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Health Law PA News

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Healthy PA Proposal Raises Many Concerns

In early December, Governor Corbett released a detailed proposal, "Healthy PA", to expand health coverage for low-income, uninsured Pennsylvanians while making significant changes to the current Medicaid* program for adults. This proposal would not impact kids under 21 or adults 65 and older. The state held a number of public hearings on Healthy PA and provided a public comment period that ended January 13, 2014.

* In Pennsylvania, our Medicaid program is called Medical Assistance (MA). Throughout the newsletter, we use the general term Medicaid. When referring specifically to Pennsylvania, Medicaid will mean Medical Assistance.

As readers likely know, the Affordable Care Act (ACA) gives states the opportunity to expand their Medicaid programs to cover adults with income up to 133 percent of the Federal Poverty Level (FPL) ($1,293 a month for a single adult in 2014). To date, Pennsylvania, unlike several neighboring states—e.g., Maryland, New Jersey, New York, and Ohio—has not expanded Medicaid coverage. Instead, Governor Corbett seeks federal approval for a special pathway (known as a Section 1115 Waiver) to expand and change Medicaid here in Pennsylvania.

There are two major components to Healthy PA's approach. The first is a "Private Coverage Option" which would make private, commercial insurance (available inside or outside the Federal Healthcare Insurance Marketplace) available to uninsured adults with incomes less than 133 percent FPL. Those with incomes above 50 percent FPL would pay a monthly premium toward their coverage unless they fall into an exempt group. The second component is

changing the scope and duration of Medicaid benefits for adults.

A summary of the proposal and the concerns raised by the Consumer Subcommittee of the Medical Assistance Advisory Committee as well as by many organizations representing the disability community are set out below.

Expanding Coverage and Changing Medicaid Eligibility

Healthy PA seeks to extend health care coverage to uninsured adults age 21-64 with incomes up to 133 percent FPL by using Medicaid funds to purchase private, commercial coverage. The proposal is unclear about whether that coverage would be through plans in the Federal Health Insurance Marketplace or outside of the Marketplace. Regardless, individuals would complete a self-assessment of their "medical frailty" and those determined to be "medically frail" would have the option to choose coverage through the traditional Medicaid program rather than private, commercial coverage.

Healthy PA would eliminate the Medical Assistance for Workers with Disabilities (MAWD) program and the General Assistance Medical Assistance program. Individuals in both programs whose income is less than 133 percent FPL could get coverage through the process described in the previous paragraph as long as they do not have Medicare.

Concerns:

1) There is insufficient information about the process of determining "medical frailty";
2) The self-assessment relies on individual applicants knowing and understanding all their health conditions and being willing to identify them;
3) The elimination of MAWD potentially leaves 30,000 disabled Pennsylvanians with only coverage through a private, commercial insurance plan that could be unaffordable and that will provide less comprehensive coverage than MAWD;
4) Eliminating MAWD will prevent some individuals from accessing Home & Community Based Services (HCBS) Waivers. Because MAWD has a higher income and resource limit than the Waiver category, some people financially qualify for HCBS Waiver services only because they qualify for MAWD. These individuals need the HCBS to work and remain in their homes, and losing MAWD places these individuals at risk of institutionalization;
5) Consumers receiving private, commercial coverage would not have all the rights and protections of those on Medicaid such as the right to continued benefits pending appeal.

Reducing Medicaid Benefits and Capping Services

Healthy PA intends to place current and future Medicaid recipients who are age 21 through 64 in either a "High Risk" or "Low Risk" Alternative Benefit Plan based on the medical frailty assessment referenced above. SSI recipients, those receiving Home and Community Based Waiver Services, pregnant women, residents of institutions and those dually eligible for Medicare and Medicaid would automatically be placed in the high risk plan.

Both benefit packages significantly reduce current benefits, with greater limits in the low risk plan. For example, there are currently no outpatient surgery limits for Medicaid eligible adults. However, under Healthy PA, adults in the high risk plan can have no more than four outpatient surgeries a year and those in the low risk plan are limited to two surgeries. Also, adults currently eligible for full Medicaid benefits have

no limit on coverage of durable medical equipment (DME) and supplies. Healthy PA will limit those in the high risk plans to no more than $2,500 per year in DME and supplies and those in low risk plans to $1,000 per year. Healthy PA also reduces current Medicaid coverage of hospital, rehab and skilled nursing facility care, inpatient and outpatient mental health and drug and alcohol services, lab work and targeted case management. Exceptions to the plan limits can be granted **if** someone meets certain criteria.

