Primer

From the House Appropriations Committee

JOE MARKOSEK, DEMOCRATIC CHAIRMAN June 26, 2013

Department of Public Welfare
Medical Assistance

Medicaid is a means-tested entitlement program that provides comprehensive health care and long-term care services to low-income individuals. In accordance with federal guidelines and requirements, each state designs and administers its own version of Medicaid. Pennsylvania's Medicaid program – known as Medical Assistance – serves nearly 2.2 million individuals, or one out of every six Pennsylvanians, and accounts for approximately 70 percent of the Department of Public Welfare's annual budget.

This primer provides comprehensive information on the Medical Assistance (MA) program, with particular emphasis on the health care services available to recipients and the long-term care services available to Pennsylvanians who are elderly or have physical disabilities. It describes federal requirements which govern who is eligible, what services are provided and how Medicaid is financed. It summarizes the specific criteria used by Pennsylvania to determine MA eligibility, explains the various program components, details the major funding sources utilized by the state to cover MA expenditures and provides historical data regarding MA enrollment and spending. Finally, the primer includes a discussion of the Affordable Care Act (ACA) and the major provisions that affect Medicaid.

Overview

Medical Assistance (MA) is the name of Pennsylvania's Medicaid program. It provides federally-entitled Medicaid benefits to eligible individuals and state-funded General Assistance benefits for adults who do not qualify for Medicaid but meet Pennsylvania standards for health care coverage.

- Medicaid is an entitlement for low-income families that qualify for federal TANF cash assistance, low-income children and low-income pregnant women. It is also an entitlement for individuals who receive federal Supplemental Security Income (SSI) – these are low-income individuals who are disabled, blind or age 65 or older.
- General Assistance recipients are typically low-income (chronically ill) adults without dependent children who have a disability that precludes employment.

The Department of Public Welfare (DPW) administers the MA program, subject to oversight by the federal Centers for Medicare and Medicaid Services. To receive federal Medicaid funds, DPW must adhere to federal requirements and rules that ensure a minimum level of health care coverage for Medicaid beneficiaries. Within these federal guidelines, DPW has flexibility in establishing eligibility criteria, benefit packages, provider payment rates and program administration.

MA provides health care coverage to more than 2.1 million (or one out of six) Pennsylvanians. The majority of MA recipients are low-income children and families (56 percent). Approximately 24 percent of MA recipients are disabled individuals, 17 percent are elderly and 3 percent are chronically ill adults.

MA services are delivered either on a traditional fee-for-service basis or through managed care plans. Most MA recipients receive coordinated health care services through the managed care program. The balance of recipients receive their care through the fee-for-service program, including more than 100,000 elderly and disabled individuals who receive long-term care services either in a nursing facility or in a community setting.

The greatest share of MA funding is for the elderly and persons with disabilities, reflecting their intensive use of acute and long-term care services. Although the elderly and disabled represent just over one-third of all recipients, they account for more than two-thirds of projected MA expenditures. By contrast, low-income children and families, which represent the majority of MA recipients, account for only one-fourth of MA spending.

Pennsylvania's MA program is jointly funded with state and federal dollars. The federal matching rate for each state is determined annually through a statutory formula that is based on per capita income. The federal match applies to almost all services provided to Medicaid beneficiaries. Historically, the federal government has paid between 53 and 55 percent of Pennsylvania's MA costs. During the 33-month federal stimulus period (October 2008 through June 2011), the federal share of MA costs averaged approximately 65 percent, providing fiscal relief to the state.

Pennsylvania relies on revenues (other than the state General Fund) to pay for MA expenditures and to draw down federal dollars. These other funds amount to $2.3 billion in the enacted 2012/13 budget. For the most part, these are revenues collected from the assessments levied on select MA providers – namely, nursing homes and hospitals – and the gross receipts tax imposed on MA managed care organizations. These provider assessments/taxes must meet stringent federal rules to qualify for federal Medicaid matching funds.

Medical Assistance Eligibility

Pennsylvania's MA program has dozens of categories and programs, each with its own qualifying criteria. DPW's county assistance offices are responsible for determining the appropriate eligibility category for each person who is applying for or receiving MA services.

Eligibility Criteria

MA eligibility is based on the following non-financial factors: age; disability (temporary, permanent and total); deprivation of support or care; specified relatives (to dependent children); employability; pregnancy; diagnosis and the need for treatment; blindness; resident in a long-term care facility; and individual receiving home and community based services. Because MA is means-tested, individuals who fall into one of these eligibility categories must also meet financial criteria based on income and resources (i.e., assets) to qualify for coverage.

Each MA category has its own income requirement. For some categories, income eligibility is tied to the federal poverty level; other categories use the federal Supplemental Security Income standard. Income counted in determining eligibility include wages, interest, dividends, Social Security, veterans' benefits, pensions and spouse's income if the person is living with him/her. Depending upon the category, certain types or amounts of income are disregarded (i.e., not counted) and certain types or amounts of expenses are allowed as deductions when determining final countable income to qualify for MA.

Resource requirements also vary among categories – some categories (such as children, families with dependent children and pregnant women) have no resource tests. Resources counted in determining eligibility include: cash; checking accounts; savings accounts and certificates; Christmas or vacation clubs; stocks and bonds; some trust funds; life insurance; vehicles (the first vehicle does not count); and non-resident property. An individual's primary residence does not count in determining eligibility, nor does their burial space and marker.

Additionally, MA has requirements which pertain to Social Security number, residency and citizenship. To be eligible for MA, an individual must have a Social Security number and must be a Pennsylvania resident; however, there is no requirement regarding the length of time that a person must live in Pennsylvania to receive benefits. MA is available to United States citizens, refugees and certain lawfully admitted aliens; however, individuals must have documentation proving their U.S. citizenship or legal alien status. Except for emergency treatment, most legal immigrants are not eligible for MA during their first five years in the United States. Undocumented immigrants, regardless of how many years they have been in the country, are never eligible for MA other than for emergency treatment.

Federal Mandatory and Optional Categories

Individuals who meet federal Medicaid criteria are entitled to MA and cannot be denied coverage. The mandatory groups include: low-income pregnant women; low-income children; persons receiving federal SSI benefits (low-income individuals who are disabled, blind or age 65 or older); and low-income families that meet TANF eligibility standards established by the state. (Pennsylvania limits TANF eligibility to the very poor, generally with family income below 50 percent of the federal poverty level.) MA is also mandatory for the following legal permanent resident immigrants who meet all other financial and eligibility Medicaid requirements: refugees for the first seven years after entering the United States; asylees for the first seven years after asylum is granted; lawful permanent aliens with 40 quarters of creditable coverage under Social Security; and immigrants who are honorably discharged U.S. military veterans.

Federal law establishes minimum income criteria for the Medicaid-eligible groups. States have the flexibility to expand the income requirement beyond the federal standard and to impose an asset requirement. Pennsylvania has opted to expand eligibility beyond the federal minimum income standard for several groups so additional people may obtain coverage. For example, the federal income standard for pregnant women is 133 percent of federal poverty level; however, Pennsylvania covers pregnant women up to 185 percent of federal poverty level.

In addition, states have the option to extend coverage to certain individuals who have incomes above the limits for a specific eligibility category by allowing them to "spend down." Under this process, individuals with high medical expenses may use their medical expenses as a deduction to reduce their income to a state-established medically needy income limit. Individuals who qualify through "spend down" are categorized as medically needy – they often incur high expenses (for hospital or long-term care) as the result of an accident, catastrophic illness, or ongoing care. Pennsylvania offers the medically needy option through two programs: a monthly spend-down and a six-month spend-down. Appendix A provides more information on MA spend-down, including a table showing the income limits for medically needy individuals to qualify.

Unless they are pregnant or disabled, adults without dependent children are excluded from traditional Medicaid. Beginning in 2014, federal health care reform (Affordable Care Act) ends the exclusion and expands Medicaid to include nearly all low-income adults under age 65 with incomes up to 138 percent of the federal poverty level. The June 28, 2012, United States Supreme Court decision in National Federation of Independent Business v. Sebelius makes Medicaid expansion optional for states. Appendix B summarizes the Medicaid provisions in the Affordable Care Act and includes a brief description of the Supreme Court's ruling.

Dual Eligibles

A significant aspect of Pennsylvania's MA population is the recipients who are dually eligible for both Medicaid and Medicare. "Dual eligibles" – comprised of low-income seniors and disabled individuals receiving Supplemental Security Income (SSI) – have substantial health care needs and rely upon both programs for services. Medicare covers most basic health care needs, including physician services, prescription drugs, and hospital services; MA covers benefits that Medicare excludes or limits, including nursing home services. MA also assists in paying their premiums and cost-sharing for Medicare Part A (hospital insurance) and Medicare Part B (medical insurance) – this assistance is federally-mandated.

Eligibility Determination

The county assistance office determines MA eligibility when an individual applies for benefits. The client must provide documentation of income, resources and other eligibility criteria before MA benefits can be authorized. In general, benefits can not begin until after verification of the applicant's income. However, Act 42 of 2005 allows the county assistance offices to authorize coverage at the time of application for pregnant women, children, the elderly, and individuals with disabilities. Within 60 days of authorizing benefits, the county assistance office must verify the applicant's self-declared income through third-party, automated sources of verification (such as DPW's Income Eligibility Verification System explained below). This process of approving MA coverage prior to final verification of eligibility is referred to as "presumptive eligibility."

After the initial approval of MA benefits, the county assistance office must periodically verify the individual's information at each reapplication or redetermination of eligibility. Redetermination is the process for reviewing eligibility factors to determine whether to continue MA coverage for a recipient. Act 42 of 2005 requires that redetermination takes place every six months for most clients. Because the circumstances for certain recipients do not change so quickly (and it would not be cost effective to require six-month redeterminations), eligibility for the following groups is redetermined annually:

- Persons receiving long-term care services;
- Persons receiving MA benefits in an elderly or disabled category of aid;
- Pregnant women;
- Children under the age of one year;
- Children living with relatives other than a parent when the adult's income does not affect eligibility;
- Children in foster care or adoption assistance programs; and
- Individuals receiving extended Medicaid coverage.

Every application for MA undergoes more than a dozen different electronic checks to verify information. Caseworkers in the county assistance office match applicants with Pennsylvania Department of Health birth certificate data to verify citizenship, with PENNDOT records (typically a driver license) to verify the applicant's identity, and with Social Security Administration data to verify Social Security numbers.

Caseworkers use DPW'S Income Eligibility Verification System (IEVS) to verify factors affecting MA eligibility and benefits. IEVS consists of state and national data that caseworkers match with information in the MA database to verify income and assets of individuals, to check the criminal history of individuals, and to discontinue benefits for deceased persons. IEVS currently has twelve data exchanges that provide the following information:

- Wages reported to the PA Department of Labor and Industry.
- Unemployment compensation claims filed with the PA Department of Labor and Industry.
- Employment information provided through the National New Hires file.
- Government benefits from the Social Security Administration (i.e., Supplemental Security Income, ministration, Social Security Disability payments, Medicare Part A and Part B, Black Lung, and Railroad Retirement Board entitlement).
- Earned income and unearned income reported to the Internal Revenue Service.
- Public benefits received in other states and the Veterans Administration, as provided through the Public Assistance Reporting Information System (PARIS is an interstate database that is coordinated by the federal government).
- Criminal history information (relating to outstanding warrants, fines, costs, and/or restitution, or incarceration) from the Commonwealth Judicial Inquiry System. This information is collected from the following County, State and Federal sources: Administrative Offices of Pennsylvania Courts, Pennsylvania Department of Corrections, Judicial Districts of Pennsylvania Courts, and the Prisoner Verification System (provided by the Social Security Administration).
- Immigration information provided by the U.S. Department of Homeland Security through the Systematic Alien Verification for Entitlements (SAVE) Program.
- Death information from the Pennsylvania Department of Health Deceased Persons FIle, the Social Security Administration Death Master File, and the managed care organization files.
- Lottery winnings from the Pennsylvania Lottery.

