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PA House Republican Budget Squeezes Medicaid

The Pennsylvania House of Representatives has passed a Fiscal Year 2017-18 general fund budget that could have significant implications for the state's Medicaid program. House Bill 218 (HB 218) was approved along strict party lines and referred to the Senate Appropriations Committee on April 4. At $31.5 billion, the House Republican budget proposal is considerably more austere than the $32.3 billion budget proposed by Governor Wolf in February, and would reduce overall state spending by just under one percent compared to the current fiscal year.

Among other funding reductions, and without specifying how such savings would be achieved, House Bill 218 contained the following Medicaid appropriations:

- MA – Capitation: $178 million less than the Governor's Budget
- MA – Fee-for-Services: $2.6 million less than the Governor's Budget
- MA – Long Term Care: $25 million less than the Governor's Budget
- Behavioral Health Services: $4 million less than the Governor's Budget
- Home & Community Based Services: $2.2 million less than the Governor's Budget
- Services to Persons with Disabilities: $2.1 million less than the Governor's Budget

Without further explanation, House Majority Leader Dave Reed, R-Indiana, told reporters that implementing managed care "lock-in" – by which Medicaid recipients could change insurance plans only once per year – would achieve $100 million in Medicaid savings. Whether the remaining Medicaid savings would require cuts to reimbursement rates, waiting lists for HCBS waiver programs, or still-to-be-announced policy changes is not yet known.

HB 218 did include the funding for the consolidation of four Departments—Aging, Drug and Alcohol Programs, Health, and Human Services. Over the last month, Legislative Committees have been holding hearings regarding consolidating the Departments and forming one Department of Health and Human Services (HHS). Separate legislation would be needed before the departments could consolidate, and lawmakers have expressed concerned about the lack of details available thus far about plans to bring the agencies together as of July 1st-the proposed start date for this action. Legislative committees held two hearings in Harrisburg on this issue with another hearing scheduled in Pittsburgh on May 1, 2017. More information about the hearings held thus far can be found here. Governor Wolf has released a website that details draft HHS unification legislation and organizational charts. The website also includes a way for the public to provide feedback.

Both chambers of the General Assembly and Governor Wolf are now expected to continue budget negotiations, with a final agreement expected before the next fiscal year begins on July 1st.

Threats to the Affordable Care Act and Medicaid Continue as AHCA is Revived

The U.S. House of Representatives has revived the Affordable Health Care Act (AHCA), its proposed legislation to repeal and replace the Affordable Care Act that also makes significant changes to Medicaid. The Bill is moving swiftly-- with a possible vote happening as soon as the first week in May. After not having enough support to bring the legislation to the floor for a vote last month, House leadership and the Trump Administration have been engaged in negotiations with Republican members of the Freedom Caucus and the more moderate Republican members of the Tuesday Group. Leaders from each of these groups have apparently struck a deal with the House leadership that resulted in the addition of a new Amendment to the AHCA that allowing states to opt out of several Affordable Care Act mandates: the requirements related to covering Essential Health Benefits and the protections for those with pre-existing conditions that prevents them from having to pay more for coverage based on their health conditions.

The drastic changes to Medicaid included in the original AHCA legislation remain. The Bill continues to phase out funding for Medicaid expansion by states (over 700,000 low-income Pennsylvanians are

currently covered through the state' s expansion) and drastically changes the way the federal government finances the Medicaid program that could result in states reducing benefits covered and limiting eligibility in the future. The Bill also increases the cost of Marketplace coverage for older adults as well as those with moderate incomes. The nonpartisan Congressional Budget Office (CBO) estimated that these aspects of the AHCA would reduce federal funding for Medicaid by $880 billion over ten years, and cause 24 million Americans to lose their health insurance coverage (including 14 million Medicaid enrollees).

Consumer advocates who have reviewed the latest changes to the AHCA have raised concerns that the new Amendment will take away access to fundamental health care benefits and will result in discrimination against those with pre-existing conditions. Analysis by the Center for Budget and Policy Priorities indicates that if states decide not to require coverage of Essential Health Benefits, health plans will likely again impose annual and lifetime limits on coverage. This is because the Affordable Care Act's prohibitions on annual and lifetime coverage limits apply only to Essential Health Benefits.

At this time, it is not known whether **all** members of the two groups involved in developing the Amendment will support the legislation. Senate Leadership has reportedly not been involved in the latest negotiations. If the revised AHCA legislation passes the House, it is not clear what its fate will be in the Senate or whether the latest revisions could be included in the budget reconciliation process that allows Senate passage with only 50 votes.

