PENNSYLVANIA Health Law PROJECT

HEALTH LAW PA NEWS & SENIOR HEALTH NEWS

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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.

Medical Assistance Budget for FY 2012-2013

Governor Corbett and the General Assembly reached agreement on the state budget just hours before the new fiscal year began on July 1st. The $27.65 billion General Fund budget is an increase of 1% over the previous year and includes no new taxes. It holds overall Department of Public Welfare funding steady at $10.58 billion, which is $64 million more than the Governor had proposed for the Department. The final fiscal year 2012-13 budget makes targeted changes to the Medical Assistance (MA) program (Pennsylvania calls its Medicaid program "Medical Assistance"). The $200 per month that is the main source of income for the 68,000 individuals on General Assistance (GA), most of whom have temporary disabilities, will end on August 1st as that program has been eliminated. Consumers losing this cash assistance can still get MA benefits; however, there may be eligibility changes (including new work requirements) that were not defined in the final budget bill.

The fiscal year 2012-13 budget alters Medical Assistance eligibility to add a work requirement of 100 hours per month for parents receiving GA-related "Medically Needy Only" (MNO) coverage. Parents who do *not* routinely submit a doctor's form about their ability to work, and whose Medical Assistance does not cover prescriptions, are most likely getting GA-related MNO coverage. Adding the 100 hour per month work requirement, however, will effectively end Medical Assistance for roughly 15,000 low-income parents who get their MA coverage through this category. Because of the very low income limits for MNO coverage, working 100 hours per month will make these parents income-ineligible. As a result, the new work requirement will likely mean that only those parents with significant ongoing medical expenses that they can use to "spend down" to the income limit will continue to receive medical coverage. The budget does *not* eliminate the GA-related MNO program for individuals aged 59 or older, as proposed by the Governor.

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The Medical Assistance Transportation program (MATP), which faced partial shutdowns in some counties this past fiscal year because of underfunding, was appropriated $72.8 million, two million less than the Governor had proposed but still 3.58 million (5%) more than the year before. Reflecting the Administration's initiative to expand the mandatory managed care program ("HealthChoices") statewide, the final budget increases the capitation appropriation to Physical Health Managed Care Plans by $450 million (14%).

The final budget bill that was signed by the Governor did not include information about the other cost-containment initiatives put forth in his proposed budget, so their status is not clear at this time. As described in the March issue of *PA Health Law News*, the Administration had proposed increasing MAWD premiums, keeping MA consumers who obtain Medical Assistance coverage through a hospital application on fee-for-service MA until redetermination, and periodically reviewing "high-cost cases" to avoid duplication of services. The future of these proposals as well as any additional changes to eligibility for GA-related MA will be reported as more information becomes available.

Other DPW Budget News

Intellectual Disabilities: In a major victory for families and advocates, the fiscal year 2012-2013 budget includes an additional $48.8 million in state funds to expand the number of slots for the Consolidated and Person/Family Directed Support (PFDS) waivers. These waivers are designed to help persons with intellectual disabilities live as independently as possible in their homes and communities by providing support services. According to the budget, "This appropriation includes sufficient funds for services for 700 special education graduates and 430 individuals with elderly caregivers who are currently on an emergency waiting list." In addition, funding will be available to enable an additional 100 individuals to move from State Centers for Intellectual Disabilities into community placements. It is also expected that the increased funding will avoid some of the reductions in reimbursement rates to service providers.

Adult Protective Services: The final budget includes $1.7 million to begin implementation of Act 70 of 2010, the Pennsylvania Adult Protective Services Act, which became effective in April 2011. This Act creates a protective services program for adults ages 18-59 who have cognitive or physical disabilities and who are at imminent risk of abuse, neglect, exploitation, or abandonment.

Adults with physical disabilities: The Independence, OBRA and CommCare waivers will receive a 23.4% increase in funding from last year-an amount greater than proposed by the Governor. The Attendant Care waiver will see a cut of $3.8 million from last year, although that is $8.5 million less than the cut proposed by the Governor.