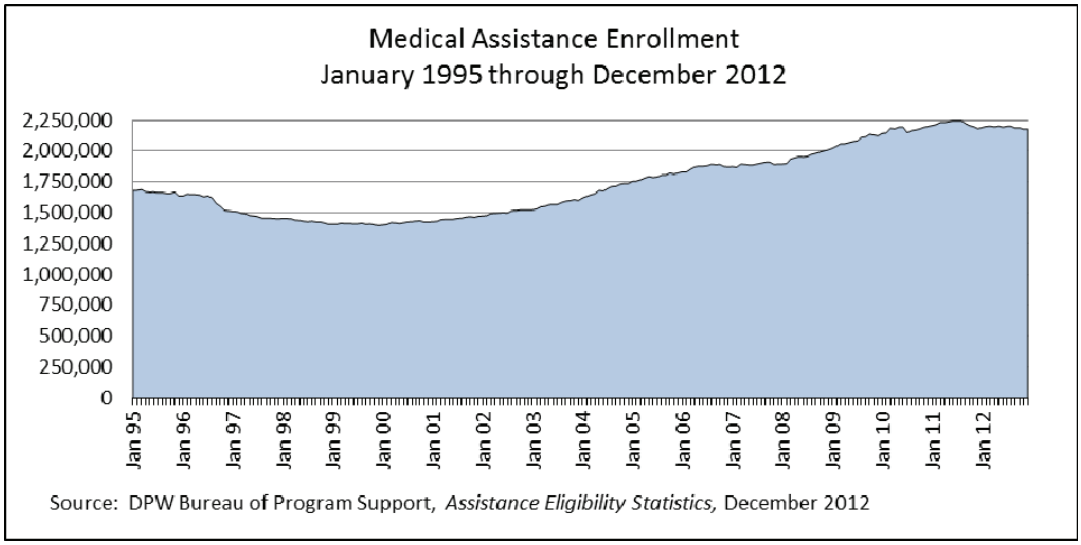
DPW'S Income Eligibility Verification System (IEVS)

DPW created its IEVS in response to the Federal Deficit Reduction Act of 1984 which mandated the exchange of information between state and federal agencies to aid in the determination of eligibility for federally-funded assistance programs. DPW began operating the required matches in 1987, shortly after passage of the 1986 federal regulations that implemented the 1984 federal act. In 2011, the General Assembly passed Act 22 which mandated enhancements to existing data exchanges in DPW's system and required the creation of new exchanges to provide additional data specified in the Act (such as wages from contiguous states and information on Federal Incarcerations and Fleeing Felons) .

Periodically, IEVS runs data exchanges and sends the updated information to the county assistance offices. Through a series of targeted edits, the system reviews all data to determine what information will have the greatest effect on MA eligibility or the benefit amount. Caseworkers are required to review IEVS information that meets the targeting criteria and initiate the appropriate action– that is, deny, terminate, suspend or reduce an individual's benefits – within 45 days. Information that does not meet the established targeting criteria must be reviewed by the worker at the next redetermination or sooner, if necessary.

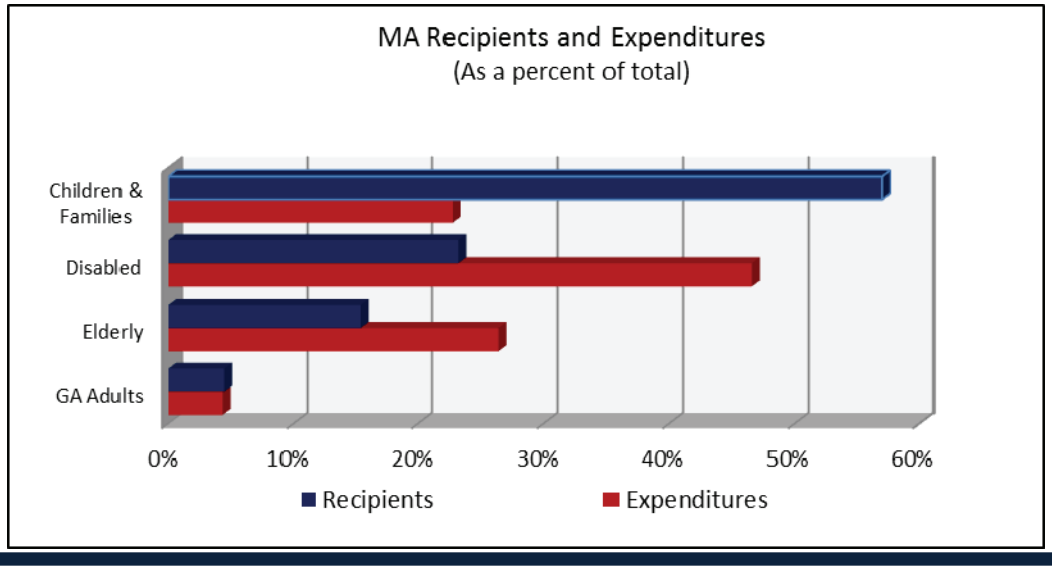
Medical Assistance Enrollment

Policy changes and economic conditions impact enrollment in the MA program. The chart below illustrates historical monthly enrollments from January 1995 through December 2012.



The number of MA recipients declined during the late 1990's, reflecting the General Assistance eligibility revisions in Act 35 of 1996 (which significantly reduced MA enrollments, effective June 1996) and the booming economy (which lifted families off the MA rolls). Enrollment dipped below 1.4 million in December 1999, but began to steadily increase in 2000 as the economy slowed. By December 2010, enrollment was nearly 2.2 million – this represented a total increase of 802,000 (or 57 percent growth) in an 11-year period that included two recessions. MA enrollment reached 2.246 million in August 2011, but decreased in subsequent months due to a combination of more aggressive eligibility redeterminations (instituted by DPW in August 2011) and further revisions to General Assistance eligibility requirements (effective August 2012).

As of December 2012, MA enrollment was 2.177 million individuals – or one out of every six Pennsylvanians. Nearly half of these enrollees (1.065 million) were children. MA recipients generally fall into one of four broad groups: low-income children and families; the elderly; the disabled; and chronically ill adults. Although the elderly and disabled together represent approximately 38 percent of all MA recipients, they account for more than two-thirds of MA expenditures. By contrast, low-income children and families represent the majority of Pennsylvania's MA recipients, yet they account for less than one-fourth of all MA spending. These differences reflect the intensive use of acute care and long-term care services by elderly MA recipients and those with a disability.



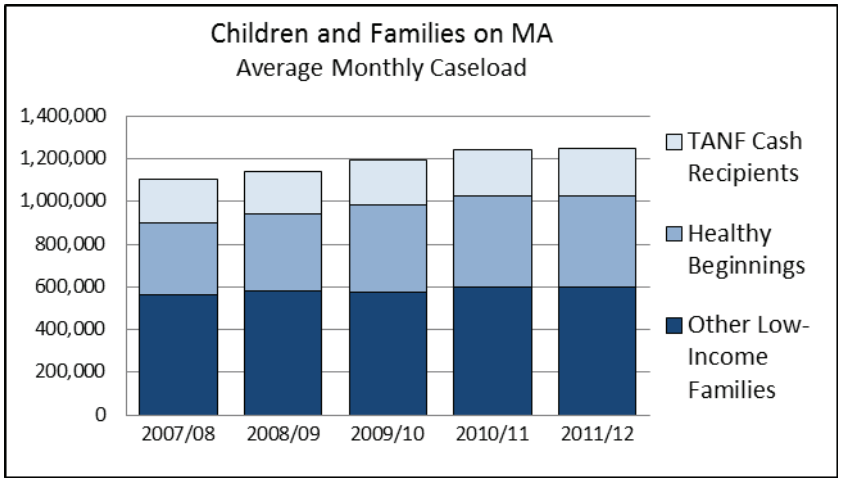
Low Income Families and Children

This group is comprised of families that meet the eligibility requirements for TANF cash assistance and medically needy families that qualify for MA by spending down. It also includes low-income pregnant women and children who receive medical coverage in the Healthy Beginnings program.

MA Eligibility Criteria for Families, Children and Pregnant Women		
Major Categories	**Income Test***	**Comments**
TANF		
TANF - Cash Recipients	Pennsylvania's July 16, 1996, welfare (AFDC) eligibility. Income limits vary by county and by the deductions/disregards a household may take. Generally, the income limit for families is less than 50% FPL (federal poverty level).	Federal Mandate - These families qualify for and receive TANF cash assistance.
TANF - Non-Money Payment		Federal Mandate - These families are eligible for TANF cash assistance, but choose MA coverage only and do not get cash payments.
TANF - Medically Needy Only	See Appendix A	Federal Option - These families have too much income to qualify for TANF, but qualify for MA through the "spend down" process.
Healthy Beginnings		
Children under age 1	Up to 185% FPL	The income limit for "children under age 1" is the Federal Option (the mandate is 133% FPL); the other income limits are the Federal Mandate.
Children age 1 through 5	Up to 133% FPL	
Children age 6 to 19	Up to 100% FPL	These children receive full MA benefits, even though their parents may not be eligible for MA.
Pregnant Women	Up to 185% FPL (household size is increased by the number of unborn children)	The income limit is the Federal Option (the mandate is 133% FPL) - Women with a verified pregnancy receive MA benefits for duration of pregnancy and through post-partum period (i.e., 60 days).

**These MA categories have income requirements only; resource requirements do not apply.*

The bar graph below shows the five-year caseload trend for low-income children and families. Approximately 1.217 million individuals were on MA in 2011/12, an increase of 13 percent from 2007/08. More than half of this population is from low - income families who do not receive any cash assistance. One third are low-income children and pregnant women receiving health care through the Healthy Beginnings program - enrollment in this program increased 27 percent over the last five years. Less than 220,000 recipients are from "welfare" families receiving TANF cash grants - caseload for TANF "welfare" recipients has grown by less than 5 percent since 2007/08.



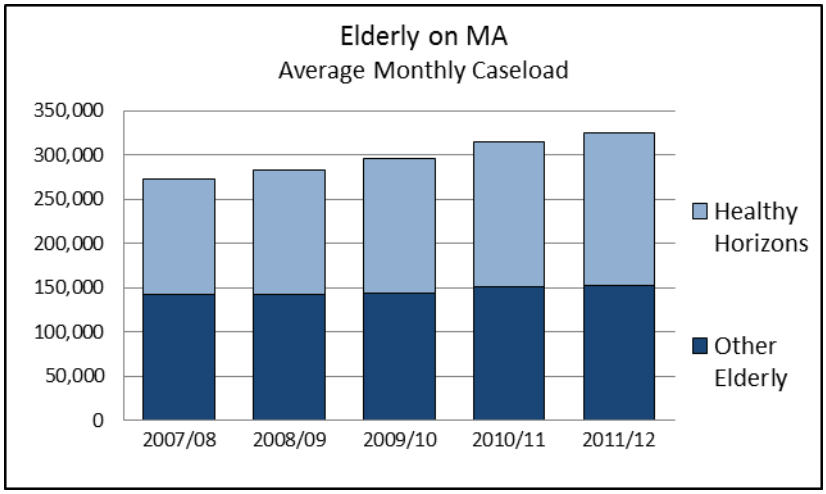
SOURCE:
House Appropriations Committee (D) analysis of *MA Enrollees for All PA Counties*, **DPW Enterprise Data Warehouse – Eligibility Table** (data extraction date 1/08/13)

Elderly

This group is comprised of older Pennsylvanians who require long-term care and other medical services. These are seniors who qualify for SSI as well as medically needy seniors who spend down their income to qualify for MA. This group also includes low-income seniors who receive financial assistance in paying their Medicare Part A and Part B premiums, deductibles, and copayments through the Healthy Horizons program.

MA Eligibility Criteria for Elderly		
Major Categories	**Income and Resource Tests**	**Comments**
SSI - Aged	**Net Monthly Income Limits (2013)**: $732.10 for an individual and $1,099.30 for two people. **Resource Limits (2013)**: $2,000 for an individual and $3,000 for two people.	Federal Mandate - These are elderly individuals (age 65 or older) who receive cash assistance under the federal Supplemental Security Income program.
Aged - Medically Needy Only	See Appendix A	Federal Option - These seniors make too much income to qualify for SSI, but qualify for MA through the "spend down" process.
Healthy Horizons		
Qualified Medicare Beneficiary (QMB)	**Income Limits:** 100% FPL (federal poverty level) **Resource Limits (2013)**: $7,080 for an individual and $10,620 for two people.	Federal Mandate - MA assists in paying their Medicare Part A and Part B premiums , deductibles and co-payments. For persons with limited resources (up to $2,000 for an individual and $3,000 for two people) MA also provides medical coverage.
Specified Low-Income Medicare Beneficiary (SLMB)	**Income Limits:** At least 100%, but less than 120% FPL. **Resource Limits (2013)**: $7,080 for an individual and $10,620 for two people.	Federal Mandate - MA assists in paying their Medicare Part B premium only
Qualifying Individuals Group 1 (Q1-1)	**Income Limits:** At least 120%, but less than 135% FPL. **Resource Limits (2013)**: $7,080 for an individual and $10,620 for two people.	Federal Mandate - The federal government pays their Medicare Part B premium, up to a capped amount. States are not required to provide any financial assistance.

Approximately 325,000 older Pennsylvanians were on MA in 2011/12, an increase of 20 percent from 2007/08. More than half were receiving assistance in the Healthy Horizons program – monthly caseload for this program has grown 30 percent over the past five years. The other seniors on MA include those who are either SSI disabled or spent down to qualify for coverage; many of whom are receiving nursing home care and other long-term care services.



