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## DHS Cancels Current HealthChoices Procurement

In response to a successful court challenge by Aetna Better Health, which stood to soon lose 180,000 members, the Department of Human Services (DHS) recently announced it would cancel all existing readiness review activities and reissue the HealthChoices' Request for Proposals. This effectively rewinds the contracting process for the state's physical health Medicaid managed care plans and starts the process over again.

Following an [order](#) from the Commonwealth Court of Pennsylvania granting Aetna's request for preliminary injunction, the Department's action will maintain the [existing Medicaid managed care plans](#) in the five HealthChoices Zones until the new procurement process is finalized. Aetna protested the use of a "secret criterion" in the initial procurement that improperly favored managed care plans with large, existing market shares.

DHS' action voids its [April selection](#) of physical health Medicaid managed care organizations (MCOs). The solicitation for bids was [re-issued](#) on July 21st, and the implementation date has been postponed to April 1, 2017. Proposals from interested insurance companies are due by August 22, 2016. The three-year contract period with the selected plans will begin April 1, 2017.

At recent meetings, state Medicaid officials emphasized that the pending quality and payment initiatives will still take effect on January 1, 2017. More information on the Value Based Purchasing proposal and Integrated Care Pay for Performance program can be found in the [October 2015 Health Law PA News](#).

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# Fiscal Year 2016-2017 Budget Enacted

In stark contrast to last year's nine month budget impasse, Governor Wolf and the legislature reached agreement on spending levels and revenue sources barely two weeks into the new fiscal year. While the details of the Medicaid program budget have not yet been released, the budget for fiscal year 2016-17 appears to maintain existing Medicaid service and eligibility levels. General fund expenditures for the Department of Human Services will increase 4.1% from \$11.51 billion to \$11.98 billion.

At the July meeting of the Consumer Subcommittee of the Medical Assistance Advisory Committee, state Medicaid officials highlighted \$15 million in new funding allocated to create "Centers of Excellence" for heroin and opioid addiction treatment. This allocation, which will draw \$5 million in federal matching funds, will be divided between the County behavioral health systems and the Medicaid managed care plans and will fund 20 new treatment centers. The Governor had sought \$34 million to create 50 new treatment centers. The initiative aims to improve both access and quality, by increasing the capacity of substance use disorder treatment facilities and by integrating medication-assisted therapy with physical and behavioral health supports. Facilities selected as a Center of Excellence will be required to create community-based care navigation teams and participate in learning networks.

Further details on the FY 2016-17 budget will be reported in the next issue of the Health Law News.

## Update on Suspension of Medicaid Benefits While Incarcerated

On July 8, 2016, Governor Wolf signed into law [Act 76](#), that, among other things, provides for suspension of Medicaid benefits for up to two years for people who are incarcerated, with automatic reinstatement upon their release. Medicaid benefits for this population are currently terminated, requiring them to make a new application when they are released from prison. As a result, these individuals often go without any health care coverage while they are waiting for their Medicaid benefits to be approved and that delays their ability to get needed physical and behavioral health care services.

As discussed in last month's newsletter, DHS staff are already taking action to help individuals leaving jail receive Medicaid benefits quickly such as [expediting applications](#) for those released from State Correctional Institutions. After Act 76 was passed, DHS officials reported plans to begin manual suspension of Medicaid when someone is imprisoned in mid-2017 and automated suspension for individuals in state custody in mid-2018. Stay tuned to future newsletters for updates!

# Attention Fee-For-Service Consumers: Make Sure Your Prescribing Doctors are Enrolled in Medicaid, Or Else Medicaid Will Not Pay

As many as 36,000 consumers using Fee-For-Service (FFS) Medicaid (the ACCESS card) could be affected by new rules changing how Medicaid pays for services **delivered** by Medicaid-enrolled providers but **prescribed** by non-Medicaid providers. Many of these individuals have other coverage such as Medicare or coverage through an employer and Medicaid is their secondary coverage.

