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Governor's Proposed Medicaid Budget for FY 2018-2019

Governor Wolf has released a proposed budget for Fiscal Year 2018-19 that maintains existing Medicaid services and eligibility levels. The proposed budget supports the Community HealthChoices initiative, a managed care program for dual eligibles and people receiving Medicaid funded long-term care services in a nursing home or at home through a Waiver program administered through the Office of Long Term Living. The budget proposal also continues funding for Centers of Excellence to combat the opioid and heroin crisis.

The Governor proposes a general fund budget of $33.0 billion for FY 2018-19 - a 3.1 percent increase over the current fiscal year budget. It contains no new broad-based tax increases and instead relies on growth in existing tax revenues as well as a new severance tax on natural gas.

To streamline administrative functions, the Governor again proposes to merge state agencies. The more modest proposal this year seeks to consolidate two Departments-- Human Services and Health—into a new "Department of Health and Human Services". The combined agency would house the Physician General and a new Office of Medical Marijuana. The other two Departments that had been included in last year's ambitious merger proposal, the Departments of Drug and Alcohol Programs and Aging, will remain free standing departments. Even though these two Departments are not part of the current merger proposal, the Administration has consolidated functions across the four Departments to reduce administrative duplication and direct more resources to services.

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The Governor proposes a total appropriation for Medical Assistance (MA), as Pennsylvania's Medicaid program is called, of $20.4 billion. This includes both federal and state funds and is an increase of 5.4 percent over the current fiscal year. The MA appropriation is comprised of $4.35 billion in state general funds, $12.8 billion in federal funds, and $3.3 billion in provider assessments and other fees. Of that overall MA budget, $15.9 billion (78 percent) is allocated for capitation payments to the physical health and behavioral health managed care organizations that cover most people on Medicaid.

The budget assumes Medicaid enrollment will grow 1 percent over the next fiscal year to serve an estimated 2.92 million Pennsylvanians, including 794,000 people covered through Medicaid expansion. The enhanced federal match for this population will reduce from 94 percent to 93 percent effective January 1, 2019.

Initiatives in the proposed Human Services and Medicaid budgets include:

- **Community HealthChoices (CHC)** – $695 million in state general funds is allocated to the new line-item CHC. Total CHC funding amounts to $3.2 billion; this includes provider assessments, lottery funds, and $1.7 billion in federal funds.

- **Expanding HCBS Waiver Programs** – $22.5 million is allocated to provide Home and Community Based Waiver Services to an additional 1,500 individuals with physical disabilities and $26.8 million to provide Aging Waiver services to an additional 2,290 older adults;

- **Expanding the LIFE Program** – $5.5 million is allocated for Living Independence for the Elderly (LIFE), a managed care program that provides a comprehensive, all-inclusive package of medical and supportive services. An alternative to CHC, this funding allows the LIFE program to serve an additional 480 consumers dually-eligible for Medicaid and Medicare;

- **Expanding Intellectual Disability Services** – $15.5 million is provided to serve another 100 individuals with an Intellectual Disability (ID) who are currently on a waiting list for an ID Waiver, 800 young adults who are graduating from special education, and 25 individuals currently residing in state ID centers.

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In March, the Pennsylvania House and Senate Appropriations Committees will be holding budget hearings with the various Departments. Notable hearings are listed below.

House Appropriations Committee Budget Hearings	Senate Appropriations Committee Budget Hearings
♦ ***Department of Health/Dept of Drug and Alcohol Programs*** – March 1st at 10 AM ♦ ***Department of Human Services*** – March 6th at 10 AM	♦ ***Department of Aging*** – March 6th at 3 PM ♦ ***Department of Health and Human Services*** – March 7th at 10 AM ♦ ***Department of Drug and Alcohol Programs*** – March 8th at 10 AM

We'll continue to update readers about any developments related to the Governor's proposed budget impacting health care programs for vulnerable Pennsylvanians.