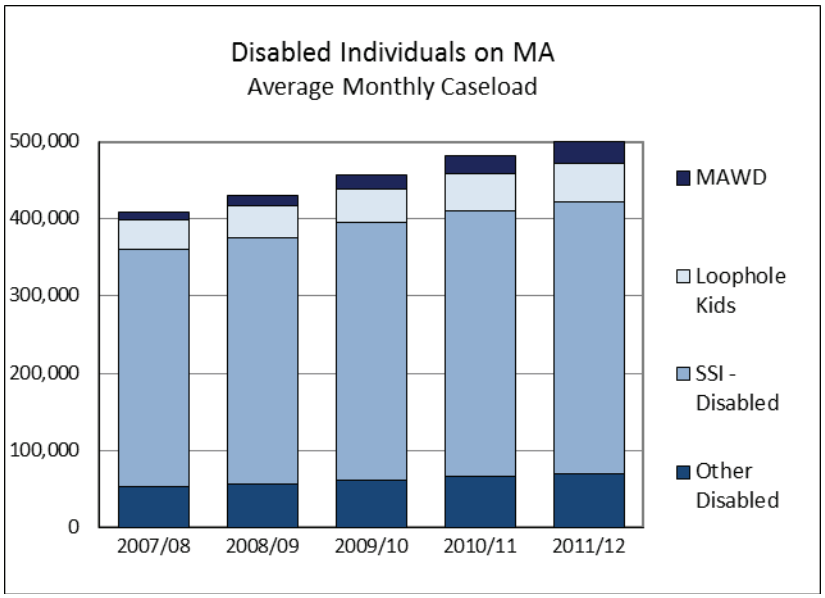
SOURCE:
House Appropriations Committee (D) analysis of *MA Enrollees for All PA Counties*, **DPW Enterprise Data Warehouse – Eligibility Table** (data extraction date 1/08/13)

Disabled

This group is comprised of non-elderly disabled individuals who have various health care needs, most of whom receive SSI and are federally entitled to MA. The non-SSI individuals in this group include: the so-called "loophole kids" who have disabilities such as autism or Down's Syndrome; the working disabled enrolled in the Medical Assistance for Workers with Disabilities (MAWD) program; and uninsured women in the Breast and Cervical Cancer Prevention and Treatment (BCCPT) Program.

MA Eligibility Criteria for Disabled Individuals		
Major Categories	**Income and Resource Tests**	**Comments**
SSI - Disabled	**Net Monthly Income Limits (2013)**: $732.10 for an individual and $1,099.30 for two people. **Resource Limits (2013)**: $2,000 for an individual and $3,000 for two people.	Federal Mandate - These are people under age 65 who receive cash assistance under the federal Supplemental Security Income program.
Disabled - Medically Needy Only	See Appendix A	Federal Option - These people make too much income to qualify for federal SSI, but qualify for MA through the "spend down" process.
"Loophole" Kids	**Income Limit:** 100% FPL (federal poverty level) **Resource Limit:** None	Federal Option - These are children with disabilities who do not qualify for federal SSI because their parental income is too high, but qualify for MA because Pennsylvania only uses the child's income in determining MA eligibility.
Medical Assistance for Workers with Disabilities (MAWD	**Income Limit:** Below 250% FPL **Resource Limit:** Less than $10,000	Federal Option - Working disabled adults (age 16 through 64) obtain MA coverage through the MAWD program by paying DPW a premium equal to 5 percent of their monthly income

Average monthly caseload for non-elderly disabled was 500,000 in 2011/12, an increase of 22 percent from 2007/08. More than two-thirds of this population is SSI Disabled and another 13 percent qualify for MA through the spend-down process. The remainder of the group includes: approximately 50,000 "loophole" children; approximately 27,000 adults in the MAWD program; and approximately 1,800 women needing treatment for cancer in the BCCPT Program.



SOURCE:
House Appropriations Committee (D) analysis of *MA Enrollees for All PA Counties*, **DPW Enterprise Data Warehouse – Eligibility Table** (data extraction date 1/08/13)

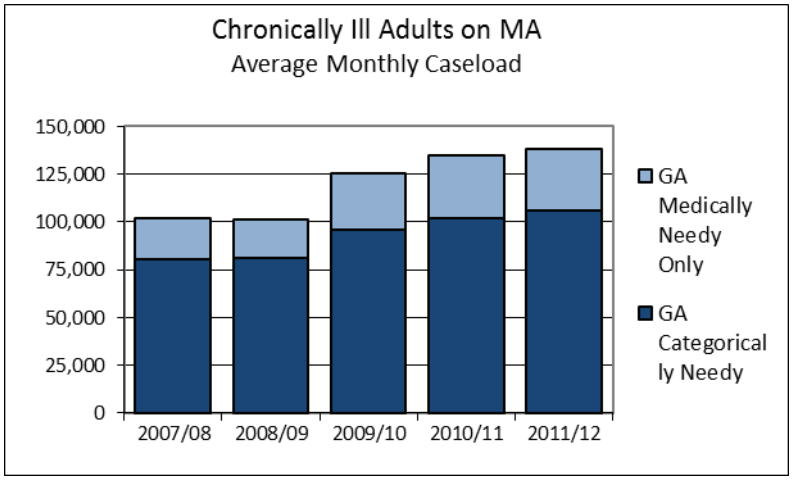
Chronically Ill Adults (GA)

This group is comprised of low-income adults (age 21 through 64 years) who do not meet federal eligibility criteria for Medicaid, but qualify for medical coverage under the state-funded General Assistance (GA) program. Pennsylvania statute (Public Welfare Code) establishes eligibility standards for two GA groups: Categorically Needy and Medically Needy Only.

- "Categorically Needy" is comprised of low-income adults who meet any of the following: they have a documented physical or mental disability which precludes employment; they are caring for a child under age 13 or another person who is ill or disabled; they are undergoing drug and alcohol treatment; or they are a victim of domestic violence.
- The "Medically Needy" group is comprised largely of low-income adults who have incurred high medical expenses and "spend down" to qualify for coverage. Act 80 of 2012 amended the Public Welfare Code to require custodial parents, age 21 through 58 years, with dependent children to work at least 100 hours per month earning at least the minimum wage in order to receive MA – previously, this work requirement only applied to non-custodial parents, age 21 through 58.

MA Eligibility Criteria for Chronically Ill Adults		
Category	**Income Test**	**Resource Test**
GA - Categorically Needy	Net monthly income limit is: $215 for one person $330 for two people $421 for three people $514 for four people $607 for five people $687 for six people $83 for each additional person	Resource limit is: $250 for one person $1,000 for two people
GA - Medically Needy Only	See Appendix A	See Appendix A

Average monthly caseload for GA adults was nearly 138,000 in FY 2011/12 – approximately three-fourths of GA recipients are categorically needy and one-fourth are medically needy. The eligibility revisions implemented in the first half of 2012/13 have reduced GA caseload to about 125,000 in December 2012.



SOURCE:
House Appropriations Committee (D) analysis of *MA Enrollees for All PA Counties*, **DPW Enterprise Data Warehouse – Eligibility Table** (data extraction date 1/08/13)

Medical Assistance Benefits

MA covers a comprehensive range of services, some of which are mandated by federal law and others are optional services that Pennsylvania chooses to offer. Mandatory services refer to those basic services that states must cover in order to receive federal matching funds for their Medicaid programs. Optional services refer to the additional services that states may cover and receive federal matching funds for the costs of those benefits.

Mandatory Benefits

Most MA recipients are entitled to receive the following mandatory acute care services:

- Physician services;
- Outpatient hospital services (preventive, diagnostic, therapeutic, rehabilitative or palliative services that are delivered on an outpatient basis);
- Inpatient hospital services (treatment provided to patients admitted to a hospital);
- Laboratory and X-ray services;
- Early and periodic screening, diagnosis and treatment (EPSDT) for children under age 21 (includes immunizations and well-child care; vision services; hearing services; dental services; and all other necessary health care and services to treat physical and mental conditions);
- Pediatric and family nurse practitioner services;
- Family planning services and supplies (abortion is not a covered family planning service);
- Nurse midwife services; and
- Rural health clinic and federally qualified health center (FQHC) services.

MA provides the following mandatory long-term care services:

- Nursing facility services for individuals 21 years and older; and
- Home health care for persons eligible for nursing facility services, including: part-time or intermittent nursing services; home health aide services; and medical supplies, equipment, and appliances suitable for use in the home.

Optional Services

Optional benefits provided by MA include a variety of acute care services, mental health services, and long-term care – optional services are listed in the table on the following page. The inclusion of these services allows MA to meet the diverse and complex needs of individuals enrolled in MA, especially the elderly and the disabled. All optional services are mandatory for children under age 21 when they are deemed “medically necessary.”

Many of the optional acute care services provide important medical benefits to all MA enrollees. For example, pharmacy benefits are among the most significant of optional services because prescription drugs are an integral component in the treatment and management of many illnesses and conditions. Mental health services are especially significant for individuals with disabilities, while long-term care is important to both disabled individuals and the elderly.

Benefit Limits

The federal government gives the states discretion in designing their benefit packages, including the amount, scope and duration of services offered. MA provides varying benefit packages to different eligibility groups. For example, adults in the Medically Needy Only eligibility categories do not receive prescription drugs. MA also imposes service limitations on certain individuals. For example, adult Medicaid recipients are limited to six drug prescriptions per month and GA recipients are limited to two hospital admissions per year.

MA Optional Services	
Acute Care	
Birthing center services	Prescription drugs
Transportation services	Optometrists' services
Drug and alcohol outpatient clinic	Podiatrists' services
Ambulatory surgical center	Chiropractors' services
Independent medical clinic/surgical center	Dental services, including orthodontics
Targeted case management	Medical supplies and equipment
Primary care case management services	Prosthetic devices
Physical therapy, speech therapy and occupational therapy services	Renal dialysis
	Rehabilitative services
Mental Health	
Psychiatric clinic services	Partial hospitalization
Long-Term Care	
Hospice care	Home and community-based waiver services
Intermediate care facilities for persons with mental retardation (ICF/MR)	Intermediate care facilities for persons with other related conditions (ICF/ORC)
Inpatient hospital and nursing facility services for persons 65 or older in an institution for mental disease	

Copayments

The federal government allows states to impose copayments on most Medicaid benefits other than emergency services, family planning services, pregnancy-related services, or preventive services for children. Most copayments are limited to nominal or minimal amounts. Federal law exempts the following groups from copayments: children, individuals residing in an institution, and individuals receiving hospice care.

In accordance with federal law, MA imposes copayments on most non-emergency services. Some services require adult recipients to pay a fixed copayment amount per unit of service. For example, adult Medicaid recipients have copayments of $3 for each brand name drug prescription or refill, $1 for each generic drug prescription or refill, $1 for each x-ray or other medical diagnostic test, $0.50 for each unit of outpatient psychotherapy services, and $3 for each day in the hospital (capped at $21 per hospital stay). The copayment amounts for General Assistance (GA) adults are double those required of Medicaid adults.

For all other services requiring copayments, the copayment is a sliding scale amount that is based on what MA pays providers for the service. Historically, the sliding scale copayment amounts ranged from $0.50 to $3.00 for adult Medicaid recipients, and from $1 to $6 for adult GA recipients.

Effective May 2012, DPW increased the sliding scale copayments by providing for an inflationary adjustment as authorized by the federal Deficit Reduction Act of 2005. Specifically, DPW increased copayment amounts to reflect the growth in the medical care component of the consumer price index since 2006. Moreover, DPW may continue to make annual adjustments to the copayment amounts based on the percentage increase in the medical care component of the consumer price index as published by the federal government in the Federal Register each October. The following table shows the sliding scale copayment amounts, effective May 15, 2012:

MA Payment for Service	Medicaid Adult Copayment	GA Adult Copayment
$2 to $10	$0.65	$1.30
$10.01 to $25	$1.30	$2.60
$25.01 to $50	$2.55	$5.10
$50.01 or more	$3.80	$7.60

Federal and state rules prohibit MA providers from denying services to any recipient who is unable to pay the copayment. However, recipients may be held liable for unpaid copayments.

Medical Assistance Programs

Services provided through MA can be divided into two broad categories – acute care and long-term care – each of which has its own delivery systems.

Acute Care

Approximately 70 percent of MA recipients receive coordinated health care services through the managed care program. The remaining recipients receive their care through the fee-for-service program.

MA has two capitated managed care programs: physical health managed care and behavioral health managed care. Each managed care organization (MCO) under contract with DPW agrees to provide a specified package of health services in exchange for an actuarially sound, fixed rate per enrollee per month. MCOs build a provider network so that they can offer comprehensive health services to enrollees. MCOs may provide additional health services beyond the specified benefits, but they do so at their own cost. DPW pays the MCOs a monthly premium for each member enrolled in their plans. The MCOs bear the full medical risk for every one of their plan members. They do not receive supplemental appropriations for operating at a loss or not fulfilling their performance commitment.

During 2011/12, more than 1.2 million MA recipients received physical health care services and more than 1.9 million recipients received behavioral health services through a managed care organization:

- *HealthChoices*, the name of the mandatory physical health managed care program, operated in three geographic zones covering 25 counties and had nearly 1.2 million enrollees in 2011/12. DPW contracts with two or three MCOs in each zone, giving MA recipients who reside in that zone a choice of plans in which they may enroll. An additional 75,000 individuals were enrolled in the voluntary managed care program operating in 25 other "non-*HealthChoices*" counties. MA recipients who resided in the voluntary counties had the option to receive physical health care through a managed care organization or the fee-for-service system.
- *HealthChoices Behavioral Health*, the name of the statewide behavioral health managed care program, provides mental health and drug and alcohol services to MA recipients in all 67 counties. DPW contracts separately with each county to provide services to MA recipients residing in that county. The county has the "right of first opportunity" to manage the behavioral health managed care component itself or may subcontract with a behavioral health MCO. This county option recognizes the county's statutory role in administering local mental health and drug and alcohol programs. *HealthChoices* Behavioral Health has been operating statewide since July 2007.

