PENNSYLVANIA Health Law PROJECT

HEALTH LAW PA NEWS & SENIOR HEALTH NEWS

Publications of the Pennsylvania Health Law Project

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This newsletter is a combined issue of our two bi-monthly newsletters.
We will return to our regular schedule of issuing monthly newsletters in August.

State Declines to Expand Medicaid At This Time

The Pennsylvania General Assembly ended up approving a state budget for FY 2013-14 that did **not** include a Medicaid expansion. The budget was signed into law by Governor Corbett on June 30th. As discussed in previous newsletters, the U.S. Supreme Court ruling in June 2012 made the expansion of Medicaid (to cover adults with income up to 138% FPL regardless of assets) optional for states. So far, about ½ of the states have chosen to expand Medicaid. Pennsylvania is not currently one of them.

Funding needs to be appropriated in order for Pennsylvania to expand Medicaid. Since this funding was not included in the final budget (and with the lack of support from Governor Corbett and certain legislative leaders at this time), it seems unlikely that Medicaid expansion could happen before July 2014 (if even then). Advocates supporting expansion were hopeful at the end of June when a Welfare Code bill passed in the Senate (HB 1075) in a 40-10 bipartisan vote that included language expanding Medicaid under certain conditions.

However, when that Welfare Code Bill went to the House, the Republican leadership removed the expansion language before the bill was brought to the floor for a vote stating their belief that Medicaid expansion was fiscally unsustainable. The Bill that then passed in the House included no provisions for expanding Medicaid and the Senate did not attempt to reinsert the language when the Bill came back to them for a final vote.

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INSIDE THIS EDITION

(Continued from Page 1) Advocates who support expansion will continue to push the Administration and legislators to pursue expansion and believe there is still an opportunity for Pennsylvania to expand Medicaid in 2014 or early 2015. The Governor continues to engage in discussions with the U.S. Department of Health & Human Services over a possible Medicaid expansion at some point in the future.

Pennsylvania To Study Delivery of Care for Dual Eligibles and Those Needing Long-Term Care Services

In July, the Secretary of the Department of Public Welfare, Beverly Mackereth, wrote a letter to legislative leaders to announce the Department's intent to form two workgroups to explore models of care for the dual eligible population and the delivery of long-term care in Pennsylvania. As a reminder, dual eligibles are individuals who receive both Medicare and Medicaid coverage. The time-limited workgroups will be formed by the end of September (within 90 days of the final 2013-2014 budget).

The dual eligible workgroup will study the care needs of the dual eligible population and models available to improve care and control costs. Specific models mentioned include but are not limited to Integrated Care, enrollment of dual eligible individuals into Medicaid managed care, intensive case management programs, and managed fee-for-service systems. The long-term care workgroup will study how long-term care is delivered to identify how that system can be improved. The goal of the workgroups will be to develop recommendations for the state to pursue in the future. Both groups' findings and recommendations will be presented to the legislature as well as the general public.

The Centers for Medicare and Medicaid Services has been emphasizing increased coordination between Medicare and Medicaid in recent years. A number of states are currently exploring various initiatives to improve the coordination between these two programs and/or to redesign how long-term care services are provided. Readers may remember that the Department of Public Welfare had pursued an Integrated Care Initiative in the past, but these efforts were halted shortly after Governor's Corbett administration began to focus on other priorities

Secretary Mackereth's letter cited concerns about the high costs of providing long-term care in Pennsylvania as well as the growing demand for services as Pennsylvania's population ages. She also mentioned fragmented systems resulting in confusion among consumers and difficulty accessing care and services. Another factor cited for exploring how care is delivered to dual eligibles and how long-term care is provided is the significant imbalance between Pennsylvania Medicaid's spending for nursing home care compared to spending for home and community-based services-we rank 41st out of 50 states.

PHLP recognizes the need to study these issues and acknowledges there are areas for improvement. We hope that both workgroups convened by the Secretary include consumer representatives and advocates representing both older adults and individuals with disabilities who will be impacted by possible changes. PHLP also hopes that the state will explore the full range of models and options available and carefully consider each option before deciding which model(s) and recommendations to pursue. We'll keep readers on developments as they occur in upcoming months.

