PENNSYLVANIA Health Law PROJECT

Health Law PA News

A Publication of the Pennsylvania Health Law Project

Volume 18, Number 7
July 2015

Statewide Helpline: 800-274-3258
Website: www.phlp.org

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DHS Announces Next Steps for MLTSS

Earlier this month, officials from the Department of Human Services (DHS) held a webinar to provide an update on their activities to develop Managed Long Term Services and Supports (MLTSS) for almost 450,000 Pennsylvanians. The stated goals of the MLTSS initiative are to improve quality, health outcomes, and service delivery.

Although the state continued to offer few details about its plan for MLTSS, officials did note during the webinar's question and answer period that they will follow the aggressive timeline proposed in their previously released Discussion Document. That means MLTSS will start in Southwestern Pennsylvania in January 2017. This is despite receiving consistent comments at every listening session that the state was moving too fast and that meaningful input from consumers and other stakeholders required a more careful and deliberate process. In addition, state officials responded that they have not made any changes to the target population identified in the Discussion Document nor to their intent that the program be mandatory.

Over 1,500 comments were submitted regarding MLTSS either through the public hearing sessions held in June or in writing as part of the public comment period related to the Discussion Document. PHLP submitted comments on behalf of our clients, the Consumer Subcommittee of the Medical Assistance Advisory Committee. In addition, PHLP submitted separate comments about designing a strong MLTSS appeals system and worked with the Pennsylvania Health Access Network (PHAN) and Project HOME to draft comments encouraging the inclusion of supportive housing services in Pennsylvania's MLTSS program.

Department staff are still analyzing comments and developing the details of how exactly MLTSS will work in Pennsylvania. The Department plans to release a "Requirements Document" in mid to

late August with more details. They also plan to continually update the information available on the MLTSS website, including posting a Question and Answer document.

New Activities Planned

As Pennsylvania continues to develop its plan for MLTSS, Department officials highlighted specific activities.

Creation of an MLTSS Advisory Committee: The Department intends to create another official Advisory Committee that will operate as part of the Medical Assistance Advisory Committee. At least half of the individuals selected for the MLTSS Advisory Committee will represent consumers impacted by MLTSS. The other half will represent stakeholders including long-term care providers and insurance companies. Citing potential conflicts of interest, PHLP and other advocates urged the state not to include insurers, or other organizations, that would be contracting with the state to deliver MLTSS services as part of the Advisory Committee while the system is developed. The Department expects the Advisory Committee to meet bi-weekly starting in September. Guidelines for participation are to be posted to the MLTSS website.

Monthly Webinars: The Department plans to hold monthly webinars about MLTSS. These will be held on the third Thursday of every month. Webinar information will be posted to the Department's MLTSS website.

Continued Opportunities for Stakeholder Input: Interested individuals can continue to offer input and ask questions via RA-MLTSS@pa.gov. There will also be public comment periods after the Requirements Document is issued in August and after the draft Request for Proposal is issued in the fall.

Other Activities: The Department is taking action on certain related areas of the long-term care system to quickly address concerns recently raised by stakeholders:

- *Nursing Home Transition (NHT)*: NHT assists consumers who want to move from a nursing facility back to a home of their choice in the community. The Department staff assigned to work on NHT will increase from five to ten people. In addition, the state is examining the current NHT system to determine how it can be improved.

- *Financial Management Services*: Individuals who use the consumer directed model for their waiver services (where they hire, train, and supervise the people who provide their personal care assistance) use Financial Management Services (FMS) to handle payroll and other paperwork associated with hiring their own workers. Right now, one FMS Provider serves the entire state: Public Partnership Limited or PPL. In November, the Department will issue a new Request for Proposal requiring FMS providers to have a regional presence in Pennsylvania. The Department also plans to choose multiple FMS providers so consumers have choice. The Department plans to continue the consumer directed service model under its MLTSS program but it is not clear how FMS would be delivered.

- *Independent Enrollment Broker*: The Department is in the process of selecting an entity to determine eligibility and enroll consumers into the Aging, Attendant Care, COMMCARE, Independence, and OBRA Waivers as well as into the Act 150 program. Currently, Maximus is the enrollment broker across Pennsylvania for all of these programs except for the Aging Waiver. During the webinar, the Department an-

nounced its intent to award a new contract in November 2015 and to have a regional contract (four regional lots) rather than the current statewide contract. Again, it is not clear what role the Independent Enrollment Broker will play in any MLTSS program the state is developing.