Community HealthChoices Update

Community HealthChoices (CHC), the state's mandatory managed care program for 1) those who have both Medicare and Medicaid (dual eligibles) and 2) older adults and persons with disabilities needing long-term services and supports at home or in a nursing home has been in effect in Southwestern Pennsylvania since January 1st. This article updates readers about the initial launch and highlights some of the areas where further attention is needed. As a reminder, the Pennsylvania Department of Human Services (DHS) contracts with three CHC plans to provide coverage under this new system. Over 85,000 Pennsylvanians living in the 14-county zone are enrolled in CHC: 52 percent are in UPMC Community HealthChoices, 28 percent are in PA Health & Wellness, and 20 percent are in AmeriHealth Caritas.

OLTL Considering Start of CHC A Success, But Many Areas Still Need Addressed

DHS' Office of Long Term Living (OLTL) is now turning its focus for Community HealthChoices from the launch phase to program improvement in Southwestern Pennsylvania. OLTL Acting Deputy Secretary Kevin Hancock has stated he considers the launch of the program mostly a success but acknowledges areas where improvement is needed. These include: issues with CHC enrollment; billing and payment for providers of long term services and supports; participant and provider education about dual eligibility; reviewing changes in Person-Centered Service Plans; and transportation. He also stated that OLTL will use the lessons learned from the launch in the Southwest region to inform and improve the January 1, 2019 launch of CHC in the five county Southeast region, especially the need to do a better job explaining how CHC works with Medicare and educating providers and participants.

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Transportation

Since CHC started in Southwestern PA, there has been much confusion over what transportation is the responsibility of the CHC plans and what is not. The state recently hosted a transportation summit with various transportation providers and the CHC plans to discuss issues that have arisen with CHC. Using the information gathered, OLTL plans to work with stakeholders to develop guidance related to transportation under CHC.

To be clear, the Medical Assistance Transportation Program (MATP) continues to be responsible for non-emergency medical transportation for all Medicaid consumers in the CHC region who are not residing in a nursing home. The CHC plans should be assisting their members who need help connecting to and arranging rides through MATP. However, the CHC plans will also be responsible to provide transportation to their members in certain circumstances:

- **Nursing Home Residents:** The CHC plans are responsible for paying for transportation of their members in nursing homes. This includes emergency and non-emergency ambulance as well as all non-emergency medical transportation.
- **CHC Members Living in the Community**: For their members living in the community, the CHC plans are responsible for emergency and non-emergency **ambulance** transportation. In addition, the plans must pay for "specialized" non-emergency medical transportation for those requiring a stretcher van or who need to be transported from one medical facility to another.

  CHC plan members who are getting long term services and supports at home can also get non-medical transportation paid for by the plan as long as it is detailed in the person's approved service plan. This could include, among other things, transportation to religious activities, to grocery shop, to employment or volunteer activities, or to Adult Daily Living Centers.

Transitions between LIFE and CHC Plans

The Living Independence for the Elderly (LIFE) program exists as an alternative to Community HealthChoices for people age 55 and older who: can be safely served in the community by a LIFE program, meet clinical and financial eligibility criteria, and live in an area that is served by a LIFE program. Individuals in LIFE do not go into CHC and people in CHC who want to enter LIFE are disenrolled from the CHC program. Currently, LIFE programs exist across the 14 county Southwest region with the exception of Bedford County and parts of Somerset County.

When people want to move from one system to another, they are finding it difficult to do so - especially when they are moving from LIFE to CHC and need in-home services in place immediately upon their enrollment into a CHC plan. When people are in LIFE, the LIFE program provides services through its own providers, often at a LIFE center, to meet a participant's needs. This ends as soon as someone is disenrolled from LIFE. However, when that person moves into a CHC plan, the plan typically has 5 days to assess new members needing long term services and supports and 30 days to

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develop a service plan. Members must then use providers in the CHC plan network for care and services that are approved. There is not a clear policy that details how this transition should work.

OLTL has been addressing cases that come to their attention on an individual basis. The state is working with the LIFE programs and CHC plans to assist the movement of individuals between these programs while it develops formal guidance to address transitioning between the two programs.