Autism: The budget for the Bureau of Autism Services has been cut by $549,000 in state funds. However, that reduction is $240,000 less than proposed by the Governor. The Bureau's budget includes funding for the Adult Autism Waiver, the Adult Community Autism Program (ACAP) program, the regional ASERT centers (ASERT stands for Autism Services-Education-Resource-Training) and the mini-grant program. Although it is not expected that this cut will result in reductions in those programs, there is no funding to expand slots for the Adult Autism Waiver or ACAP which are currently at capacity.

Human Services Funding Cuts Partially Spared; Advocates Remain Concerned

As a result of strong advocacy and the support of key legislators, the final DPW budget for county-based human service programs was less severe and less extreme than the Governor proposed in February; however, **consumers, providers and advocates remain very concerned.** As reported in our March Newsletter, the Governor's 2012-2013 budget proposed severe cuts to human services funding and significant changes to how those services were funded. In addition to a 20% cut to human services funding, the Governor also proposed combining categorical pots of money into one "Human Services Development Fund Block Grant".

Instead of the proposed 20% cut, the final budget resulted in a 10% reduction to human services funding-from $842 million to $758 million. Although the block grant was not approved as proposed by the Governor, a revised version **was** approved.

The final budget bill signed by the Governor (H.B. 1261) outlines the provisions of the "Humans Services Block Grant Pilot Program". As detailed in this bill, no more than 20 counties in the Commonwealth can participate in the Block Grant Pilot Program in any fiscal year. Interested counties must provide a written request to the Department of Public Welfare. The counties approved for inclusion in the Block Grant will receive one lump sum amount for human services programs previously delineated by separate line items to fund the following services: mental health, drug and alcohol, intellectual disability, child welfare, homeless assistance and the Human Services Development Fund.

Counties selected to participate in the Block Grant for 2012-2013 will be required to expend 80% of their allocated sum on: 1) community based mental health services; 2) intellectual disability services; 3) child welfare services; 4) drug and alcohol treatment and prevention services; 5) homeless assistance services and 6) behavioral health services. Over the next three fiscal years, the requirement imposed on these counties to allocate a certain amount of their funds to the listed categories decreases, so that by 2015-2016, they will only be required to spend 25% of their allocated sum on these services. After that, counties can spend block grant funds on county based human services as determined by local need. In addition to the six categories listed above, county based human services include aging services, services for dependent or delinquent children and services to low-income individuals.

Each year of the block grant, participating counties must submit proposed plans to DPW for how funds will be spent. Counties will be required to hold at least two public hearings "which shall include an opportunity for individuals and families who receive services to testify about the plan" prior to submitting their plan. DPW retains the power to approve all plans; counties are still bound by federal and state requirements and DPW must monitor the plans and assure statutory compliance.

In addition to the obvious concern over reducing funding by 10% to human services; consumers, providers and advocates are worried about the delivery of services by counties who participate in the Human Services Block Grant Pilot Program. An initial concern is the misnomer that the block grant is a "pilot" program. A pilot program is generally viewed as a way to test or try out a new concept and then evaluate its success before deciding on further implementation. The Human Services Block Grant Program, however, appears to actually be a phase-in program, rather than a test program as

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there is nothing in the bill that calls for an evaluation to occur before statewide implementation. In fact, the bill is silent on if, or how, statewide implementation would occur.

Opponents of the block grant concept worry that it will pit the human service needs of one local population against another in an environment where funding is already in short supply. In any given county, one population could end up short-changed even beyond the 10% cut for all human services.

First Take: What the Supreme Court Decision on the ACA Means for Pennsylvania

Last month's Supreme Court decision to uphold the Affordable Care Act (ACA) brought clarity to the future of health care reform and its implementation. The following represents PHLP's initial take on the ruling and its implications. In the weeks and months ahead, we will provide more details on how the ruling, and future guidance from the federal government, impacts Pennsylvanians.

The Decision: A sharply divided Court (5-4) ruled that the ACA requirement for individuals to have insurance or pay a tax penalty **is** constitutional. In a surprise move, however, the Court determined the enforcement mechanism for requiring states to expand Medicaid to all those with incomes up to 133% FPL is overly coercive. In short, the Court did **not** strike down the Medicaid expansion but it did hold that the federal government could not terminate all federal Medicaid funding to a state that does not implement the expansion. Pennsylvania budgeted approximately $12 billion in federal funding for its Medicaid program in 2011-2012.

