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In This Issue

Pennsylvania Pursuing Major Changes to Medicaid Coverage of Waivers and LTC Services — Comments Due July 15th!

Pennsylvania's Department of Human Services (DHS) and Department of Aging (PDA) issued a "discussion paper" describing their intent to combine coverage of services currently offered through certain Home and Community Based Service Waiver programs and through nursing facilities, with Medicaid coverage of both medical and behavioral health services as well Medicare coverage (for persons who are dually eligible for both Medicare and Medicaid). These combined services would be administered by Managed Care Organizations (MCOs) who will submit bids after the state issues a Request for Proposal, scheduled for October. Pennsylvania is calling this proposal Managed Long Term Services and Supports (MLTSS).

Shortly after releasing the discussion paper, state officials held public hearings across Pennsylvania in June to provide some basic information about the MLTSS initiative and to gather input from people who would be impacted by the changes—especially consumers currently receiving long term care services. We provide readers with some basic information about Pennsylvania's plans based on the information available so far.

Enrollment

The following people would be required to enroll in these combined-service managed care plans:

- Persons age 21 and older who are eligible for both Medicare and Medicaid (dual eligibles). There are currently 422,000 dual eligi-

bles in Pennsylvania, but only 104,000 of these individuals receive long term care services;

- Persons age 18 and older who are "nursing facility clinically eligible" and receiving services in a nursing facility or through the following OLTL Waiver programs: Aging, Attendant Care, CommCare and Independence. DHS is undecided whether people in the OBRA Waiver would also be put into managed care plans (they are not considered "nursing facility clinically eligible" since the program uses a different level of care standard); and
- Persons in the Act 150 program (which provides attendant care services to persons not eligible for a Waiver program).

The Consolidated, Person Family Directed Supports (PFDS), and Adult Autism Waivers as well as the Adult Community Autism Program (ACAP) would **not** be part of this new system. Also, persons with Intellectual Disabilities who are not enrolled in an OLTL Waiver program would be exempt from MLTSS enrollment.

Coverage

As with Pennsylvania's current HealthChoices program, MCOs would recruit providers for their respective networks and enrollees would need to use providers in their plan's network, unless they obtain permission to use an out-of-network provider. Unlike current HealthChoices, MCOs would not only be responsible for having a network of medical providers (e.g., hospitals, doctors, labs, home health agencies) but also behavioral health providers (e.g., psychiatrists, psychologist, mental health therapists) as well as providers of long term services and supports. This is very different from the current Medicaid program where behavioral health coverage is "carved out" into a separate managed care system, and both the Waiver system and nursing home care operate separately from managed care.

MCOs would also be responsible for providing Medicare covered services to Pennsylvanians dually eligible for Medicare and Medicaid. Thus, it is likely MCOs would need to be enrolled in Medicare as Medicare Advantage Special Needs Plans. It is less than clear whether a managed care insurer would operate both a Medicare Special Needs Plan and a separate Medicaid plan that would include coverage of long term services and supports or whether all coverage will be combined under one plan.

MCOs would be responsible for assessing the needs of their enrollees—i.e., medical, behavioral and functional - then determining the type and amount of services they will cover. Individuals will be able to appeal their plan's decisions related to coverage of services. It is unclear how people would apply for Home and Community Based Services under the new system and whether the eligibility criteria for the current Waivers would remain.

Providing Input About Pennsylvania's Development of the MLTSS System

DHS and PDA seek comments and suggestions on their discussion paper, which is purposely vague on some of the basic concepts. It is especially critical that the state hear from people who will be required to enroll in the MLTSS program as well as their caregivers.

The discussion paper can be found at: www.dhs.state.pa.us/ForAdults/ManagedLongTermSupports. DHS recommends that comments be made using the template found in Appendix A of the discussion paper. **Comments are due by July 15th!**

Comments can be made via email to RA-MLTSS@pa.gov or by phone at (717) 783-8412 or using the Pennsylvania AT&T Relay Service at (800) 654-5984 (TDD users) or (800) 654-5988 (voice users). Written comments should be mailed to:

April Leonhard
Department of Human Services
Office of Long-Term Living
Bureau of Policy and Regulatory Management
P.O. Box 8025
Harrisburg, PA 17105-8025

PHLP will post our concerns and recommendations on our website, www.phlp.org, before the July 15th deadline.