Even if the revived and revised AHCA does not pass, the threats to Medicaid will likely continue. President Trump is expected to release his FY 2018 Budget Proposal during the week of May 22nd and there is concern that it will include deep cuts to Medicaid and other critical safety net programs. The Administration has also signaled its willingness to allow states to pursue changes to how they administer their Medicaid program such as imposing work requirements for certain populations and increasing cost-sharing for covered services. The Administration has also indicated openness to easing existing federal Medicaid requirements related to benefits and eligibility.

Those wishing to express their opinion about the AHCA or concerns about Medicaid and its future funding are encouraged to contact their U.S. Representative and Senators.

Independent Enrollment Broker RFP Released for Bids

On April 7, 2017, the Pennsylvania Department of Human Services issued a Request for Proposal (RFP) seeking bids from entities interested in being the next Independent Enrollment Broker (IEB) for the state's Office of Long Term Living. The responsibilities of the IEB will include helping people choose and enroll into a Community HealthChoices plan and providing enrollment assistance to older adults and people with physical disabilities seeking long term services and supports through programs administered through the Office of Long Term Living.

There will be three regions for the IEB-matching the CHC regions (Southwest, Southeast, and the remainder of the State). Bidders can apply to be the IEB in just one region or in multiple regions. Bids are due May 22, 2017.

Prior to CHC starting in a region, the selected IEB will be responsible for taking applications from people applying for the following programs and shepherding these applications through the approval process:

- Aging Waiver
- Attendant Care Waiver
- Independence Waiver
- OBRA Waiver
- Act 150 Program

Once CHC is fully implemented in a region, the selected IEB will help participants enroll into the program. This involves helping them choose a CHC Plan and select a Primary Care Provider as well assigning certain people to a plan who failed to make an enrollment choice on their own. The IEB will also help people navigate the process to get long-term services and supports through CHC. Individuals who choose the LIFE Program will not be in CHC. Nonetheless, the IEB will assist consumers who are applying for long term services and supports through the LIFE Program and will continue to take applications for the OBRA Waiver and the Act 150 program. As a reminder, the OBRA Waiver will be the only OLTL Waiver that will continue to exist after CHC is fully implemented across the state. It will provide coverage to people age 18 through 20 with physical disabilities who meet program criteria as well as those age 21 and older who meet the OBRA level of care but who are not considered Nursing Facility Clinically Eligible.

Once the bids are received, DHS plans to move quickly through the selection process and hopes to choose the IEB so that it can begin work in July and operate alongside the current OLTL Independent Enrollment Broker (Maximus) during a transition period. Beginning January 1, 2018, the chosen IEB

in each of the three regions will begin to operate as the state's sole IEB. The chosen IEB(s) will have a three year contract with DHS that the state could choose to extend for an additional two years.

The final RFP did include changes from the draft RFP document the state issued last year for feedback and comments. DHS received almost 1,200 comments from 38 outside individuals or organizations including consumers, advocates, providers, and trade associations as well as 300 comments from people who work within the Department. Changes included:

- Adding training requirements to ensure that IEB staff are adequately trained and demonstrate knowledge and competence before providing services to consumers.
- Detailing the steps which the selected offerors must take and the time frames in which those steps must be taken to ensure that LTSS applications are processed within the federally required 90 days.
- Strengthening requirements to ensure that the selected offeror(s) effectively communicate with individuals with limited English proficiency (LEP) and track the use of translators for participants with LEP.
- Adding content and functions to the IEB website to enable individuals, their representatives, and other interested persons to learn about the available programs and the status of their LTSS applications.
- Adding reporting requirements that will enable DHS to effectively monitor the IEB's performance, and to identify and mitigate problems as they arise.

Community HealthChoices Update

At the April 27th meeting of its Medical Assistance Advisory Committee, the Department of Human Services (DHS) provided an update on Community HealthChoices (CHC). The Department is moving forward with contract and rate negotiations with the three selected plans: AmeriHealth Caritas, UPMC for You, and PA Health and Wellness. The Office of Long Term Living (OLTL) has also held implementation and readiness review meetings with the CHC plans. Representatives from those plans will be available to answer stakeholder questions at the Managed Long Term Services and Supports Subcommittee meeting on Wednesday May 3, 2017.