- *Home Modifications:* The Department plans to issue a Request for Proposal in August to begin a broker model for home modification services now available under many of the waiver programs administered by the Office of Long Term Living. The broker will contract with providers that will actually do the work to complete the home modifications. The Department plans to choose two brokers to operate in each of the five HealthChoices regions across the state.

More information about these activities can be found here. Readers interested in MLTSS are encouraged to check the Department's MLTSS website regularly for updates and continue to provide input and ask questions. Stay tuned for updates in future newsletters!

Final Phase of Traditional Medicaid Expansion Begins

Governor Wolf's transition plan for ending *Healthy PA* and instead launching a traditional Medicaid expansion continues with its final phase this month. The transition started in April when the single Adult Benefit Package began and adults newly approved for Medicaid were no longer placed in the Private Coverage Option (PCO). In addition, approximately 108,000 individuals were moved from Private Coverage Option plans to the Health Choices Managed Care system. In Phase Two, which started July 27, 2015, the 79,272 adults still remaining in Private Coverage Option plans began to transition to the HealthChoices managed care delivery system. As of September 1, 2015 this transition should be complete and the Private Coverage Option will no longer exist.

What Happens During Phase Two?

Starting the last week of July and through the end of August, all remaining PCO enrollees will receive coverage through both PCO **and** Medicaid fee-for-service (ACCESS) until they transition to a HealthChoices Plan on September 1st. DHS mailed a notice explaining these changes to affected individuals in late July. During the transition period, individuals will continue to use their PCO coverage for most health care services but will also have additional coverage through the ACCESS card for benefits not covered through PCO, such as dental coverage and non-emergency medical transportation.

To find a dentist who accepts the ACCESS card, consumers should try calling dentists listed in the "Find a Doctor" section of the PA Enrollment Services website. Dentists listed in this database accept Medicaid managed care but not necessarily the fee-for-service ACCESS card, yet it is still the best available resource. To obtain medical transportation, consumers must register with the Medical Assistance Transportation Program (MATP) vendor for their county. For more information, see the MATP website.

All PCO enrollees who had not previously been sent an ACCESS card will receive one. People can also request a new ACCESS card, if needed, by calling the Pennsylvania Customer Service Center at 1-877-395-8930. Begin-

ning September 1st, these individuals will then be enrolled into a HealthChoices managed care plan. If consumers wish to choose their HealthChoices plan, they must do so **before August 13th** to be in their preferred plan by September 1st. Otherwise, consumers will be assigned to a plan; if possible, they will be assigned to the same plan a family member already has or to a plan that is operated by the same company as their PCO plan. To choose a HealthChoices plan, consumers can go to www.enrollnow.net or call 1-800-440-3989. Consumers who have an open prior authorization with their PCO plan should have that prior authorization honored by their new HealthChoices managed care plan for up to sixty days.

Anyone having a problem with the Phase Two transition should call PHLP's Helpline at 1-800-274-3258.

"One Set Per Lifetime" Dentures Limit Reset

Recent changes to the Medicaid benefit package will allow more beneficiaries to obtain dentures. In undoing his predecessor's *Healthy PA* initiative, Governor Wolf simplified Medicaid expansion and enacted a new Adult Benefit Package. The Adult Benefit Package, which went into effect in April, replaced three different benefit packages for adults and removed a number of benefit limits, such as the six drugs per month pharmacy limit. Even though the new Adult Benefit Package still includes the dental benefit limits that started in 2011, including the "one per lifetime" limit on dentures, the dental benefits were effectively "reset" when the system updated in April to start the new Adult Benefit Package.

In practice, this means that Medicaid consumers who need dentures can now receive them under normal prior authorization guidelines, even if Medicaid covered full or partial dentures for the consumer in the past. A consumer who gets dentures paid for by Medicaid after April 2015, and then needs another set in the future, will have to meet the more restrictive "Benefit Limit Exception" (BLE) criteria in order to get the second set of dentures covered. (For more information on BLEs, see the January 2012 Health Law News.) Recent guidance issued to Medicaid managed care plans clarified that this change applies to Medicaid consumers in Fee-for-Service (ACCESS) **as well as** consumers in the HealthChoices system.