Supreme Court Ruling Upholds Health Care Subsidies for Pennsylvanians

On June 25th, the U.S. Supreme Court issued its decision in *King v. Burwell* and ruled that individuals who receive tax credits and subsidies to buy insurance through the federal Marketplace (HealthCare.gov) can continue to receive this help. As a reminder, the Affordable Care Act expanded health care coverage options by allowing individuals to buy insurance through either a state-run exchange or one run by the federal government and receive tax credits and subsidies to lower the cost of this insurance. Individuals use the federal Marketplace when they live in a state, like Pennsylvania, that does not operate its own state-run exchange.

The petitioners in *King v. Burwell* argued that the language of the Affordable Care Act (ACA) only allows tax subsidies to be provided to people who purchase health insurance through "an Exchange established by the State". Furthermore, they maintained that an IRS issued rule that permitted subsidies through federally established exchanges contradicted the Act and therefore should not stand. However, the Supreme Court ruled that the overall goal and structure of the ACA indicated the intent for tax subsidies to be supplied through both state and federal exchanges.

The Supreme Court ruling is especially relevant to Pennsylvania since almost 349,000 residents currently have insurance through the federal Marketplace and receive some level of tax subsidy to help them pay for their coverage. Shortly after the decision was released, Governor Tom Wolf announced that Pennsylvania would withdraw its contingency plan to create a state-run exchange (see next page). This means that Pennsylvanians will continue purchasing health insurance coverage through HealthCare.gov and, if eligible, receive tax credits and subsidies. In addition to the positive impact for Pennsylvanians, nearly 8.7 million Americans will continue to have access to affordable health insurance coverage as a result of the Supreme Court's decision.

Pennsylvania Ends Plans To Set Up A State Exchange After *King v. Burwell* Ruling

Just hours after the Supreme Court issued its ruling in *King v. Burwell*, where it upheld subsidies for insurance purchased through the federal Marketplace, Governor Tom Wolf announced that Pennsylvania would no longer pursue setting up its own state-run exchange. "I am extremely pleased with the Supreme Court's ruling in *King v. Burwell*," Wolf said in a statement. "I took steps to protect Pennsylvania's consumers by putting in place a contingency in the event the Supreme Court ruled people are not eligible for subsidies, but I am pleased to say that we will no longer need to rely on this plan."

Pennsylvania was one of three states in the process of setting up its own exchange in case the Court ruled that people living in states relying on the HealthCare.gov marketplace would no longer be eligible for federal subsidies under the Affordable Care Act. Officials in the other two states, Delaware and Arkansas, confirmed that they still intend to set up their own state-run exchanges despite the recent ruling.

Discussion of a state-run marketplace in Pennsylvania initially began under the Rendell administration, but ended when Governor Corbett took office in 2011. Although state-run exchanges allow for greater local autonomy, some states have struggled with the cost of implementing the necessary technology and infrastructure. If Governor Wolf had decided to go ahead with his preliminary plans for a state-run exchange, he would likely have had to convince the Republican-led General Assembly to approve funding.

CMS Proposes New Rules for Medicaid Managed Care

On June 1st, the Centers for Medicare & Medicaid Services (CMS) published a Notice of Proposed Rule Making to update federal managed care regulations for Medicaid and for the Children's Health Insurance Program (CHIP). This is the first update of these managed care regulations since 2002.

The proposed rules support CMS' mission of *better care, smarter spending and healthier people.* The key principles of the proposed rule making are to: provide better alignment with other insurers, particularly Marketplace and Medicare Advantage plans; create delivery system reform; improve beneficiary protections; modernize regulatory requirements; and improve quality of care.

The federal government is required to seek comments about the proposed rules from various interested parties. All comments are reviewed and then final rules developed. Once the final rules are issued, state Medicaid and CHIP programs must comply with them. States can continue to be more flexible but cannot be more restrictive than the final rules.

Comments to the proposed rules are due to CMS by July 27, 2015.

PHLP is reviewing and analyzing several areas that will affect consumers: definitions and measures of network adequacy; beneficiary supports such as counseling for enrollees as they choose a managed care plan; and new rules related to grievances and appeals. PHLP plans to post its comments to our website before the

July 27th deadline. The following is a description of the areas we see as most ripe for comment by advocates.

Network adequacy

In the proposed rules, CMS says states must develop standards to ensure that managed care plans have adequate provider networks. For certain provider types, such as primary care, OB/GYN, hospital, and some specialists, states are required to establish time and distance standards. While CMS does not prescribe specific access standards, it does require states to establish their specific access standards for medical, behavioral, and Managed Long Term Services and Supports (MLTSS). Pennsylvania currently has travel time and distance standards for primary and specialty care but these alone may not be sufficient. CMS will require states to annually certify that managed care networks are sufficient to assure access to care for enrollees and will require states to have an external quality review that includes direct testing of the plans' networks.

