Health Law PA News

A Publication of the Pennsylvania Health Law Project

Volume 16, Number 3
May 2013

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

Deadline Nears for Pennsylvania to Expand Medicaid

Pennsylvania has an unprecedented opportunity to improve the lives and health of hundreds of thousands of uninsured Pennsylvania by adopting the Medicaid expansion provision under the Affordable Care Act (ACA). Last June, the U.S. Supreme Court made expanding Medicaid a state option. Under the ACA, the expansion would cover low-income people making up to 138 percent of the federal poverty level, about $16,000/year for an individual and $32,000/year for a family of four.

In order for the Medicaid expansion to be effective in January 2014 (when the other ACA coverage provisions begin), Governor Corbett and the General Assembly must enact a state budget that appropriates funds for this purpose. Governor Corbett has written that the expansion would be "fiscally unsustainable without significant reforms to the program itself." He wants "the federal government to provide flexibility and independence in crafting our state's programs."

State Representative Gene DiGirolamo (R-Bucks) recently introduced legislation—House Bill 1492—that allows Pennsylvania to take part in the expansion program. "I think I've addressed the main issues the governor has," DiGirolamo has stated. The legislation includes protections for Pennsylvania including the ability to drop the program if the federal commitment to reimbursement is not maintained. Pennsylvania could also end the program if our state's Gross Receipts Tax is disapproved by the federal government. In addition, the Department of Public Welfare will be able to institute cost offsetting mechanisms in the fourth year (2017) such as: premiums, deductibles and copayments.

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(Continued from Page 1) Three different analyses of the state's costs and savings—one by the RAND Corporation, another by the Pennsylvania Economy League, and a third by the Independent Fiscal Office (IFO) of the General Assembly—show substantial savings if Pennsylvania opts to expand eligibility. These analyses include the projected additional costs of adding adults to the Medicaid program as well as projected savings in county-based behavioral health services, Medicaid services to the General Assistance population, and disproportionate share payments to hospitals.

Recently, Department of Public Welfare Secretary Beverly Mackereth sent a letter to the Director of the IFO, disputing some of the economic assumptions in the IFO report. Overall, the Secretary does not contest the IFO's conclusion that the Medicaid expansion would both increase federal funding and allow Pennsylvania to reduce current expenditures, but she does disagree with amount of projected savings and additional costs.

One area of concern raised in Secretary Mackereth's letter involves the Gross Receipts Tax, a funding mechanism for the Medicaid program allowed by the federal government. However, State Senator Jay Costa (D-Allegheny) has stated that the Center for Medicare and Medicaid Services (CMS), the federal agency governing Medicaid, has confirmed it will continue to allow the tax as a funding mechanism, which is important both to the funding for the current Medicaid program and for expansion opportunities. Again, Rep. DiGirolamo's legislation could end the program if the state's Gross Receipts Tax is disapproved by the federal government (should CMS change their current position).

So far, 26 states have said that they plan to expand Medicaid. An estimated 600,000 Pennsylvanians would qualify for coverage under Medicaid expansion. Individuals who support Medicaid expansion may want to contact their local state Representatives and Senators, especially since the budget bills are being negotiated now. Stay tuned to future PHLP newsletters and our website, www.phlp.org, for updates.

Additional Note: Governor Corbett and his administration have raised a concern that tens of thousands of children in families with income between 100-138 percent poverty who are currently covered under the Children's Health Insurance Program (CHIP) will be moved to Medicaid. Regardless of the U.S. Supreme Court's decision making Medicaid expansion optional for adults, the ACA requires all states to expand the eligibility limits of Medicaid for children ages 6 to 19 beginning in 2014. The Corbett administration has cited this as one of the reasons for its hesitancy to expand Medicaid and is seeking flexibility from the federal government on this matter. However, this position has no relevance to optional Medicaid expansion for adults. CMS has stated it cannot overturn what is mandated in the law. Children in these income brackets **must** be moved to Medicaid in 2014 regardless of the state's decision to expand Medicaid for adults.

