Health Law PA News

Newsletter of the Pennsylvania Health Law Project

Harrisburg Philadelphia Pittsburgh

Statewide Help Line: 1-800-274-3258/ TTY: 1-866-236-6310

On the Internet: www.phlp.org

Volume 10, Number 6 November 2007

DPW Posts 2005 and 2006 Tobacco Settlement Reports Detailing Carve Up of $81 Million to Hospitals

Over $81 million was distributed to Pennsylvania hospitals last year under a formula set out in the Tobacco Settlement Act of 2001, according to a report just posted to the DPW website. The report, made public in response to a request from the Consumer Subcommittee of the Medical Assistance Advisory Committee, details which hospitals qualified for either "disproportionate share (DSH) funds," which are for those hospitals with a high percentage of uninsured patients, or "extraordinary expense" funds, which are for hospitals with extraordinary expenses such as an uninsured, high cost trauma patient. A hospital can only qualify for one of the two types of payments.

Twenty-three hospitals received over one million dollars each in DSH payments. The biggest beneficiaries were Temple University Hospital - $4.6 million; University of Pittsburgh Medical Center Presbyterian Shadyside - $3.7 million; Thomas Jefferson - $3 million; Albert Einstein - $2.9 million; Hospital of the University of Pennsylvania - $2.5 million; Hahnemann - $2 million and Crozer Chester - $2 million. Other hospitals that received between one and two million dollars were: Children's Hospital of Philadelphia, Children's Hospital of Pittsburgh, Mercy Hospital of Pittsburgh, Mercy Hospital of Philadelphia, Pennsylvania Hospital, Lehigh Valley, Pinnacle Health, Frankford, Friends, St. Joseph's (Philadelphia), Penn Presbyterian, York, Girard, Hershey, Western Hospital (Monroeville) and St. Christopher's. Two hospitals qualified for an extraordinary expense payment of over a million dollars. They were Allegheny General (Pittsburgh)- $1.2 million and St. Luke's (Bethlehem)- $1.4 million.

The Consumer Subcommittee has criticized the lack of a specific quid pro quo for the DSH payments. In order to qualify, hospitals must attest to DPW that they have a plan in place for providing charity care. However, DPW has not put into place any rules defining what constitutes a legitimate charity care plan. Issues like who should qualify for charity care, how much free care a hospital should be giving away, how to uniformly value the services that hospitals claim as charity care, and how to notify patients of the availability of charity care pro-

(Continued on Page 2)

INSIDE THIS EDITION

Two Bills Introduced to "Cover All Pennsylvanians"

Legislators in the Pennsylvania House and Senate have introduced stand alone bills to establish Governor Rendell's proposed program, called "Cover All Pennsylvanians" or "CAP," to insure 700,000 adults currently without health insurance. House Bill 1870, introduced by Representative Sturla, and Senate Bill 1117, introduced by Senator Costa, would create the program to provide subsidies for low-income families and small employers that the governor first described in January as part of his "Prescription for Pennsylvania."

The bills essentially lift the CAP piece from House Bill 700, which also contains many other reforms, and puts it into its own legislation. HB 1870 and SB 1117 are very similar. Both bills propose to reduce the number of uninsured adults in the state by offering affordable health insurance to persons 19-64 that they can obtain either as an employee of a small, low-wage business or by purchasing coverage individually. Individuals with household income less than 200% of the federal poverty level (FPL) who have been without insurance for at least 90 days would pay:

- $0/mo. if income is less than 150% FPL
- $40/mo. if income is between 150-200% FPL

Individuals with income greater than 200% FPL who have been uninsured at least 180 days would pay:

- $60/mo. if income is 200%-300% FPL
- $267/mo. if income is above 300% FPL

The basic benefit package that each bill proposes would include: annual wellness and health assessments; inpatient hospital care; ER visits; emergency ambulance; outpatient care (up to 18 visits/year); prescription drugs, and limited mental health and drug & alcohol treatment.

Both bills propose creating a restricted account known as the Cover All Pennsylvanians (CAP) Fund that would be funded through a combination of: money received from the federal government, Tobacco Settlement Funds dedicated to the adultBasic Program (those with adultBasic coverage as well as those on the waiting list would be moved over to the CAP program), and other appropriations.

The major difference between the two bills is that the House Bill contains an employer Fair Share Assessment of 3% on all wages paid by employers who do not offer qualifying health care coverage to their employees. The Senate Bill does not contain this penalty which has been opposed by some employers across the state, citing reasons similar to those raised against the minimum wage increase last year. Other employers have supported the assessment, arguing that they are carrying the burden for employers who do not provide health insurance for employees, since 6.5% of their health insurance costs go to covering the uninsured.