Dental services covered by Medicaid for adults include exams, x-rays, cleanings, fillings, and extractions. Exams and cleanings are limited to two times per year. One set of dentures are covered. Root canals, crowns, and deep cleanings are only covered if a Benefit Limit Exception is approved. For a full listing of benefits and limits contained in the Adult benefit package, see the "Consumer Resources" section of healthchoicespa.com.

New Guidelines for Hepatitis C Medications

Medicaid consumers will soon be able to more easily access the highly effective and highly expensive medications now available for treating Hepatitis C. Through revised prior authorization guidelines now in effect, the Department of Human Services (DHS) relaxed the coverage criteria for the medications Sovaldi, Harvoni, and Viekira Pak.

Hepatitis C is transmitted mostly through blood-to-blood contact. It usually progresses very slowly, and it can take decades before symptoms appear. Of the more than 3 million Americans infected with Hepatitis C, many, if not most, don't know they have it. Treatment options other than Sovaldi, Harvoni, and Viekira Pak can be extremely uncomfortable.

Following the recommendation of DHS' Pharmacy and Therapeutics Committee, the new guidelines relax the liver damage severity requirement and no longer require recipients to have abstained from drug or alcohol use for six months prior to treatment. Consistent with the medical literature and national and international guidelines, the new guidelines require only that documentation show that Medicaid consumers who are actively abusing alcohol or using intravenous drugs were counseled by their prescribing doctor about the risks of their abuse and offered a referral for substance use disorder treatment.

While these guidelines only apply to consumers in Fee-for-Service Medicaid (ACCESS), Department officials confirmed that they expect the HealthChoices managed care plans will revise their own prior authorization criteria for Hepatitis C medications so that they are substantially similar to the new DHS guidelines. Consumers who experience a problem accessing Sovaldi, Harvoni, and Viekira Pak because their Medicaid managed care plan is applying more restrictive coverage criteria are encouraged to call PHLP's Helpline at 1-800-274-3258.

AIDS Waiver Ending: Participants Moving Into Other Waivers

At the June meeting of the Consumer Subcommittee of the Medical Assistance Advisory Committee, officials from Department of Human Service's Office of Long Term Living (OLTL) announced that Pennsylvania's AIDS Waiver is being phased out. OLTL officials noted that they have been evaluating this waiver at the request of the federal Centers for Medicare & Medicaid Services because of major discrepancies in the reported data between the number of persons enrolled in the waiver versus the number of service claims being submitted for payment. OLTL discovered that only 52 individuals with AIDS or symptomatic HIV are actively being served under the AIDS Waiver, almost all of whom were using personal assistance services.

Given the small number of active participants, the state and federal government decided to end this waiver at the end of September 2015. All current participants have been contacted and are being transitioned to a different OLTL Waiver program— Aging, Attendant Care or Independence— as appropriate. OLTL anticipates the transitions will be completed by the time the AIDS Waiver ends in September.

DHS Releases Summary of HealthChoices RFI Responses

In advance of issuing a Request For Proposal to insurance companies seeking to take part in Pennsylvania's Medicaid managed care program (called HealthChoices), Department of Human Services (DHS) officials recently released a request to the general public seeking ideas and strategies for improving the state's HealthChoices program (see our May newsletter). In late July, DHS released a summary of the suggestions it received in response to this Request for Information.

In the document summarizing the major themes and comments it received, DHS states that it is considering making the following changes to its contract with Medicaid managed care plans:

- Setting targets for value-based payments;
- Encouraging the use of Accountable Care Organizations;
- Increasing value-based purchasing and pay for performance;
- Encouraging patient-centered medical homes;
- Improving access to quality care; and
- Streamlining the provider experience.

DHS invites further comment on the concepts and ideas summarized in this document, which is available here. Consumers, advocates, and other interested stakeholders have until **August 10, 2015** to submit additional suggestions and comments regarding the HealthChoices program. Responses should be submitted electronically to RA-PWHCRFIResponses@pa.gov.

Key Affordable Care Act Considerations in Family Court for Medicaid and CHIP

More children and parents now qualify for coverage through Medicaid and the Children's Health Insurance Program (CHIP). In addition, households with income above the limits for Medicaid and CHIP may qualify for financial help to buy coverage through the Health Insurance Marketplace.

Family Courts are in a unique position to ensure that children and their parents have access to health insurance. Family court judges, masters, and conference officers are frequently in the position of determining which parent is responsible for obtaining health insurance coverage for a child. The availability of Medicaid and CHIP can also impact a family court's determination of custody and child support for the child.