Concerns: The benefit limits are too drastic. People in poor health will be unable to get the care they need or will be billed for care they cannot afford. The proposal violates the federal law that requires Medicaid benefits "meet the needs" of the target population.

In addition, Healthy PA appears to illegally reduce coverage of mental health and substance abuse services in violation of the Mental Health Parity and Addiction Equity Act of 2008. The Act prohibits a health plan offering both physical and behavioral health benefits from applying more restrictive limitations to mental health and substance abuse services than it does to physical health services of the same classification. Healthy PA allows coverage of three non-emergency admissions for physical health hospitalization but limits psychiatric and substance abuse hospitalizations to a total of 45 days per year. Advocates maintain this does not meet the definition of parity in the Act when even one physical health hospitalization could last more than 45 days.

Premiums

Under Healthy PA, persons with incomes above 50 percent FPL would be required to pay a monthly premium of $13 - $25 regardless of whether they enroll in traditional Medicaid or in the private option. Those falling into an exempt group, such as pregnant women, those on SSI, and dual eligibles on Medicare and Medicaid, would **not** have to pay a premium. Adults required to pay premiums who fail to comply will be excluded from Medicaid for 3 months or more, depending on the number of episodes of non-compliance.

Concerns: Premiums of any amount are unaffordable for people living in poverty. In addition, collecting premiums would be another administrative burden on the already-overwhelmed County Assistance Offices. Experience in other states has shown that charging premiums for Medicaid resulted in disenrollment from the program by nearly half the affected population, leaving those individuals without insurance and access to health care. Premiums that would cause low-income individuals to lose their insurance would lead to worse, not better, health outcomes.

Imposing a Work Search Requirement

Under Healthy PA, many individuals will be required to either work a minimum of 20 hours per week or engage in a minimum of 12 work search activities per month as a condition of Medicaid eligibility. Some groups, such as those on SSI, pregnant women, and full or part-time students, would be exempt from these requirements. Individuals **not** yet on Medicare who are eligible for Medicaid based on a disability or because they receive a HCBS Waiver **will** have to meet the work/work search requirement in order to maintain their Medicaid eligibility.

Concerns: Tying Medicaid eligibility to work is not permissible under federal Medicaid law. In addition, most people on Medicaid are already working and this requirement would present a barrier to health care for those who are not. Tracking Medicaid recipients' work and work search activities would be an

unreasonable administrative burden for caseworkers involving unnecessary costs to the state.

What's Next?

At January's Medical Assistance Advisory Committee meeting, the state reported receiving over 1,000 comments to the Healthy PA proposal from across the state. Once the state reviews the comments submitted, it may refine or revise the Healthy PA proposal. Once the proposal is finalized, it must be submitted to the federal Center for Medicare and Medicaid Services (CMS) for review and approval. There will be another opportunity for public comment. CMS will announce the 30-day public comment period after they receive the application from the state. To be notified of the CMS public comment period, readers can sign up here.

DPW Still Experiencing Backlog in Processing MAWD Premium Payments

The Department of Public Welfare (DPW) continues to experience a backlog in processing Medical Assistance for Workers with Disabilities (MAWD) premium payments. The backlog began in September and was discussed in greater detail in our November Health Law Newsletter. DPW is currently in the process of choosing an outside entity to contract with who will take over the functions of processing MAWD premium payments. In the meantime, DPW is using existing staff to process the premium payments.

Because of the backlog in processing premiums, DPW has issued instructions to the County Assistance Offices (CAOs). Upon receiving an alert of unpaid MAWD premiums, the caseworker must contact the MAWD recipient and ask if they sent in their payment for the previous month(s). If the answer is yes, the caseworker should note that in their system and not terminate the MAWD recipient for non-payment of premiums.