SB 1117 was referred to the Senate Banking and Insurance Committee on October 25th. House Bill 1870 was referred to Insurance Committee of the House on October 3rd. To check the progress of these and other Bills, one can go to www.legis.state.pa.us/cfdocs/legis/home/session.cfm?papowerNav=1.

(Continued From Page 1)

grams are left to the hospitals' discretion. The state has recently indicated that these issues will be addressed in upcoming changes to the Health Department's hospital licensure regulations. The 2005 and 2006 Tobacco Settlement Reports may be viewed on line at: http://www.dpw.state.pa.us/PubsFormsReports/ReportsPoliciesPlans/

House Insurance Committee Approves Reforms to Lower Health Insurance Costs, Help Spread Risk and Increase Access to Coverage

Another piece of health care reform legislation is currently being considered in the PA House of Representatives. House Bill 2005, introduced by Representative DeLuca, includes several provisions aimed at reducing and more fairly spreading health care costs among small businesses.

House Bill 2005 would prohibit insurers from using health status as a factor in adjusting small group rates. This would help to spread the risk across the community rather than resulting in small employers paying significant premiums if employing individuals with chronic conditions or other pre-existing conditions.

The bill would also require that a minimum of 85% of small group premium dollars be spent on medical costs. If an insurer's expenses are less than 85% of the cost of premiums (known as the medical loss ratio), it would be required to refund those savings to the policyholders. This proposed legislation would also give the Insurance Commissioner the authority to review and approve rates to make sure that insurers are complying with the provisions of the bill and passing cost-savings on to small employers and individuals.

The bill includes other components to expand access to health care coverage. The bill would allow children and young adults to remain covered under their parents' health insurance through age 29 if they meet certain conditions such as being a resident of PA and not being married or having dependents. This proposed legislation also requires small group health plans to offer a standard plan that does not apply pre-existing condition exclusions and contains a minimum benefit package. However, the minimum benefit package need not include coverage of behavioral health services except as required by Federal law.

The bill was voted out of the House Insurance Committee on November 20, 2007. It was referred to the Appropriations Committee and is awaiting a vote on the House Floor. More information about HB 2005 and all pending legislation is available at http://www.legis.state.pa.us/.

Do you currently get the Health Law PA News through the mail?
Would you like to get this newsletter by e-mail?

If so, contact staff@phlp.org to change the way you get the Health Law PA News!

DPW Issues First Comparison of Quality under Access Plus and HealthChoices

DPW conducted and released a statistical comparison of the performance of the Access Plus program and the HealthChoices (Managed Care) program. The survey results indicate that the Access Plus program (in its second full year of operation) is generally outperforming the lowest-performing HealthChoices plans, and is even with the average-performing HealthChoices plans in the four areas studied. The study focused on: Women's Health, Chronic Disease Care, Access to Care, and Dental Visits.

In Women's Health, DPW analyzed how many women age 42-69 had received a breast cancer screening by mammography and how many were screened for cervical cancer. For mammographies, the lowest HealthChoices plan scored at 40%, the average HealthChoice plans scored at 47%, Access Plus scored at 50%, and the highest HealthChoices plans scored at 51%. For cervical cancer screenings, the lowest HealthChoices plan scored at 57%, the average HealthChoice plans scored at 67%, Access Plus scored at 61%, and the highest HealthChoices plans scored at 77%.

In Access to Care, DPW studied what percentage of various populations attended preventive care appointments or had access to primary care doctors. For Children and Adolescents' Access to Primary Care Practitioners, Access Plus outperformed the lowest and average HealthChoices plans for ages 12-19, outperformed the lowest HealthChoices plans for ages 7-11, and outperformed the lowest, average and highest HealthChoices plan for ages 1-6.

In Chronic Care, Access Plus scored better than all HealthChoices plans in some areas, such as Blood Pressure Control in Diabetics. They scored worse than all HealthChoices plans in other areas, such as Retinal Exams for Diabetics. However, in most areas, the previous pattern emerged with AccesPlus performing on par with the average HealthChoices plans.

The only dental access analysis done looked at Childrens' Access to Dental Care. Results showed Access Plus (39%), outperforming the lowest HealthChoices plans (37%), but slightly behind the average HealthChoices plans (41%) and the highest HealthChoices plans (44%).