Attention will now turn from *whether* and *if* reform will happen to *how* and *at what pace*. The decision puts Harrisburg—and the Corbett administration in particular—in the driver's seat to create and operate state health insurance exchanges and modernize its Medicaid system.

Impact on the ACA: With the exception of not allowing the federal government to withhold all Medicaid funding for states who fail to expand Medicaid, the Court leaves the rest of the ACA intact. Most notably, the Court upheld:

- The requirement that individuals obtain coverage or subject themselves to a tax penalty;
- The law's insurance reforms including those that guarantee an individual's access to coverage regardless of pre-existing conditions and that prohibit adjusting premiums based on health status or gender;
- Federal funding for the creation of health insurance exchanges in every state;
- Substantial premium and cost sharing subsidies to those with incomes between 100%- 400% FPL to purchase insurance through exchanges; and,
- Insurance reforms such as premium rebates when insurers do not spend a certain percentage of the premiums collected on medical benefits (called the medical loss ratio), and reviews of premium increases for individuals and small business.

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Implications for the ACA Medicaid Expansion: Pennsylvania now confronts a new landscape. It will have to decide whether to expand its Medicaid programs to cover residents with incomes under 133% FPL (currently, $14,868 for a single person, and $30,660 for a family of four) regardless of assets. The coverage expansion is an attractive option allowing Pennsylvania the opportunity to provide health insurance to an estimated 682,000 low income residents who do not currently qualify for Medicaid **and** driving new revenue to health care providers. If Pennsylvania decides to expand Medicaid as allowed under the ACA, the federal government will fund 100% of the expansion for the first three years. The federal funding will decrease to 90% in 2020.

If Pennsylvania opts out of the Medicaid expansion, a key issue will be availability of coverage for low income adults. Those with incomes **under** 100% of poverty— less than approximately $11,170 for a single person and less than $23,050 for a family of four in 2012—will be ineligible for a premium tax credit to purchase health insurance through the health insurance exchange. This is because the ACA generally limits tax credits to individuals with incomes between 100% and 400% of poverty, assuming individuals below this level would be eligible for Medicaid.

Implications for Exchanges: With the Supreme Court case decided, Pennsylvania must move quickly to set up and start implementing an exchange. Implementation plans are due to the Secretary of Health and Human Services (HHS) by November 16th so that they can be certified by January 1, 2013.

In November 2011, the Corbett administration announced it would pursue a state-based health insurance exchange. Since then, Pennsylvania has delayed action and has not passed any authorizing legislation. The critical period for passage of enabling legislation will be the three to four week session in September and October before the legislative session closes for the campaign season.

Assuming Pennsylvania enacts exchange legislation, it will still have a difficult time achieving full certification from HHS to operate its own exchange. However, HHS' regulations give Pennsylvania other options: conditional certification of a state Exchange or a state/federal partnership Exchange. Conditional certification allows states that are making substantial progress toward meeting the requirements for a state-run Exchange more time to prove their readiness. In a state/federal partnership, Pennsylvania would work with the federally-operated exchange and share functions with the federal government. Given the tight timelines, Pennsylvania may decide to choose a state/federal partnership exchange for its submission to HHS.

What's Ahead: The political repercussions of the Supreme Court's decision will continue to dominate the news but, very quickly, the practical implications of the decision will come to the forefront. States like Pennsylvania that have been reluctant to implement the ACA are likely to accelerate their efforts toward compliance. Individuals who favor Medicaid expansion in Pennsylvania can contact their state representatives and senators and the Governor's office to voice their support.

DPW Delays HealthChoices Expansion in New West Zone

Responding to pressure from the Consumer Subcommittee of the Medical Assistance Advisory Committee and its counsel, PHLP, DPW decided to delay implementation of HealthChoices into the New West Zone by one month-until October 1st. As reported in previous newsletters, DPW is expanding HealthChoices (mandatory managed care for most Medicaid consumers) across the Commonwealth in phases. The next phase of expansion is the creation of a New West HealthChoices Zone comprised of 13 counties in northwestern Pennsylvania: Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango and Warren.

