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Governor's Proposed Medicaid Budget for FY 2017-2018

Despite a looming budget deficit, Governor Wolf released a proposed budget for Fiscal Year 2017-18 that maintains existing Medicaid service and eligibility levels. The proposed budget for the next fiscal year moves forwards with the Community HealthChoices initiative, which will implement managed care for dual-eligibles and recipients of long term supports and services, and continues funding for Centers of Excellence to combat the opioid and heroin crisis.

The Governor proposes a general fund budget of \$32.3 billion for FY 2017-18. This would be an increase of \$571.5 million (1.8%) over the current fiscal year budget. It contains no new broad-based tax increases, and instead aims to address the budget deficit through consolidating state agencies, closing tax loopholes, and other revenue enhancements and administrative efficiencies. As part of these savings initiatives, the budget proposes to consolidate the Departments of Human Services, Aging, Health, and Drug and Alcohol programs into a new "Department of Health and Human Services." This would achieve \$90 million in savings through reducing duplication and administrative overhead, with an additional \$45 million achieved through consolidating multiple prescription drug programs.

The Governor's budget proposes a total appropriation for Medical Assistance (MA) of \$19.4 billion, which includes both federal and state funds. As a reminder, Pennsylvania calls its Medicaid program "Medical Assistance". Of this \$19.4 billion MA budget, \$15 billion (77%) is allocated for capitation payments to the physical health and behavioral health managed care organizations. The capitation appropriation is comprised of \$3.7 billion in state general funds, \$10.1 billion in federal funds, and \$1.3 billion in provider assessments. Of the overall MA budget, \$3 billion is allocated to the Fee-for-Service appropriation, of which \$460 million is state general funds, \$1.9 billion is federal funds, and \$602 million is provider assessments.

The MA budget assumes enrollment growth of 2.5% overall to serve an estimated 2.9 million Pennsylvanians. Enrollment growth for adults through Medicaid expansion is expected to slow to a 3.3% in-

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crease (to 775,000 enrollees) over the upcoming fiscal year.

Initiatives included in the proposed Human Services and Medicaid budgets include:

- **Community HealthChoices** – \$44 million is allocated to implement managed care for most dual-eligibles, people receiving Home and Community Based Services through the Office of Long Term Living Waiver programs, and nursing facility residents (in the Long-Term Care appropriation). Implementation will begin first in the Southwest, with a start date now scheduled (after two delays) for January 2018;
- **Community Opportunities** – \$21.2 million is allocated to provide Home and Community Based Services to an additional 1,470 individuals with disabilities and \$12.9 million to provide HCBS services (Aging Waiver) to an additional 1,428 older adults;
- **Expanding the LIFE Program** – \$14.1 million is allocated for the LIFE program to serve an additional 600 consumers dually-eligible for Medicaid and Medicare (\$7 million) and to expand the program into nine additional counties (\$7.1 million);
- **Expanding Intellectual Disability and Autism Services** – \$15.4 million is provided to serve another 1,000 individuals with intellectual disabilities who are currently on the waiting list and \$8.6 is provided to serve 820 students graduating from high school. \$642,000 is provided to serve an additional 50 adults with autism spectrum disorder through the Adult Autism waiver;
- **Substance Use Disorder Centers of Excellence** – the budget maintains funding for the 45 Opioid Use Disorder Centers of Excellence created in fiscal year 2016-17;
- **Continuous Eligibility until Age 3** – approximately \$1 million of the capitation appropriation is provided to expand continuous eligibility for newborns until age three. This would ensure that infants and toddlers experience no lapses in their MA coverage during this important developmental period.

Appropriations Committees in both the Pennsylvania House and Senate are currently holding hearings with various state agencies to gather further information and details about the Governor's budget proposal. In response to the proposal to combine four existing departments into a new Department entitled "Health and Human Services", the Senate now plans to hold a full day of hearings starting at 10 a.m. on March 8th to hear from the agencies slated to be part of this new Department.