DPW has stated that it considers all of these results encouraging, and believes the Access Plus numbers will improve relative to HealthChoices plans in future years since the Access Plus program is much newer and is still developing its networks and membership resources. Earlier this year, DPW's proposal to eliminate the HMO option in 18 mostly rural counties was rejected by the legislature amid allegations that evidence of quality in Access Plus was lacking. For further information about the DPW Access Plus-HealthChoices comparison, contact PHLP at 1-800-274-3258.

PHLP staff are available in Southeastern PA to conduct trainings on Part D to help social service agencies and their clients navigate the Part D system. Trainings focus on the rights that dual eligibles have under Part D and the appeals and grievance processes that are available to all Part D enrollees.

To learn how to help get your clients' needs met through Medicare Part D, contact the PHLP HELPLINE to schedule a training (1-800-274-3258 voice or 1-866-236-6310/TTY). Please let us know if you require any special accommodations for persons with hearing and/or vision needs.

Medicare Beneficiaries Encouraged To Review Part D Plan Options for 2008

A recent national analysis of Medicare Part D plans found that the most popular Medicare Part D plans would cover fewer drugs next year. In addition, consumers can expect to pay higher cost-sharing for medications. Every year, plans can change their costs, their list of covered drugs, and their rules for accessing the medications. Therefore, it is critical that ***all*** Medicare beneficiaries review their Part D plan choices for next year (even if they are happy with their current plan). Individuals currently enrolled in a Part D plan should review information sent by the plan or talk with a plan representative to find out whether their drugs will continue to be covered and how the costs are changing for 2008. Individuals enrolled in Medicare Advantage Plans should also make sure their doctors and other health care providers will continue to be in the plan's network and find out how the plan's benefits may be changing.

In 2008, there will be 63 stand-alone Prescription Drug Plans. Of these 63 plans, 18 will be zero-premium plans for dual eligibles and others approved for the full low-income subsidy. Prescription drugs plans must be available statewide. There are 255 Medicare health plans available in 2008. Medicare health plan options differ depending on the county in which a Medicare beneficiary lives. Finally, there are 27 Medicare Special Needs Plans available in 2008. Medicare Special Needs Plans can limit their enrollment to certain Medicare beneficiaries including persons who: have both Medicare and Medicaid, live in a nursing home, or have certain chronic conditions (such as diabetes).

More information about 2008 plan options can be found at www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227 or 1-877-486-2048/TTY). Also, 2008 Medicare plans are listed in the **Medicare & You 2008** Handbook that was mailed to all Medicare beneficiaries in October.

Individuals have until December 31, 2007 to enroll in or change plans for coverage in 2008. The Centers for Medicare & Medicaid Services (CMS) is encouraging individuals who are changing plans to enroll in the new plan by the end of the first week in December to ensure that the enrollment is processed and coverage is in place for January 1, 2008. Generally, people are locked-in to their plan choice for the entire year (unless they qualify for a Special Enrollment Period). Individuals can enroll in plans by contacting the plan they want to join directly, enrolling online at www.medicare.gov, or calling 1-800-MEDICARE (1-800-633-4887 or 1-877-486-2048/TTY).

Medicare beneficiaries who need additional help in finding out about 2008 plan options or picking a plan can contact the APPRISE Program at 1-800-783-7067. Dual eligible individuals can contact PHLP's HELPLINE for assistance at 1-800-274-3258 or 1-866-236-6310/TTY.

Medicare Reassigning 17,000 Pennsylvanians to New Part D Plans for 2008

Earlier this month, Medicare notified certain beneficiaries that they would be reassigned to a new Part D plan starting January 1, 2008.

Blue Notices Sent To Those Enrolled by Medicare
Reassignment notices were sent to consumers with a full low-income subsidy (LIS) who were enrolled in their current Part D plan by Medicare. The notice, printed on blue paper, told the consumers that they would be assigned to a different plan for 2008 because their current plan's premium would increase and it would therefore no longer be a "zero premium plan" for someone with the full LIS in 2008 (to view a copy of this notice go to http://www.cms.hhs.gov/partnerships/downloads/11209.pdf.

The new plan assignment is identified in the notice. The consumer then has two choices: 1) she can choose a different Part D Plan and enroll before the end of 2007 in which case she will be in her plan of choice beginning in 2008; or 2) she can do nothing in which case she will be enrolled into the plan Medicare assigned her to beginning in 2008. Consumers who get these notices are encouraged to review their Part D options and choose a "zero premium plan" that will cover their medications, let them use their current pharmacy, and not require prior authorizations for medications they had previously been able to access without a problem. Medicare's reassignment process picks zero-premium plans at random for affected consumers, so the assigned plan may not be the best choice . See the previous page for more information about 2008 plan choices.