A major initiative in the 2012/13 budget was the expansion of *HealthChoices* to encompass the 42 counties in which the program had not previously operated. This statewide expansion was implemented in three stages and moved approximately 400,000 MA recipients into the *HealthChoices* program, including 71,000 people previously enrolled in the voluntary managed care program (which ended as *HealthChoices* expanded into counties). With expansion completed March 1, 2013, the *HealthChoices* program now operates in five zones covering all 67 counties and serving an estimated 1.9 million MA recipients.

- Effective July 1, 2012, seven counties were incorporated into two of the existing *HealthChoices* zones – the Southwest Zone and the Lehigh/Capital Zone.
- The remaining 35 counties were divided into two new zones – the new *HealthChoices* West Zone began operating October 1, 2012, in 13 counties located in the northwest region on; the new *HealthChoices East Zone* which began operating March 1, 2013, in 22 counties located in the northeast and northcentral regions.

The five *HealthChoices* zones and the counties that they cover are listed in the table below.

Physical Health Mandatory Managed Care - HealthChoices Zones and Counties	
HealthChoices Southeast Zone	**Implemented February 1997** in the following 5 counties: Bucks, Chester, Delaware, Montgomery and Philadelphia.
HealthChoices Southwest Zone	**Implemented January 1999** in the following 10 counties: Allegheny, Armstrong, Beaver, Butler, Fayette, Green, Indiana, Lawrence, Washington and Westmoreland.
	Expanded July 2012 to include the following 4 counties: Bedford, Blair, Cambria and Somerset.
HealthChoices Lehigh/Capital Zone	**Implemented October 2001** in the following 10 counties: Adams, Berks, Cumberland, Dauphin, Lancaster, Lebanon, Lehigh, Northampton, Perry and York.
	Expanded July 2012 to include the following 3 counties: Franklin, Fulton and Huntingdon.
HealthChoices New West Zone	**Implemented October 2012** in the following 13 counties: Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango and Warren.
HealthChoices New East Zone	**Implemented March 2013** in the following 22 counties: Bradford, Carbon, Centre, Clinton, Columbia, Juniata, Lackawanna, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne and Wyoming.

The fee-for-service delivery system provides payment on a per-service basis for health care services provided to eligible MA recipients who are not in capitated managed care. DPW contracts with more than 67,000 health care providers – such as doctors, hospitals and pharmacies– and pays for each service in accordance with promulgated fee schedules or rates of reimbursement. During 2011/12, approximately 865,000 MA recipients received services through the fee-for-service system. This included the following groups:

- 340,000 individuals who resided in the 42 "non-*HealthChoices*" counties and received their physical health care through the *Access Plus* program. (DPW established *Access Plus* in 2005 to provide enhanced primary care case management and disease management to eligible MA recipients.) These individuals were moved to managed care, and *Access Plus* ended as *HealthChoices* expansion expanded into these 42 counties.
- 525,000 individuals statewide who are automatically enrolled in fee-for-service (but not in *Access Plus*) and are specifically excluded from participating in managed care. These include: newly eligible MA recipients while they are awaiting enrollment in a managed care organization, dual eligibles who are age 21 or older, nursing home residents, individuals with intellectual disabilities who are admitted to intermediate care facilities, and women enrolled in the Breast and Cervical Cancer Prevention and Treatment Program. These groups of MA recipients were not impacted by the *HealthChoices* expansion and continue to receive their physical health care through the fee-for-service system.

Long-Term Care

MA provides long-term care services for individual who meet functional criteria as well as financial requirements for services. People needing long-term care include the elderly, who may require services due to physical and cognitive impairment that comes with aging, and the non-elderly, who may require a lifetime of services due to a disability or a degenerative disease. The non-elderly, for example, include teenagers and adults who incur traumatic brain injury or who are ventilator-dependent, people with cerebral palsy or multiple sclerosis, and individuals with AIDS.

Long-term care services range from institutional care to a variety of community-based services and supports that enable individuals to avoid institutionalization. Approximately 130,000 elderly and individuals with physical disabilities (or roughly 6 percent of MA recipients) use long-term care services. About 84,000 MA recipients

receive care in a nursing facility, including 9,000 persons who are under age 60. The remaining 27,000 individuals receive services provided at home or in community-based settings.

Many community services are provided through Medicaid home and community–based services (HCBS) waivers. HCBS Waivers are programs that use federal Medicaid funds to pay for community services as an alternative to institutional care. The name "waiver" comes from the fact that the federal government waives or sets aside its Medicaid rules so that states can receive federal Medicaid matching funds for expenditures that would otherwise not qualify for federal participation. To obtain federal approval for a waiver, the state must ensure that waiver services are cost effective compared to the cost of institutional care and must also demonstrate that it has safeguards to protect the health and welfare of people served in the waiver program. Appendix C provides additional information on the various Medicaid waivers, including HCBS waivers.

Area Agencies on Aging conduct an assessment of MA recipients to determine whether they meet functional eligibility for long-term care – that is, they require the level of care provided in a nursing facility. The county assistance office determines financial eligibility for long-term care, which has an income limit of 300 percent of the federal SSI benefit rate, or $2,130 a month in 2013. Depending upon the recipient's income, the resource limit ranges between $2,400 and $8,000. The following assets are excluded from the resource test: personal effects (i.e., jewelry and clothing), one motor vehicle, prepaid funeral plans, life insurance with a face value maximum of $1,500 and a family residence worth less than or equal to $525,000. Many people needing nursing home care enter as self-pay residents and qualify for MA by spending down their income and assets. Medicaid has special rules regarding the assets of nursing home residents, including a "look back" period of five years for assets transferred to qualify for MA and penalties for transferring assets at less than market value. Medicaid also requires estate recovery where the state seeks repayment for nursing home costs from the estate of certain deceased MA beneficiaries.

Nursing facility care is the most expensive part of long-term care, with annual costs averaging approximately $58,000 per resident. MA recipients must pay most of their income to the nursing home, less certain deductions for personal needs ($45 per month), uncovered medical costs, and an allowance for a community spouse or dependent child living at home. MA pays the difference between the nursing home cost and the amount the resident must pay from their monthly income.

Nursing Home Rates

State regulations establish a case-mix payment methodology for determining the per diem rates paid each year by DPW to nursing facilities. Under case-mix, residents are classified into categories based on the intensity of care they require, with nursing facilities paid more for services provided to residents with higher care needs. Rates generated by the case-mix system are uncapped; between 1996 (when the system was implemented) and 2005, nursing home per diem rates grew more than 50 percent. Beginning in FY 2005/06, the General Assembly amended the Public Welfare Code, authorizing DPW to apply a budget adjustment factor (BAF) in order to cap rates and ensure MA payments to nursing homes do not exceed the amount appropriated in the budget. Act 22 of 2011 extended the BAF until June 30, 2013, or the date on which a new rate-setting methodology for medical assistance nursing facility services takes effect, whichever is sooner.

Home and community-based services are provided to older MA recipients through two programs:

- The *Aging Waiver* provides personal care, attendant care, home health care, home-delivered meals, specialized medical equipment, and other services to people age 60 or older who otherwise would require nursing home care.
- *LIFE (Living Independence for the Elderly)* is a managed care program for frail elderly, aged 55 or older, who have been determined to need nursing facility level of care. The LIFE program provides comprehensive medical and support services to adults. The program is centered around an adult day health center where recipients receive most services; however, services such as personal care and meals are also provided in the home as needed.

DPW administers three HCBS Waiver programs for non-elderly people with severe physical disabilities:

- *OBRA Waiver* provides services to persons age 18 or older with severe developmental physical disabilities – such as cerebral palsy, epilepsy or similar conditions – that require an Intermediate Care Facility/Other Related Conditions (ICF/ORC) level of care. Other related conditions (ORCs) include physical, sensory, or neurological disabilities which manifested before age 22 and are likely to continue indefinitely.
- *Independence Waiver* provides services to persons age 18 or older who are physically disabled – but not with intellectual disability or have a major mental disorder as a primary diagnosis – and who are clinically eligible for nursing facility care.
- *COMMCARE Waiver* provides services to adults with traumatic brain injury who are age 21 or older and require nursing facility level of care.

DPW also administers the Attendant Care program which provides in-home personal care to mentally alert adults, age 18 through 59, who have a physical disability and need assistance to carry out functions of daily living, self-care and mobility. To be eligible for attendant care services, the disability must be a medically determined physical impairment which can be expected to last continuously for at least 12 months or that may result in death. Attendant care is available through two programs:

- Individuals who are Medicaid eligible receive services through the *Attendant Care Waiver*. The waiver program is funded with state General Funds and federal Medicaid matching funds.
- Adults with disabilities who are not Medicaid eligible receive basic services through the Act 150 program that is funded with state dollars (i.e., no federal funding). Although most Act 150 participants do not pay for their services, individuals with higher incomes may be assessed a co-payment for services based on a sliding scale fee.

All HCBS waiver services and Act 150 attendant care services are furnished through qualified providers who meet criteria established by DPW. The department pays for each service in accordance with fee schedules and reimbursement rates established by DPW in accordance with its expedited rulemaking authority under Act 22 of 2011.

Medical Assistance Funding Sources

Financial responsibility for the MA program is shared between the federal government and the commonwealth. The federal government matches state spending on Medicaid-eligible recipients only (state funds pay for General Assistance recipients). The federal share, or Federal Medical Assistance Percentage (FMAP), is determined annually through a formula based on per capita income as specified in the Social Security Act. The annual FMAP is in effect during the 12-month period of the federal fiscal year which begins October 1. The formula is designed to pay higher federal reimbursement to states with lower incomes, relative to the national average, and lower federal reimbursements to higher income states. Pennsylvania's FMAP typically ranges between 53 percent and 55 percent – annual changes to the FMAP can mean the gain or loss of tens of millions of federal funds for the MA program.

In the last two economic downturns, Congress has provided additional federal funds to states through a temporary increase in each state's FMAP. To receive the higher FMAPs, states could not reduce their Medicaid eligibility during the time the fiscal relief was in effect. The federal Jobs and Growth Tax Relief Reconciliation Act of 2003 gave all states a 2.95 percentage point increase in federal Medicaid reimbursement for five quarters, April 2003 through June 2004. Significantly greater fiscal relief was provided to state Medicaid programs under the federal American Recovery and Reinvestment Act of 2009 (ARRA) and subsequent legislation which increased state FMAPs for 11 quarters, October 2008 through June 2011 – in accordance with formulas set forth in federal law, Pennsylvania's quarterly FMAP increased by an average of nearly 10 percentage points during this period.

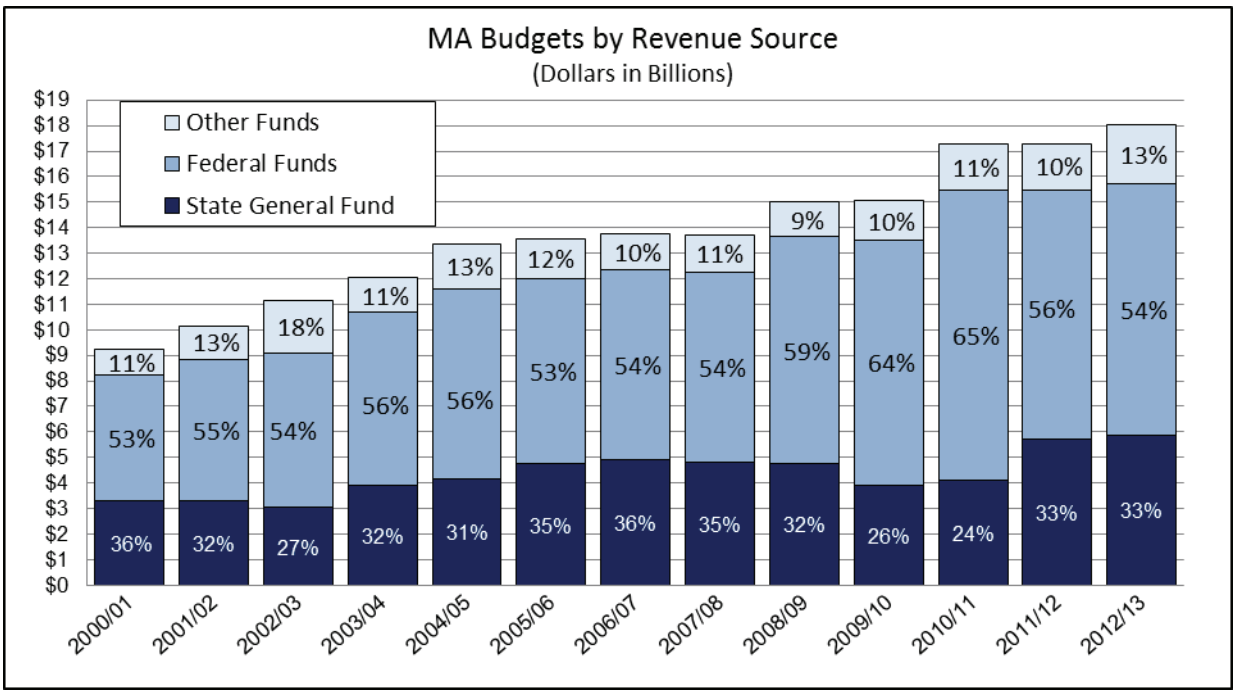
Other Funds

States can earn federal Medicaid matching funds by spending state, local and other non-federal dollars for covered services. Consequently, Pennsylvania uses revenue other than the state General Fund revenues to help finance the MA program. In 1990/91, Pennsylvania began using Intergovernmental Transfer (IGT) revenue from county governments to support MA, particularly long-term care. However, the federal government changed its Medicaid rules in January 2001 to curtail states' use of IGT – in accordance with this federal change, Pennsylvania was required to phase-out its IGT over a six-year period starting in 2003/04. Beginning in 2005, DPW turned to assessments on providers (nursing homes, managed care organization and hospitals) to generate additional revenue to fund MA. Recent budgets have also used revenues from the Tobacco Settlement Fund and the Lottery Fund to help pay for MA.