Effective September 25, 2016, FFS Medicaid will no longer pay for services that are ordered, referred, or prescribed by a health care provider who is not enrolled in Pennsylvania's Medicaid program. Under new rules required by the Affordable Care Act, the prescribing or ordering provider **must** be enrolled in Medicaid in order for Medicaid to pay for the drug, test, device, or service being ordered.

This means patients who currently see a non-Medicaid doctor using Medicare or employer-sponsored insurance as primary coverage will no longer be able to use Medicaid to pay for any prescriptions, lab work, or medical devices ordered by that non-Medicaid doctor, **even if** the pharmacy, lab, or supplier providing the service accepts Medicaid.

This change will primarily impact dual eligibles (those with both Medicare and Medicaid) or those with employer-sponsored health insurance using Medicaid as secondary coverage. It could also affect consumers who pay out-of-pocket to visit a specialist or urgent care center that doesn't accept Medicaid. Come September 25th, these consumers could leave their doctor's office with prescriptions, only to find Medicaid will not pay to fill them. Even though dual eligibles receive most of their medications through Medicare Part D and Medicaid does not pay as secondary to Part D, this could impact Medicaid's coverage of certain over the counter prescriptions that Part D does not cover. It could also impact Medicaid's coverage of diabetic testing supplies such as test strips and lancets that are covered through Medicare Part B with Medicaid covering the remaining 20 percent.

Initially, this rule change only applies to FFS Medicaid recipients; however, beginning July 1, 2018, it will apply to those in Medicaid managed care plans as well.

At the July meeting of the Consumer Subcommittee of the MAAC, state Medicaid officials reported that they identified 36,000 FFS consumers with recent claims for services ordered by non-Medicaid providers. These claims are being flagged with a special edit warning consumers and providers that the services will no longer be covered after September 25th unless the prescribing or ordering physician enrolls in MA.

DHS is working with the Consumer Subcommittee to develop a mailing to all affected FFS consumers, and welcomed a suggestion by the subcommittee to place phone calls to consumers receiving high-intensity services such as dialysis, chemotherapy, hospice, and home healthcare, who could suffer dire health consequences if their care is disrupted.

Advocates should advise Medicaid recipients, particularly those who use Fee-for-Service Medicaid as secondary coverage, to confirm that all of their providers are enrolled in Medicaid. Recipients should also be encouraged to check when scheduling an appointment with a new provider to confirm that provider is enrolled in Medicaid. If the doctor is not enrolled and does not intend to enroll, FFS recipients can call the Medical Assistance FFS Recipient Service Center at 1-800-537-8862 to request a list of local providers enrolled in the Medicaid program. The [provider directory](#) maintained by the HealthChoices Independent Enrollment Broker is another good source for finding providers enrolled in Medicaid. While some of the providers listed in the managed care provider directory choose not to accept FFS recipients, all have enrolled in the Medicaid program.

## Pricey Hepatitis C Drugs a Tough Pill for DHS to Swallow

More than two months after it landed on his desk, a recommendation by the Pharmacy and Therapeutics (P&T) Committee that would provide thousands of Pennsylvanians with hepatitis C access to life-saving, but expensive, new drugs is still being considered by Department of Human Services Secretary Ted Dallas.

In May, the P&T Committee voted 10-7 to remove a requirement that Medicaid recipients must have liver damage before they can receive certain powerful new hepatitis C medications. These new drugs, which include Sovaldi, Harvoni, and Viekira Pak, have been shown to cure hepatitis C in over 90 percent of patients - a far higher cure rate than any other therapy on the market.

Unfortunately, the new drugs are astonishingly expensive. A single 12-week course of treatment can cost \$80,000 to \$120,000. Even with mandatory Medicaid rebates and other discounts, Pennsylvania reportedly still pays \$31,000-\$58,000 per patient for these medications. As a result, Pennsylvania's Medicaid program adopted liver damage requirements to restrict the use of the drugs to only the sickest patients.

