Health Law PA News

A Publication of the Pennsylvania Health Law Project

Volume 16, Number 6
November 2013

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

DPW Backlog In Processing MAWD Premium Payments

The Department of Welfare's (DPW) central office in Harrisburg, which is responsible for processing premium payments made to the Medical Assistance for Workers with Disabilities Program (MAWD), has been experiencing a backlog in processing payments that began with September premiums. This means payments are not getting entered into the system as quickly as they should be, and that individuals on MAWD may be receiving premium statements that inaccurately show they are behind on premiums even though they did make timely payments. In some cases, local County Assistance Offices (CAOs) sent out termination notices for failure to pay MAWD premiums when, in fact, the individual is current with their payments. Paying a monthly premium is a requirement to maintain coverage under the MAWD program.

Given these system "glitches" and processing delays, MAWD recipients should continue to pay their monthly premiums as usual and try to keep a record of their payments. In cases where the individual is confident that he paid his premium each month (and has some record of this), he should disregard statements showing he is behind and only pay what is actually owed. MAWD recipients should **not** skip payments.

At the end of October, DPW issued a Policy Clarification to notify CAOs about the backlog, which they say is temporary. The CAOs were instructed to review MAWD cases that have been closed for non-payment of premiums and to re-open cases if the system showed only September's premium as unpaid.

If a MAWD recipient receives a termination notice due to unpaid premiums, despite having sent in premiums, the recipient should immediately appeal the termination in order to receive continued benefits. It is recommended that she send in her appeal in a way that she has proof of mailing and delivery (for example, registered mail). These individuals can call PHLP's Helpline for further advice and help at 1-800-274-3258.

INSIDE THIS EDITION

Kids Who Aged-Out of Foster Care Keep Medical Assistance Until Age 26 under ACA

An important provision of the Affordable Care Act (ACA) requires all states to provide Medicaid (called Medical Assistance in Pennsylvania) to all former foster care youth regardless of their income after they age out of the system. These individuals will now qualify for Medical Assistance (MA) until they turn 26, as long as they were in foster care ***and*** receiving MA on their 18th birthday. This provision applies to all youth who are currently in care and those young adults who have aged out since January 1, 2007. It applies to foster youth in all states regardless of whether the state is choosing to expand Medicaid. The provision is aimed at giving foster care youth the same access to affordable health care as their peers who would be eligible for coverage under a parent's insurance policy until age 26.

Why is it so important for this population to have access to affordable health insurance?

According to a report by the Georgetown Center for Children and Families, approximately 80 percent of foster youth have a chronic medical condition, and 25 percent have three or more chronic health problems. Yet, despite the high prevalence of health care needs among foster youth, studies show that access to health insurance for this population is significantly lower compared to their peers. According to Pennsylvania Partnerships for Children, Pennsylvania has about 13,000 current foster youth who would qualify for MA until age 26 if they remain in foster care until they age out. In addition, there are 11,000 youth who already aged out of foster care, but who have not yet turned 26, who would be eligible for MA under this new requirement.

Implementing this new policy

For those youth currently in foster care who age out of the system after January 1, 2014, the change should be automatic. MA regulations require eligibility to be continued automatically whenever a County Assistance Office (CAO) has information sufficient to demonstrate continued eligibility. In these cases, the CAO will close the individual's MA case in the foster care category of eligibility and open the case in the former foster youth category. There should not be any break in MA coverage for these young adults.

Those who have aged out of foster care prior to January 1, 2014 will need to apply for MA and indicate that they are former foster youth. They do this by answering the "questions for persons under age 26" section at the bottom of page 2 of the newly created MA application (PA 600HC). The questions asked in this section are: 1) "Was this person in foster care at age 18 or older?" 2) "If yes, did their foster care end because of their age?" 3) "At what age?" 4) "In which state?"

At this time, Pennsylvania plans to provide former foster youth currently living here with MA regardless of which state they received their foster care benefits and aged out from at age 18. The Centers for Medicare and Medicaid Services does not require states to do this, but gives them the option to do so.

The ACA provision requires Pennsylvania to provide former foster youth with the full MA 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 MA benefits for adults (which includes coverage for prescriptions and dental care).

