PENNSYLVANIA Health Law PROJECT

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MAWD Saved! Advocacy Efforts Prevail

Department of Public Welfare (DPW) Secretary Beverly Mackereth announced in late July that DPW has decided **not to eliminate** the Medical Assistance for Workers with Disabilities (MAWD) program as planned. Readers may recall the program was scheduled to end effective January 1, 2015 as part of the Healthy PA Waiver application that is still awaiting approval by the federal government.

MAWD provides health coverage to over 34,000 working Pennsylvanians with disabilities who don't qualify for other categories of Medicaid—usually due to their earnings. The program provides an important incentive for people with disabilities to work and still be able to access Medicaid coverage. It also allows individuals with disabilities to work without fear of losing their critically important health insurance coverage, which, for some, includes Waiver services such as personal assistance services and other supports needed to get and keep a job and remain in the community.

PHLP worked closely with persons on MAWD and with disability organizations to highlight how eliminating this program would have a devastating effect on those who have come to rely on MAWD coverage. Our advocacy efforts included drafting and coordinating comments to state and federal officials, assisting affected individuals in drafting their own comments, and providing information to stakeholders about the importance of this program and the impact of its elimination.

PHLP applauds the decision by Secretary Mackereth and the Corbett Administration to continue the MAWD program that provides

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vital health coverage and community supports for working Pennsylvanians with disabilities. During the meeting in which Secretary Mackereth announced that MAWD will continue, she also noted that Governor Corbett's Administration continues to negotiate with the federal government on the terms and conditions for expanding Medicaid to low-income adults through the Healthy PA Waiver. She commented that both sides are close to an agreement and that she expects news about federal approval soon. We will keep readers updated on any developments.

New Budget Increases Availability of Home and Community Based Services

On June 30th, just hours before the start of the new fiscal year, the General Assembly passed an appropriations bill (HB 2328) containing the state budget for the Fiscal Year (FY) 2014-15 General Fund. In an effort to force the legislature to reform the state's pension program, Governor Corbett initially withheld signing and approving the budget. Despite the assembly's failure to respond and act on the pension reform, the Governor ultimately signed the budget into law on July 10th - but not before vetoing several line items worth $72 million that primarily relate to the legislature's own operating budget.

The overall General Fund fiscal budget for FY 2014-15 amounts to $29.03 billion, an increase of 1.5 percent over last year's budget. The Department of Public Welfare's (DPW) appropriation increased 1.1 percent over last year's figures. Most noteworthy is that the budget reflects cost savings, as well as additional expenditures, related to the Governor's proposed Healthy PA Waiver which has not yet been approved by the federal government. If federal approval is obtained, the state budget assumes Healthy PA would be fully implemented beginning January 2015.

DPW's budget includes $40 million in increased funds to County Assistance Offices, who are expected to hire an additional 700 staff to handle the nearly half-million individuals who will be newly eligible for coverage under Healthy PA. This represents a 14 percent increase from last year's appropriation. Additionally, the DPW Information Systems line item is appropriated approximately $17 million to prepare for Healthy PA's implementation.

The FY 2014-15 budget presents a major victory for persons with disabilities as it substantially increases funding for Home and Community Based Services (HCBS) Waiver programs. An additional $40 million in funding is allocated for those seeking services through the Intellectual Disability Waiver programs. The Governor indicated those funds will allow an additional 700 people aging out of special education in 2014 to receive day program services, typically through the Person Family Directed Supports Waiver. The funding will also allow 400 people currently on the emergency waiting list for a Waiver slot to start receiving services through either the Consolidated or the Person Family Directed Supports Waiver by the end of the year. However, Governor Corbett's numbers were based on a nearly $60 million increase in funding that he in-

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cluded in his budget proposal in February. Advocates are concerned that the $20 million shortfall (the difference between the $60 million requested and the $40 million appropriated) will result in the state's delaying the enrollment of additional persons into the Waivers and/or the implementation of services.