Tips for individuals currently on MAWD:

- The consumer should continue paying monthly premiums on time and keep a record of all payments;
- If someone receives a bill showing a past balance owed in addition to the current month's premium, and the individual can show that she has made all previous payments owed, she should only pay the current premium due;
- If someone receives an improper termination notice from the CAO for failure to pay premiums, she should appeal the termination right away by completing the appeal page that comes with the termination notice. It is important to mail it back to the CAO in a way that she has proof of mailing and delivery (i.e., registered or certified mail). These individuals should keep a copy of their appeal request, too, if possible.

Anyone who believes they were improperly terminated from MAWD for non-payment of premiums can call PHLP's Helpline at 1-800-274-3258.

Medicaid Coverage for Former Foster Care Youth Expanded January 1st!

Former foster care youth can now qualify for Medicaid coverage until they turn 26 years old under the Affordable Care Act. This new requirement applies to individuals aged 18 to 26 who received Medicaid coverage in a federal or state-funded foster care category on or after their 18th birthday. These former foster care youth do not have to meet any income or resource guidelines in order to qualify for Medicaid.

Here is what former foster care youth or individuals currently in foster care and their advocates need to know:

- Individuals aging out of foster care after January 1, 2014: Current foster care youth who turn 18 and age out of the foster care system now or in upcoming years should automatically transfer to this new category with no break in coverage. The County Children and Youth Agency will send discharge paperwork to the County Assistance Office (CAO) which will act as an application and the Medicaid caseworker will change the Medicaid category from a federal or state foster care category to the new category for former foster care youth. **The person leaving foster care should not have to take any action to have their Medicaid continue**.
- Individuals who aged out of foster care before January 1, 2014: Those who are under age 26, and who aged out of the foster care system between 2007 and 2013, will need to apply for Medicaid to obtain coverage under this new category. They should use the PA 600HC application and answer the questions for persons under age 26 at the bottom of page 2. Those individuals who received previous foster care and Medicaid benefits in Pennsylvania will not need to prove this because the CAO caseworker will be able to verify this in their system. Anyone who previously received foster care and Medicaid from another state will need to provide proof they received those benefits when applying for Medicaid in Pennsylvania.

Individuals can apply any of the following ways:

- Online, go to www.compass.state.pa.us;
- Over the phone, call 1-866-550-4355 (between 8am and 5pm);
- Through the mail, use the PA 600 HC; or
- In person, visit the local County Assistance office

Former foster care youth should receive the full Medicaid benefit package. Those aged 18 through 20 continue to qualify for benefits under Early Periodic Screening, Diagnosis, and Treatment (EPSDT) which allows them to receive all medically necessary health care services, including behavioral health rehabilitation services (also called wraparound), shift nursing, home health aide services and unlimited prescription coverage. Once they turn 21, these individuals will receive the full package of Medicaid benefits for adults including certain behavioral health services and prescription drug coverage with limits.

Former foster care youth who are experiencing problems with Medicaid eligibility can call PHLP's Helpline (1-800-274-3258) for advice and assistance.

New Medicaid Presumptive Eligibility Process Available

As of January 1st, qualified hospitals can make Presumptive Eligibility (PE) determinations for certain groups of people applying for Medicaid. The Affordable Care Act requires states to implement the hospital PE process to help get people Medicaid coverage quickly.

Previously, Pennsylvania allowed certain providers, including clinics and private medical practices, to grant Presumptive Eligibility to pregnant women. This process will continue. However, the new rules expand the process to allow certain hospitals approved by the Department of Welfare to grant PE Medicaid to the following groups of people who may qualify for Medicaid under the new Modified Adjusted Gross Income (MAGI) rules: children (18 and under), parents and caretakers, pregnant women, and former foster children under the age of 26 who have aged out of foster care.

Only hospital staff who have completed a required training program will be allowed to determine eligibility under this new process. Hospitals will rely on a person's self-attestation of income and assets and cannot require a person to provide verification documents. The hospital will grant PE to qualified individuals giving them immediate coverage through the Medicaid fee-for-service program. It is not yet clear how qualified hospitals and DPW will coordinate their efforts to ensure that those granted PE obtain a temporary ACCESS card as quickly as possible.

The hospital will then submit the PE application to the County Assistance Office (CAO) who will review the application to determine if the person qualifies for ongoing Medicaid coverage. The CAO will use electronic means to verify as much information as possible. If any additional verification information is needed to process the application, the CAO will notify the applicant. Verification documents must be provided to the CAO within the PE period or the applicant will be determined ineligible for ongoing Medicaid. Once all documents are received by the CAO, the application should be reviewed for all possible categories of Medicaid and a decision made about ongoing eligibility.

