in the Private Coverage Option.	Denied
Benefits under the current Medical Assistance program (*HealthChoices managed care and fee-for-service)*	Replaces the multiple packages that currently exist for adults with two new plans that incorporate reductions in benefits: > a "high risk" benefit plan for adults with complex health needs, including newly eligible adults determined to be medically frail; and > a "low risk" benefit plan for all other adults. Benefits for children under age 21 are not changed.	Removed CMS removed this proposal from the waiver and is negotiating the proposed benefit changes separately through the state plan amendment process, which is the standard approach for states seeking to change benefits in current Medicaid programs. Details on the new benefits plans will not be available until negotiations are completed, which is expected to be in time for Jan. 1, 2015, implementation.
Retroactive coverage	Requested CMS to waive the state's responsibility to provide 3 months retroactive coverage for newly eligible adults enrolled in the Private Coverage Option.	Denied

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Cost Sharing (Premiums and Copayments)		
Groups subject to premium requirements	Beginning in 2016, the state may charge monthly premiums to all current and newly eligible adults (ages 21 through 64) with incomes above 100% FPL who are not otherwise exempt (see below).	Modified CMS only authorized charging premiums to certain current adults in Medicaid (see list below) and non-medically frail newly eligible adults with incomes above 100% FPL.
Groups exempt from premium requirements	> Adults with incomes up to 100% FPL > Pregnant women > Individuals who are institutionalized > Elderly individuals, ages 65 or older > Persons who are dually eligible for Medicare and Medicaid > Individuals under age 21	Modified CMS also exempted medically frail newly eligible adults and all other current adults with incomes above 100% FPL, other than those receiving the following Medicaid coverage: > Transitional Medical Assistance; > Extended Medicaid because of spousal support; and > Home and community-based services under institutional rules.
Monthly premiums	For 2016, the monthly premium would be $25 for one adult and $35 for households with two or more adults. Premiums would be adjusted annually for medical inflationary increases.	Modified CMS capped premium amounts at no more than 2% of household income (consistent with what individuals would pay for coverage through the private insurance exchange).
Lock-out period	Medicaid eligibility denied for up to 9 months to individuals who fail to comply with premium requirements.	Modified CMS rejected any lock-out for individuals who fail to pay premiums. > Instead, they will lose coverage after a required 90-day grace period, but may subsequently re-enroll without a waiting period. > After 90 days, unpaid premiums may be considered a collectible debt owed and, at state option, subject to collection by the state.
Copayments	Beginning in 2015, providers may deny service for adults with incomes greater than 100% FPL for failure to pay the copayment.	Modified CMS only authorized this provision for newly eligible adults.
	Beginning in 2016, individuals above 100% FPL who pay a monthly premium will not be charged copayments, other than the new copayment for non-emergency use of a hospital emergency room (see Page 5).	Approved

Major Provisions	As Submitted by Gov. Corbett (2/19/14)	As Approved by CMS (8/28/14)
Cost Sharing (Premiums and Copayments) Continued...		
Copayment for non-emergency use of the emergency room	Beginning in 2016, current and newly eligible adults, age 18 and older who are not institutionalized, must pay a new $10 copayment for non-emergency use of the emergency room.	Rejected CMS rejected the request for a $10 copayment because $8 is maximum amount allowed under federal regulations. Furthermore, this copayment may only be implemented through the state plan amendment process (i.e. not part of the waiver).
Healthy behavior incentives	Beginning in 2016, an individual's premium or copayments can be reduced for completion of healthy behaviors (e.g. an annual wellness visit).	Approved
Other Provisions		
Employment requirement	Required able-bodied adults, over age 21 and working fewer than 20 hours a week, to participate in a new "Encouraging Employment" program. This requirement applied to current and new Medicaid enrollees. > On March 5, 2014, the Corbett Administration dropped the mandatory work requirement and instead proposed a voluntary pilot program. The pilot provided reductions to individuals' premiums and copayments as an incentive for them to participate in job training and work opportunities.	Denied CMS rejected any effort to link job training and work incentives to Medicaid coverage. Consequently, the Corbett Administration has decided to establish a state-funded initiative that will provide incentives for people who participate - no federal Medicaid dollars will be used.
Appeals	Individuals in the Private Coverage Option must use the private plan's process for appeals relating to provider access and denials of covered benefits.	Denied Enrollees in the Private Coverage Option will be entitled to use DPW's Medicaid fair hearing process for all appeals.
Duration of waiver	5 years, from 2015 through 2019	Approved
Implementation date	Jan. 1, 2015	Approved

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