The proposal to combine Departments has raised concerns and questions both among legislators and various communities that would be impacted by the change. Aging advocates have expressed particular concern over the elimination of the Department of Aging. There is fear that focused attention on senior issues and senior priorities would be lost when older adults are just one of the many populations served in the new Department. Also, advocates note that the Department of Aging is solely funded by federal funding and by the Pennsylvania Lottery and does not receive state tax dollars. By law, all proceeds from the lottery must be used to fund services and programs that serve older adults. Advocates worry that if the merger occurs it will be much harder to track the lottery funds and to assure the funds are used only for seniors and much more potential for the funds to be transferred into the General Fund instead. Governor Wolf has stated his commitment to not moving any additional lottery funds to offset General Fund expenditures.

Various budget documents can be viewed [here](#). We will continue to update readers about the Administration's budget initiatives as further details become available.

Latest ACA Repeal Efforts Target Drastic Changes to Medicaid Funding

Republicans in Congress continue to debate how to replace the Affordable Care Act (ACA) and are not yet unified behind any of the proposals that have been introduced thus far. In mid-February, Republican leadership in the House presented a [draft policy brief](#) that included significant changes to Medicaid's financing as a way to pay for repeal and replacement of the ACA. The changes mentioned include Medicaid block grants as well as per capita caps to reduce federal funding for Medicaid. Although the outline lacked details on how these funding changes would exactly work, both approaches would significantly change the way the Medicaid program has been financed since the program started and advocates are deeply concerned that either approach would shift more costs to the states and lead to cuts in services, eligibility, and reimbursements to health care providers.

How Medicaid Is Financed Now

Medicaid financing is shared between the federal government and the states. In exchange for states meeting federal minimum standards that include covering certain groups of people with limited incomes (i.e., children, pregnant women, people with disabilities, and older adults) and covering a minimum set of services, the federal government reimburses states, or "matches," a percentage of their actual Medicaid program costs. Every state's match is different. Pennsylvania's current federal match rate is 51.78%, meaning the federal government pays slightly over half of the state's standard Medicaid costs. Because Medicaid is an entitlement program, this federal matching commitment is open-ended. If enrollment increases during an economic downturn, or drug costs increase following the release of a new highly effective, but expensive, medication, states know that the federal government will continue to pay its portion of Medicaid costs under the current funding structure.

The Affordable Care Act allowed states to expand their Medicaid program to adults with income less than 138% of the Federal Poverty Level. For this population, the federal government funds almost all of the costs related to providing Medicaid to this group. Specifically, for the first three years the federal government paid all of the costs of Medicaid expansion. Beginning in 2017, the federal government pays 95% of the costs and then over time the funding will gradually reduce to 90%. As a reminder, Pennsylvania expanded Medicaid in 2015 and over 700,000 people have gained coverage through this expansion.

In total, Pennsylvania's Medicaid program currently covers over 2.8 million people including 1.2 million children. Nearly two-thirds of Pennsylvania's Medicaid spending is for older adults and people with disabilities, many of whom receive long-term care services in the community or a nursing home.

How Medicaid Financing Would Change by Moving to Block Grants or Per Capita Caps

Under block grants, the federal government would give each state a fixed amount of federal money to use for its Medicaid program and then allow the state to decide how to use that funding. Block grants are designed to control federal funding and ultimately give states less money for their Medicaid programs over time. Under most proposals offered so far, states would only face small losses in funding at the outset. However, future block grant increases would be tied to inflationary measures that typically fail to keep up with medical inflation. This means that, over time, states would have to bear more of the cost of their Medicaid programs and would likely face large budget shortfalls. If block grants are enacted, Medicaid would no longer be an entitlement and many federal Medicaid requirements such as mandating coverage of certain groups and a minimum service package would be eliminated. Supporters argue that states could save money through innovation when they are not

subject to these federal requirements but consumer advocates fear that reductions in federal funding will leave state Medicaid programs hard pressed to make up the difference with little flexibility except to limit enrollment or to reduce benefits.

Per capita caps are slightly different from block grants. Under this funding mechanism, the federal government would give the states a fixed amount of money for each person enrolled in its Medicaid program. The fixed amount would be set at a point in time and would require Congressional action to change the amount making it difficult for states to adjust to increased costs resulting from medical inflation or other factors like advances in technology. Like block grants, per capita caps are designed to control federal Medicaid spending and over time would reduce the federal support provided for state Medicaid programs. As with block grants, the concern is that states would not be able to make up the difference with state funds and will limit Medicaid enrollment or reduce services.