PHLP recently published a manual to help family court judges better understand health care coverage options. Hard copies of the manual will be distributed to all Pennsylvania family court judges, and will be posted on www.phlp.org. In this newsletter, we highlight some basic information about Medicaid and CHIP from that manual that may help our readers.

Custody

Generally, the parent with primary custody must submit an application or a renewal for Medicaid or CHIP coverage on behalf of their child. Custody orders can also impact household size and composition as it relates to qualifying for coverage through these programs.

Household Size

Eligibility for Medicaid and CHIP depends on household size and income. A change in custody will alter who is counted in a recipient's household, and whose income counts in determining eligibility.

Non-Parent Custodians

Generally, for Medicaid and CHIP, a child's household is the tax household. When non-parents are granted custody, such as when a grandparent has custody of a grandchild, an exception applies. Regardless of whether the non-parent custodian claims the child on his or her taxes, the household for the child in these cases is the child and any siblings, stepsiblings, parents or stepparents living with them, but it does not include the non-parent custodian or that custodian's income.

Support

Child support is not counted as income for children (under age 19) when determining their eligibility for Medicaid or CHIP. However, support orders often include decisions about which parent is to provide health insurance for the child, and which parent will claim the child on their taxes. These decisions can have an impact on a child's eligibility for CHIP and Medicaid.

Health Insurance

Courts must decide which parent should provide health insurance, and will often order the non-custodial parent to provide the child's insurance. However, as noted above, only the custodial parent can apply on behalf of a child for Medicaid or CHIP. If the non-custodial parent does not have access to employer sponsored insurance to cover the child, he or she will not be able to turn to Medicaid or CHIP and may need to purchase insurance through the Marketplace to cover that child.

Tax Dependency

Absent a court order to the contrary, the parent with primary custody claims the child as a tax dependent. Often, however, child support orders will allow the non-custodial parent to claim the child as a tax dependent instead. In that case, the household size used to determine the child's eligibility for Medicaid and CHIP will not be based on the tax household. Instead, the child's household will include their custodial parent, as well as any siblings, stepsiblings and stepparents living with the child.

Families with children who are denied Medicaid or CHIP (or who are being terminated from these programs) can call PHLP's Helpline (1-800-274-3258) for advice and assistance.

PA Chooses 2017 Benchmark Plan– But There Are Concerns About Coverage for Habilitative and Rehabilitative Services

The Affordable Care Act requires periodic review of the essential health benefits (EHBs) that must be covered by individual and small group plans. That means each state must have a benchmark plan that establishes minimum essential health benefits offered by these insurance plans. Pennsylvania's current benchmark plan (offered by Aetna) was established in 2012 for plans effective 2014 - 2016. The Pennsylvania Insurance Department recently selected Keystone Health Plan East (offered by Independence Blue Cross) as its 2017 Benchmark Plan.

The selection of Keystone Health Plan East (KHPE) as the benchmark plan does **not** mean consumers have to become Independence Blue Cross members and it will **not** impact the choice of insurance carriers and scope of insurance products available to Pennsylvania consumers. All of the insurance carriers in Pennsylvania must use Keystone Health Plan East as a **blueprint** to design their own benefit packages, and while they are allowed some variation, the value of each insurer's benefit package has to be equal to the benchmark plan.

PHLP submitted joint comments with individuals, family members, and disability advocacy organizations regarding the proposed Benchmark plans for Pennsylvania. Collectively, this group believed all of the plans offered as possible Benchmark options fell short of meeting the needs of people with significant health issues and disabilities. PHLP and other disability advocacy organizations are concerned about using Keystone Health Plan East as the Benchmark, especially for habilitative and rehabilitative services. Although the KHPE definition of habilitative services is not as comprehensive as advocates would like, it does appear similar to the federal definition. However, KHPE's definition fails to include devices; an alarming omission because federal rules require plans to cover devices for both rehabilitative and habilitative services.

Another concern relates to coverage for physical and occupational therapy. Under the KHPE plan, coverage for physical and occupational therapy is limited to a total of 30 visits. A number of commenters suggested that this combined visit limit did not meet federal requirements and argued instead that a benchmark plan should have no limits or, at minimum, should cover 30 physical therapy visits and 30 occupational therapy visits.

