Health Law PA News

Newsletter of the Pennsylvania Health Law Project

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GOVERNOR PROPOSES SWEEPING CUTS TO HEALTH CARE FOR PENNSYLVANIA'S MOST VULNERABLE

On February 9, 2005 Governor Rendell proposed a budget which would overhaul Pennsylvania's Medical Assistance system by imposing service caps, expanding and increasing co-payments for services, restricting eligibility and requiring parents of some disabled children to pay premiums. All of these changes could severely affect Medical Assistance recipients' ability to receive medically necessary care.

Sweeping Changes to the Medical Assistance Program

Caps. The Governor has proposed unprecedented service caps to limit the type and number of services Medical Assistance recipients are entitled to receive. The budget includes limits on prescriptions, inpatient hospital physical health admissions, inpatient medical rehabilitation admissions, outpatient visits, Durable Medical Equipment and ambulance services. All adults (21 years and older) would have caps on services. Services that childless adults (GA category) are entitled to receive would be more limited, in some areas, than those that parents, the elderly, individuals with disabilities and pregnant women could receive. The caps would be applied in the fee-for-service system and could be applied at the in the managed care system, at the option of the HMO. Managed care plans would be paid a lower rate whether or not they impose the cuts. The Department of Public Welfare (DPW), the state agency that administers the Medical Assistance budget, has indicated that there would be an exceptions process for individuals who have needs beyond the service caps. The shape and form of that process is still unclear, except that proving medical necessity for the service would not be enough to get an exception. For more information on the proposed caps, see page 3. For information on caps in the behavioral health system see page 8.

Co-Pays. The Governor has proposed increasing and expanding co-payments for services under Medical Assistance. Under the current Medical Assistance pro-

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SPECIAL BUDGET ISSUE

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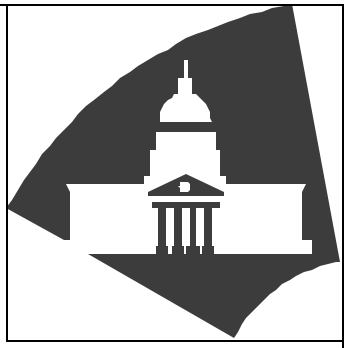

gram, individuals in the fee-for-service system have co-pays on some services. The budget would expand the types of services which require co-payment and increase the amounts of many existing co-pays. It also would extend co-pays to consumers in the managed care system who are currently exempt from co-pays. Finally, the Governor has proposed the elimination of caps on co-pays which prevent consumers from having to spend too large a portion of their already limited income on their medical care. These caps are currently $90 in a six-month period for most MA recipients, and $180 for GA recipients. For more details on co-pays and their impact on consumers, see page 4.

Changes to "Spenddown" eligibility. Despite statements that the budget would not change eligibility, the proposal does contain an eligibility change which would prevent some people from qualifying for Medical Assistance. The budget proposes changing the rules for qualifying for the "Spenddown" program. These changes would prevent 8,000 individuals from becoming eligible for Medical Assistance in 2005-2006 alone. For more information on changes to "Spenddown" rules, see page 5.

Premiums. The Governor has also proposed implementing a premium system for disabled children from families with income above $40,000/year. The amount of the premium would be based on a sliding scale factoring family income, family size and number of disabled children in the family. Services available to these children will not be changed in any way. For more information on premiums for disabled children from non-poor families, see page 7.

Tight Finances Led to Program Changes

Due primarily to a decrease in available federal funding for the Medical Assistance program, DPW had a $1.2 billion hole in its budget for 2005-2006. The Governor and DPW were faced with a variety of options for closing this hole. Among their choices were increasing revenue, cutting eligibility, cutting services and cutting provider payments. The Governor and DPW chose to rely on the sacrifices of Medical Assistance consumers to help fill the budget hole. Caps on services were imposed as well as the above described eligibility cuts. Revenue was increased, but Medical Assistance consumers would be paying, in the form of premiums and co-pays. Despite the tight fiscal situation, payments to some providers were actually increased. Managed Care Organizations and Nursing Homes would get a 2% increase. Some hospitals would receive an increase of up to 2%, although increases would be tied to profit margins. A 2% cost of living adjustment (COLA) was also approved for direct care workers.