The budget also increased funding for Waiver programs that serve individuals with physical and/or other developmental disabilities. The increased funding for the Attendant Care Waiver and the Act 150 Program includes monies to serve the nearly 300 people currently on the Act 150 waiting list. These individuals, many of whom have been on the waiting list for several years, are ages 18 to 59 with physical disabilities who need help with activities of daily living to remain living in the community but who do not qualify for a Waiver program. The Independence, OBRA, and CommCare Waivers also received additional funding to serve more people in each of these programs.

The General Fund budget reflects a savings of nearly $41 million through the reduction of funds to the Aging Waiver. However, the state was able to achieve this reduction without actually affecting services by using Lottery Funds which in turn will actually increase the Aging Services Waiver budget.

The Governor used one-time expenditure delays to create a balanced budget. Techniques such as delaying payments by one month to Medicaid managed care organizations appear to be saving $400 million as DPW would only be making eleven payments to managed care organizations during this fiscal year. Though this strategy results in a balanced budget for the 2014-15 fiscal year, it leaves many questions about the long-term sustainability of funding for these programs given the state's serious and ongoing revenue problems.

Pennsylvania Moves Forward with Balancing Incentive Program

As reported in our last newsletter, the U.S. Department of Health and Human Services approved Pennsylvania to receive up to $94 million in federal matching funds to improve access to Medicaid funded home and community based services (HCBS). The funding started July 1st and will end September 30, 2015.

On July 9th, DPW's Office of Long Term Living (OLTL) held a statewide conference call on the Balancing Incentive Program for interested stakeholders to describe the program and how the state plans to proceed. The stated objectives of the program are: 1) to improve consumer understanding of HCBS Waiver services, what services are available and how to access services, and 2) to improve and streamline the Waiver enrollment process. After the call, OLTL sent out an online survey tool to participants to solicit feedback and recommendations for actions the state should take and/or best practices that should be adopted to assist consumers access HCBS Waiver services and to ensure timely enrollment into Waiver programs.

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OLTL also announced it is planning to conduct focus groups in the near future to address these four topics:

- No wrong door system of entry points/LINKs
- HCBS application and enrollment processes
- HCBS website and call center expansion
- Information & Referral tool development

Anyone interested in participating in a focus group should send an email to ra-pwbip@pa.gov giving their contact information and specifying the focus group they are interested in joining. If the person is interested in participating in more than one group, they should list and prioritize all the groups in which they are interested.

PHLP is working with other disability organizations to influence how the state proceeds with its Balancing Incentive Program. Recommendations provided by the group so far address the long delays in the current HCBS application process with the aim of helping consumers get services quickly. The group is advocating that OLTL:

- allow the No Wrong Door/Single Entry Point entities (community organizations trained to educate consumers about HCBS services and help them access needed services) to "presumptively" determine a consumer's financial eligibility so that those at imminent risk can get Waiver services in place quickly while the County Assistance Office (CAO) completes its formal determination process;
- allow CAOs to pull financial information from existing data sources whenever possible and to use consumer/family self-declaration to establish initial financial eligibility for HCBS in cases where promptly starting services is critical to preventing harm to a consumer;
- improve data collection and monitoring of the HCBS intake and application process to determine where the delays are occurring so they can be addressed quickly;
- include in the HCBS assessment process an evaluation of the person's current situation to identify any imminent risk in addition to screening for functional and financial eligibility ;
- ensure that any waiting lists developed for any of the HCBS Waivers be as transparent as possible. Waiting list information should be current and publicly available, and anyone on a waiting list should be able to get clear and current information about their individual status on the list.

PHLP will keep readers informed in future newsletters about DPW's process and progress toward meeting the goals of the Balancing Incentive Program.

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Update on Merger of Aetna and Coventry Cares

As reported in our last newsletter, Coventry Cares and Aetna are merging into one plan. Effective October 1st, all Medicaid consumers who are members of Coventry Cares will be enrolled into Aetna Better Health. As of that date, Aetna Better Health will be the only health plan operating in all five HealthChoices zones.

Letters were mailed to all Coventry Cares members in the HealthChoices Southeast zone in early June informing them of the upcoming merger. In early July, Coventry Cares sent a similar letter to their members in the HealthChoices New West, New East and Southwest zones. A second letter will go out in the middle of August to **all** Coventry Cares members officially notifying them that their enrollment in Coventry Cares is ending and that they will be enrolled into Aetna Better Health as of October 1st. The letter will provide members with information regarding their right to continuity of care during the switch.