Secretary of Human Services Ted Dallas has stated that Pennsylvania would not be able to cover the cost shift that would result from changes to how Medicaid is financed and the reduced federal spending that would follow the changes described above. The proposed Medicaid budget for the upcoming fiscal year (discussed on page 1) is based on current federal Medicaid funding.

Pursuing Changes Through Budget Reconciliation

The Affordable Care Act cannot be repealed in its entirety through the budget reconciliation process; however, Congress can change parts of the law that directly affect the federal budget. In addition, block grants or per capita caps can be enacted through federal budget reconciliation legislation that only requires simple majorities to pass in both the House and the Senate. The House of Representatives is expected to reveal its budget reconciliation plan very soon now that the Congressional recess is over.

What's next?

At this time, no legislation has passed in either the U.S. House or the Senate that repeals the ACA or changes how the Medicaid program is funded. If and when the two chambers pass any legislation, it is not certain what will be included or when any changes would go into effect.

If you are interested in learning more about Pennsylvanians who could be impacted by changes to Medicaid funding, please see our [website](#). Anyone who wishes to express their opinion or concern about Medicaid and its future funding is encouraged to contact their [U.S. Representative](#) and [U.S. Senators](#).

States Encouraged to Support Dual Eligibles' Access to DME and Supplies

The Center for Medicare & Medicaid Services (CMS) recently issued [an Informational Bulletin](#) suggesting strategies states could use to support timely access to durable medical equipment, prosthetics, orthotics and supplies for their residents who have both Medicare and Medicaid (referred to as “dual eligibles”). A common barrier dual eligibles face is that Medicare and Medicaid have different, and conflicting, approval processes for durable medical equipment, prosthetics, orthotics and supplies (hereinafter “DMEPOS”). That can result in suppliers refusing to provide the DMEPOS when a consumer needs it because the supplier does not have assurance on how, or if, either program will cover the DMEPOS.

Generally, Medicare is the primary payer for DMEPOS but it only covers equipment *used in the home*. Also, Medicare typically processes claims *after* the equipment is delivered. Medicaid is usually the secondary payer—meaning it only pays *after* Medicare approves and pays for the DME and then covers the consumer’s Medicare cost-sharing. However, Medicaid’s coverage for DMEPOS can be broader than Medicare’s coverage—including coverage for specialized, costly equipment that can be used *outside the home* to support the consumer’s independence.

The Informational Bulletin lists strategies states can use to address the barriers dual eligibles face trying to access DMEPOS and encourages states to employ one or more of these strategies:

- Offer a Medicaid prior authorization process *up front* to suppliers of expensive DMEPOS for dual eligibles. Though the supplier must still submit the claim to Medicare first and get a denial before submitting to Medicaid for payment, this strategy gives suppliers confidence Medicaid will pay even if Medicare does not and encourages timely delivery of the DMEPOS to the consumer.
- Ensure that Medicaid claims for DMEPOS submitted on behalf of dual eligibles are assessed using Medicaid’s broader criteria for coverage. That means Medicaid coverage of DMEPOS cannot be limited to the home setting (that is Medicare’s standard) as Medicaid must cover appropriate DMEPOS suitable for use in any setting in which normal life activities take place, other than inpatient settings.
- Accept receipt of a Medicare non-affirmed prior authorization decision as sufficient to meet the state’s obligation to pursue other coverage before considering Medicaid coverage of the DMEPOS. The scope of Medicare’s prior authorization program is limited to certain types of DMEPOS and so the state can only require a Medicare non-affirmed prior authorization decision for the specific items covered by Medicare’s prior authorization process.

It is important to note that Pennsylvania intends to move most of its dual eligible population into managed care plans to receive their Medicaid coverage and their long term services and supports (under Community HealthChoices) beginning in the Southwest in 2018. Community HealthChoices plans will then be responsible for reviewing requests for DMEPOS coverage made on behalf of their members. As a reminder to states like Pennsylvania, the CMS Bulletin ends by saying states should consider incorporating these requirements and strategies into their contracts with Medicaid managed care plans when contracting with them to deliver Medicaid DMEPOS to dual eligible persons.