The P&T Committee's recommendation to lift the liver damage requirement is consistent with current medical guidelines that recommend treating hepatitis C early in order to avoid long-term complications such as cirrhosis, liver failure, liver transplant, cancer, and kidney disease. Early treatment also prevents the spread of the virus to others.

State Medicaid officials recently confirmed that the P&T Committee's recommendation was still under review and there is no deadline by which a decision will be made. They acknowledged that the cost of the drugs will factor in to the Secretary's decision, and noted the cost of treating the 3500-4000 people currently on Medicaid with hepatitis C who meet the existing coverage requirements and are expected to receive these new medications this year is already more than the Medicaid program's entire budget for emergency department services.

It should be noted that other states and private insurers are slowly expanding access to these new drugs, often under the threat of litigation. Over the past 6 months, Medicaid programs in Florida, New York, Delaware, Massachusetts, and Washington have all lifted their liver damage requirements; Washington State's requirement was enjoined by a federal judge. Meanwhile, Medicare and the Department of Veterans Affairs, as well as a growing number of private insurers, have announced that they will begin covering the new drugs for all hepatitis C patients, regardless of liver damage.

## **Task Force Formed to Address Barriers to Substance Abuse Treatment in PA**

On May 16, 2016, [House Resolution 590](#) was passed by the General Assembly directing the Pennsylvania Department of Drug and Alcohol Programs (DDAP) to assemble a Task Force that would include representatives from several state departments, licensed substance use disorders treatment providers, and advocates. The purpose of the Task Force is: to review existing laws governing access to treatment; identify barriers to access; and issue a report to the General Assembly that lays out the barriers identified and recommends potential regulatory or other remedies to improve access to substance abuse treatment.

The Task Force will be reviewing existing laws in place, including:

- [Act 152 of 1988](#) (providing for Medicaid benefits for nonhospital detox and full continuum of treatment);
- [Act 106 of 1989](#) (mandating minimum treatment provisions by third party, private insurers in PA);
- [Act 65 of 1993](#) (providing for the establishment of residential drug and alcohol treatment programs for women who are pregnant or with dependent children);
- [Act 53 of 1997](#) (providing for the involuntary commitment of minors into drug and alcohol treatment); and
- [Act 198 of 2002](#) (requiring a portion of DUI fines collected be used in that county for substance abuse treatment).

The Task Force members have been selected and they will meet for the first time in August in Harrisburg.

HR 590 also directs DDAP to hold public hearings to obtain testimony from Pennsylvanians impacted by barriers to accessing treatment. The information gathered from these hearings, along with the regulatory review and analytical work of the Task Force, will inform a report to the General Assembly due by May 16, 2017 (one year from the date of HR 590's passage).

# Update on Funding for APPRISE

In our last newsletter we reported on a U.S. Senate committee vote to eliminate federal funding for the State Health Insurance Assistance Program (SHIP). Since then, a U.S. House Subcommittee took action and approved a massive spending bill that included \$52 million in funding for the SHIP program. The \$52 million maintains the current level of federal funding for SHIPs. Senior advocates, elder law attorneys and other organizations had urged the House leadership to restore SHIP funding. In Pennsylvania, the SHIP program is known as APPRISE. APPRISE staff and volunteers help Medicare beneficiaries understand and make choices about their Medicare coverage. They also help low-income beneficiaries apply for programs that help with Medicare costs.

The House Appropriations Committee is expected to approve the spending bill before the August recess. Once the full House and the full Senate vote on their spending bills, negotiations will begin to reconcile differences between the two bills. Advocates are cautiously optimistic that continued funding for SHIPs will be included in the final House-Senate agreement. Anyone concerned about continued funding for APPRISE is urged to contact their [U. S. Congressperson](#) to express their support for this important program.

## 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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