Pennsylvania Seeking MAGI Waiver

The Department of Public Welfare (DPW) recently issued a notice that it intends to apply for a waiver from the federal government to allow the state to implement the Modified Adjusted Gross Income (MAGI) income deeming rules for Medicaid eligibility beginning October 1, 2013.

Without this waiver, when the open enrollment period for the new Marketplace starts October 1st, DPW would have to begin accepting applications and determining eligibility for Medicaid using current Medicaid income eligibility rules for coverage from October 1st to December 31st and then determine eligibility using MAGI rules for coverage from January 1st onward. Given that complexity, the Center for Medicaid and Medicare Services (CMS) has given states the option to apply for a waiver that will allow them to use ***only*** the new MAGI rules for both current and future Medicaid eligibility.

The Affordable Care Act requires states to use these new MAGI income rules starting January 1, 2014 when determining Medicaid and CHIP eligibility for certain populations-specifically, pregnant women, children, and families. These same MAGI rules are also used to determine who qualifies for the Advanced Premium Tax Credits and Cost Sharing Reductions which will help reduce the costs of buying insurance through the new Marketplace which opens October 1st for enrollment into coverage starting January 1, 2014.

Please note: the MAGI rules do <u>not</u> apply to the elderly, blind, and disabled Medicaid populations, so these new rules will not change how these populations qualify for Medicaid.

The MAGI rules differ from current Medicaid eligibility rules, especially in terms of counting income and household composition. MAGI generally follows IRS tax filing rules, allowing deductions for dependents (even if dependents do not physically live with the person filing taxes) and counting some, but not all, income that is currently counted by Medicaid and CHIP. For instance, under current program rules, workers compensation, veterans' benefits, and child support are counted as income, but under tax rules, they are not counted as income. Also, under the new MAGI rules, all current earned income disregards (such as child care and transportation expenses) will be eliminated and will be replaced by a flat 5% income disregard. To assure that no one's eligibility is adversely affected, CMS and DPW have adjusted the income eligibility for each category of the MAGI population.

PHLP staff have reviewed the draft waiver application and other available information. While the prospect of running a single eligibility system seems reasonable and appropriate, some concerns remain including:

- The Children's Health Insurance Program (CHIP) will **not** implement MAGI rules early. While CHIP will screen new applicants for Medicaid eligibility between October and December using the MAGI rules, it is less clear whether CHIP will screen its renewals of current members for Medicaid using MAGI during those same months. This non-alignment of income deeming rules could mean a child would not be enrolled in the correct program between October1st and December 31st.

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- DPW has stated that it will not have full access to IRS income information available through the federal data hub on October 1st and therefore it will need to rely on current paper verification processes until full access is established.
- At the time of this writing, there appears to be confusion over how to correctly apply the 5% income disregard required by MAGI rules.
- This is a significant undertaking for DPW's information technology systems, policies, and procedures all of which must be learned by individual workers within the CAOs. Will DPW be completely ready to shift the systems by October 1st?

Applying for a federal waiver involves a formal process with many steps. DPW must allow for public comment prior to its submission and CMS must act within a specific timeframe approving or rejecting the waiver application. Public comments are due to DPW by August 13th. The PA Bulletin announcement and the draft waiver application can be found here.

Some Children Will Soon Transition from CHIP to Medicaid

Under the Affordable Care Act, children's eligibility for Medicaid will change. Beginning January 1, 2014, income eligibility for children ages 6 to 19 will increase from 100% to 133% of the federal poverty level (FPL). Currently, when a child applies for Medicaid but their family's income is over 100% FPL, the child is sent to the Children's Health Insurance Program (CHIP) program for coverage. Once the income limits for Medicaid increase in January, children whose family income meets the new Medicaid income limits will transition from CHIP to Medicaid.

To assure that children moving between programs do not experience an unnecessary disruption in their health care, PHLP along with Community Legal Services, the Pennsylvania Chapter of the American Academy of Pediatrics, Pennsylvania Partnerships for Children, and Public Citizens for Children and Youth have made a set of recommendations to the Departments of Insurance and Public Welfare.