Scathing Report Highlights DPW's Lack of Oversight of Providers That Pay Caregivers of Individuals Receiving Long-Term Care Services In their Homes

A recent performance audit conducted by the Department of the Auditor General identified long-term mismanagement by the Department of Public Welfare (DPW) of providers that pay direct care workers under Medical Assistance (MA) Waiver programs. According to the report, this mismanagement caused undue financial and emotional strain on tens of thousands of people and resulted in significantly higher costs to the MA program and to taxpayers. The audit focused on the duties and responsibilities of DPW as it relates to financial management services (FMS). It began after a high volume of calls were made earlier this year to the Auditor General's office, and to members of the PA Legislature, from individuals receiving Waiver services and from their direct care workers who were not getting paid timely or correctly.

Readers may recall previous newsletter articles about significant problems with payments to caregivers of individuals receiving long-term care services at home through Home and Community Based Services Waiver programs. Several Waiver programs (Aging, Attendant Care, OBRA, COMMCARE, Independence, Consolidated and Person/Family Directed Support) allow for "consumer-direction" of certain services such as personal care services. Individuals in these Waiver programs who choose consumer direction have the authority to hire, train, schedule and supervise their workers thereby giving them the most control over the care. If someone uses the consumer model, she also receives FMS services to handle the administrative tasks associated with being an employer: tasks such as issuing paychecks and withholding taxes.

Prior to 2013, 36 different agencies across the state provided these FMS services. DPW decided to reduce the number of providers of this service and began to use a new statewide vendor, Public Partnerships Limited LLC (PPL), in January 2013. Over 20,000 individuals transitioned to the new vendor for FMS. The report notes that thousands of workers had paychecks delayed for up to four months. These payment problems led some of the individuals receiving Waiver services to switch and go through an agency to provide them with a caregivers/home care workers or to go to a nursing home-both of which are more costly to the MA program and to taxpayers.

The main findings of the audit include:

- DPW's poor oversight of the FMS providers in place prior to PPL's contract led to undue stress and financial strain for hundreds of direct care workers;
- DPW's procurement process was unfair to other vendors who might have bid lower and ultimately performed better;
- DPW's mismanagement of the FMS transition led to thousands of direct care workers not getting paid on time. DPW ignored numerous red flags, thereby missing the opportunity to ensure that waiver participants transited to PPL as seamlessly as possible;
- DPW incurred additional costs with PPL, and it did not achieve expected efficiencies;
- DPW continues to put the well-being of Waiver participants and direct care workers at risk by not adequately monitoring PPL; and
- DPW failed to ensure that only allowable hourly wage rates were paid to direct care workers and allowed this noncompliance to continue for years.

(Continued on Page 4)

(Continued from Page 3) The report made several recommendations for DPW to follow in order to improve its oversight of these services now and going forward. The recommendations urged DPW to conduct initial and ongoing reviews of PPL to determine compliance with all applicable laws, regulations and standards, and to take quick, specific action when they find noncompliance. DPW disagreed with all of the performance audit findings and said they'd "consider" the recommendations made. The entire report can be viewed here.

Adults on MA Should Ask for An Emergency Supply If Prescription Limit Is Reached

An emergency supply process is available for Medical Assistance (MA) recipients who have reached their six prescriptions per month limit. As readers may remember, most adults on MA are limited to coverage of six prescription drugs per month. Adults who get their MA coverage through Fee-for-Service (the ACCESS card) have been limited to six drugs per month since January 2012. Currently, all but four of the HealthChoices plans (MCOs) across the state are imposing the six prescription drug per month limit. The four plans that have not yet limited their prescription coverage are: Aetna Better Health, Coventry Cares, Geisinger, and Health Partners. Children under age 21 on MA are not subject to a coverage limit for prescription drugs. If a drug is denied at the pharmacy because of the six prescription limit, MA recipients can ask the pharmacist for an emergency supply of medication so they have access to their medication while their doctor seeks approval from their insurance.

As a reminder, all drugs count toward the six drugs an individual can get in a given month. Certain types of drugs are automatically exempt which means that someone can get these medications at the pharmacy even after the limit is reached. Examples of medication types that are automatically exempt from the limit include medications to treat HIV/AIDS, cancer, serious mental illness, and diabetes. If an individual has reached their limit and needs a medication that is not automatically exempt, the doctor must request a Benefit Limit Exception that must be approved before the individual can get this medication. Consumers can contact their plan's Member Services Department to find out which of their drugs are auto-exempt from the limit (this phone number should be on the back of the plan ID card). Those who receive coverage through the ACCESS card can contact Recipient Services at 1-800-537-8862, Option 2.