Dual eligibles, and others on Medicaid, who are having problems accessing durable medical equipment and other medical supplies they have been prescribed are encouraged to call PHLP’s Helpline at 1-800-274-3258.

Hospitals Required to Give Medicare Patients Notice of Their Observation Status

Effective March 8, 2017, hospitals will be required to provide written and verbal notification to Medicare beneficiaries who, though they are in the hospital, are determined to be in “observation status”. These individuals are not considered to be inpatients but rather are getting outpatient services from the hospital. The Centers for Medicare and Medicaid Services has issued a standardized notice, the [Medicare Outpatient Observation Notice \(MOON\)](#), that hospitals must provide to any individual receiving observation services as outpatients for more than 24 hours. This notice, along with an oral explanation, must be provided within 36 hours of the start of services. The notice explains the status of the individual as an outpatient, not an inpatient, and the implications of such status.

The ramifications of a person being classified by a hospital as an outpatient versus an inpatient are twofold. First, a Medicare beneficiary is billed differently for an inpatient hospital stay (covered by Medicare Part A) than they are billed for outpatient services (covered by Medicare Part B). Generally, Medicare beneficiaries will likely have higher cost-sharing for hospital services received as an outpatient. Second, if a patient ends up being directly discharged from the hospital to a skilled nursing facility, Medicare will **only** cover the skilled nursing care **if** the patient was considered an **inpatient** in the hospital for at least three consecutive days prior to receiving skilled nursing facility care. If the person was in the hospital under observation status, they are considered to be outpatients and therefore do not meet the requirements for Medicare to pay for their subsequent stay in a skilled nursing facility.

More information about the MOON can be found [here](#).

PA LINK's Person-Centered Counselors Offer Variety of Services

In our [November/December 2016 newsletter](#), we informed readers about the assistance available through the PA LINKs for those needing help applying for Waiver programs administered through the Office of Long Term Living (Aging, Attendant Care, COMMCare, Independence, and OBRA). However, assisting individuals with Waiver applications is just one of the many services that the PA LINKs' Person-Centered Counselors provide. The main focus of Person-Centered Counseling is to connect individuals with the public and private resources available to meet their specific needs. To date, over 600 people who work for local aging or disability agencies or organizations have been trained to provide this service.

Person-Centered Counselors work directly with individuals needing help and place that individual at the center of the process. This process should include:

1. A personal interview identifying the individual's needs, preferences and values;
2. An overview of the options/resources available;
3. Decision making support;

4. The creation of an Action Plan prioritized by the individual; and
5. Follow-up.

The Pennsylvania LINKs, also called the Aging and Disability Resource Centers, are administered through the state's Department of Aging and operate in 15 service areas across Pennsylvania. The LINKs provide objective information, advice, counseling and assistance to empower people to make informed decisions about their long term supports and help them more easily access public and private long term supports and services.

To find out more about Person-Centered Counselors or to obtain their assistance, contact the PA LINK to Aging and Disability Resource Center Helpline at 1-800-753-8827.

Federal Poverty Level Guidelines Published

The new Federal Poverty Level (FPL) Guidelines were published in the Federal Register in late January. The new limits are slightly higher than the 2016 guidelines. These FPL guidelines are used to determine eligibility for public health programs such as Medicaid, CHIP, Medicare Part D Extra Help and Marketplace Premium Tax Credits.

PHLP has updated its chart showing income and resource Limits for Medicaid and other health programs to include the 2017 amounts. Click [here](#) to view this resource.

Our Mission

Founded in the mid-1980s and incorporated in 1993, PHLP protects and advances the health rights of low-income and underserved individuals. Our talented staff is passionate about eliminating barriers to health care that stand in the way of those most in need.

We seek policies and practices that maximize health coverage and access to care, hold insurers and providers accountable to consumers, and achieve better outcomes and reduce health disparities.

PHLP advances its mission through individual representation, systemic litigation, education, training, and collaboration.

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For Southeast PA, go to uwsepa.org and select donor choice number 10277.

For the Capital Region, go to uwcr.org and pledge a donation to PHLP.

For the Pittsburgh Region, go to unitedwaypittsburgh.org and select agency code number 11089521.