The recommendations stress the importance of allowing families to choose a health plan that includes their child's current primary and specialty care providers and encourages the two Departments to work together to inform and assist families in that process.

Readers can view the complete recommendations here.

Medicaid Budget for FY 2013-2014

Governor Corbett and the General Assembly reached agreement on the state budget but failed to reach any agreement on the Governor's proposed state pension changes, transportation funding, or liquor store privatization plan. The $28.375 billion General Fund budget is an increase of 2.3% over the previous year. The final Fiscal Year 2013-2014 budget for the Medicaid program is most noteworthy for what it does **not** contain: Medicaid expansion (as discussed previously). None of the line-item appropriations and initiatives that are contained in the final Medicaid budget approach the scale of the Medicaid expansion, which would have expanded Medicaid to nearly a half million additional uninsured adults in Pennsylvania.

Unlike in recent years, this budget does not cut eligibility or reduce the services available to Medicaid consumers. It funds the Department of Public Welfare (DPW) at $10.96 billion, an increase of 3.1% over the past fiscal year. The overall budget for the Medicaid program is $20.2 billion, which includes $6.5 billion in state General Funds, $2.6 billion in "other" state funds, and $11.1 billion in federal funds.

The final Medicaid budget contains reauthorization of the statewide hospital assessment, a 2% rate increase for nursing facilities, and a 2% increase in the capitation rates for Medicaid managed care organizations. It also contains an 8% increase in funding for the Medical Assistance Transportation Program.

Specific highlights of the final FY 2013-2014 Medicaid budget include:

- **Human Services Block Grant:** The budget expands the Human Services Block Grant program, through which counties receive flexibility in spending their county-based human services funds, from 20 to 30 counties. The Governor had proposed expanding this program statewide.

- **Intellectual Disability (ID) Waiver Funding:** The budget provides additional funds to reduce waiting lists for the Consolidated and Person/Family Directed Supports (PFDS) Waivers. DPW officials estimate the additional funding will allow them to serve 380 individuals currently on an ID waiver waiting list. They also estimate the funding will be sufficient to provide waiver services to an additional 118 individuals with autism spectrum disorders.

- **Funding for Individuals with Physical Disabilities**: The budget provides additional funds to serve approximately 1680 more people through waivers for individuals with physical disabilities. It is not clear at this time whether this increased funding will result in people being able to enroll into the COMMCARE or the OBRA waivers again (these programs currently have an enrollment moratorium). There is a 13% increase in funding for the Attendant Care waiver and Act 150 program, but DPW officials did clarify that this increased funding would **not** be used to reduce the waiting list for Act 150 services. The state-funded Act 150 program is for adults with physical disabilities who do not qualify for the Attendant Care Waiver because they don't meet the level of care or financial eligibility requirements.

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- **In-Home Services for Older Adults**: The budget included an increase in funding for the Aging Waiver program which provides in-home services to individuals age 60 and older who are determined to meet the nursing home level of care. The increased funding allows for an additional 1550 older adults to be served under this program.

- **"Fair Share" Premiums for Families with Disabled Children:** The final budget includes a new premium for the families of children with disabilities (PH-95 category) with incomes above $100,000 per year. Department officials, however, do not believe implementing this premium is permitted under the federal maintenance of effort protections in place until 2019 for children.

CMS Launches New Website for Consumers and Advocates

In June, the Centers for Medicare & Medicaid Services (CMS) updated its website, www.healthcare.gov, to feature information for consumers about the Affordable Care Act, with a particular emphasis on the upcoming Health Insurance Marketplaces. The easy-to-use website includes frequently asked questions that cover topics from health insurance basics to eligibility for financial assistance when purchasing insurance in the Marketplace.

The site has two main tabs at the top of the page: "Learn," and "Get Insurance." Under the "Learn" tab, people can answer a few basic questions about themselves, such as their state, age, and approximate yearly income. They will then be told which potential coverage options could be available to them including Medicaid, the Children's Health Insurance Program (CHIP), or financial assistance to purchase health insurance in the Marketplace. People can also print out a personalized checklist of materials they can start gathering together in preparation for the start of the open enrollment period on October 1, 2013.