Dual Eligibles with Intellectual Disabilities Who Are Not in an ID Waiver or Receiving County-Funded Base Services

PHLP recently received clarification from OLTL that people with Intellectual Disabilities (ID) or Autism who are on a Waiting List/Interest List for a Waiver administered through the Office of Developmental Programs (ODP) will be enrolled into CHC **if**: (1) they are dual eligible **and** (2) they are not getting base funded services through their county's Office of Intellectual Disabilities. If the only service someone is receiving from their county is Supports Coordination, they are generally not considered to be receiving county-funded base services.

In recent PHLP publications and during our trainings in the Southwest region, we noted that anyone on a Waiting List for an ID or Autism Waiver should be excluded from CHC. That sweeping statement is incorrect given OLTL's recent clarification and instead, individuals on the Waiting Lists will be exempted only as long as they are receiving county base-funded services. This clarification was obtained after PHLP was contacted regarding individuals who were enrolled into CHC and who were now having trouble moving into an ID Waiver when a slot became available. OLTL is working with ODP on this issue to resolve problems experienced by individuals in this situation. As a reminder, people receiving services through an ID Waiver or the Autism Waiver are **not** part of CHC.

Resources

Anyone in CHC having problems in these areas or other problems getting care are encouraged to call the Office of Long Term Living's Participant Helpline at 1-800-757-5042. People can also call PHLP's Helpline at 1-800-274-3258.

PHLP recently created a fact sheet about appealing CHC plan denials. This can be found on our website here. Individuals who want to receive emails about CHC are encouraged to sign up for the OLTL Community HealthChoices list-serve. This can be done by visiting the Community HealthChoices website at www.healthchoices.pa.gov. This website also includes other information about CHC for both participants and providers.

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Pennsylvania Activities to Address Missed Nursing Shifts

Home health services, such as shift nursing care, allow children with complex medical needs to remain and flourish in their homes. Families rely on services from home health aides and skilled nurses to care for their children when they are working or sleeping, or when a parent has limitations or household responsibilities that prevent them from performing all the tasks required to care for their child with special health care needs.

Commercial insurance available through employers often does not cover home health services or limits these services. As a result, many children with special health care needs turn to Medicaid (Medical Assistance or MA in Pennsylvania) for additional coverage of these services. The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) provisions of the federal Medicaid Act require Pennsylvania to ensure that children on MA have access to services like shift nursing when it is medically necessary.

Unfortunately, many families struggle to find staffing to cover shift nursing services that have been approved by Medicaid. The absence of these authorized services puts children's health at risk and it threatens their well-being and ability to be cared for at home with their families. In addition, their parents' lives are disrupted making it difficult for them to hold steady employment, care for their other children, and meet the many other responsibilities that come with running a household and caring for their child with special needs.

PHLP's Advocacy with DHS Regarding Unstaffed Nursing Shifts

PHLP is concerned about these unstaffed or "missed" nursing shifts and invited state officials from the Department of Human Services (DHS) to discuss the problem for families in Pennsylvania. In response, staff from DHS' Bureau of Managed Care Operations attended the January 2018 meeting of the Medical Assistance Advisory Committee Consumer Subcommittee. They addressed missed nursing shifts and shared the results of their new internal data collection and monitoring mechanisms. Below are highlights from this presentation:

- From 2013 to 2017, the number of kids receiving shift nursing through Medicaid grew by 65 percent. At the same time, there was an apparent shortage of nurses available to provide shift nursing care, due in part to the lower wages home care nurses receive compared to the wages received for comparable work in other settings like hospitals;
- In 2017, DHS began requiring home health agencies to submit monthly reports detailing the number of missed nursing shifts and the reason(s) for the missed shifts;
- DHS has formed teams tasked with reviewing the data and identifying "problem" cases— defined as Medicaid consumers who chronically missed authorized coverage over a multiple week period due to the home health agency being unable to provide staff;

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- DHS acknowledged there is a need for better communication between managed care plans, home health agencies, and members/families.

These efforts are first steps but there is more work to be done. PHLP recognizes a simple "one size fits all" solution will not likely be found to resolve such a complex problem. We'll continue urging DHS officials to identify and intervene in individual problem cases, and to implement policies that provide relief for all families.

The Role of Special Needs Units (SNUs)

The bulk of Medicaid enrollees are enrolled in a managed care plan, and each plan has a designated Special Needs Unit (SNU) tasked with helping their members access care, coordinate their care, and connect to other community resources. Unfortunately, many families are not aware of the SNU or its services, or even how to contact the plans' SNU for help.