Pharmacists have discretion about whether or not to issue an emergency supply. Under the MA rules, they can provide up to a five day emergency supply of the prescribed drug if, in the professional judgment of the pharmacist, the MA recipient has an immediate need for the drug. However, the pharmacist will not dispense the drug if he or she determines that taking the prescribed drug, either alone or with other drug(s), would jeopardize the health and safety of the recipient. The emergency supply does not count toward the six drug per month limit.

Pharmacists who have questions about how to bill for the emergency supply for their patients on MA through the ACCESS card should contact DPW Pharmacy Services Provider Call Center at 1-800-537-8862. Otherwise, pharmacists can contact the individual's managed care plan with questions about billing the emergency supply.

Individual consumers who are having trouble getting their medications through MA because of the six prescription limit should call PHLP's Helpline. More information about the limits can be found at www.phlp.org under the Resources and Publications Tab/Prescription Drug Access and Coverage.

CHIP Reauthorized, Six Month Waiting Period Dropped

Last month, Governor Corbett signed a bill reauthorizing Pennsylvania's Children's Health Insurance Program (CHIP) until December 31, 2015. Most significantly, the bill eliminates the "go-bare" period which up until now required children over the age of two applying for CHIP to be uninsured for six months before coverage could start. This change to the program was effective immediately upon the bill's passage.

The "go-bare" period, intended to prevent parents from voluntarily dropping employer coverage in favor of state funded health insurance, was opposed from the program's inception in 1992. Many believed the "go-bare" period made little sense in a program directed at serving children. For most families having a child go without insurance for six months was never an option and therefore those families never applied for CHIP despite being eligible for the coverage.

The elimination of the "go-bare" period is a part of Governor Corbett's Healthy Pennsylvania campaign. This first piece of legislation associated with the campaign will ensure that all children in the state of Pennsylvania have timely access to quality, affordable health care coverage.

Applying by Phone for Medical Assistance Now Possible

The Department of Public Welfare has a new "Consumer Service Center" that accepts applications for Medical Assistance over the phone. Representatives take applicants' information by phone and enter it into DPW's online COMPASS application. This is a particularly good option for individuals who have limited or no access to a computer. The call center representatives do not make eligibility determinations and cannot advise the applicant on whether he or she will qualify for coverage. Application information is sent to the applicant's local County Assistance Office who makes the eligibility decision and informs the applicant of that decision by written notice.

The ability to apply for Medical Assistance by phone is one of many changes brought about by the Affordable Care Act, which intended to increase access to health insurance by allowing consumers to apply in-person, by phone, or online. The phone application process is only available for Medical Assistance benefits and not for other public benefits.

DPW contracts with the Pennsylvania Industries for the Blind and Handicapped to operate its 'apply by phone' call center, which began operations on October 1, 2013. According to early reports, there is little to no wait time for applicants to reach a representative. The new Consumer Service Center is open from 8:00am to 5:00pm Monday through Friday.

Apply by Phone	
PA Consumer Service Center	(866) 550-4355

Private Insurance Policy Being Cancelled? Tips for Seeking Coverage

In recent weeks, hundreds of thousands of Pennsylvanians with individual coverage policies received cancellation notices from their insurance company informing them that their coverage will end this year. This includes low-income Pennsylvanians who are covered by SpecialCare, a limited-benefit, income-based insurance program offered by the Blue Cross/Blue Shield Plans. These cancelation letters have caused significant confusion, and continued problems with enrollment in coverage through the Marketplace have left consumers worried about having coverage after January 1st. To address these problems (which are not unique to Pennsylvania), the federal government and the Pennsylvania Insurance Department are now giving insurance carriers options to: extend these existing plans, guide consumers to different plans that comply with the Affordable Care Act, or continue on their current course to end existing plans. The Blue Cross/Blue Shield plans across Pennsylvania have agreed to extend the Special Care coverage until June 30, 2014.