Starting August 2013, PHLP newsletters will *only* be available online.

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DPW Expands Drug Types Auto-Exempt From Six Prescription Limit

In April, the Department of Public Welfare added four types of medications to their list of drugs that are automatically exempt from Medical Assistance's coverage limit of six prescriptions per month for adults. Medical Assistance (MA) is what Pennsylvania calls its Medicaid program. The four drug types are: chronic kidney disease medications, gout medications, statins for plaque stabilization, and vaccines. Individuals who are subject to the prescription drug limit should be able to receive these types of medications automatically-even if they have already gotten six medications filled in a month.

As a reminder, adults who get their MA coverage through the ACCESS card have been limited to six drugs per month since January 2012. **All** medications count toward the six drugs someone can get in a given month; however, once the limit is reached, individuals will only be able to get additional medications covered if the type of medication is listed as one that is auto-exempt from the limit, or if their doctor requests a Benefit Limit Exception and MA approves it.

All but three of the HealthChoices plans across the state are imposing the six medications per month limit. The three plans that have **not** limited their prescription coverage are: Coventry Cares (operating everywhere but the Lehigh/Capital Zone), Geisinger Family Plan (operating in the New East Zone), and Health Partners (operating in the Southeast Zone).

The other six plans that have implemented the monthly drug limit (Aetna Better Health, AmeriHealth Mercy Health Plan, Gateway Health Plan, Keystone Mercy Health Plan, United Healthcare Community Plan, and UPMC for You) must follow DPW's rules regarding which types of medications are auto-exempt from the limit. This means that the four new types of medications listed above should be auto-exempt from the six drug limit for individuals enrolled in one of these managed care plans. Some of these plans have auto-exempted additional types of drugs beyond what is required under DPW's rules. Individuals can contact their plan to find out which of their drugs are auto-exempt from the limit.

Individuals having trouble accessing their medications through MA because of the six prescription limit should call PHLP's Helpline at 1-800-274-3258. More information about the prescription limits can be found at www.phlp.org under the Resources and Publications Tab/Prescription Drug Access and Coverage.

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.

Name Change for Two HealthChoices Plans

As of June 1st, Keystone Mercy Health Plan and AmeriHealth Mercy Health Plan have new names. Both are Medical Assistance managed care plans in Pennsylvania. Keystone Mercy, which operates in the Southeast HealthChoices zone, is now called **Keystone First**. AmeriHealth Mercy, operating in the Lehigh Capital and New West HealthChoices zones, is now called **AmeriHealth Caritas Pennsylvania***. The name changes are the result of a change in ownership for these two plans.

Members of these two plans should have received information about the name change and new ID cards. Individuals will **not** get new ID numbers, nor will they have to change their PCPs. The name change has no impact on member's benefits and services they receive. Furthermore, the plan's phone numbers will not change.

*Note: The AmeriHealth Northeast plan that operates in the newest HealthChoices zone (the New East Zone) will not be impacted by this change.

DPW Increasing Oversight of Managed Care Statewide

With the expansion of the HealthChoices program, mandatory managed care is now statewide. Approximately 75 percent of the Commonwealth's two million Medicaid consumers are now enrolled in a physical health managed care organization (PH-MCO).* The expansion of managed care to cover more territory and more consumers than ever before has created challenges for both PH-MCOs and the Department of Public Welfare (DPW), whose officials have acknowledged that they are renewing their focus on MCO oversight.

*Certain individuals on Medicaid are exempt from PH-MCOs. Individuals dually-eligible for Medicaid and Medicare are the largest exempt group. See the March 2013 issue of the HLN for more information on which Medicaid consumers are exempt from in managed care, and instead access their benefit through "fee-for-service" (the ACCESS card).

The Consumer Subcommittee of the Medical Assistance Advisory Committee and the Pennsylvania Health Law Project have identified a host of problematic practices by the PH-MCOs and have brought these problems to DPW's attention:

Right to Written Notice

Some managed care plans have failed to send their members a written notice of their decision to deny or reduce a service. To only notify the prescriber or provider (i.e., a home health agency) is insufficient. Members are entitled to written notice at least 10 days in advance of any adverse action taking place.