As a reminder, current Coventry Cares members should check with all of their important medical providers (PCPs, specialists, hospitals) to see if they accept Aetna Better Health. If they do not, the member can either go with Aetna and change to a new medical provider within Aetna's network OR enroll in another plan in their HealthChoices zone that their current provider accepts.

CMS Issues Guidance Clarifying Medicaid Coverage of Services to Treat Autism

In July, the Centers for Medicare & Medicaid Services (CMS) issued guidance to clarify that federal Medicaid law allows for the coverage of autism treatment services, including Applied Behavior Analysis (ABA). Advocates are hopeful that this guidance, in addition to other advocacy efforts underway, will encourage Pennsylvania to cover ABA as a separate and distinct service under its Medicaid program. ABA is a treatment modality for autism that has the greatest body of research supporting its efficacy.

While this guidance does not specify that a state's Medicaid program must cover ABA or other autism treatment services, it does make clear that there are several provisions in federal law under which a state can cover these services. The guidance discusses Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) as creating an entitlement to autism treatment services for children and youth under 21. As noted in the guidance, EPSDT requires Medicaid programs to arrange for and cover all medically necessary services allowed under federal Medicaid law, including those which are optional for adults. The guidance's discussion of the EPSDT mandate focuses on the requirement of Medicaid programs to cover medically necessary diagnostic and treatment services following a screening usually performed by a pediatrician.

The guidance also highlights other authority that exists for Medicaid to cover autism treatment services including ABA. The "other licensed practitioner services" provision in the law allows licensed practitioners acting within their scope of practice to provide medical or remedial care or services. Since Board Certi-

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fied Behavior Analysts can now be licensed under Pennsylvania's Autism Insurance Law (Act 62 of 2008), the services they provide, which include ABA, can clearly be covered under Medicaid—without requiring those individuals to work for an agency with a mental health license! CMS also clarifies that "non-licensed practitioners" (such as ABA techs) can be covered under this provision if the state scope of practice requirements allow the licensed practitioner to supervise non-licensed professionals and to assume professional responsibility for the services they provide.

Another provision of federal law mentioned in the guidance is "preventive services" which allows Medicaid to cover services by non-licensed practitioners. While ABA isn't commonly thought of as a "preventive service", the federal regulation's definition of preventive service includes services to "promote physical and mental health efficiency". As of January 1, 2014, preventive services can be provided by non-licensed practitioners so long as they are recommended by licensed practitioners. This would appear to authorize coverage of an ABA interventionist (similar to a Therapeutic Staff Support or TSS) whose services were recommended by a licensed behavior specialist or other licensed person and probably supervised by the licensed behavior specialist. Pennsylvania would have to set out the qualifications of the non-licensed practitioners who provide ABA, as they do now for TSSs and Mobile Therapists, in a Medicaid State Plan Amendment.

While this guidance is not as direct on Medicaid coverage of ABA as autism advocates would have hoped, is important for three reasons:

1) While CMS issues many guidance documents and bulletins, it is rare that they issue one devoted to a single diagnosis and it demonstrates recognition of the importance of this issue.

2) The bulletin specifically mentions ABA as an autism treatment modality even though it contains no further discussion specific to ABA.

3) It recognizes that Medicaid can be used to fund a variety of autism treatment services including ABA.

Adult Protective Services for Persons with Disabilities

Beginning July 1, 2014, anyone suspecting abuse, neglect, exploitation or abandonment of adults with disabilities who are between the ages of 18 through 59 should contact the Older Adults Protective Services Program at 1-800-490-8505. That program will field calls for this age group in addition to the calls it already handles related to protective services for seniors. The Older Adult Protective Services Program will direct these calls to the local Area Agency on Aging (AAA) for the initial intake. The AAAs will record the pertinent information about the allegation and will then forward the information to the entity responsible for the investigation of the case. DPW is in the process of procuring agencies to conduct these investigations. Once the agencies are in place, DPW will be doing more public outreach and education about the Adult Protective Services Program.