The Presumptive Eligibility period will end on the last day of the month following the submission of a PE application to the CAO, or on the date an ongoing eligibility determination is made, whichever is earlier. For example, if a PE application is submitted February 2nd, the PE period will last until March 31st -- unless the CAO makes a decision about ongoing Medicaid eligibility before the end of March. Pregnant women are limited to one PE period per pregnancy whereas all other PE applicants are limited to one PE period every twelve months.

Advocates and providers hope that the PE Medicaid process will alleviate the current lag time that occurs once a person applies for Medicaid and until they are processed and notified of eligibility. Expanding the PE process will give eligible individuals immediate coverage and ensure they get the care they need right away.

New Rules for Medicaid Home and Community-Based Services Include Many Positive Changes for Consumers

Earlier this month, final regulations were released by the federal government regarding Home and Community-Based Services (HCBS) provided by Medicaid programs. These regulations include many positive changes that should improve the quality of programs as well as promote independence and community-living for older adults and people with disabilities who rely on these services as an alternative to receiving long-term care in a nursing home or other institution. The new regulations apply to the various HCBS Waiver programs that currently exist in Pennsylvania (such as the Aging Waiver, the Attendant Care Waiver, Independence Waiver, and the Consolidated Waiver). The new rules also provide states with new opportunities to offer long-term services and supports to people at home or in their communities.

States have a year to make changes to their programs in order to comply with these new rules. Pennsylvania, as well as other states, will have to develop plans describing the changes they will make to meet the new requirements. The Centers for Medicare and Medicaid Services (CMS) will be developing further information and guidance to help states plan for changes and there will be future opportunities for public input as states prepare to make the necessary changes to their delivery of Medicaid HCBS.

Highlights of the final rules include:

- Clearer requirements for person-centered planning to ensure the service planning process is directed by the person needing the long-term services and that the service plan developed through this process supports and reflects the individual's preferences and goals;
- Definitions and descriptions of the requirements for home and community-based settings where people can receive home and community-based services that focus on consumer choice and promote meaningful access to the community and community activities;
- Enhanced requirements regarding public input in Waiver development as well as when Waiver changes are being proposed;
- Opportunities for states to combine coverage for multiple target populations in order to allow services based on need, rather than diagnosis or condition, and to streamline administration of the programs; and
- The provision of additional enforcement mechanisms for CMS to use to ensure state compliance with Waiver rules.

These changes were supported by numerous consumer advocates across the country, including PHLP. Individuals can read more information about the new rules here. PHLP will provide updates in future newsletters on how Pennsylvania plans to make changes to meet these important new requirements.

CHIP to Medicaid Transition Update

Recently, the Pennsylvania Insurance Department reached an agreement with the Center for Medicaid and Medicare Services regarding children who are now eligible for Medicaid but who are currently enrolled in the Children's Health Insurance Program (CHIP). Estimates of the number of children who fall into this category range from 30,000 to 45,000.

Under the Affordable Care Act, eligibility for the CHIP and Medicaid programs changed. As a result, children with family income between 100 and 133 percent of the federal poverty guidelines are now eligible for Medicaid rather than CHIP. However, Governor Corbett has been reluctant to move these children from CHIP to Medicaid, citing potential disruptions in their health care services.

The agreement allows families in this income range with children currently in CHIP a choice of when to move their kids to Medicaid: immediately; at their annual renewal; or January 1, 2015. This option only applies to children currently enrolled in CHIP. New applicants whose family income is below 133 percent FPL will only be eligible for Medicaid and cannot get CHIP. Details are expected soon on how and when families will make their choice and we will update readers in upcoming newsletters.

2014 Federal Poverty Levels Announced

The 2014 Federal Poverty Level (FPL) guidelines were published in the Federal Register on January 22, 2014 and are slightly higher than last year's poverty level figures. Public benefit programs such as Medicaid and the Children's Health Insurance Program (CHIP) use these guidelines to determine who qualifies for coverage. Our next newsletter will include more detailed information about the new income limits for Medicaid and CHIP programs in 2014.