Despite these limitations, the Benchmark plan is the **minimum** standard individual and small group plans must meet in 2017. Insurers can offer a more robust benefit package and disability advocates are hopeful that they will.

Trying to Get ABA Services for a Child with Autism? Share Your Story!

The ABA in PA Initiative, an autism advocacy group, seeks stories from families trying to get Applied Behavioral Analysis (ABA) therapy for their children with autism to assist in their efforts to ensure access to ABA via Pennsylvania Medicaid. The ABA in PA Initiative is an advocacy organization made up of parents, industry professionals, and advocates dedicated to changing the future for all children in Pennsylvania with Autism Spectrum Disorder by seeking to have Medicaid cover ABA therapy as a distinct service. Applied Behavior Analysis is a science in which processes are systematically applied to improve socially significant behavior to a meaningful degree. An ABA therapy program is a systematic teaching approach that involves breaking skills down into small, easy-to-learn steps. Praise or other rewards are used to motivate the child, and progress is continuously measured so the teaching program can be adapted as needed. ABA is endorsed for autism by the American Academy of Pediatrics and the U.S. Surgeon General and is widely recognized as the single most effective treatment for children with autism spectrum disorder.

If you have a story regarding your efforts to obtain ABA treatment for your child, click here for more information about sharing your story.

Comments Sought on Adult Autism Waiver

Pennsylvania's Bureau of Autism Services seeks comments on changes it is considering to the Adult Autism Waiver as part of the required renewal of this waiver. Comments need to be received by **Friday, August 7th**. The Bureau is particularly interested in the following:

Interest List Prioritization - Application for the Adult Autism Waiver is made by calling a special number at the Bureau of Autism Services. Callers (or their family member) are placed on an "interest list" in the order in which they called. When a waiver slot opens up, the person who was on the lnterest List the longest is interviewed to determine their age and what services, if any, they are currently receiving. If that individual is at least 21 and not receiving services, they will invited to apply for that open waiver slot. Unlike the PFDS and Consolidated Waivers, someone's position on the Autism waiver list is not determined by the urgency of that person's need for services.

The Bureau seeks input about whether it should continue this first come-first served approach or prioritize applicants based on the urgency of their need for services. Some self-advocates currently on the waiver argue that prioritization based on urgency of need might deprive individuals of services if their needs are less obvious. Others argue that keeping the first come-first served system makes it impossible for the Bureau to use waiver slots to avoid an imminent institutionalization or to get people out of institutions. A hybrid approach, designating some percentage of slots as first come-first served and the rest based on urgency of need, is another possibility.

The Bureau is also considering allowing people who reach the top of the list before they turn 21 (the minimum age for the Adult Autism Waiver), to stay at the top of the list, if they are at least 18, until they reach age 21.

Changes to Services - The Bureau is interested in input on a number of service proposals:

- Changing the Job Finding service from obtaining "paid and volunteer work" to only "obtaining paid work".
- Creating a new category of staff covered under the waiver entitled "Skill Building Specialist". This person would specify instructional methods for supporting the individual's acquisition of skills.
- Adding "Personal Assistance" as a covered service. However, the Bureau is proposing that this service be subject to the combined 50 hour a week limit that currently applies to Community Inclusion, Day Habilitation, Supported Employment, and Transitional Work Services. Imposing this limit would undermine the usefulness of Personal Assistance services for individuals living independently who already use most of their 50 hours for day activities under the 4 services listed above. The Bureau is seeking comments on the 50 hour a week limit as well.
- Adding "Non-medical Transportation" to community activities that are not a part of Community Inclusion, Day Habilitation, Supported Employment, Transitional Work Services or Residential Habilitation.
- Increasing training requirements and raising reimbursement rates.

Comments should be sent to Lea Sheffield, Bureau of Autism Services, at c-lsheffie@pa.gov and Erica Wexler at c-ewexler@pa.gov by Friday, August 7th.

See you in the fall!

As in previous years, PHLP will not publish an August newsletter. We will return to our regular monthly publication schedule in September. If necessary, we will issue a special alert to all newsletter subscribers in the event of news that cannot wait until our next newsletter. Enjoy the rest of the summer!

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.

Support Our Work

Please support PHLP by making a donation on our website at phlp.org. You can also donate through the United Way.

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.

PHLP: Helping People in Need Get the Health Care They Deserve