The "Get Insurance" tab has more information about the upcoming Marketplace. During the open enrollment period, which initially will span from October 1, 2013 through March 31, 2014, consumers will be able to enter the online Marketplace through this tab. In states like Pennsylvania where the federal government is operating the Marketplace, this will be the place where people can compare and purchase insurance plans starting October 1st.

In addition to the improvements to the website, CMS has also established a toll-free number individuals can call (1-800-318-2596 or TTY: 1-855-889-4325) to have their Marketplace questions answered by a customer service representative. The hotline is staffed 24 hours a day and seven days a week. Website users who need help can also use the live chat feature to speak with a CMS representative in real time.

There are links at the bottom of the website's homepage that have more specific, technical information for the media, partner organizations, and state agencies. These links also include publicity materials that advocacy groups can print out and share with consumers at educational events. The website is also available in Spanish by visiting www.cuidadodesalud.gov.

PA Fair Care Enrollees Transitioned to the Federal Pre-existing Condition Insurance Plan July 1, 2013

Due to federal funding changes, PA Fair Care (Pennsylvania's Pre-existing Condition Insurance Plan or "PCIP") is now being run by the federal government. The PA Fair Care Program was established as a requirement of the Affordable Care Act. Effective July 1, 2013, the program is now administered by the federal PCIP Plan. Pennsylvanians enrolled in the PA Fair Care Program were notified of the change by the National Finance Center and should have received an identification card, a premium notice, and an enrollee handbook for the federal PCIP program. Those transitioned to the federal PCIP plan will not have to re-apply; but, they must pay their monthly premiums to maintain their coverage. According to the website, www.pciplan.com, the monthly premium for Pennsylvanians is $241. Premium payments must be sent to: **USDA, National Finance Center, PCIP Collections, PO Box 790275, St. Louis, MO 63179-0275.**

The deductible for the federal PCIP Transition Plan is $1,000. Any medical expenses that have already been paid in the first half of 2013 by PA Fair Care enrollees will **not** count toward the $1,000 Transition Plan deductible. Once the $1,000 deductible has been met, the co-insurance for enrollees for most services under the new plan is 30%. There is a separate $250 deductible for prescription drugs.

Provider networks may differ between the former PA Fair Care Program and the federal PCIP Transition Plan. The PCIP plan will pay any provider that accepts Medicare. Providers use the same claim form to bill the PCIP as they do to bill Medicare. Either providers or enrollees can file the claim. See PHLP's fact sheet, "Pre-existing Condition Insurance: Getting Your Care Covered" at www.phlp.org/pa-fair-care-ended-july-1-2013 for more information.

The federal PCIP Transition Plan will continue until December 31, 2013 as this plan was only intended to help fill a gap until the full implementation of the Affordable Care Act on January 1, 2014 when additional coverage options will be available through the Marketplace and plans are no longer allowed to deny coverage based on pre-existing conditions. Beginning October 1, 2013, those enrolled in the Transition Plan can and should shop at the Marketplace for a new health plan to be effective in 2014.

For more information on the federal PCIP Transition Plan call 1-866-717-5826.

Please **support PHLP** by making a donation through the United Way.

For Southeast PA, go to www.uwsepa.org and select donor choice number 10277.

For the Capital Region, go to www.uwcr.org and pledge a donation to PHLP.

For the Pittsburgh Region, go to www.unitedwaypittsburgh.org and select agency code number 11089521.

HealthPartners Implementation of Drug Limits on Hold

In late May, HealthPartners sent out notices to all plan members and providers informing them that the plan intended to implement a six prescriptions per month coverage limit for Medicaid enrollees whose benefit package includes pharmacy benefits beginning July 1st.

PHLP recently learned that HealthPartners experienced some technical difficulties trying to implement the drug limit and reported to the Department of Public Welfare (DPW) that they would not be able to go forward with the change at this time.