Right to Appeal

A number of managed care members have been verbally told that they cannot appeal the reduction

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(Continued from Page 4) or denial of a service, and that only their provider could appeal. This is completely incorrect. A member can either file the grievance and/or a fair hearing herself *or allow* her provider to file the appeal on her behalf .

Prior Authorization Decisions based on Medical Necessity

At least two managed care plans have recently denied requests for home health aide or skilled nursing services on an improper basis. MCOs must base their coverage decisions on whether the service meets the Department of Public Welfare definition of "medical necessity" (see below). A service is considered to be medically necessary if it meets *any one of the three prongs* of the definition. MCOs cannot substitute more restrictive criteria, such as requiring skilled needs for home health aide services or requiring a minimum period of continuous need for nursing services (i.e., 4 hours).

Medical Assistance Definition of Medical Necessity:

A service, item, procedure or level of care that is necessary for the proper treatment or management of an illness, injury or disability is one that:

Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.

Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

Will assist the recipient to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and those functional capacities that are appropriate of recipients of the same age.

Right to In-person Appeal Proceedings

Individuals filing a complaint or grievance with their plan have the right to request an in-person proceeding before the panel deciding their appeal. At least one MCO has provided, instead of a face -to-face proceeding, a local office for the member to go to for the appeal meeting with the review panel connected by a telephone conference call. Members requesting in-person meetings believe they will be face to face with the panel making the decision- only to find out there are no members of the panel in the same room with them during the meeting.

Right to Appeal before a Medical Director

For appeals involving medical necessity or a clinical issue, managed care members have the right to a review panel that includes an MCO medical director not involved in the initial denial. This right extends to appeals of a "benefit limit exception" denial where the member claims that his health will be seriously harmed by the plan denying coverage of the exception (for dentures or a seventh medication, for example).

Consumers or advocates who experience any of these or other due process violations are encouraged to contact the Pennsylvania Health Law Project at 1-800-274-3258.

Final Month to Enact PA State Budget for FY 2013-14

Lawmakers are in the midst of budget negotiations. To meet their obligations, under the state constitution, they need to enact a budget for the next fiscal year that begins July 1, 2013 and ends June 30, 2014 (FY 2013-14). Governor Corbett has passed budgets by the June 30th deadline in past years.

In late May, the Pennsylvania House Republican leaders introduced a FY 2013-14 budget that is $100 million less than what Governor Tom Corbett proposed in February. Overall, the $28.3 billion plan cuts $230 million in spending proposed by the Governor, shifting nearly $130 million of the savings to other budget priorities.

According to the Pennsylvania Budget and Policy Center, the House plan reduces the Governor's proposed spending levels for the Department of Public Welfare by $32 million. County child welfare is cut by $23 million, Medicare prescription drug clawback payments to the federal government by $15 million, services to persons with disabilities by nearly $8 million, attendant care by $2 million, and county assistance offices by $2 million. The plan also adds $20 million to Medical Assistance for managed care capitation payments, nearly $8 million to long-term care, and nearly $4 million for critical care hospitals. Mental health services also got a slight increase.

The House plan makes no commitment to expand Medicaid as permitted in the federal Affordable Care Act, but notes the administration is consulting with federal officials. Representative Bill Adolph, Chairman of the House Appropriations Committee, stated the House was awaiting the Governor's decision on Medicaid expansion and that the budget may have to be adjusted if the state opts to do so in

Building a Consumer-Friendly Application for Health Care Coverage

The Affordable Care Act will significantly increase coverage options through the creation of new health insurance exchange marketplaces, and hopefully, the expansion of Medicaid for adults. The Center for Medicaid and Medicare Services (CMS) recently released a simplified and significantly shortened application for coverage in the health insurance marketplaces.

After substantial testing with consumers about the content, format, and flow, CMS has designed three applications: one for individuals who need financial assistance, one for individuals who do not need financial assistance, and one for families. Consumers will be able to apply online, by phone or paper when open enrollment begins on October 1, 2013.