Below are suggestions from the Pennsylvania Insurance Department for individuals who currently have individual coverage but are receiving cancellation notices from their insurance company:

- **Carefully read your current insurance company letter —**It will have important information about your specific situation and your possible next steps. If you have any questions, contact your insurance company at the telephone number provided.
- **Explore coverage options through the Marketplace** —Ask if your current insurance company has any plans on the "*Health Insurance Marketplace"*, or explore other options at www.Healthcare.gov. Help is also available 24 hours a day, 7 days a week by calling 1-800-318-2596.
- **Seek in-person assistance —**Information regarding community resources can be obtained by visiting https://localhelp.healthcare.gov or by calling the Marketplace.
- **Before purchasing a plan, be certain that you understand any cost-sharing**. Co-pays, deductibles, and coinsurance may be part of the products you are considering. Also be certain that the doctors and hospitals you want to use are included in the network of the plan(s) you are considering as this can have a real impact on your cost and your ability to access services.
- **You now have until *Monday, December 23rd* to enroll in a Marketplace plan in order to get coverage on January 1, 2014.**

Coventry Cares Ending "Additional" Dental Benefits for Members

Not all adults over the age of 21 enrolled in Medical Assistance (MA) in Pennsylvania qualify for dental coverage. Those getting MA through the "General Assistance" categories receive a more limited benefit package that includes no outpatient dental benefits. As an inducement for MA consumers to join its managed care plan, Coventry Cares had offered limited dental coverage to **all** of its adult members regardless of their MA benefit package. As a result, adults in the General Assistance category who enrolled into Coventry Cares were eligible for two exams and two cleanings a year at no cost to them.

That "additional" dental benefit is now ending . Coventry Cares mailed a notice out to approximately 4,200 of its members across the state who will be impacted by the change telling them that their dental benefits are being discontinued effective January 1, 2014. Anyone who already has an appointment scheduled for these services after January 1st, will be able to have the services covered as long as the work is done by February 1, 2014.

Please note that this change only affects Coventry Cares members who do not otherwise qualify for dental coverage through MA. Anyone under age 21 in Coventry Cares, as well as anyone 21 and older whose MA benefit package includes outpatient dental benefits, will not be impacted and they will continue to be able to access dental care as usual through the plan. Anyone with questions about the change and who it affects can contact PHLP's Helpline.

Applying to DPW for MA & CHIP Likely a Faster Path to Enrollment than Applying to the Marketplace

As widely reported and described in prior PHLP newsletters, people can now apply for the health insurance premium tax credits and cost-sharing subsidies under the Affordable Care Act, through the federally facilitated Marketplace. Not everyone will be able to qualify for these reduced costs, but it will help people who currently cannot afford any coverage or those who are struggling to afford the coverage they do have. PHLP recently released a flyer that can help you figure out if you should apply for Medical Assistance or CHIP, or if you should use the Marketplace to apply for other low-cost health insurance.

Although the Marketplace is receiving applications for Medical Assistance and CHIP (and then sending that information to Pennsylvania for an eligibility determination), consumers seeking speedy enrollment in those programs would be better served applying directly through the Department of Public Welfare. Pennsylvania is just starting to receive information from the Marketplace and it remains to be seen how smoothly the information gets transferred and how quickly eligibility determinations are made after receiving this information.

Individuals can contact PHLP's Helpline for advice and direction about where to apply given their particular situation.

Health Law News to Be Published Monthly

For years, PHLP has published two bi-monthly newsletters, the *Health Law PA News* and the *Senior Health News*.

Effective January 2014, these two newsletters will be combined into a single monthly publication titled *Health Law PA News*. This will allow us to ensure our readers have timely access to important information. The combined newsletter will continue to report on topics of specific interest to seniors and persons with disabilities, such as Medicare, the Medicare Savings Program, the Medicare Part D Low-Income Subsidy (LIS), and Home and Community Based Services Waiver programs.

If you have questions or would like to change your subscription settings, please email staff@phlp.org.

Happy Holidays from PHLP!

PHLP is a small non-profit law firm that stands by people in distress: people who did not do anything wrong but whose physical and mental well being is compromised. The services we obtain for our clients are important to their well being, and provide peace of mind: the kind of peace we wish for anyone who needs medical care.

At the heart of PHLP are the 1.4 million Pennsylvanians who live without health coverage, and the two million low-income Pennsylvanians in the Medicaid program. Their experiences and health care needs keep us grounded. We strive to help in every way we can. We've obtained health coverage for the uninsured, restored skilled nursing care for developmentally disabled children and adults, and advised low-income seniors confused about Medicare enrollment. It is a privilege to do this work.

This year, PHLP celebrated its 20th anniversary and Pennsylvania began working to implement the Affordable Care Act. Please consider us when you are making any year-end contributions to charitable organizations and help us continue to advocate for the most vulnerable Pennsylvanians as our Commonwealth makes historic decisions about health law. Donations can be made by mail or by using our secure online form at www.phlp.org.

PHLP wishes you and your family a happy holiday season and good health in the New Year!