Improving Quality of care

In the proposed rules, CMS requires quality improvement standards for Medicaid (including managed care, fee-for-service, and MLTSS) as well as CHIP. In addition, the managed care plans must:

- Conduct performance improvement projects;
- Collect and submit performance measurement data;
- Have mechanisms to detect underutilization and overutilization of services and mechanisms to assess the quality of services;
- Have mechanisms to assess the appropriateness of care for enrollees with special health care needs;
- Have mechanisms to assess the quality and appropriateness of care for enrollees using long term services and supports; and
- Participate in efforts by the state to prevent, detect, and remediate critical incidents, based on applicable state standards for Home and Community Based Waiver programs.

CMS also proposes that states seek public input as they develop core measures and performance improvement projects.

Beneficiary supports and accessibility

The proposed rules require managed care plans to provide certain beneficiary supports, including making MCO information available and accessible to beneficiaries, and providing choice counseling before and after plan enrollment as well as when an enrollee changes plans or at renewal. Choice counseling is described in the proposed rules as unbiased information and facilitated enrollment provided by entities without a conflict of interest. Currently, choice counseling is done by Pennsylvania Enrollment Services to help people in Pennsylvania choose and enroll in a HealthChoices physical health MCO.

Important plan information like provider directories, member handbooks, appeal and grievance notices and other notices that are critical to obtaining services must be made available in English and other prevalent Non-English languages. The proposed rule does not provide a methodology for identifying prevalent languages besides English, but instead leaves it to the states to determine an identification method. All information must be available by paper, phone, in person and electronically and also be available in formats accessible for people with disabilities. The proposed rule requires the state to operate a website where

important information like member handbooks, provider manuals, and provider directories will be kept up-to-date.

Enrollment and Disenrollment

Under the proposed rules, newly-eligible Medicaid beneficiaries are given at least 14 days to choose a managed care plan before being auto-enrolled. Once enrolled, the proposed rules only require that states provide individuals one opportunity to change plans within the first 90 days of their enrollment. Pennsylvania's current policy is more generous and allows people in Medicaid and CHIP managed care to change plans at any time.

Grievances and Appeals

Under the proposed rules, managed care plans are only required to offer their enrollees one level of internal appeal. In addition, enrollees must exhaust that internal appeal process before they can seek a Fair Hearing from the state. Pennsylvania law currently requires managed care plans to offer **two** levels of internal appeal and enrollees are not required to exhaust the plan's internal appeal process before they request a Fair Hearing.

The proposed rules set out a universal appeal deadline of 60 days from the notice of the adverse benefit determination. They also make some changes to the availability of benefits while an appeal is pending. Specifically, enrollees can continue receiving benefits if they file an appeal either within 10 calendar days or prior to the effective date of the determination **and** if the enrollee requests an extension of the benefits. In Pennsylvania, the enrollee does not need to request an extension of benefits and instead benefits continue automatically if an enrollee files an appeal within 10 days of the adverse benefit decision. In addition, under the proposed rules, it seems that benefits would continue (when requested) until one of the following occurs: the enrollee withdraws the appeal; ten days pass after the managed care plan has sent notice of appeal resolution, unless the enrollee has filed a request for a State Fair Hearing within that 10 day period and requested continued benefits; a State Fair Hearing Officer issues a decision adverse to the enrollee.

Individuals interested in viewing PHLP's comments to these proposed rules should check our website before the end of July or contact Laval Miller-Wilson for more information.

Changes Coming to Family Planning Services

The Department of Human Services (DHS) announced it will file a State Plan Amendment to change eligibility and coverage for family planning services under Medicaid. The changes will take effect July 1, 2015. The new program will be called Family Planning Services.

Essentially an expansion of the SelectPlan for Women program, the new Family Planning Services program ensures coverage of family planning continues and includes the following important changes:

- In addition to women and teens, men will be able to receive family planning services;
- There is no longer an age limit to qualify;
- The income limit increased slightly to 215% of the Federal Poverty Level ($2,109/month for a single person and $4,345/month for a family of four);
- Expansion of services covered to include colposcopy, HPV vaccinations, and vasectomy. The program will continue to cover family planning counseling and services, birth control prescriptions and supplies, STD testing and treatment, and lab tests.