DPW is currently reviewing a draft letter HealthPartners intends to send out rescinding the drug limits previously announced. Once DPW approves the notice, it will be sent out to all plan members and providers. Should HealthPartners decide to go forward with the six drug limit in the future, it will be required to send out a new notice at least 30 days prior to implementing the benefit change.

HealthPartners is a Medicaid managed care organization in the HealthChoices Southeast Zone that includes Philadelphia, Delaware, Chester, Montgomery and Bucks counties.

Correction:

Please note that in our previous *Health Law News* issued in May, we had incorrectly reported that Aetna Better Health was implementing the prescription limits. That is not the case and Aetna currently does ***not*** limit their members to six prescriptions per month. PHLP regrets the error.

CHIPRA Outreach and Enrollment Grant Awarded to Pennsylvania

The Center for Medicaid and Medicare Services (CMS) has awarded a CHIPRA outreach and enrollment grant to Pennsylvania Legal Assistance Network (PLAN). PHLP will be a subcontractor for that grant and will conduct in-person trainings across the Commonwealth starting this fall for legal services entities, juvenile justice and child welfare officials, and pediatric office staff.

The trainings will include information about the health coverage options for children under 19 and discuss changes in eligibility rules, policies, and application/renewal procedures under the Affordable Care Act. The trainings will also highlight promising outreach and enrollment strategies.

For more information contact Ann Bacharach, abacharach@phlp.org

"Aid Paid Pending" When Appealing Medicaid Denials

Individuals whose Medicaid coverage ***or*** Medicaid-covered services are being reduced or terminated are entitled to receive written notice before the reduction or termination takes effect. These individuals also have a right to appeal the termination or reduction of coverage and/or services. Under Medicaid rules, when coverage or services are being reduced or terminated and the appeal is made within certain timeframes, individuals have a right to continue receiving the previously approved benefits during the appeal process. This important protection is called "aid paid pending" or "continued benefits pending appeal".

To get aid paid pending, individuals must appeal Medicaid **eligibility** changes within 15 days of the mail date on the eligibility notice sent by the County Assistance Office**. Service** denials must be appealed within 10 days of the date on the denial notice sent by the Department of Public Welfare or the Medicaid managed care plan. All denial notices sent to Medicaid consumers include information about how to file an appeal.

PHLP and other legal services programs routinely talk to clients who file timely appeals but whose Medicaid benefits don't continue as they should during the appeal process. For eligibility cases, our legal services colleagues have raised this issue to DPW officials who have sent out an e-mail clarification to all the County Assistance Offices reminding them of the aid paid pending rules and instructing them to reinstate benefits in cases where individuals have appealed the termination in time to qualify for continued benefits.

DPW has also developed training materials for CAO staff to make sure they understand consumers' appeal rights and rights to aid paid pending. The CAO staff can tell individuals who appeal that they may be charged an overpayment if they lose the appeal, but they are not to discourage people from filing appeals or to encourage them to withdraw an appeal already filed. For service cases, PHLP has raised issues directly to DPW when clients' rights to aid paid pending have been violated by Medicaid managed care plans when terminating or reducing services.

Here are some tips for individuals who are appealing Medicaid coverage or service denials:

Eligibility Denials:

⇒ Medicaid eligibility appeals must be in writing and sent to the individual's local County Assistance Office.

⇒ Individuals can appeal eligibility denials using the eligibility notice they receive from the County Assistance Office. There is a section in that notice the individual can complete to appeal.

⇒ Appeals must be filed within 30 days of the mail date on the eligibility notice. **To get aid paid pending, however, an appeal must be filed within 15 days of the mail date on the notice**.

⇒ Individuals should try to keep a copy of their appeal and send in their appeal

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(Continued from Page 9) using either registered mail or certified mail (so they have proof that the appeal was mailed timely and that the appeal was delivered to the CAO). Individuals who take their appeal to the CAO should ask for a receipt from the front desk.