DHS released an infographic titled, *Understanding Community HealthChoices vs HealthChoices*, outlining the similarities, differences, eligibility requirements, and timelines for implementation for the two programs. Community HealthChoices will provide managed care for dual eligibles and long-term services and supports (LTSS) recipients, beginning January 2018 in the Southwest zone. Another infographic describing the transition from OLTL waivers (Aging, Attendant Care, Independence, OBRA) into CHC will be released early next month. The Department also is finalizing arrangements with an

entity called Aging Well to deliver at least 20 in-person orientation sessions to CHC participants in the Southwest zone, expecting there will be at least one session in each of the zone's 14 counties.

OLTL expects to submit its CHC Waiver application to the Centers for Medicare & Medicaid Services by April 28th. The Waiver application is a comprehensive document which the federal government must approve for Pennsylvania to move forward with CHC.

Once Pennsylvania submits its application, the federal agency has 90-days to make a decision. That 90-day clock can be extended if the federal government asks the state to clarify questions or concerns. Pennsylvania is required, among other things, to show that its Waiver will be cost effective, meaning that implementation of the Waiver will not cause expenditures to be higher than they would have been without the Waiver. Similarly the Waiver must be cost neutral, meaning that Pennsylvania must provide assurances that the average per capita expenditures for covered home and community based services under the Waiver will not exceed 100 percent of the average per capita expenditures that would have been made if the care had been provided in an institution.

Pennsylvania Continues to Take Action to Address the Opioid Crisis

Last month, Governor Wolf announced additional steps his administration is taking to stem the opioid crisis in the Commonwealth. Because Medicaid pays for various forms of Medication Assisted Treatment (MAT) for opioid use disorders (drugs such as buprenorphine and suboxone), the Governor has taken steps to ensure these medications are prescribed as needed and in coordination with other drug and alcohol and medical treatment a consumer may be receiving.

The March 6th press release stated that the state's Department of Human Services will:

- Require that all ordering, prescribing or referring providers who are identified on claims submitted to Medicaid be enrolled in the Medicaid program. This will prevent current providers who require cash payments from their patients and who are not enrolled in the Medicaid program from having their prescriptions filled at the pharmacy;
- Work with the Department of Drug and Alcohol Programs (DDAP) to stop the practice of providers accepting cash payments from their Medicaid patients;
- Audit and potentially disenroll providers from the Medicaid program who prescribe medications such as buprenorphine without an office visit;
- Encourage Medicaid Managed Care Organizations to terminate poor performing providers who

do not meet certain quality metrics;

- Implement standardized prior authorization guidelines for Medicaid managed care plans that are similar to those most recently implemented for the Medicaid Fee-For-Service Program; and
- Refer high-volume Medicaid providers with poor quality records to DHS' Bureau of Program Integrity for review and action.

The federal Medicaid rule requiring that **all** ordering, prescribing or referring providers be enrolled in Medicaid for services to be paid for by Medicaid is a mandate of the Affordable Care Act. Under the Governor's directive, DHS will focus particular attention to this rule as it relates to providers who are not enrolled in Medicaid yet who prescribe Medication Assisted Treatment to Medicaid patients for opioid use disorders. Treatment providers and advocates have expressed support for this rule and its implementation while at the same time noting their concern that if this rule is applied too quickly, Medicaid recipients will be unable to get the necessary medications such as buprenorphine, suboxone and naltrexone for their opioid use disorder. Federal rules already require that all doctors prescribing buprenorphine and suboxone be certified and limits the number of patients they are permitted to treat at one time. In the midst of the opioid abuse epidemic, Medicaid recipients may have difficulty finding a Medicaid doctor to treat them. If they can't obtain the necessary treatment, these individuals are at high risk for relapse and overdose.

Providers and advocates are urging DHS to proceed cautiously and to closely monitor this situation to ensure there are no unintended consequences of a swift enforcement of this Medicaid rule. Medicaid recipients who are having problems finding a Medicaid provider for their Medication Assisted Treatment or who are being denied access to this treatment because their physician is not enrolled in Medicaid are urged to call PHLP for assistance at 1-800-274-3258.

Information on the federal Medicaid rule regarding the enrollment of ordering, referring or prescribing providers can be found here: http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/c_224393.pdf

Policy Clarifications on Verifying Income Should Help Some People Applying for Medicaid or Renewing Benefits

Earlier this month, the Department of Human Services issued two policy clarifications to County Assistance Offices (CAO) addressing verification of income in certain situations. When people apply for Medicaid or renew their Medicaid benefits, they must complete a form and verify certain information they report on this form. Up until now, if the person reported having no income, or reported a loss of income, CAOs (who determine whether someone qualifies for Medicaid) have routinely required written verification of this information.