Individuals who receive coverage for family planning services will be able to seek services from any provider that accepts Medicaid.

Women currently enrolled in SelectPlan will automatically be enrolled into either Medicaid or the Family Planning Services program in upcoming months (between July 1st and October 1st). Women with income at or below 138 percent of the Federal Poverty Level will be enrolled in Medicaid. Women with income above 138 percent will be enrolled in Family Planning Services. DHS will be sending letters to SelectPlan enrollees over the next few weeks to explain the transition and the services available through the new Family Planning Services program.

Anyone who applies for Medicaid or Family Planning Services after July 1st will be screened for Medicaid eligibility first and enrolled if they qualify. If they do not qualify for Medicaid, but indicate a need for Family Planning Services, they should be enrolled in that program. For now, individuals who are interested in the Family Planning Services program can indicate this in the comment section toward the end of the online application available through COMPASS. System changes are scheduled to take effect in October so that applicants will no longer need to specifically ask to have their eligibility for Family Planning Services reviewed.

For more information, see DHS' website on the Family Planning Services program here.

New PHLP Publication Explores MAWD vs. Marketplace Coverage for Persons with Disabilities

Thanks to support from the Pennsylvania Developmental Disabilities Council, PHLP created a publication, *MAWD or Marketplace? – What Pennsylvanians with Disabilities Need to Know about Choosing Health Insurance Coverage*, to help consumers, family members and health care navigators understand and choose between these two options. Generally, MAWD is a better health insurance option than the Marketplace for people with disabilities.

Medical Assistance for Workers with Disabilities (MAWD) is a Medicaid program for Pennsylvanians age 16 through 64 who have significant health issues or disabilities and who are also doing some type of paid work. These individuals, as long as they do not have Medicare, can also explore insurance options through the Marketplace (HealthCare.gov).

PHLP's publication describes the eligibility criteria for each insurance option, the covered benefits, and the costs. It then compares the possible pros and cons of each and uses examples of more detailed comparisons for readers to consider. After analyzing the relevant considerations for health care coverage, we conclude that for the majority of Pennsylvanians who meet the criteria for both MAWD and Marketplace coverage, MAWD is the better choice. There may be isolated exceptions when an individual would choose Marketplace coverage over MAWD because their health care provider accepts the Marketplace plan but does not accept Medicaid. Otherwise, when considering cost, coverage, access to medical transportation and other significant factors, MAWD appears to be the better choice for persons with disabilities or serious health issues.

DHS Addresses Use of Psychotropic Medication by Foster Care Youth

A recent issue of *The Impact*, created by the Department of Human Services to regularly highlight work done to address various problems, focused on psychotropic drug use among Medicaid-eligible foster children. At the request of the Department, PolicyLab, a research center at the Children's Hospital of Philadelphia, undertook an analysis of the number of psychotropic drugs prescribed to children in foster care placement who have Medicaid.

The key findings of this analysis include: for youth ages 6-18 in foster care, the use of psychotropic drugs was nearly three times higher than for youth in the overall Medicaid population; the use of antipsychotic drugs, a subset of psychotropic drugs, was four times higher among children in foster care than for other youth in Medicaid; more than half of youth who take antipsychotic medications had a diagnosis of ADHD and no other diagnosis that would indicate this type of medication as an appropriate treatment;

and youth in foster care were less likely to have received any behavioral health provider visits within the year while on psychotropic medications. Psychotropic drugs can have adverse side effects including seizures, weight gain, trouble sleeping, and increased feelings of anxiety.

As a result of these findings and recommendations made by PolicyLab, DHS is taking a number of steps to address this issue including: offering child psychiatric consultative services by telephone to assist health care providers in the prescribing of psychotropic medications for children; updating assessment toolkits; revising regulations to encourage the use of trauma screening tools; and requiring the use of state-approved screening and assessment tools.

More information about the research, findings, recommendations, and DHS' action steps can be found here.

Lessons Learned from California

California currently requires a judge to approve psychotropic drug prescriptions for youth in foster care. New bills, passed unanimously in the State Senate, would further strengthen the court system of prior approval in a number of ways. First, doctors would have to show that other therapies were tried prior to prescribing psychotropic drugs. Second, judges could ask for a second opinion or more information, and children over the age of 14 would have to give written consent. Third, group homes would be monitored on the number of resident prescriptions for psychotropic drugs and nurses would monitor side effects of anti-psychotic drugs for each child or youth.

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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