Service Denials:

For Individuals in Medicaid Fee for Service/ACCESS card:

⇒ Appeals of service denials by the Department of Public Welfare fee-for-service program, for individuals who use the ACCESS card, must be in writing. The denial notice gives the mailing address for appeal requests. These service denials must be appealed within 30 days from the date of the denial notice, but **to get aid paid pending the appeal must be filed within 10 days of the date on the denial notice.**

⇒ Individuals should keep a copy of their appeal and send in the appeal request using registered mail or certified mail so that they have proof of when the appeal was mailed and that it was delivered to the Department of Public Welfare.

For Individuals in Medicaid managed care plans:

⇒ First and second level grievance appeals of service denials by managed care plans can be done verbally over the phone by contacting the plan directly or can be submitted in writing to the plan. Individuals have 45 days to appeal service denials by managed care plans. However, **appeals must be filed within 10 days of the date on the denial notice to get aid paid pending** during the appeal process.

When requesting the first or second level appeal, individuals should keep a note with the date the appeal was requested and the name of the plan representative who took the appeal. Individuals who make their appeal requests in writing should keep a copy and mail it in a way that provides proof of mailing and delivery.

⇒ Managed care plan service denials that are appealed to an External Review (generally this is an option after the second level grievance occurs) or to a Fair Hearing (can happen at any stage during the appeal process) must be made in writing. External Review requests must be made within 15 days of getting the notice and Fair Hearing requests must be made within 30 days of the date on the denial notice. **In both cases, however, appeal requests must be filed within 10 days of the date of the most recent denial decision to get aid paid pending during the appeal process**. Again, individuals are encouraged to keep a copy of their appeal and mail the appeal request in such a way that they have proof of when it was mailed and that it was delivered to the entity handling the appeal.

Individuals with questions about their appeal rights or how to appeal should call PHLP's Helpline at 800-274-3258. Individuals should also call PHLP if they have already filed an appeal and are having problems getting aid paid pending.

Training on HealthChoices
New West & New East Zones "Part Two"

Attention:
Medicaid Consumers, Providers, Family Members and Advocates

Sponsored in part by the Pennsylvania Office of Rural Health

Across the state, most individuals with Medicaid coverage are now enrolled in a managed care plan. ACCESS PLUS has ended. HealthChoices (mandatory managed care) is statewide.

This is an important change for Medicaid recipients, effecting how they access health care services and providers and what they can do if their plan denies a service or medication.

Now that HealthChoices has been implemented in the new zones, we know there are still questions and concerns about this new delivery system. PHLP is offering "Part Two" of our trainings to educate consumers, family members and professionals with additional information they need to know:

- How has coverage changed with HealthChoices (a refresher),
- What if I am unhappy with my current plan,
- What to do if a plan is denying a service or medication,
- How does HealthChoices increase rights with the Medical Assistance Transportation Program (MATP)?

Come to a **FREE** in-person training by the Pennsylvania Health Law Project to learn about these changes.

Wednesday, August 7
1 pm – 4pm
Toftrees Conference Center
One Country Club Lane
State College, PA 16803
Warren, PA 16365

Thursday, August 8
1 pm – 4 pm
JC Blair Hospital
Education Building
1225 Warm Springs Ave
Huntingdon, PA 16652

Friday, August 16
9 am – 12 pm
Charles Cole Hospital
Wellness Center
1001 East 2nd Street
Coudersport, PA 16915

Space is Limited. Please RSVP for a training through PHLP's Helpline (800-274-3258) or staff@phlp.org.

ATTENTION: Starting Next Month, PHLP Newsletters Only Available Online

Dear Readers,

Due to the high production cost of sending newsletters though the mail, **this is the last PHLP newsletter that will be mailed by USPS**. The August Senior Health News and all future newsletters will only be available online. You can receive our newsletters by e-mail or download them from our website at: www.phlp.org/home-page/news/newsletters. We apologize for any inconvenience this may cause.

We encourage you to join our electronic mailing list so that we can continue to send you the latest news. If you currently receive PHLP's Health Law News or Senior Health News through the mail and would like to receive it electronically, please contact staff@phlp.org.

As a reminder, if you need legal advice you can call our Helpline at 800-274-3258. Our Helpline is open on Monday, Wednesday, and Friday.

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