The graph on Page 18 shows the funding history for the most recent MA budgets, from 2000/01 through the enacted budget for 2012/13. The amounts shown are for the seven major MA appropriations that fund the managed care and fee-for-service programs, nursing homes and the alternative community-based programs for seniors (the Aging Waiver and LIFE) – these appropriations account for 95 percent of overall MA spending.

This graph illustrates the growth in annual MA budgets, which is driven by several factors including: the number of recipients; the utilization of services by recipients; MA rates and the cost of services paid by DPW; policy decisions to expand optional eligibility and services (i.e., expanding the number of Aging Waiver slots in order to serve more seniors); and the effectiveness of savings initiatives (i.e., redesigning the MA benefit package in 2005 and implementing preferred drug lists in 2005 to contain program costs).

Additionally, the graph shows the increased use of "other" funds to help pay the state share of MA budgets and reduce the need to spend State General Fund dollars. Of particular importance is the 2002/03 budget in which "other funds" provided 18 percent of all MA funding, allowing the State General Fund share to decrease to 27 percent even as the total MA budget was increasing. The 2002/03 budget represented the peak in utilizing IGT revenues to pay for MA expenditures. During the late 1990's, DPW increasingly relied on county IGT revenue to help pay program costs -- specifically, IGT funding escalated from $300 million in the 1995/96 MA budget to $1.85 billion in the 2002/03 MA budget. The availability of IGT funds allowed Pennsylvania to meet its soaring MA obligations during this period without the need for significant increases in state General Fund spending.



Note: The 2008/09 and 2009/10 budgets are impacted by the roll-back of approximately $740 million of total 2009/10 MA expenditures to 2008/09. Without this roll-back, 2009/10 would have been about $15.8 billion (or $740 million higher) and 2008/09 would have been about $14.3 billion (or $740 million lower).

When the Rendell Administration took office in January 2003, it was confronted with the loss of IGT funds which, in accordance with the federal rule revision, would start to phase-out in 2003/04 and would no longer be available to support the MA program after 2008/09. The administration opted to replace the disappearing IGT revenues with a series of assessments (i.e., fees or taxes) on health care providers to help finance their share of Medicaid spending and to maximize the receipt of federal funds. Similar to the case of the IGT, the provider assessments must meet stringent federal rules and comply with federal law to qualify for Medicaid matching funds.

- **Nursing Facilities**

  As part of the 2003/04 budget, the Rendell Administration proposed an assessment on nursing facilities as a new funding source to support the MA rates paid to nursing homes. In September 2003, the General Assembly passed Act 25 authorizing a nursing facility assessment for four years, through June 2007. After receiving federal approval in January 2005, DPW implemented the assessment (retroactive to July 2003), collecting two years of assessment revenue in 2004/05. Act 16 of 2007 extended the assessment five years, through June 2012. Act 80 of 2012 extended the assessment another four years, through June 2016.

- **Managed Care Organizations (MCOs)**

  As part of the 2004/05 budget, the Rendell Administration proposed an assessment on all behavioral health and physical health MCOs that participate in MA's managed care program as a new funding source to support the rates paid to MCOs. In July 2004, the legislature passed Act 69 authorizing the managed care assessment for four years, through June 2008. DPW began collecting the assessment after receiving federal approval in January 2005. Act 44 of 2008 reauthorized the MCO assessment beyond June 30, 2008. However, due to changes in the Federal Deficit Reduction Act of 2005 (enacted by Congress in February 2006), Pennsylvania's managed care assessment was no longer in compliance with federal regulations and was terminated after Sept. 30, 2009. The General Assembly passed legislation in October 2009 (Act 48) replacing the terminated assessment with a new Gross Receipts Tax on each managed care organization that receives payments from DPW pursuant to its Medicaid contract.

Additionally, Act 48 established a restricted receipts account for the deposit of tax revenues and earmarked the revenues for the MA managed care program. The federal government approved the new managed care Gross Receipts Tax for drawing down Medicaid matching funds, and Pennsylvania's Department of Revenue began collecting the tax in March 2010.

- **Philadelphia Hospitals**

  For 2008/09, the administration proposed an assessment on Philadelphia hospitals to support MA fee-for-service payments to hospitals. Act 44 of 2008 authorized Philadelphia to impose an assessment on certain hospitals for five years, through June 2013 – revenues would be used for MA payments to hospitals and for county health services. The federal government approved the Philadelphia assessment and it was implemented January 2009. The assessment expires after June 30, 2013, and legislation is required to extend it.

- **Statewide Hospitals**

  In July 2010, the General Assembly passed legislation (Act 49) which authorized DPW to implement a statewide hospital assessment (Quality Care Assessment) program for three years, beginning in 2010/11. In addition to providing $232 million to DPW over the three-year period to pay for MA services, revenue from the statewide hospital assessment is used to: implement a new hospital payment system APR-DRG) that more appropriately supports patient needs and the levels of service unique to MA patients; fund new and existing supplemental payments to hospitals; and increase reimbursement for hospital inpatient services through the HealthChoices managed care program. In October 2010, the General Assembly passed legislation (Act 84) that adjusted the assessment percentage in Act 49 in order to assure sufficient revenues would be generated under the assessment. The federal government made the necessary approvals for DPW to implement the statewide hospital assessment in March 2011. In June 2011, the General Assembly passed Act 22 which raised the assessment rate and increased the state's share of revenues (to pay for MA services in 2011/12 and 2012/13) by $107.5 million. The assessment expires after June 30, 2013, and legislation and federal approval are required to extend it.

Revisiting a practice previously used by the Ridge Administration in 2002/03, in which $198.5 million of **Tobacco Settlement Fund revenue** was **redirected to pay for MA long-term care**, the Rendell Administration also proposed using a portion of Tobacco Settlement Fund revenue for MA long term care beginning in 2005/06. Tobacco funds were diverted to MA as the result of legislative action to temporarily change the allocation provisions in the Tobacco Settlement Act which govern the use of payments received by the commonwealth under the 1998 Master Settlement Agreement with tobacco manufacturers. In each of the last eight budgets, the General Assembly has amended the Fiscal Code to redirect Tobacco Settlement Funds (including investment earnings and strategic contribution payments) to MA long-term care, as follows: $57.4 million in 2005/06; $65.9 million in 2006/07; $104.8 million in 2007/08; $134.1 million in 2008/09; $130.9 million in 2009/10; $103.6 million in 2010/11; $162.6 million in 2011/12; and $121.7 million in 2012/13.

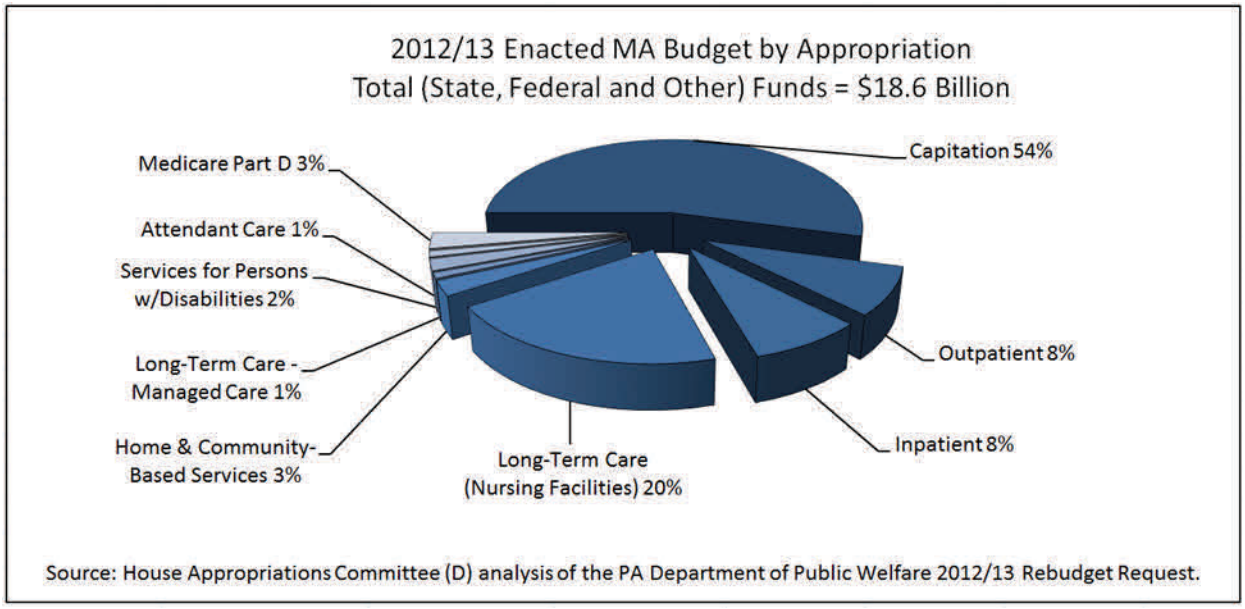
Additionally, the Rendell Administration revisited a previous practice used by the Thornburgh and Casey Administrations (1983/84 through 1993/94) in which **Lottery Funds** were **appropriated to help pay for MA long-term care**. Beginning in 2006/07, the following Lottery Fund revenues have been appropriated for MA long-term care: $248.8 million in 2006/07 and in 2007/08; $300.7 million in 2008/09; $178.4 million in 2009/10 through 2011/12; and $309.1 million in 2012/13.

Medical Assistance Appropriations

This section examines nine appropriations which account for the lion's share of the annual MA budget.

- Three appropriations pay for health care: the Capitation appropriation funds the managed care program; the Outpatient and Inpatient appropriations fund the fee-for-service system.
- Five appropriations pay for long-term care provided to seniors and individuals with physical disabilities: the Long-Term Care appropriation funds nursing facilities; community-based alternatives for seniors are funded through the Home and Community-Based Services and the Long-Term Care-Managed Care appropriations; community-based alternatives for individuals with physical disabilities are funded through the Attendant Care and the Services for Persons with Physical Disabilities appropriations.
- The final appropriation, Payment to Federal Government for Medicare Drug Program, funds the mandated monthly payments that Pennsylvania must make to the federal government to finance Medicare Part D drug benefits for dual eligible persons.

A total of $18.6 billion in funds (state, federal and other) are budgeted for these nine MA appropriations in 2012/13. The chart below shows the distribution of the budgeted funds by appropriation.



Capitation funds the health care costs for MA recipients enrolled in the managed care program. The major revenue sources are state General Funds and federal Medicaid funds appropriated in the annual state budget; other revenues from the managed care Gross Receipts Tax and statewide hospital assessment account for approximately 8 percent of funding. This appropriation pays for the following expenses:

- Monthly capitated rates paid to physical health MCOs and behavioral health MCOs.
- Special maternity payments to physical health MCOs for prenatal, delivery and post-partum services provided to female MA recipients.
- Pay for performance (P4P) bonus payments made to MCOs for meeting certain quality targets.
- Enhanced capitation payments (per the statewide hospital assessment program) to hospitals.

Outpatient funds primary health care and preventive services for MA recipients in the fee-for-service program. The major revenue sources are state General Funds and federal Medicaid funds appropriated in the annual state budget; other revenues from the Philadelphia hospital assessment and the statewide hospital assessment account for approximately 11 percent of funding. This appropriation pays for the following expenses:

- Outpatient services including prescription drugs, Early and Periodic Screening, Diagnostic and Treatment

(EPSDT) for children, physician, dental, psychiatric, drug and alcohol treatment, hospital outpatient services, ambulance, renal dialysis, hospice, home health services, and medical equipment/supplies.

- Supplemental payments to qualifying hospitals, including the Outpatient Disproportionate Share (DSH) payment to hospitals that serve a disproportionate share of low-income or uninsured patients.
- Medicare Part B premiums, copayments and deductibles for dual eligibles.