What Happens Next?

The Governor's proposed budget is now in the hands of the General Assembly. Hearings will be held by the Appropriations Committees of each chamber of the General Assembly on March 7th (Senate) and 9th (House). These hearings will eventually result in budget bills in both the House and Senate which must be passed by both houses and signed by Governor Rendell by June 30th.

For more details on the Governor's proposed budget please read the other articles in this newsletter. Additional information will also be available on the Pennsylvania Health Law Project website: www.phlp.org.

Service Caps Hurt Those Who Need the Most Help

The Governor's proposed budget contains a series of unprecedented caps on services that Medical Assistance consumers are entitled to receive. The caps, which would be imposed on all individuals age 21 and older, would inevitably have the most impact on individuals who have high medical needs, like the elderly and disabled, since they would be prohibited from accessing medically necessary care.

The caps would be implemented in the fee-for-service program. Managed care organizations can choose whether or not to impose the same caps. However, the payment rate to the HMOs is based on the service caps so it is extremely likely that they would impose them.

There are caps on a variety of services:

Prescription Drugs. The budget proposes capping the number of prescriptions individuals on Medical Assistance can receive in a month. The cap for childless adults would be 3 prescriptions per month. Other adults (disabled individuals and elderly not on Medicare, parents, pregnant women) would be limited to 6 prescriptions per month. Individuals who are dual eligible – receiving Medical Assistance and Medicare – would be exempt from these prescription limits since coverage of their prescription drugs will shift from Medical Assistance to Medicare on January 1, 2006. Many Medical Assistance consumers take far more than 6 prescriptions per month. The cap on prescriptions would force these individuals to choose which medications to take.

Inpatient Admissions. The budget proposes capping the number of inpatient hospital physical health admissions an individual could have in one year. Childless adults would be limited to 1 inpatient hospital admission per year while other adults on Medical Assistance would be allowed 2 admissions. The Hospital Association of Pennsylvania reports that more than 18,000 Medical Assistance recipients exceeded these limits in 2002. The cap on admissions would either prevent these individuals from getting care they need or require Pennsylvania's hospitals to further increase the amount of uncompensated care they provide.

Inpatient Medical Rehabilitation Admissions. The budget also proposes limiting inpatient medical rehabilitation to one admission per year for all adults.

Outpatient Visits. The budget proposes limiting the outpatient services an adult consumer could receive to 18 per year. Services that would count against the 18 visit limit include physician/nurse practitioner services, services provided at federally qualified health centers and rural health care centers, outpatient hospital services, independent medical/surgical services, optometry, podiatry and chiropractor services. Implementation of these limits have not been finalized, but it is likely that individuals would be given 18 vouchers at the start of the year and would have to provide a voucher at the time of service to guarantee that Medical Assistance would cover the service. This restriction would most impact individuals with chronic or life threatening conditions that need to visit a variety of specialists. Pregnant woman would be exempt from this restriction.

Durable Medical Equipment (DME). The budget proposes capping medical equipment and supplies expenses at $5,000 per year per consumer. Members of the disabilities community report that a power wheelchair with necessary attachments costs much more than $5,000.

Ambulance Services. The budget proposes limiting ambulance services for childless adults to 1 ambulance ride per year.

Exceptions Process. The Department of Public Welfare has indicated that there would be an exceptions process for these services, but the

(Continued on page 6)

Expansion of Co-pays Will Leave Many

The Governor's proposed budget for 2005-2006 includes expanding co-pays for Medical Assistance services which would significantly impact adult consumers including those who are disabled or elderly and leave them struggling to pay for their medical care. Currently, some adult consumers in fee-for-service (FFS) MA, and those in certain categories (like General Assistance), have to pay co-pays for some services including some prescription drugs, doctor's visits, and hospitalizations. The proposed budget includes the following changes in regard to co-pays:

- Expanding the services that require a co-pay;
- Charging a co-pay to consumers who currently do not have to pay co-pays;
- Increasing the co-pays that some consumers currently pay under the MA program;
- Removing the semi-annual limit on co-pays;

Expanding the services that require a co-pay

The current MA system requires that consumers pay a co-pay for some services but not for others. Under the proposed budget, consumers would have to pay a co-pay for many of the services that are currently exempt from co-pays. The table below includes some of these services and the proposed co-pays.