Different Notices Sent to "Choosers"
If a person with the full LIS enrolled in a Part D plan on his own that will no longer be a zero-premium plan in 2008, he will get a tan notice from Medicare telling him the plan will no longer be zero-premium and that he will have to pay a premium if he stays in that plan. If he does not want to pay the premium, he will need to join a plan that will be zero-premium in 2008 by December 31, 2007.

ACCESS Plus RAC Mail Box

The Department of Public Welfare recently created a Mail Box for consumers, providers, and other interested parties to e-mail questions and raise concerns about the ACCESS Plus Program. ACCESS Plus is the Medical Assistance health care delivery system that operates in the 42 non-HealthChoices counties in Pennsylvania. The ACCESS Plus counties are divided into four regions, each of which has a Regional Advisory Committee (RAC) that meets quarterly. The RAC meetings are attended by DPW and ACCESS Plus administrative staff, MA consumers, service providers and community groups. The purpose of the meetings is to provide a place for consumers and providers to raise concerns and issues about the program and to promote the exchange of ideas between consumers, providers and interested public and private sector organizations.

Because the RAC meetings only occur quarterly, DPW created the Mail Box to provide consumers and providers an opportunity to submit questions over the internet about MA or ACCESS Plus in the time between RAC meetings which DPW/ACCESS Plus staff can then respond to in a more timely manner. Non-urgent inquiries are to receive a response within 10 business days, while urgent inquiries will receive a response within 24 hours. Questions submitted within 15 business days of a scheduled RAC meeting will be presented and responded to during the meetings for all regions.

The RAC Mail Box can be accessed through either the ACCESS Plus website at www.ACCESSPlus.org or the DWP website (look under managed care) at www.DPW@state.pa.us. The RAC mailbox address will also be listed on the provider ACCESS Plus Desk Reference at www.ACCESSPlusRACmail@state.pa.us.

Secretary of Public Welfare Announces Pennsylvania Youth and Family Institute

On Nov. 9th, Secretary of Public Welfare Estelle Richman announced the creation of the PA Youth and Family Training Institute designed to strengthen mental health services for children and their families. The Institute is a partnership of the University of Pittsburgh, family organizations, youth organizations, providers, community organizations and managed care organizations. The Offices and Departments within the University that will be involved with the Institute include the Office of Education and Regional Programming, the Office of Child Development, the Department of Social work and the Department of Psychiatry. Some of the other partner organizations include PA Families, Inc., NAMI-PA, PA Community Providers Association, County Mental Health Administrators, and Community Care Behavioral Health Organization.

The Institute was created based on recommendations from the Children's Behavioral Health Task Force that has been tasked with transforming the children's behavioral health system in PA to a system that is "family driven and youth guided". Included in the many recommendations to achieve that objective was the need for statewide training for providers, families and other stakeholders. DPW's Office of Mental Health and Substance Abuse Services (OMHSAS) wholly supports the recommendations of the Task Force, including the need for the Youth and Family Training Institute. OMHSAS supports a "Call to Action" based on spending $1 billion on children's behavioral health services, having little more than anecdotal evidence that their efforts result in desired outcomes, and believing there is a wealth of talented, committed people who share a passion for change in the system.

DPW released a Request For Proposals for the Youth and Family Institute and received three proposals. The proposal review team consisted of youth, family and other stakeholders who met with the three applicants and ultimately awarded the bid to the University of Pittsburgh. The University, DPW and the partner organizations will:

1. Provide training, support and monitoring of Youth and Family Teams based on a national model of "High Fidelity Wraparound" – **not to be confused with PA's current version of wraparound services!**
2. Develop a mechanism for Medicaid payment of the Youth and Family Team process; and
3. Begin the process of implementing Youth and Family Teams throughout the state.

High Fidelity Wraparound

This is a process for supporting youth and families with co-occurring disorders that involve kids and families in multiple systems. The process is defined by 10 principles and has four phases. The principles require family voice and choice, an individualized approach that is culturally competent, strength based, community based, collaborative, outcomes based and cost responsible. High Fidelity Wraparound approaches children's strengths and struggles as pieces of a puzzle that are not yet connected. The Youth and Family Training Institute will, among other things, teach facilitators how to help youth and families decide for themselves what pieces belong in their puzzle, how to organize the pieces, and equip them with the skills needed to design, assess and monitor their puzzle. The Institute will create an evaluation and monitoring function to continually assess the quality of each child's puzzle and the impact it is having on improving the lives of the youth and family. The Insti-

(Continued on Page 8)

(Continued from Page 7)

tute will share relevant information about fidelity, outcomes, services and costs with the counties and OMHSAS to effect change.