Inpatient funds inpatient hospital care provided to MA recipients in the fee-for-service program. The major revenue sources are state General Funds, federal Medicaid funds and the statewide hospital assessment (which accounts for approximately one-fourth of all funding). This appropriation pays for the following expenses:

- Reimbursement rates paid to acute care hospitals, private psychiatric hospitals, rehabilitation hospitals and residential treatment facilities for inpatient services provided to MA recipients.
- Supplemental payments made to qualifying hospitals, including Inpatient Disproportionate Share, Medical Education, Community Access Fund payments, and the various supplemental payments funded under the Quality Care Assessment program.
- Medicare Part A premiums, copayments and deductibles for dual eligibles.
- Health information technology incentive grants to hospitals and other health care providers. These grants are part of federal stimulus under the American Recovery and Reinvestment Act of 2009 (ARRA) and are funded fully with federal ARRA Medicaid funds.

Long-Term Care funds nursing facility care provided to MA recipients. The major revenue sources are state General Funds, federal Medicaid funds, and assessment revenue from nursing facilities. Other revenue used in 2013/14 to help pay the state share of nursing home expenditures are Tobacco Settlement Funds and Lottery Funds. This appropriation pays for the following expenses:

- The cost of home and community-based services for MA recipients.
- Per diem rates paid to nursing homes for the care of MA residents.
- Supplemental payments that DPW pays to nursing facilities in return for their participation in the assessment program.

Long-Term Care Appropriation

Historically, nursing facility care as well as alternative home-and community-based services for older MA recipients were funded through a single **Long-Term Care** appropriation. However, beginning with 2011/12, these services are funded through three separate appropriations**: Long-Term Care** now only funds nursing facility care; **Home and Community Based Services** funds the *Aging Waiver*; and **Long-Term Care – Managed Care** funds the *LIFE* managed care program.

Home and Community-Based Services funds the *Aging Waiver* program which provides home and community-based services to seniors, age 60 or older, as an alternative to nursing facility care. The major revenue sources are state General Funds and federal Medicaid funds appropriated in the annual state budget. Additional revenue is allocated annually from the Tobacco Settlement Fund, in accordance with provisions in Act 77 of 2001 (the Tobacco Settlement Act), accounting for approximately 9 percent of funding. This appropriation pays for the following:

- Rates paid to providers for services furnished to Aging Waiver enrollees.
- Administrative costs associated with the waiver.
- Expenses for the Nursing Home Transition program which assists individuals who want to move from a nursing facility back into the community.

Long-Term Care – Managed Care funds the *LIFE* program that provides community-based managed care services to people, age 55 or older, who otherwise would require nursing home care. The program is funded with state General Fund revenue and federal Medicaid matching funds. These revenues pay the monthly capitated rates paid to approved LIFE providers for each enrollee.

Services for Persons with Disabilities funds the Community Services Program for Persons with Physical Disabilities, providing alternatives to nursing home care for adults with severe physical disabilities. It is funded with state General Fund revenue and federal Medicaid matching funds. This appropriation pays for the rates paid to providers for services furnished to adults enrolled in the following waiver programs: OBRA, Independence and COMMCARE.

Attendant Care funds in-home personal care to adults who have a physical disability. The major revenue sources are state General Funds and federal Medicaid funds appropriated in the annual state budget. Other revenues from parking fees and patient fees generated in the Act 150 Attendant Care Program account for less than 1 percent of funding. This appropriation pays for the following expenses:

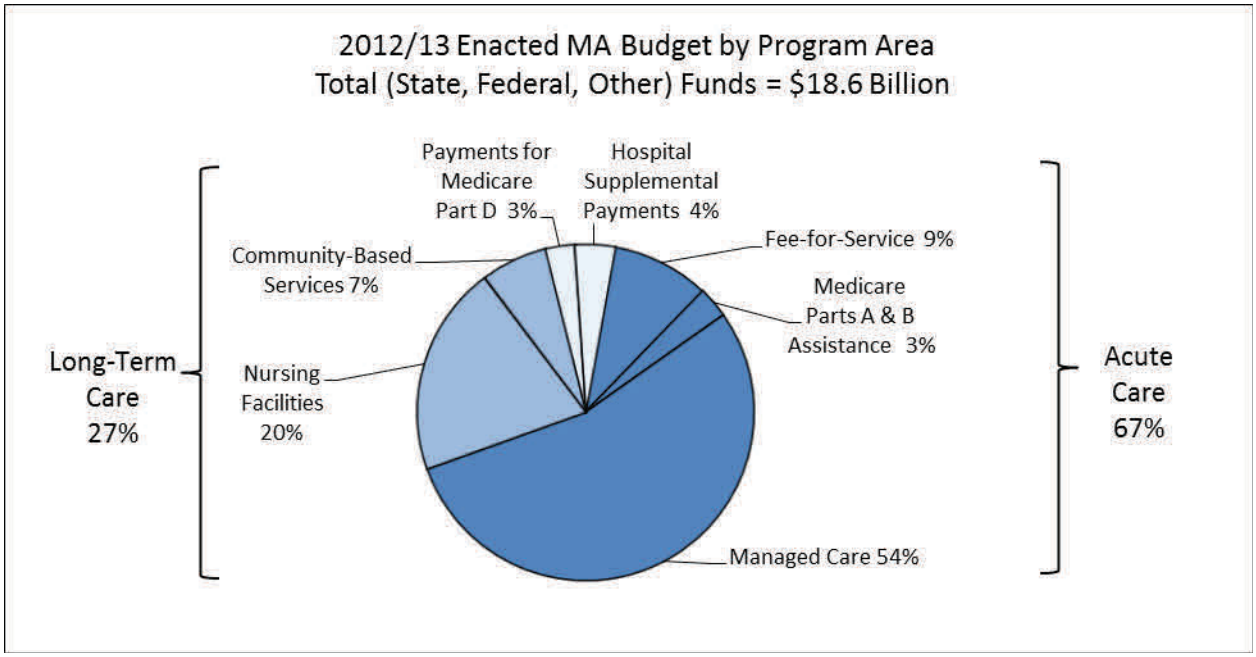
- Rates paid to providers for services furnished to Attendant Care Waiver enrollees.
- Rates paid to provider for services furnished to individuals in the Act 150 program.

Payment to Federal Government for Medicare Drug Program is a state appropriation that funds the monthly payments Pennsylvania must make to the federal government for each dual eligible enrolled in Medicare Part D. Each month, DPW receives an invoice from the federal government showing the amount Pennsylvania owes for each dual eligible in the Part D program. As explained below, the amount of the monthly payment – also known as the "clawback" payment – does not reflect actual Part D costs; instead, it is based on a formula in federal law that uses factors unrelated to Medicare spending.

Prior to the January 2006 implementation of Medicare Part D, each state's Medicaid program covered the prescription drugs for its dual eligible population. Federal assumption of drug coverage for the dual eligibles relieved the states of substantial pharmacy costs in their Medicaid programs – for Pennsylvania, dual eligible pharmacy coverage was costing MA approximately $400 million per year. However, rather than allowing states to keep their savings, the federal government required states to pay most of the savings to the Medicare program to help finance the Part D drug benefit. This payment requirement became known as the "clawback" to signify the federal government grabbing a share of the state savings. The calculation of the monthly "clawback" payment is stipulated in the Medicare Modernization Act of 2003, which established the Part D drug program, and is designed to reflect a portion of expenditures that the state would have incurred had it continued to pay the prescription drugs costs for its dual eligibles through its Medicaid program.

Medical Assistance Budget by Program Area

The chart below shows the distribution of MA funding in the enacted 2012/13 budget by program area. The $18.6 billion of budgeted funds is for the nine MA appropriations described in the previous section.



SOURCE: House Appropriations Committee (D) analysis of DPW's 2012/13 Rebudget Request.

About $11.8 billion is budgeted for acute care services that will be provided to 2 million MA recipients. Managed care is the largest component of MA, accounting for more than half of total budgeted funds ($10.1 billion). Fee-for-Service is budgeted to receive $1.75 billion to provide outpatient and inpatient care to approximately 500,000 MA recipients expected to receive services during 2012/13.

Long-term care accounts for nearly $5 billion of MA spending – approximately three-fourths ($3.75 billion) is for nursing facilities and one-fourth ($1.2 billion) is for alternative home and community-based programs. Nursing home care is the most expensive part of the entire MA budget, with one out of every five MA dollars budgeted for a program that serves some 84,000 elderly and disabled MA recipients. Funds for the various waivers and other programs allow approximately 27,000 seniors and 17,000 adults with physical disabilities to live safely in their homes as an alternative to nursing home care.

An estimated **$713 million is budgeted for supplemental hospital payments** – these payments are in addition to the reimbursement rates hospitals receive for serving MA patients. It includes existing supplemental payments (identified earlier in the Outpatient and Inpatient appropriations) as well as new payments funded under the statewide hospital assessment. It does not include payments that hospitals may receive from managed care plans – these are shown as part of managed care funding.

Nearly $1.1 billion is budgeted for Medicare-related payments associated with the dual eligibles. This includes $510 million for the monthly "clawback" payments the state must make to the Part D program and $550 million to assist dual eligibles in paying their Part A and Part B premiums, deductibles and copays.

GLOSSARY OF KEY TERMS

Actuarially Sound – This is the federal statutory standard that states must use when setting Medicaid rates for managed care organizations. In 2002, the Centers for Medicare and Medicaid Services (CMS) issued regulations defining actuarially sound rates as those that are: (1) developed in accordance with generally accepted actuarial principles and practices; (2) appropriate for the populations to be covered and the services to be furnished: and (3) certified as meeting applicable regulatory requirements by qualified actuaries. In order to receive federal funds for its managed care program, a state is required to submit its rate-setting methodology and rates to CMS for review and approval.

Ambulatory Surgical Center – A place other than a hospital that does outpatient surgery.

Amount, Duration and Scope – The criteria used to determine the Medicaid benefits and limitations in a state's Medicaid plan. Each state defines the following parameters to specify the services covered within a benefit category (such as physician, hospital, prescription drugs); how often a person may receive a service (amount); for how long (duration); and the exact nature of what is provided (scope).

Birthing Center – A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of new-born infants.

Capitation – A payment method for health services in which a provider is paid a fixed amount for each individual served, usually on a monthly basis, without regard to the actual number of services actually provided to the individual. Capitation is used to pay managed care organizations (MCOs) a fixed amount per month for each person enrolled in the MCO.

Categorical Eligibility – A term describing the Medicaid eligibility requirement that an individual fit within a specified group (e.g., children, the elderly, persons with disabilities). Individuals within these categories must also meet financial eligibility requirements to qualify for benefits.

Centers for Medicare and Medicaid Services (CMS) – The federal agency within the U.S. Department of Health and Human Services that is responsible for the administration of Medicare, Medicaid, and the State Children's Health Insurance Program.

Community Spouse – When one member of a married couple is a Medicaid recipient who resides in a nursing facility, the at-home spouse who lives in the community is referred to as the community spouse. In such cases, federal law requires states to apply a set of Medicaid financial eligibility rules (for the spouse entering the nursing facility) which are designed to prevent the impoverishment of the community spouse. These "spousal impoverishment" provisions specify minimum amounts of the couple's income and resources that the community spouse is allowed to retain.

Disregards – A terms that relates to a state's methodology for counting income and resources when determining Medicaid eligibility. For certain categories of individuals, the state may disregard (i.e., not count) certain income or resources. Such disregards enable individuals to qualify for Medicaid even if their gross income or resources exceed the financial requirements.

Dual Eligibles – Individuals who are entitled to Medicare and who are also eligible for Medicaid benefits.

Durable Medical Equipment – Equipment which can stand repeated use, such as hospital beds, oxygen equipment and wheelchairs.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) – The health program component of Medicaid for children under the age of 21. Federal law mandates states to cover a comprehensive set of benefits and services for children, different from adult benefits. EPSDT involves: identifying problems early, starting at birth; checking children's health at periodic, age-appropriate intervals; doing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems; performing diagnostic tests to follow up when a risk is identified; and treating the problems found.

Estate Recovery – This refers to the federal requirement that states seek to recover certain Medicaid costs from the estate of a deceased Medicaid beneficiary. At minimum, states must seek recovery for services provided to a person of any age in a nursing facility, intermediate care facility, or other medical institution. For individuals age 55 or older, states must seek recovery of payments for nursing facility services, home and community-based services, and related hospital and prescription drug services. States have the option of recovering payments for all other Medicaid services provided to these individuals. States are required to establish procedures, under standards specified by the Secretary of Health and Human Services, for waiving estate recovery when recovery would cause an undue hardship.

Federal Medical Assistance Percentage (FMAP) – Percentage used to determine the amount of federal matching funds for state Medicaid expenditures. For medical services, the FMAP is calculated annually using a statutory formula based on a state's per capita income and ranges from a minimum of 50 percent to a maximum of 83 percent. For administrative costs, the FMAP does not vary by state and is generally 50 percent – some functions (such as the operation of Medicaid fraud control units, and the survey and certification of nursing facilities) qualify for enhanced FMAPs of 75 percent or more.

Federal Poverty Level (FPL) – The low-Income guidelines established annually by the U.S. Department of Health and Human Services. State and federal public assistance programs, including Medicaid, often use FPL to define income limits for eligibility. The table below shows the 2013 poverty guidelines and the percentage multiples (such as 185 percent of federal poverty level, or 185% FPL) that Pennsylvania uses to determine eligibility for certain Medical Assistance categories.