The applications are designed to gather the information needed for eligibility decisions without an undue burden on the applicant. CMS has also designed a web-based, electronic, dynamic version of the model paper application. In the web-based version, the electronic "logic" behind the questions will be flexible, asking only pertinent questions based on information obtained from the applicant. As an example, the electronic version will not ask males about pregnancy.

These paper and electronic models are available to states for their use but are not required. Pennsylvania is in the process of refining its COMPASS application for use for Medicaid, CHIP and the Marketplace/Exchange. Once that refinement is completed, Pennsylvania will ask CMS to approve it as an alternate application.

Qualified Health Plans on the Exchange Should Use Essential Community Providers

The Affordable Care Act requires qualified health plans participating in health insurance marketplaces (a/k/a Exchanges) to maintain a sufficient number of Essential Community Providers (ECPs) in their provider network. ECPs are safety-net providers within the following categories: federally qualified health centers, family planning clinics, Ryan White HIV/AIDS centers, public or non-profit hospitals, and others such as mental health and substance abuse providers and STD Clinics. They are the "essential" and trusted source of primary care for poor and low-income communities with the greatest health needs. Many of them work to reduce health disparities as well as provide culturally and linguistically competent services.

Recently, the Center for Consumer Information and Insurance Oversight (CCIIO) published a list of essential community providers. 551 are in Pennsylvania. Safety-net providers are not automatically included in qualified health plans' provider networks. However, to meet the demand ahead, especially in rural areas, there needs to be a strong relationship between Pennsylvania's safety net providers and qualified health plans.

In April, the Department of Health and Human Services (HHS) released a Letter to Issuers (insurers) warning them to include ECPs in their network of providers for products they offer through Federally Facilitated marketplaces or risk being held out of compliance.

Future PHLP newsletters will have more detail about the number of qualified health plans on PA's Exchange/Marketplace and the role of the states' ECPs in the coverage opportunities ahead.

Governor Corbett signed into law Act 10 of 2013 (Senate Bill 5) in recent weeks that creates a Community-Based Health Care Program in the Department of Health. This program will provide grants to community-based health care clinics to increase their capacity to deliver quality health care to more people, especially those who will gain insurance through the exchanges and tax subsidies.

Upcoming Changes Impacting Medicare Consumers Who Need Medical Equipment and Supplies

Starting July 1st, certain beneficiaries who receive their Medicare benefits through the **Original Medicare** program (red, white, and blue card), and who need certain medical equipment and/or supplies, will need to get those items from a limited number of contracted suppliers. Medicare has recently mailed beneficiaries letters explaining these changes. More information about these changes can be found in our April 2013 Senior Health News available at www.phlp.org.

Consumers who get their Medicare coverage through a Medicare Advantage plan are **not** impacted by these changes and will continue to get their medical equipment or supplies through a provider that participates in their plan's network. These individuals can contact their Medicare Advantage plan for more information about how to access equipment and supplies.

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Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Round 2

Medicare began its DMEPOS Competitive Bidding Program in January 2011 in nine areas around the country in an effort to help control Medicare's costs for medical equipment and supplies and to save money for beneficiaries and taxpayers. Beneficiaries living in specific zip codes in the Greater Pittsburgh area (which includes Allegheny County and several surrounding counties) were part of that first group. Now, in Round 2, the Competitive Bidding Program is extending to 91 areas across the country and will include many zip codes in the following PA counties: Bucks, Chester, Delaware, Lackawanna, Lehigh, Luzerne, Mercer, Montgomery, Northampton, Philadelphia, and Wyoming counties. Small areas of Berks, Bradford, Carbon, Columbia, Crawford, Lancaster, Lawrence, Monroe, Schuylkill, Susquehanna, Venango, and Wayne counties are also included in Round 2. Starting July 1st, individuals whose zip code is participating in Round 2 are required to get the following equipment through a DMEPOS contract supplier:

- Oxygen, oxygen equipment, and supplies,
- Standard (Power and Manual) wheelchairs, scooters, and related accessories,
- Walkers and related accessories,
- Enteral nutrients, equipment, and supplies,
- Continuous Positive Airway Pressure (CPAP) devices and Respiratory Assist Devices (RADs) and related supplies and accessories,
- Hospital beds and related accessories,
- Negative Pressure Wound Therapy pumps and related supplies and accessories,
- Support surfaces (Group 2 mattresses and overlays)

Medicare beneficiaries can contact 1-800-MEDICARE or visit www.dmecompetitivebid.com to find out if their particular zip code is part of Round 2 and for more information about specific items included in the categories listed above. Please note that the zip code used for the beneficiary is the one that is on her file with the Social Security Administration (SSA).

National Mail-Order Program for Diabetic Testing Supplies

Individuals who have Original Medicare and who have diabetic testing supplies delivered to their home will need to use a national mail-order contract supplier starting July 1st. The testing supplies are those that are covered by Medicare Part B and include blood sugar monitors, test strips, and lancets. These individuals will still have the option to go to a retail pharmacy that participates with Medicare or a local Medicare-enrolled supplier storefront to get their diabetic testing supplies.

Much Work Ahead in PA for Effective Outreach and Enrollment Under the Affordable Care Act

The Affordable Care Act (ACA) will significantly increase coverage options through the creation of new health insurance exchange marketplaces, and hopefully, the expansion of Medicaid for adults. However, effective outreach and enrollment efforts will be critical to ensuring these new opportunities translate into increasing the number of people with health coverage. The Kaiser Commission on Medicaid and the Uninsured recently released, "Key Lessons from Medicaid and CHIP for Outreach and Enrollment", which identifies several lessons learned through previous Medicaid and CHIP experience to help inform the outreach and enrollment work ahead:

- Individuals want to have health coverage and value the Medicaid program for the key benefits it provides to their health and lives more broadly.
- A combination of broad and targeted outreach strategies is crucial to reaching eligible families.
- Providing accessible, welcoming, and family-friendly application and enrollment processes helps reduce enrollment barriers for families.
- One-on-one enrollment assistance provided by trusted individuals within the community is a key component of successful enrollment efforts.
- Facilitating renewals of coverage is important for promoting stability of coverage over time.

The ACA establishes new streamlined eligibility, enrollment, and renewal policies for Medicaid programs as of 2014 (regardless of whether Pennsylvania expands Medicaid or not). But, even with the new streamlined enrollment process in place, a broad range of outreach and enrollment strategies, including targeted approaches for specific populations, will be important to reach and enroll eligible individuals into available programs (i.e., Medicaid, CHIP, and tax subsidies to buy insurance through the marketplace).

The Navigator program included in the Affordable Care Act will play an important role in educating and helping consumers. Navigators are required to provide information in a fair, accurate, and impartial manner. The federal government will award the first grants for the Navigator program in August 2013. However, because Pennsylvania's marketplace will be operated by the federal government, the amount of outreach and enrollment funding available for Pennsylvania's Navigator is only $2 million compared to $24 million in neighboring Maryland and $31 million in New York, which are both operating their own health insurance marketplaces.

PHLP, Enroll America and the PA Office of Rural Health are co-hosting a one-day conference in Scranton in mid-July about outreach and enrollment. This meeting is not a forum to bring critiques about federal or state progress. We seek constructive engagement from all attendees about getting Pennsylvania residents covered. The focus of the meeting will be on three primary questions:

- Why are enrollment and coverage important?
- What are the PA-specific lessons learned from past outreach and enrollment efforts, and
- What does it takes to successfully connect Pennsylvanians to coverage?

Newsletter readers that are part of organizations in Northeast Pennsylvania seeking to learn how to be involved in the work ahead may contact event@phlp.org for more information.

ATTENTION: Starting August 2013, PHLP Newsletters Only Available Online

Dear Readers,

Due to the high production cost of sending newsletters though the mail, PHLP will stop mailing newsletters after our July newsletter. 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 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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