Under Medicaid rules, County Assistance Offices (CAOs) are **not** to count Social Security Cost of Living Adjustments for individuals age 65 and older or those with disabilities who are receiving benefits under the Healthy Horizons categories (including QMB, QMB Plus, SLMB and QI-1) until the second month after the Federal Poverty Levels are updated. Since the 2014 FPLs were announced in January, the CAOs can start to count someone's 2014 Social Security amounts in March 2014. Until March, CAOs are to use last year's Social Security amounts when determining an individual's eligibility for the above-mentioned programs; this policy applies to new applicants as well as to individuals whose benefits are being renewed. Individuals receiving termination notices from the CAOs who believe that their 2014 income is being counted prematurely are encouraged to call PHLP's Helpline (1-800-274-3258) for advice and assistance.

PA Reports Problems with Medicaid File Transfers from Federal Website

In early January, Pennsylvania officials announced that at least 25,000 low-income Pennsylvanians who applied for coverage on www.HealthCare.gov (the Federal Marketplace) since October 1, **and** who the Federal Marketplace found eligible for Medicaid, have not been enrolled in that coverage. Problems with data transfers from the federal government to Pennsylvania's Medicaid program are preventing enrollment.

Readers may recall that since October 1, 2013, the Federal Marketplace has the authority to determine whether an applicant is eligible for Medicaid in Pennsylvania. When the Federal Marketplace makes a determination that an applicant qualifies for Medicaid, it should hand off the application to the Pennsylvania Department of Public Welfare; transferring a file of information to the state for completion of processing and enrollment in Medicaid. The file transfer should include all the information provided on the application as well as any verification of income eligibility the Federal Marketplace conducted. In this way, the applicant does not need to re-submit information and Pennsylvania does not have to repeat verifications already done.

However, the file transfers from the Federal Marketplace to Pennsylvania are not working. Until the situation is resolved, PHLP recommends that individuals who were told by the Marketplace they are Medicaid eligible apply directly to the state to ensure that their Medicaid coverage starts as soon as possible.

1. Apply online (www.compass.state.pa.us) or
2. Call the PA Consumer Assistance Center (1-866-550-4355).

Applicants who incurred medical expenses in the past three months should ask for retroactive coverage in their application and submit copies of past medical bills. Medicaid coverage normally begins in the month of application but it can go backwards up to three months if the applicant was eligible during that time period.

Individuals should also keep notices received from the Federal Marketplace about Medicaid eligibility. PHLP is interested in hearing from people in this situation to ensure that their cases are handled appropriately under current Medicaid rules as well as Affordable Care Act requirements. Please contact the Helpline at 1-800-274-3258 for advice and assistance.

Special Note about CHIP Coverage: Pennsylvania families who believe their child is CHIP eligible should apply directly to the CHIP plan of their choice (the listing of available plans can be found on www.chipcoverspakids.com) or online at www.compass.state.pa.us.

Federal PCIP Coverage Extended Through March

In early January, the federal government announced that the Pre-Existing Condition Insurance Plan (PCIP) would now be extended through the end of March to allow current enrollees more time to find coverage through the Marketplace and enroll in a plan that meets their needs before Marketplace open enrollment ends. This is the second extension for a program that was originally scheduled to end December 31, 2013. Pennsylvanians enrolled in the PCIP were previously covered by PA Fair Care before being transferred to the federally-run program for coverage starting in July 2013. Current PCIP enrollees were notified of the coverage extension through mail and through the program's website.

State FY 2014-2015 Budget Update

Governor Corbett releases his proposed FY 2014-2015 Budget on February 4th. Throughout February, Appropriations Committees in the state House and Senate will hold hearings with every state agency. For the first time, the House Appropriations Committee is inviting citizens to submit questions for agency officials to answer during the hearing. For more information and to submit questions, click here.

House Appropriations Budget Hearings

Department of Aging – February 10th
Department of Health and Department of Drug and Alcohol Programs – February 24th
Department of Insurance – February 25th
Department of Public Welfare – February 26th

Senate Appropriations Budget Hearings

Department of Drug and Alcohol Programs – February 12th
Department of Insurance – February 12th
Department of Aging – February 13th
Department of Health – February 19th
Department of Public Welfare – February 24th

Future PHLP newsletters will provide analyses of what the Governor's budget proposal means for health coverage for vulnerable Pennsylvanians.

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

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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