2013 HHS Poverty Guidelines for the 48 Contiguous States and D.C.

Persons in Family	FPL	120% FPL	133% FPL	135% FPL	185% FPL	250% FPL
1	$11,490	$13,788	$15,282	$15,512	$21,257	$28,725
2	$15,510	$18,612	$20,628	$20,939	$28,694	$38,775
3	$19,530	$23,436	$25,975	$26,366	$36,131	$48,825
4	$23,550	$28,260	$31,322	$31,793	$43,568	$58,875
For each additional person, add	$4,020	$4,824	$5,347	$5,427	$7,437	$10,050

Federally Qualified Health Center (FQHC) – Community-based organizations that provide primary and preventive care, and have been approved by the government to receive grants under section 330 of the Public Health Service Act. FQHCs include community health centers, tribal health clinics, migrant health centers, and health centers for the homeless.

Fee-For-Service – The traditional health care system under which physicians, hospitals and other providers receive a payment for each unit of service they provide. Under a fee-for-service payment system, expenditures increase if the fees themselves increase, if more units of service are provided, or if more expensive services are substituted for less expensive ones.

Financial Eligibility – The Medicaid requirement that limits eligibility to individuals with limited income. Financial requirements vary by state and by category of eligibility (e.g., children, elderly, disabled, etc.), but they generally include limits on income and the amount of resources an individual is allowed to have in order to qualify for coverage.

Home and Community Based Services (HCBS) Waiver – Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to alter Medicaid rules so that a state may offer special services to elderly or disabled individuals who are at risk of being placed in a nursing facility or facility for individuals with intellectual disabilities. These HCBS Waiver services, which otherwise would not be covered with federal matching funds, include: case management, personal care services, homemaker/home health aide services, rehabilitation services, and respite care. See **Appendix C** for more information on Medicaid Waivers.

Hospice Care – Palliative and supportive services provided to terminally ill patients and their families.

Inpatient Hospital Services – These services include bed and board, nursing services, diagnostic or therapeutic services, and medical or surgical services.

Intermediate Care Facility (ICF) – A private facility which is licensed under state law to provide on a regular basis, health-related care and services to individuals who do not require the degree of care or treatment which a hospital or skilled nursing facility is designed to provide. Facilities that provide care to individuals with intellectual disabilities (previously called mental retardation) are also included in the definition and are known as ICFs/ID.

Managed Care Organization (MCO) – An entity that provides certain benefits to Medical Assistance recipients for a monthly capitation payment for each enrollee as set forth in a state contract. Medical Assistance MCOs only provide services to Medical Assistance recipients; they do not serve commercial or Medicare enrollees.

Medically Needy – An optional Medicaid eligibility group consisting of individuals who qualify under a state "medically needy" income standard that is separate from the Medicaid standard. Medically Needy individuals must meet the Medicaid categorical requirements (i.e., aged, disabled, adults with dependent children) and may meet the "medically needy" income standard by incurring high medical expenses, usually from hospital or nursing home care, which are deducted from their incomes in the "spend down" process. See **Appendix A** for information on the Medical Assistance spend-down.

Outpatient Hospital Services – Medical or surgical care that does not include an overnight hospital stay. Such services include diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization.

Partial Hospitalization – A treatment program designed for patients with moderate to severe mental or emotional disorders, who require less than 24-hour care, but more intensive and comprehensive services than are offered in outpatient treatment programs. Partial hospitalization is provided on a planned and regularly scheduled daily basis and includes services such as group therapy, individual therapy, and medication management.

Participating Provider – An entity that provides a covered service to a Medical Assistance enrollee and agrees to accept Medical Assistance reimbursement as payment in full.

Physical Therapy – Treatment of injury, disease and physical disorders that uses mechanical devices and physical means such as exercise, massage, heat, cold, light and electricity. Physical therapy does not include the use of X-rays or other types of radiation.

Preventive Care – Health care emphasizing prevention, early detection, and early treatment of conditions. Preventive care includes routine physical examinations, immunizations, and "well person" care.

Primary Care – Basic or general level of care usually provided by doctors who work with general and family medicine, internal medicine (internists), pregnant women (obstetricians), and children (pediatricians). A nurse practitioner (NP), a state-licensed registered nurse with special training, can also provide this basic level of health care.

Primary Care Case Management (PCCM) – A system of managed care in which a primary care provider is responsible for the provision and/or coordination of medical services to individuals under their care. Most PCCM programs pay the primary care physician a monthly case management fee in addition to reimbursing services on a fee-for-service basis.

Provider Network – A group of doctors, hospitals, pharmacies, and other health care providers hired by a health plan to take care of its members.

Rehabilitative Services – Services recommended by a physician that help an individual recover from an illness or injury. Under Medicaid, rehabilitation encompasses a broad range of services that include counseling, therapy,

and mental health and substance abuse treatment. Such services are provided by physicians, nurses, social workers, case managers, speech therapists, recreation therapists, aides, counselors, and other health professionals.

Rural health clinic – A clinic located in a rural area designated as a health care shortage area and certified to receive special Medicare and Medicaid reimbursement. Rural health clinics provide primary care services and basic laboratory services. A nurse practitioner, a physician assistant, or certified nurse-midwife must be available to provide services at least 50 percent of the time the clinic operates.

State Medicaid Plan – This is a comprehensive document written by the state, as required under Title XIX of the Social Security Act, which outlines the design of the state's Medicaid program including eligibility, benefits, reimbursement, and administrative policies. Essentially, the plan is a contract between the state and federal government whereby the state agrees to administer the Medicaid program in accordance with federal law and policy. The Centers for Medicare and Medicaid Services (CMS) must approve the original State Plan, as well as all future changes to the plan, for the state to receive federal Medicaid funds for its program.

State Plan Amendment – States periodically amend their Medicaid plans to reflect changes in state law or policy (such as changes in eligibility, benefits or provider reimbursements) and to conform with changes in federal law or regulations. Any proposed change that a state wants to make to its plan must be submitted to the Centers for Medicare and Medicaid Services (CMS) in a State Plan Amendment. CMS must approve the state plan amendment before any change can take effect.

Supplemental Security Income (SSI) – A federal entitlement program, established in Title XVI of the Social Security Act, that provides cash assistance to low-income aged, blind and disabled persons.

Targeted case management – Refers to case management services when such services are furnished to specific populations. TCM services include assessment of the individual to determine service needs, development of a specific care plan, referral to needed services, and monitoring and follow-up of needed services.

Temporary Assistance for Needy Families (TANF) – This is the federal block grant program, established by the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, which provides cash assistance and work opportunities to needy families. TANF replaced the earlier cash entitlement program known as Aid to Families with Dependent Children (AFDC).

Third Party Liability (TPL) – The legal obligation of third parties (i.e., certain individuals, entities or programs) to pay all or part of the expenditures for medical claims of Medicaid recipients. By law, the Medicaid program is intended to be the payer of last resort; that is, all other available third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual. Examples of third parties which may be liable to pay for services include: commercial health insurance, self-insured plans, court-ordered health coverage, settlements from a liability insurer, workers' compensation, Medicare, and Veteran Administration benefits. States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the State plan.

Utilization – A measure of the extent to which individuals use a program or obtain a particular service over a given period of time. Utilization is usually expressed as the number of services used per year or the number of services used per number of eligible persons (i.e., claims per person).

APPENDIX A - Medical Assistance (MA) Spend-Down

Individuals who meet the eligibility requirements for a particular Medical Assistance (MA) category, but have too much income to qualify for MA, may obtain medically needy eligibility through the "spend-down" process. Under this process, individuals may deduct medical expenses, both paid and unpaid, to reduce their incomes to the medically needy eligibility level. Deductible medical expenses are limited to those incurred within the three-month period prior to applying for MA, provided they were not previously deducted to meet a spend-down.

The table below shows Pennsylvania's Medically Needy Only income criteria, which varies by household size. These limits apply to all medically-needy categories – the TANF-related groups (families and children), the SSI-related groups (elderly and disabled) and GA-related (chronically-ill adults). When income less medical expenses meets the income criteria, medically needy eligibility is established and the individual qualifies for MA for the remainder of the period.

Medically Needy Only (MNO) Spend-Down Income Limits*

Number of People	Net Monthly Income Limit	Net 6-Month Income Limit
1	$425	$2,550
2	$442	$2,650
3	$467	$2,800
4	$567	$3,400
5	$675	$4,050
6	$758	$4,550
7	$850	$5,100
8	$942	$5,600
each additional person	$92	$550

*These income limits are tied to the cash welfare grants for families under the old the Aid to Families with Dependent Children (AFDC) levels established in 1990. Federal rules require that the medically needy income limit be no higher than 133 percent of the maximum state AFDC levels as of July 16, 1996.

The table below shows the medically needy resource limits for the SSI-related groups and GA-related groups. The TANF-related groups have no resource requirements.

Medically Needy Only (MNO) Spend-Down Resource Limits

Number of People	Net Monthly Income Limit
1	$2,400
2	$3,200
each additional person	$300

APPENDIX B – Medicaid Provisions in the Affordable Care Act (ACA)

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act. These two pieces of federal legislation, collectively known as the Affordable Care Act (ACA), include comprehensive reforms designed to provide quality, affordable health care to millions of uninsured Americans. For individuals with incomes at or below 400 percent of the federal poverty level (FPL), the ACA provides access to affordable health care through either expanded Medicaid eligibility or subsidized private health insurance coverage beginning in 2014.

- Medicaid is expanded to all non-Medicare eligible individuals under age 65 -- children, pregnant women, parents, and adults without dependent children -- who have incomes up to 133 percent FPL. (Because the law requires a five percent income disregard when determining Medicaid eligibility, this effectively increases income eligibility to 138 percent FPL.) States will receive enhanced federal matching funds for newly eligible adults, age 19 through 64, who do not qualify for Medicaid under one of the existing mandatory coverage groups.
- Subsidies in the form of income tax credits will be available to individuals and families, with incomes between 100 percent FPL and 400 percent FPL, to help them purchase coverage through the new health insurance exchanges established in the ACA. To receive the tax credit, an individual must not be eligible for public coverage – including Medicaid and Medicare – and must not be offered affordable employer-sponsored coverage that meets minimum standard established in the ACA.

The same day that President Obama signed the ACA, the state of Florida filed a lawsuit challenging the constitutionality of two major provisions in the act: the individual mandate and the Medicaid expansion. The lawsuit alleged the individual mandate infringed upon the constitutional rights of citizens by requiring most individuals to maintain qualifying health care coverage or pay a penalty; it also claimed the Medicaid expansion imposed onerous new operating rules on the state that threatened its fiscal health and thus infringed on the sovereignty of the states. Twenty-five other states (including Pennsylvania) and the National Federation of Independent Businesses joined Florida's lawsuit. The United States Supreme Court agreed to hear the case and held three days of oral arguments in March 2012.

On June 28, 2012, the Supreme Court issued its landmark decision (*National Federation of Independent Business v. Sebelius*) upholding most of the ACA. The court ruled the individual mandate constitutional under Congress's taxing power and upheld Congress's authority to expand Medicaid; however, it limited the ability of the federal government to penalize states that that do not implement the ACA Medicaid expansion requirements. Specifically, the court found the provision giving the Secretary of Health and Human Services (HHS) the option to withhold all federal Medicaid funding from non-expanding states amounted to unconstitutional coercion. The court remedied this by prohibiting HHS from withholding a state's existing Medicaid funding for noncompliance with the Medicaid expansion; HHS may only withhold the new ACA federal matching funds offered to finance the "newly eligible" adults. The practical effect of the Court's decision to restrict the secretary's enforcement powers was to make Medicaid expansion optional for states. The decision left intact Medicaid expansion and all other ACA provisions.

The ACA includes many provisions that affect Medicaid. The following sections summarize major Medicaid provisions that take effect in 2013 and 2014.

Expanded Eligibility - Starting January 1, 2014, the minimum income eligibility for Medicaid is expanded to 133 percent of the federal poverty level (FPL) for most individuals, other than disabled, under age 65. (The effective eligibility is 138 percent FPL due to the new Modified Adjusted Gross Income (MAGI) rules explained below.) This expansion impacts childless adults, parents and children as follows:

- It extends eligibility to low-income childless adults who are not currently eligible for Medicaid – these are adults who are not pregnant, do not have dependent children, and do not have a disability that meets the disability requirements in the federal SSI program.
- It establishes a uniform Medicaid income eligibility level across all states for parents with dependent

children, covering parents with incomes above the state's current eligibility levels. (Pennsylvania's current income eligibility for low-income parents is below 50 percent FPL.)

- It raises the mandatory Medicaid income eligibility level to 133 percent FPL for children ages 6 to 19 (Pennsylvania's current income eligibility for these children is 100 percent FPL.)