Service	Adults on MA	General Assistance
Laboratory tests	Up to $3.00	$6.00
Home health agency services	$3.00	$6.00
Hospice services	$3.00: Max $21.00	$6.00: Max $42.00
Rental of durable medical equipment	Up to $3.00	$6.00
Medical Assistance Paratransit trips	$1.00 each way	$1.00 each way
All drugs including immunizations and those given by a physician	$1.00-generic $3.00-brand	$6.00-generic $12.00- brand

Note that children less than 18 years of age and pregnant women would continue to be exempt from all co-pays.

Co-payments Can Apply to Managed Care Recipients

Previously, only adults in the fee-for-service (Access) program could be subject to co-pays. Those enrolled in HealthChoices were exempt. The proposed budget would reduce payments to managed care HMOs to reflect the fact that they could get the lost money from the consumer. The health plans would not be required to apply co-payments, however. The co-payments which could apply for the first time in managed care include doctor visits up to $3.00 per day, hospital inpatient co-payment up to $21

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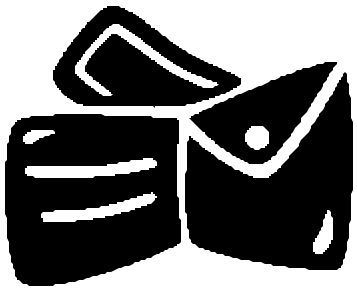

Eligibility Cuts: Changes to Spenddown Rules will Affect 8,000 Individuals

While DPW has noted that no one will be thrown off of Medical Assistance as a result of eligibility changes, the Governor's budget does in fact propose cuts to Medical Assistance (MA) eligibility which would prevent about 8,000 individuals from qualifying. The individuals that would be affected by the proposed change are those that use unpaid medical bills to "Spenddown" to become eligible for MA.

The "Spenddown" is a tool for individuals whose income is a bit too high to qualify for MA, but who are permitted to use their medical bills as a deduction in order to qualify. The program provides much needed relief to individuals who have very high medical bills from a hospitalization, surgery or other expensive medical procedure. The "Spenddown" option allows these individuals to access medically necessary care while saving them from loss of their home or bankruptcy and ensuring that providers are reimbursed for the care they provide.

Currently, individuals can only deduct paid medical bills which were incurred in the three months prior to application. However, they can use unpaid medical bills incurred at any time prior to application. The Governor proposes placing the same three month retroactive time limit on unpaid bills that currently exists for paid bills.

The proposed change would reduce the number of Spenddown eligible individuals by 8,000 and save the state's MA program $16 million dollars. Most of these saving ($14 million) would be in the inpatient program. The savings to the state would come at a cost to consumers – who could be forced to either forego medically necessary care or face bankruptcy – or providers – who may be forced to either deny medically necessary care to patients or be left uncompensated for the care they provide.

Premiums for Disabled Children in Non-Poor Families

Children with disabilities who meet the Social Security disability criteria are eligible for Medical Assistance regardless of their parent's income. Although the Governor's proposed budget does not interfere with this provision or cut services, the proposal implements sliding scale premiums based on income level, family size, and how many children in the family have disabilities. Children with disabilities whose families have incomes above $40,000 would be assessed a monthly premium for their Medical Assistance benefits – this affects 25,300 of the more than 38,000 children in this category, and the anticipated savings are projected to be approximately $21 million. Select examples of draft proposed premiums (DPW has not finalized the proposal) include the following:

Family of Three:
Income under $40,000 - No co-pay
Income of $50 - 60,000 - Co-pay $33/month
Income of $100 - 110,000 - Co-pay $220/month
Income of $120 - 130,000 - Co-pay $440/month
Income of $150 - 160,000 - Co-pay $770/month
Income over $160,000 - Co-pay $875/month

Family of Four:
Income under $40,000 - No co-pay
Income of $50 - 60,000 - Co-pay $40/month
Income of $100 - 120,000 - Co-pay $200/month
Income of $120 - 130,000 - Co-pay $400/month
Income of $150 - 160,000 - Co-pay $700/month
Income of $160 - 200,000 - Co-pay $800/month
Income over $200,000 - Co-pay $875/month

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per stay, and prescription drugs at $1.00 generic and $3.00 name brand.