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Good News! CHIP Now Covers 1 Pair of Replacement Eyeglasses

At the end of July, Pennsylvania's Children's Health Insurance Program (CHIP) issued a policy clarification to all of its CHIP plans noting that they are required to cover one pair of replacement eyeglasses to members if they report their previous eyeglasses were lost, stolen or broken beyond repair. In effect, the policy clarification expands CHIP's current vision benefit of one complete pair of eyeglasses (lenses and frames) every twelve months. It also brings CHIP coverage of eyeglasses closer to Medicaid's coverage that covers eyeglasses as well as an unlimited number of replacement frames and lenses for children under 21.

The policy clarification was issued after a group of advocates led by Public Citizens for Children and Youth (PCCY) identified a discrepancy among the CHIP plans – some plans provided replacement glasses, some provided replacements only under certain circumstances, and some plans did not cover replacements at all. The advocates (including PHLP) encouraged the Pennsylvania Insurance Department to address the discrepancy and the Department responded by issuing the policy clarification to assure consistency across plans.

Families of children in CHIP who are experiencing problems getting replacement eyeglasses are encouraged to call PHLP's Helpline at 1-800-274-3258.

Low-Income Consumers Using LINET May Have Problems Getting Medications at the Pharmacy

Recent changes to Medicare's back-up Part D plan for low-income individuals could cause delays in getting medications at the pharmacy. This back-up plan is known as LINET (the Limited Income Newly Eligible Transition program). LINET provides temporary, safety-net, drug coverage for low-income individuals with Medicare who qualify for the Part D Extra Help but who are not yet enrolled in a Medicare prescription drug plan. In some cases, Medicare enrolls individuals receiving the Extra Help in LINET for temporary prescription drug coverage. In other cases, individuals become enrolled in LINET when the pharmacy bills this back-up plan for the medications they need.

Part D Extra Help is also called the **Low-Income Subsidy**

In mid-July, the Centers for Medicare & Medicaid Services started to require individuals to submit proof of their eligibility for Medicaid or for the Part D Extra Help **before** LINET will cover their medications at the pharmacy. Pharmacies can run a query to see if someone on Medicare has any prescription drug coverage or qualifies for Extra Help. If that query shows someone has Part D coverage and/or the Extra Help, then the pharmacy can proceed with billing the individual's Part D plan or LINET for the person's medication.

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If that query **does not** show this information, documentation must be sent to LINET to verify that a Medicare beneficiary is entitled to Extra Help. Proof includes:

- A Medicaid eligibility notice showing the effective date;
- An ACCESS card, so the pharmacy can check the PROMISE Eligibility and Verification System (EVS) and verify Medicaid eligibility; or
- An award letter from Social Security or Medicare showing that an individual is approved for the Extra Help.

Once this proof is submitted to LINET and LINET updates their systems (this can take up to 7 days), then the pharmacy should be able to bill LINET for the medications and individuals should only have to pay the small co-pays associated with their level of Extra Help. Pharmacies or advocates can fax the proof documentation to LINET at 1-877-210-5592. If someone has an urgent or immediate need, information should be faxed to 502-301-5835.

Individuals who are having problems getting their medications due to this change are encouraged to call APPRISE at 1-800-783-7067 or PHLP's Helpline at 1-800-274-3258.

Conflicting Court Decisions on Subsidies for Health Insurance Premiums Mean No Changes for Consumers

In July, two federal appeals court panels issued contradictory rulings on the same day regarding whether the federal government could subsidize health insurance premiums for the millions of Americans who applied for health care coverage and premium tax credits through HealthCare.gov. The conflicting rulings mean there will be **no immediate impact** on the consumers (including 300,000 Pennsylvanians) who are relying on premium tax credits to purchase coverage through the federal Health Insurance Marketplace.

The court conflict centers on the validity of an Internal Revenue Service (IRS) regulation that authorizes the payment of premium subsidies in the thirty-six states that do not run their own health insurance marketplaces and who instead use the Health Insurance Marketplace established and operated by the federal government. Pennsylvania is one of those states.