In a December 10, 2012, letter to governors, HHS clarified that there is no deadline for a state to notify the Centers for Medicare and Medicaid Services (CMS) of its intentions regarding Medicaid expansion. Additionally, the letter clarified that states have the flexibility to decide whether and when to expand. This means a state can decide to implement ACA Medicaid expansion after January 1, 2014. It also means a state can decide to implement the expansion for a period of time and then stop. An expanding state would indicate its intention to adopt the new coverage group by submitting a Medicaid state plan amendment to CMS. If an expansion state later chooses to discontinue coverage for the adult group, it would submit another state plan amendment to CMS.

- If a state does not expand Medicaid, individuals with incomes below 100 percent FPL who do not meet their state's current Medicaid eligibility requirements will not have any other options for affordable coverage. That is because the premium tax credits to help people purchasing private coverage in the new insurance exchanges will only be available to people with incomes above 100 percent FPL.

Additionally, effective January 2014, the ACA requires states to cover former foster kids, who "aged out" of Medicaid, until they are age 26.

Federal Matching Funds - States that choose to expand Medicaid will receive generous federal matching funds for the cost of Medicaid coverage provided to newly eligible adults, ages 19 through 64. The federal government will pay 100 percent of their Medicaid costs from 2014 through 2016, and no less than 90 percent thereafter. Specifically, the federal share for newly eligible adults decreases to 95 percent in calendar year 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and each year thereafter. States cover the costs not paid by the federal government (5 percent in 2017, increasing to 10 percent by 2020).

- Although states have the flexibility to opt in and out of the Medicaid expansion, the enhanced federal match of 100 percent is only available in 2014 through 2016.

Modified Adjusted Gross Income (MAGI) - Beginning in 2014, states must use Modified Adjusted Gross Income (MAGI) for determining income eligibility for most Medicaid enrollees. MAGI, which is based on IRS adjusted gross income, replaces the complex income rules currently in place and establishes a single income eligibility standard across the states. Instead of the various deductions and disregards currently used to count income, the new MAGI method requires states to disregard (not count) dollar amounts equal to 5 percent FPL. This automatic 5 percent disregard, when combined with expanded eligibility of 133 percent FPL, effectively raises the income eligibility level to 138 percent FPL.

MAGI will apply to most categories of children and non-disabled adults under age 65, including pregnant women, parents and other caretaker relatives, and adults in the new ACA expansion group. The MAGI method for determining Medicaid eligibility will take effect January 1, 2014, for new applicants. For existing Medicaid recipients, MAGI will take effect either March 31, 2014, or at the time of the next scheduled eligibility renewal, whichever is later.

- MAGI will also be the income standard used to determine eligibility for premium tax credits for the purchase of private insurance coverage through new ACA insurance exchanges.

The MAGI rules will not apply to elderly and disabled categories – such as people over age 65, people who are blind, people with long-term care needs, people eligible for Medicare cost-sharing assistance, and people who qualify for Medicaid through a spend-down. The existing SSI and AFDC income counting rules will continue to apply to these exempted populations.

Benefits - As an alternative to traditional Medicaid benefits, states may provide certain populations a benchmark benefit package or benchmark equivalent (known as Alternative Benefit Plans) that at least meets the minimum essential health benefits available in the new ACA insurance exchanges. Essential health benefits

include the following 10 benefits: (1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance abuse services, (6) prescribed drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care. All benchmark packages must also cover family planning services and supplies.

- The federal Deficit Reduction Act of 2005 gave states the option to provide benchmark and benchmark-equivalent benefit coverage to state-specified groups; the ACA modifies the benefit package by adding mental health services and prescription drugs. Children receiving benchmark and benchmark-equivalent benefit coverage must receive all Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.

States that opt to expand Medicaid must provide Alternative Benefit Plans to newly eligible adults, age 19 to 64. Certain groups are exempt from mandatory enrollment, including former foster care children and individuals with special needs.

Streamlined Enrollment. Beginning in 2014, states must use streamlined application, enrollment and renewal procedures for their Medicaid programs. The new approach (designed to transform enrollment into a real-time, electronically-driven and consumer-friendly process) includes the following requirements for states:

- Using a single application form for all insurance affordability programs – Medicaid, Children's Health Insurance Program (CHIP) and the health insurance exchange – with the option for consumers to submit online, in-person, by mail, by phone or by fax.
- Relying on electronic data sources to the maximum extent possible to verify eligibility information provided by individuals – states may require paper documentation only when the self-attested information and electronic data sources are not reasonably compatible.
- Eliminating in-person interviews as part of the application or renewal process for individuals who are Medicaid eligible based on MAGI.
- Limiting eligibility renewals for individuals who enroll through the new MAGI rules to once every 12 months, unless the individual reports a change or the agency has information to prompt a reassessment of eligibility. If renewal can not be completed using available information, the state Medicaid agency must send a pre-populated form containing the information that is available to the agency and provide the individual at least 30 days to provide the necessary information or correct any inaccuracies. If eligibility can be renewed based on available data, the agency will send the appropriate notice to the enrollee without requiring any additional action from the enrollee, such as signing and returning the notice, as a condition of continued eligibility enrollee.
- Allowing hospitals that participate in the Medicaid program to make presumptive eligibility determinations for all populations eligible under the new MAGI rules.

Coordination with Exchanges - To establish a "no wrong door" enrollment approach – and ensure that everyone who is eligible is enrolled in the appropriate insurance program – the ACA requires coordination between state Medicaid programs and the new health insurance exchange. States must improve outreach and enrollment for Medicaid and coordinate Medicaid eligibility with the exchange. The ACA requires states to establish a secure electronic interface between the state's Medicaid agency and the exchange to transfer information.

Federal IT Funding - An enhanced federal match (greater than the 50 percent match generally available for Medicaid administrative expenditures) is available to states for the new or improved eligibility systems that states must develop to accommodate the new MAGI rules and to coordinate coverage with the exchange. Implementing the new MAGI standard requires states to convert their entire eligibility systems and existing data files to the new methodology – this conversion necessitates massive changes to the Medicaid agencies' information systems, databases, procedures and work flows.

On April 19, 2011, CMS published a final rule that makes 90 percent federal matching funds available until December 31, 2015, for the design, development and installation or enhancement of state Medicaid eligibility

systems; an enhanced 75 percent matching rate will be available indefinitely for maintenance and operations of such systems as long as the systems meet applicable program requirements. To qualify for the enhanced federal match, all Medicaid Management Information Systems (MMISs) must meet a set of standards and conditions, including seamless coordination with the new Health Insurance Exchanges.

Disproportionate Share (DSH) Payments to Hospitals - Beginning October 2013, federal funding will be reduced for the Medicaid DSH payments that states make to hospitals that serve large numbers of Medicaid and low-income patients. States have flexibility in defining DSH hospitals and calculating DSH payments, subject to federal guidelines. Each state may claim federal matching funds for its DSH payments based on the state's federal medical assistance percentage (FMAP); however, the amount is limited by a state-specific allotment. Currently, each state's federal DSH allotment is capped at either the amount of the DSH allotment for the previous year or 12 percent of the state's total Medicaid payments for the allotment year, whichever is greater.

The ACA reduces federal DSH allotments across all states by a total of $18.1 billion during federal fiscal years (FFY) 2014 through 2020. The reductions are nominal for the first three years, phasing up to an estimated 43 percent reduction by FFY 2019, and then phasing down to an estimated 30 percent reduction. The scheduled reductions are as follows: $500 million in FFY 2014, $600 million for each of FFY 2015 and FFY 2016, $1.8 billion for FFY 2017, $5 billion for FFY 2018, $5.6 billion for FFY 2019, and $4billion for FFY 2020. The HHS Secretary is responsible for reducing each state's DSH allotment in order to achieve the specified savings.

In distributing the DSH reductions, the Secretary is required by the ACA to develop a methodology that imposes the **largest percentage reductions to states with the lowest percentages of uninsured individuals** and to states that do not target their DSH payments to hospitals with high volumes of Medicaid patients or high levels of uncompensated care. The ACA also required the secretary to impose smaller reductions on low DSH states. The secretary is only responsible for determining state-specific DSH reductions; each state will determine the methodology for reducing its DSH payments to hospitals.

The premise for reducing federal DSH allotments was that hospitals would be treating fewer uninsured people due to ACA provisions that expand coverage through Medicaid and private insurance. However, with the Supreme Court making ACA Medicaid expansion optional, a number of states are not expanding Medicaid in 2014 and so the projected decrease in the number of uninsured Americans is less than initially anticipated. In his FFY 2014 budget proposal (released April 10, 2013), President Obama proposed postponing the start of the DSH reductions until 2015 and redistributing the $500 million reduction slated for FFY 2014 over federal fiscal years 2016 and 2017. Any changes to the ACA DSH reductions require approval by Congress.

On May 13, 2013, HHS issued its long-awaited proposed methodology for implementing the DSH reductions. Because HHS did not have sufficient information on the relative impacts that would result from state decisions to expand Medicaid (and does not expect such information before 2016), the proposed rule applies only to the first two years (FFY 2014 and FFY 2015). Moreover, the proposed methodology for distributing the DSH reductions across states does not take into account the potential impacts of Medicaid expansion on factors such as the amount of uncompensated care and the percentage of uninsured individuals within states.

- Table 1 in the proposed rule illustrates the potential state-specific reductions associated with applying the proposed methodology and associated reduction factors. This preliminary analysis indicates that Pennsylvania's DSH allotment would be reduced by approximately $34 million in FFY 2014.

The proposed rule indicates that HHS will continue evaluating the potential implications for accounting for Medicaid expansion and will issue separate rulemaking for DSH allotment reductions for FFY 2016 and thereafter. Public comments for the proposed rules are due July 12. Once finalized, the rule will take effect on October 1, 2013 (the start of FFY 2014)… assuming Congress does not enact President Obama's proposal to delay the DSH reductions until FFY 2015.

APPENDIX C – Medicaid Waivers

The Social Security Act authorizes the Secretary of Health and Human Services to grant an exception to the usual Medicaid requirements, giving states flexibility in operating their Medicaid programs. Upon the request of a state, the Secretary may grant a waiver and allow the state to receive federal Medicaid matching funds for expenditures that otherwise would not qualify for federal reimbursement. Waivers are generally approved initially for a period three to five years, and states must submit renewal requests to continue the waiver for additional periods of time.

Below is a summary of sections in the Social Security Act which authorize waivers, including a brief description of the programs that Pennsylvania operates under that waiver authority.

Section 1115 – Research and Demonstration Projects: This section of the Social Security Act provides the Secretary broad authority to approve experimental, pilot or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. States use Section 1115 waivers to expand eligibility to individuals not otherwise eligible for Medicaid, provide services that are not typically covered, or use innovative service delivery systems.

Pennsylvania uses Section 1115 waiver authority to operate the *Family Planning Project*, a Medical Assistance program implemented in 2007 to extend family planning services to uninsured women, ages 18 to 44 with income at or below 185 percent of the federal poverty level. (Note: The 90,000 women receiving family planning services under this waiver are not included in the MA caseload numbers reported in this primer.)

Section 1915(b) – Managed Care/Freedom of Choice: This section provides the Secretary authority to grant waivers that allow states to implement managed care delivery systems or otherwise limit individuals' choice of providers under Medicaid. Pennsylvania uses this waiver authority to operate the *HealthChoices* mandatory managed care program.

Section 1915(c) – Home and Community Based Services (HCBS): This section authorizes the Secretary authority to waive Medicaid provisions in order to allow long-term care services to be delivered in community settings. States have the flexibility to develop HCBS waiver programs designed to meet the specific needs of targeted elderly or disabled populations who are at risk of being placed in a nursing facility or facility for individuals with intellectual disabilities. To obtain federal approval for an HCBS waiver, the state must ensure that waiver services are cost effective compared to the cost of institutional care and that it has safeguards to protect the health and welfare of persons served in the waiver program.

Examples of HCBS Waiver services include: therapies and counseling; nursing; personal care services; homemaker/home health aide services; respite care; case management; rehabilitation services; supported employment and training adaptive appliances and equipment; and home accessibility adaptations. States have the discretion to choose the number of consumers to serve in an HCBS waiver program. This ability to set enrollment caps differentiates wavier programs from the open-ended entitlement in the traditional Medicaid program, which obligates states to serve everyone who qualifies.

Pennsylvania operates the following HCBS waivers:

- *Aging Waiver* for individuals age 60 and older
- *AIDS Waiver* for individuals with HIV/AIDS.
- *Independence Waiver* for individuals, age 18 to 60, with a severe physical disability that results in substantial limitations in at least three of the following major life functions: mobility, communication, self-care, self-direction, capacity for independent living and learning.
- *OBRA Waiver* for individuals, age 18 to 60, with a severe developmental physical disability that occurred before age 22 and results in substantial limitations in at least three following major life functions: mobility, communication, self-care, self-direction, capacity for independent living and learning.

- *COMMCARE Waiver* for individuals with brain injuries, age 21 or older.
- *Attendant Care Waiver* for mentally alert individuals with physical disabilities, age 18 through 59, who experiences any medically determinable physical impairment which can be expected to last for a continuous period of 12 months or may result in death.
- *Consolidated Waiver* for individuals with intellectual disabilities, age 3 or older.
- *Person/Family Directed Support Waiver* for individuals with intellectual disabilities, age 3 or older.
- *Adult Autism Waiver* for adults with autism, age 21 or older.