Implementation start-up activities will occur from November 2007 through April 2008. Activities will include:

- Hiring Vroon VanDenBerg (an international consulting company rooted in the wraparound process) and initiating a train the trainer model;
- Recruiting, training and preparing an Advisory Board;
- Hiring, training and preparing Institute staff that will consist of 50% youth and families;
- Providing High Fidelity Wraparound orientation and training to all appropriate stakeholders;
- Developing a county readiness assessment/ RFP process and selecting the first 8 demonstration counties; and then
- Implementing High Fidelity Wraparound in the demonstration counties.

To view the Powerpoint presentation on the Youth and Family Training Institute shared at the November 1st OMHSAS Advisory Joint Committee meeting please contact Deborah Hodges at dehodges@state.pa.us. For more information on Pennsylvania's

Implementation of Medicaid Tamper Proof Prescription Pad Rules Delayed

Implementation of a new Federal law requiring Medicaid prescriptions to be written on tamper proof prescription pads has been delayed six months by Congress. The previous Health Law PA Newsletter (September 2007) explained the new rules in detail. The rules were to go into effect on October 1, 2007. Physicians will be able to use regular paper for prescriptions until April 1, 2008. The longer lead time will allow for preparation and education regarding the requirements. In addition, Congress may consider changing the requirement to apply only to certain classes of narcotics.

The requirement was part of an Iraq Appropriations Act. It was designed to save a purported $510 million over ten years. However, a diverse group of stakeholders including Medicaid advocates, physicians, and pharmacists expressed concern that the provision could not be implemented in two months, would place increased administrative burdens on physicians and pharmacists, and could result in Medicaid patients going without prescriptions, and could possibly discourage physicians from participating in the Medicaid program. Read future newsletters for additional updates.

Important Reminder About Authorization Periods and Continued Benefits Pending Appeal

One of the most important protections Medical Assistance (MA) recipients have is the right to "continued benefits pending appeal". That is, if an MA consumer is currently receiving a benefit or a service, and DPW or an MA managed care plan decides to reduce or end the service, the consumer can appeal quickly (within 10 days of the decision) and continue to receive her current benefits until the appeal is decided.

Consumers seeking continued benefits pending appeal sometimes run into a roadblock, however, when the services/benefits at issue require prior authorization. That is because, the providers in these cases are waiting and not requesting authorization for a new period until *after* the current authorization period ends. If a request to continue an authorized service is not submitted before the end of the current authorization period, DPW takes the position that this is a new request for services. That means that neither DPW nor the managed care plans (physical or behavioral health) provide continued benefits pending appeal in these situations.

For consumers who receive services and therapies that require prior authorization* (services that need to be approved in advance before Medical Assistance will pay for it), it is important that their doctor or provider submits the request for the next authorization period **before** the current authorization period ends. If the request for the service is submitted before the end date for the current authorization period and DPW or the MA managed care plan decides to deny or reduce coverage of the service, individuals can get continued benefits if they appeal within 10 days of the date on the decision. This means that they will continue to get their services at their current level during the appeal process.

* Some examples of services that require Prior Authorization are medications that are not on the managed care plan's formulary or on the MA preferred drug list, medications that require step therapy (trial of a formulary alternative), shift nursing services, home health aide services, speech therapy, physical therapy, occupational therapy, and behavioral health wraparound services.

If DPW or the MA health plan tells the doctor or provider that they cannot submit a new prior authorization request before the current one ends, you can contact the PA Health Law Project HELPLINE at 1-800-274-3258 or 1-866-236-6310/TTY for help.

Update on Mental Health Parity Legislation

In recent months, both the US House and the Senate passed legislation that would require health insurance policies to provide equal coverage of mental and physical illnesses. Sponsors of the House legislation are Patrick Kennedy (D-RI) and Jim Ramstad (R-MN), and the Senate sponsors are Pete Domenici (R-NM) and Edward Kennedy (D-MA). The sponsors of the legislation are currently in negotiations about some of the differences between the two bills. One area of difference is the timeframe for implementation-the House bill would go into effect January 1, 2008 while the Senate version would be implemented one year after the legislation becomes law. Another difference is that the House bill includes a broader definition of medical conditions that insurers would have to cover while there is no such provision in the Senate bill. Lawmakers are also discussing how to fund this legislation. Any agreements reached by the Sponsors during the negations could be added as a manager's amendment to the House bill before it reaches the floor. We will keep you updated about developments in future newsletter editions.

Pennsylvania Health Law Project
Lafayette Building, Suite 900
437 Chestnut St.
Philadelphia, PA 19106