Significant Increases in Co-Pays for Childless Adults Who, Have Temporary Disabilities or Need Health Sustaining Drugs in Order to Work (GA category recipients)
Persons receiving MA under the General Assistance (GA) category are typically adults without children. These consumers usually qualify for MA because they have a temporary disability and are unable to work for a certain period of time or they require medications in order to allow them to work. Consumers in this category of MA must have very low income, which varies by county, but is approximately $200 per month.

Consumers in the GA category currently have to pay co-pays for many services. However, these co-pays would increase substantially under the proposed budget. The most significant changes are as follows:

- Prescription Drugs: The co-pay for generic drugs would increase from $2 to $6 and the co-pay for brand name drugs would increase from $2 to $12. Consumers will have to pay the brand name co-pay even if there is no generic alternative available.
- Emergency Services: a $25 co-pay is proposed. Currently, there is no co-pay for these services.
- Doctor's visits: proposed co-pays include $6 for each doctor's visit and $10 for specialists. The current co-pay for doctor's visits is up to $6 depending on the MA fee for the particular service.

Elimination of Cap on Co-Pays
Under the law, there is currently a limit on the amount of co-pays an MA consumer has to pay. This limit is $90 in a six-month period for most MA consumers and $180 in a six-month period for GA recipients. Consumers are reimbursed for the amount they pay over these limits.

The budget as proposed removes these limits, so there would be no cap on how much a person spends out-of-pocket in co-pays for their MA services.

Impact on Consumers
The expansion of co-pays would impact virtually all users of Medical Assistance services. Expected revenue to the state from reduced payments for co-pay services is $4.8 million dollars. The state also expects to save an undisclosed amount through reduced utilization of services.

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exact form of the process is still very unclear. The Department has said that the standard for granting an exception would be higher than the medical necessity standard and would require a provider to apply for the exception. In describing the exception process at her budget briefing, Welfare Secretary Estelle Richman said that the DPW would not want anyone to die because of a cap, nor would the department want to pay more money because a recipient was forced into an institution.

These caps on services represent an unprecedented shift in Pennsylvania's Medical Assistance program. The program used to provide persons with disabilities, the elderly, and parents full array of covered services, so long as they could demonstrate medical necessity. The revised program is structured to deny necessary care, potentially at the time of greatest need.

Budget Would Limit Services and Medications for those in Need of Mental Health Treatment

The Budget proposed by the Governor will impact Medical Assistance (MA) recipients who need mental health services in several ways. First, there are reductions in the amount of mental health services MA consumers who are in the fee-for service (FFS) system can receive. Specifically, these cuts include:

- Inpatient Hospitalization Days limited to 30 days per year (current limit is 60 days)
- Partial Hospitalization hours limited to 540 hours per year (current limit is 720 hours)
- Outpatient Visits limited to 5 per month (current limit is 7). Please note: medication visits and psych evaluations do not count toward the limit

These limitations do not apply to consumers who are getting their mental health services through a Behavioral Health MCO.

Second, the proposed budget will limit the number of prescriptions MA will cover for adult recipients. This limit applies to prescriptions for physical health as well as behavioral health medications. For those adults who are getting MA through a General Assistance category, MA will only cover 3 prescriptions per month. For all other adults, the state will limit MA coverage to 6 prescriptions per month. These prescription limitations do not apply to mental health consumers who are "dual eligibles"-that is, who are on Medicare and MA. That is because effective January 1, 2006 these persons will no longer be getting their medications covered by MA but will instead be receiving prescription coverage through a Medicare Part D plan.

Third, under the proposed budget all mental health consumers who are "dual eligibles" and who are enrolled in MA managed care will be put back into the MA-FFS system. Please note, however, that though these consumers will get their physical health care through the FFS system, they will remain in a BH-MCO who will provide their behavioral health services.

There is some good news. The Governor's Budget proposes a 2% cost-of-living increase for mental health and drug and alcohol direct care workers. This is good news for consumers of behavioral health services because it increases the likelihood of recruiting and retaining qualified staff in mental health and drug and alcohol programs.