Verification of no income could include a letter from a friend or family member who may be providing someone with food or shelter or giving them financial assistance. If the person reported the loss of a job, verification could include a letter from the previous employer stating when the employment ended and when the last paycheck was issued. Sometimes getting this additional documentation is burdensome and it can even be a barrier to those applying for or receiving Medicaid benefits.

No Income Reported At Application or Renewal: According to the Policy Clarification, when someone applies for Medicaid and reports no income, the CAO caseworker must check income using all available electronic data systems. If these systems show no current income for the person, then no further verification information should be needed to process the application.

The CAO should only request additional information in situations where either the zero income reported by the applicant contradicts what the electronic data systems show, or when other information from the application or in the CAO case record calls into question the zero income reported by the applicant.

When someone on Medicaid is having her benefits renewed, the CAO should only be seeking verification of no income when that information contradicts their case record with the CAO or when the state's electronic data systems show different income information from what was reported at renewal.

Someone Loses a Job: When someone reports that their income from a job has ended, the Policy Clarification specifies the CAO should only request verification of this circumstance when information provided by the individual is incomplete, unclear, contradictory to information in the CAO case record, or contradictory to the state's electronic data systems.

Anyone denied or terminated from Medicaid or having trouble getting verifications requested by their CAO can contact PHLP's Helpline for assistance at 1-800-274-3258.

Accessing Prescription Medication When Moving from Medicaid to Medicare

Many of the calls to PHLP's Helpline come from people who are transitioning from Medicaid to Medicare coverage and who are experiencing problems trying to access services, particularly medications, or who need help understanding how to use their health insurance going forward. Most of these individuals will continue to have Medicaid as a secondary insurance to their Medicare. People that have both Medicare and Medicaid are called "dual eligibles".

When someone moves from Medicaid to having Medicare as their primary insurance, they lose their prescription drug coverage through Medicaid and instead must obtain their medications through a Medicare Part D prescription drug plan.* These individuals need to choose and enroll into a Part D plan - either a standalone Part D plan or a Medicare Advantage Plan with drug coverage. If they do not choose, they will be auto-assigned to a plan by Medicare. All dual eligibles will automatically get Full Extra Help from Medicare that will cover almost all of the cost of Part D coverage and limit co-pays to no more than $3.30/generic or $8.25/brand name for their Part D covered medications.

> * The only time the ACCESS card works at the pharmacy for those who are dual eligible is to cover certain over-the-counter medications that are not covered by Medicare Part D.

Limited Income Newly Eligible Transition (LI-NET) Program

One problem that people in this scenario can encounter is that even if they act quickly to enroll into a Part D plan, there may be a gap in their prescription coverage between when their Medicaid drug coverage ends and their Part D plan starts. This is where the LI-NET program comes in.

LI-NET is a "back-up" plan through Humana that provides temporary Part D coverage and is available to those who are on Medicare and who have Extra Help but who are not currently covered by a Medicare Part D plan. If these individuals go to a pharmacy and provide verification that they have Extra Help - either by showing their ACCESS card or their Extra Help award letter from Social Security - the pharmacist can bill LI-NET for the medication and the consumer should only be charged the modest Extra Help co-pays. If a pharmacist is unfamiliar with LI-NET, or needs help submitting a claim, she can call LI-NET at 1-800-783-1307. Written guidance on the LI-NET process can be found here.

Best Available Evidence Policy

Another problem that new dual eligibles (and others awarded Extra Help) may encounter is that the Medicare system, www.medicare.gov, has not yet been updated to show their Extra Help. These individuals may already be enrolled in a Part D plan but they are being charged deductibles and/or co-pays far beyond what they should have with Extra Help.

The Best Available Evidence (BAE) policy was created by Medicare to address this problem. Under this policy, anyone who is a dual eligible or who has been given Extra Help can submit verification of their circumstances to their Part D plan in the form of a Medicaid approval notice or an Extra Help award letter. Individuals can contact their Part D plan's member services to find out how to submit this information; this number can be found on the back of the Part D plan's member identification card.

Once the plan receives the information, it must provide the member with immediate access to medications at the lower Extra Help co-pay level. Then, the plan has 72 hours to update the Extra Help information in its system. It must also notify Medicare so that system can also be updated as well.

Any dual eligible encountering problems obtaining prescription medications or who is being charged excessive co-pays for their medications can contact PHLP for help at 1-800-274-3258.

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.

You can help

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