A panel of the United States Court of Appeals for the District of Columbia Circuit struck down the IRS regulation by a vote of 2 to 1. The DC Circuit ruled that the specific language of the Affordable Care Act (ACA) states that subsidies are available only to customers on **state-run** exchanges. The DC Circuit held that a strict interpretation of the wording of the ACA means subsidies must be limited only to those marketplaces run by state governments.

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Within hours of the DC Circuit issuing its decision, a three-judge panel of the United States Court of Appeals for the Fourth Circuit issued a unanimous ruling that reached the opposite conclusion. The Fourth Circuit upheld the subsidies saying the IRS acted within its discretion when it issued the regulation and deferred to the IRS noting that the ACA language at the center of the lawsuit is "ambiguous and subject to multiple interpretations".

Both cases will be appealed. Moreover, additional cases on the same issue—challenging the subsidies in federal exchange states—are still making their way through trial courts in Indiana and Oklahoma. It is unlikely that the U.S. Supreme Court will decide this matter in the near future. The Court is currently on recess until October. Once the Court returns it would have to decide to accept the case(s) for review, receive briefs, and hear arguments. In the meantime, while appeals are being pursued, the government will continue to pay the premium subsidies to insurance companies in the 36 states that use the federal marketplace.

In short, these conflicting decisions do not change anything for Pennsylvanians currently receiving subsidies to help pay for health insurance purchased through the federal marketplace, and nothing will change regarding the availability of subsidies when consumers use the federal marketplace in the next open enrollment period which starts November 15, 2014 and ends February 15, 2015.

Upcoming Listening Sessions for Persons with Disabilities

The PA Developmental Disabilities Council, in conjunction with the Institute on Disabilities at Temple University and the Disability Rights Network, is looking for input on "the issues that matter most to Pennsylvanians with disabilities and their families."

Specifically, these organizations would like to hear ideas regarding:

- The disability and social issues they should pursue to better support people with disabilities and their families;
- How they can ensure that civil and human rights of people with disabilities are protected;
- The training opportunities they should make available, and;
- The research needed in Pennsylvania to guide policies to improve services, supports, systems and communities, as well as to ensure civil and human rights.

Public Forums Will be Held at the Following Dates & Locations

September 4, 10am-12noon – **Williamsport**, Roads to Freedom CIL, 24 E. 3rd Street

September 4, 3pm-5pm – **State College**, Borough Bldg, 243 S. Allen Street, Room 210

September 5, 10am-12noon - **King of Prussia**, PaTTAN, 200 Anderson Road

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September 5, 4pm-6pm – **Lancaster**, Manheim Township Bldg, 1840 Municipal Drive

September 15, 9am-11am – **Erie**, Voices for Independence CIL, 1107 Payne Avenue

September 15, 3pm-5pm – **Meadville**, Arc of Crawford County, 222 Chestnut Street

September 16, 9am-11am – **Washington**, TRIPIL, 69 E. Beau Street

September 16, 2pm-4pm - **Pittsburgh**, ACHIEVA Arc of Greater Pittsburgh, 711 Bingham Street

September 30, 9am-11am – **Windber** (Johnstown) Windber Community Bldg, 1605 Graham Ave.

September 30, 3pm-5pm – **Camp Hill**, CIL of Central PA, 207 House Avenue, Suite 107

October 6, 10am-12noon – **Stroudsburg**, Monroe County Safety Center, 100 Gypsum Rd, Room 2

October 6, 3pm-5pm – **Scranton,** Center for Independent Living, 1142 Sanderson Avenue

October 8, 6pm-8pm – **Webinar** – http://paddc.adobeconnect.com/listeningtour/; Telephone: 1-866-210-1669, Participant #3478987

For questions or accommodations call 800-692-7443 Ext. 300 or TTY: 877-375-7139 or email Eric Howell at ehowell@drnpa.org. For information in Spanish: 215-204-9348 or latino@temple.edu.

Please note: those needing accommodations should make contact at least 2 weeks prior to the date of the meeting you plan to attend.

Written feedback can also be provided by **Wednesday, October 8, 2014** to:

Disability Rights Network of Pennsylvania
ATTENTION: Eric Howell
1414 N. Cameron Street, Second Floor
Harrisburg, PA 17103-1049

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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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

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