During their January presentation, DHS staff noted that many SNUs were not even aware of their members "problem cases" that were identified as a result of the state's data collection efforts. PHLP will continue advocating for SNU information to be displayed more prominently in the plans' member handbooks, websites, and in other communications to their members.

Families experiencing difficulty with missed nursing shifts should call their plan's SNU to make them aware of the problem and to request help. The telephone number for each SNU is listed below:

Aetna Better Health:	855-346-9828
AmeriHealth Caritas:	800-684-5503
AmeriHealth Caritas NE:	888-498-0766
Geisinger Health Plan:	855-214-8100
Gateway Health Plan:	800-392-1147
Health Partners:	866-500-4571
Keystone First:	800-573-4100
United Health Care:	877-844-8844
UPMC for You:	866-463-1462

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Families of children whose Medicaid coverage is not through a managed care plan but through the ACCESS card can contact DHS' Intense Medical Case Management Unit at 1-800-537-8862. They should use the following prompts to connect to someone: option 1, option 2, option 5, and finally option 2.

We'll keep readers updated about any future developments in this area.

Medicaid and Work Requirements: What New Federal Guidance Could Mean for Pennsylvania

Recent guidance from the Trump Administration allows states — for the first time — to take away Medicaid coverage from people who are not working or engaged in work-related activities. The federal government has already approved work requirement policies in Kentucky and Indiana. Eight other states are seeking approval for similar approaches.

The move is unlikely to affect Pennsylvania in the short-term. Governor Wolf vetoed a work-search requirement for the Medicaid program that the Republican-controlled state legislature passed last year. But several candidates seeking to replace him in this year's gubernatorial election say they support the idea. Moreover, House Republicans in Harrisburg are still seeking a Medicaid work requirement and included the concept in a package of welfare reform proposals introduced earlier this year.

Medicaid work requirement proposals generally require adult recipients to verify their participation in approved activities (such as employment, job search, or job training programs) for a certain number of hours in order to receive health coverage. For example, Kentucky's newly approved program requires at least 80 hours of work or community engagement per month or recipients risk losing coverage.

Even though supporters of Medicaid work requirements often describe these policies as applying to "able-bodied" adults, in reality they impact all enrolled adults. Those who are working must document and verify their compliance. Those who are exempt, such as those with disabilities, must verify their exempt status. Such documentation and verification requirements increase Medicaid costs not only for the information systems needed to track work verification and exemptions but also for the additional staff needed to implement the requirements.

Consumer advocates emphasize the real risk of people losing coverage who are otherwise eligible simply because of the complicated documentation and administrative processes involved in complying with work requirements. For example, people with disabilities may have challenges

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navigating the system to obtain an exemption and end up losing coverage. Studies of eligibility and enrollment experiences with both the Medicaid and the Children's Health Insurance Program show that complex enrollment rules and burdensome documentation requirements can be barriers to coverage in that people lose their insurance simply because they don't understand the process or because they cannot get the requested documentation.

The focus of the Medicaid program has historically been to provide health insurance to people with limited incomes so that they can get the care they need. If a state Medicaid program also wants to help Medicaid beneficiaries find work, it should do so without making it a condition of eligibility. Previous federal administrations of both political parties have denied waiver requests from states that included Medicaid work requirements - on the basis that such provisions would not further the program's purposes of promoting health care coverage and access to care.

The Trump administration's new Medicaid work-rule and Governor Wolf's earlier veto could make this topic a campaign issue in Pennsylvania's gubernatorial election. PHLP will keep readers updated and educated about this topic.

2018 Federal Poverty Level Guidelines Published

The 2018 Federal Poverty Levels (FPLs) were published in the Federal Register in January. The new limits are slightly higher than last year's guidelines. The poverty guidelines are used to set income limits for public health programs such as Medicaid, CHIP, Medicare Part D Extra Help and Marketplace Premium Tax Credits.

PHLP updated its chart showing income and resource limits for Medicaid and other health programs to include the 2018 amounts. Click here to view this resource.

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