Governor's Budget Includes Big Changes for Dual Eligibles

The Governor's proposed 2005-2006 budget has some specific provisions for people who receive both Medicare and Medical Assistance (MA), also known as "dual eligibles."

Dual eligibles will not have any limitations on the number of prescriptions that they receive since they will be receiving their prescription drug coverage from Medicare starting on January 1, 2006. However, the other proposed limitations on doctor's visits, durable medical equipment and hospitalizations will apply to dual eligibles. These limits would be devastating for the dual eligible population since many of them have high health care needs. Furthermore, dual eligibles will likely have a hard time navigating these limits since there will be no central entity coordinating or monitoring their utilization.

In addition to the limitations mentioned above, the Governor's budget proposes shifting dual eligibles who are currently enrolled in a managed care organization into the fee-for-service program. This will make it more difficult for dual eligibles to access providers and other services since they will not be able to rely on the managed care plan for any assistance.

The changes in benefits that the Governor has proposed may cause confusion for many dual eligibles since their implementation will coincide with the start of the new Medicare prescription drug program.

Budget Includes Statewide Drug Formulary

In order to save costs, the Governor has proposed instituting a statewide formulary called a Preferred Drug List (PDL) for the Medical Assistance program. Medications that are on this list will be covered by the Medical Assistance program. In order to get medications that are not on the list, consumers will have to qualify for some type of exception. There are not details currently available about that process. The consumer sub-committee of the MAC has cautioned that any such formulary should be developed by disinterested experts, be subject to public review and include an appropriate and just exception process that would enable consumers to get necessary off-formulary medications.

At this point DPW has not determined whether they will include behavioral health drugs as part of the list. All managed care organizations in MA, which currently have their own formularies, would also be subject to the state's formulary. The PDL will allow the State to use its purchasing power to get 22% rebates from drug companies.

Good News for Individuals in Need of MR Services

The Governor's budget includes good news for individuals who have been waiting for mental retardation services. The budget dedicates $1.428 billion to community mental retardation services – a 5.7% increase compared to last year's allocation.

Over $30 million dollars of this money will be dedicated to serving individuals on the emergency waiting list. The Governor's budget nearly doubles the amount of funding dedicated to the emergency waiting list. The extra funding will allow the Department of Public Welfare to serve 910 individuals that are currently on the waiting list. Last year only 505 persons were served. Serving 910 individuals would reduce the 2,182 person waiting list by 42%.

The budget also includes a 2% cost of living adjustment (COLA) for direct care workers which will apply to workers that serve individuals with mental retardation. This COLA is intended to help ensure that competent, well-trained staff is available to serve individuals with mental retardation.

More Funding for adultBasic Waiting List

Relief is on the way for approximately 34,000 individuals on the adultBasic waiting list. Two days before releasing his budget, the Governor announced a historic agreement with the four Blue Cross Plans in the state of Pennsylvania. The agreement defines the charitable obligations of the Plans and requires, as part of that obligation, that they make direct, financial contributions to the adultBasic program. The combined contribution to adultBasic from the four plans is expected to exceed $85 million annually over the next six years. This new funding source will allow the Insurance Department to serve an additional 29,000 individuals who are currently on the adultBasic waiting list.

The Governor's budget also proposed funding an additional 5,000 adultBasic slots through the Tobacco Settlement Fund. Funding for the 39,000 slots that currently exist comes directly from the Tobacco Settlement Fund. Money from the Fund is used to fund other programs and project as well. The Governor has proposed that the money in the Fund be reapportioned so that more money can be dedicated to adultBasic. A reallocation of the Fund would result in 5,000 additional adultBasic slots in 2005-2006.

The adultBasic program provides low-cost, limited-benefit health insurance to individuals with income below 200% of the Federal Poverty Level. Need for the program far outweighs the program's current funding. There are currently 39,121 individuals enrolled in the program and nearly 100,000 individuals on the waiting list.

Will You or Someone You Know
Be Effected by the Proposed
Caps, Co-pays, Premiums or Eligibility Cuts?

SHARE YOUR STORY WITH US.

Complete the information below, detach this sheet, fold it, post it and send it back to us. Your name or other identifying information will not be used by anyone without your specific permission.

Name: _____

Consumer's Name (If different than Above): _____

How will you be affected by the cuts?

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Do you give the Pennsylvania Health Law Project Permission to contact you regarding your story? (check one)

Yes _____ No _____

I can be contacted at: Phone Number _____

Email: _____

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Family of Five:
Income under $40,000 - No co-pay
Income of $50 - 60,000 - Co-pay $36/month
Income of $100 - 110,000 - Co-pay $180/month
Income of $120 - 130,000 - Co-pay $360/month
Income of $150 -160,000 - Co-pay $630/month
Income of $160 - 200,000 - Co-pay $720/month
Income over $200,000 - Co-pay $787/month

Children with disabilities often need intensive skilled nursing care, durable medical equipment, wrap-around services and other costly medical goods and services that are not covered or are capped by private insurance. At her budget briefing, Welfare Secretary Estelle Richman made a point of noting that this program is unique to Pennsylvania, and now covers 3,000 families with incomes over $200,000.

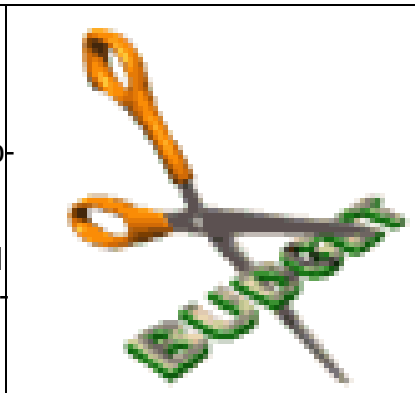
Impact of MA Cuts On Pennsylvania's Economy and Health Care System

This year, Governor Rendell's proposed budgets slashes Medicaid funding. The impact of the cuts would extend beyond the 1.8 million persons who are expected to rely on Pennsylvania's Medical Assistance program for their health care next year.

It is estimated for every $1 million dollars Pennsylvania spends on Medicaid, Pennsylvania creates $2.7 million dollars in new business activity and about 25 new jobs. A large portion of total health care costs in Pennsylvania are paid for through the Medicaid program. In 2002, for example, Medicaid contributed a full $1 Billion dollars to Pennsylvania's state hospital system. Medicaid is the primary payer for 64% of Pennsylvania's certified nursing facility residents.

Health care utilization by the uninsured is a major factor in rising health care costs. Lost Medicaid coverage due to caps on services and eligibility changes would likely that the cost of providng "charity care" would be shifted onto insured individuals and employers in the form of higher health care premiums.

JUST THE BEGINNING? Federal Budget Cuts will Lead to More Cuts in the Future



On February 7, 2005, President Bush issued his proposed Federal Budget for 2005-2006. This Federal Budget is for the fiscal year which begins on October 1, 2005. Soon, the House and Senate Budget Committees will draft budget resolutions and produce a final Congressional budget resolution by April 15, 2005. This budget will set the funding levels for numerous important government programs for the coming year, and many years into the future.

The proposed Bush budget would pass millions of dollars of costs onto the states. The Administration's budget would cut $45-60 Billion dollars of Federal Medicaid funding over the next 10 years. According to Families USA, the estimated cost to Pennsylvania over 10 years would be $2.26 Billion dollars.

Pennsylvania MAAC Adopts Resolution Condemning Proposed Cuts: Recommends that Secretary Stop Defending and Find a Fix

In its February meeting the Medical Assistance Advisory Committee (MAAC) passed a resolution which calls on the Secretary of the Department of Public Welfare to stop defending the massive cuts proposed by Governor Rendell's budget. The resolution recommends that the Secretary turn her attention and energy to working with the MAAC, the legislature, consumers and the provider community to plug the holes in the budget.

The MAAC is the federally mandated advisory committee to the state's Medicaid program. Before passage by the entire MAAC, the resolution was passed by the consumer sub committee, co-chaired by Yvette Long of the Philadelphia Welfare Rights Organization and Shirley Beer of the Armstrong County Low-Income Rights Organization. The MAAC includes representatives from the Hospital Association of Pennsylvania, the Pennsylvania Medical Society, the Pennsylvania Association of Non-Profit Homes for the Aging, the Medical Assistance managed care organizations and other providers and consumers of physical health and behavioral health services, appointed by the Secretary of the Department of Public Welfare.

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