DPW originally announced it would implement HealthChoices in the New West Zone effective September 1st. At their June meeting, the Consumer Subcommittee strongly urged the Department to delay implementation noting that insufficient groundwork had been laid in the New West zone to educate and prepare consumers, providers and community agencies for HealthChoices. In addition, the Consumers were informed that the managed care plans were continuing to work on their provider networks and they feared those networks would still be in development when consumers began enrolling into plans. The Consumers are hopeful that delaying implementation by even a month will allow sufficient time to address these concerns and improve the chances of a smoother transition for Medicaid consumers enrolling into managed care for the first time.

Under the new timeframes, DPW will be mailing out managed care plan enrollment information to Medicaid consumers in the New West Zone in August. Consumers will have from August 10th until September 6th to enroll into one of the four available plans. Those who do not enroll in a plan by September 6th will be auto-assigned to a plan effective October 1st. The four plans available to consumers in the New West Zone are: **Amerihealth Mercy, Coventry Cares, Gateway Health Plan** and **UPMC for You**. Those currently enrolled in a Voluntary Plan with either Gateway Health Plan or UPMC for You can stay in the plan they are in (in which case they will move into HealthChoices in the same plan effective October 1st) **or** they can switch to a new plan (by enrolling no later than September 6th) which will go into effect October 1st. **Those currently enrolled in a Voluntary Plan with United Healthcare Community Plan will *not* be able to stay in this plan because it is no longer doing business in the Zone as of the end of September**. Therefore, all those in United Healthcare will need to enroll in one of the four available plans by September 6th or else they will be auto-assigned to a plan.

As a reminder, certain Medicaid consumers in the New West Zone will not be affected by the expansion of HealthChoices because they are exempt from Medicaid managed care. To be exempt consumers must fit into one of these groups:

- **Full Dual Eligibles**—those on Medicare who also have full Medicaid through their ACCESS card
- **Aging (PDA) Waiver participants**
- **LIFE Program participants**
- **HIPP participants**- Medicaid consumers who are also enrolled in employer-sponsored health insurance for which Medicaid is paying the premium
- **Women eligible for Medicaid under the Breast & Cervical Cancer Prevention and Treatment Program (BCCPT)**

Please see the next page for upcoming PHLP trainings throughout the New West Zone!

Attention:

ACCESS PLUS

Consumers, Family Members, Providers, and Advocates

ACCESS PLUS will no longer operate in Erie, Crawford, Mercer, Venango, Warren, Forest, Clarion, Jefferson, Elk, McKean, Cameron, Clearfield, and Potter Counties as of October1st, 2012.

Everyone who has ACCESS PLUS needs to join a Managed Care Plan by September 6th! If an ACCESS PLUS recipient does not pick a plan by this date, they will be auto-enrolled into one. Additionally, any consumers enrolled in United HealthCare Community Plan will need to choose a new plan by September 6th, since they will not be serving the New West Zone.

This is an important change for Medicaid recipients in these counties, impacting how they access health care services and providers. Consumers, family members and professionals need to know:

- How coverage will change after October 1st
- Managed Care Plan choices available
- What to think about before choosing a plan
- What to do if a plan isn't meeting someone's needs

Come to a FREE training by the Pennsylvania Health Law Project (PHLP) to learn about these changes and more!

Monday, August 6, 2012
1 pm- 3pm
Main Street Center
516 Main Street
Clarion, PA 16214

Wednesday, August 8, 2012
1:30pm-3:30pm
Gunzburger Building
1 North Main Street
Coudersport, PA 16915

Monday, August 13, 2012
1pm-3pm
Family Center
913 Payne Avenue
Erie, PA 16503

Tuesday, August 14, 2012
1:30pm-3:30pm
Heritage House Center
4 Sylvania Street
Brookville, PA 15825

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Space is Limited. Please RSVP through PHLP's Helpline at 1-800-274-3258 or staff@phlp.org.

Lawsuit to Reinstate adultBasic Moves Forward

In two nearly identical related cases, *Sears v. Corbett* and *Weisblatt v. Corbett*, the Pennsylvania Commonwealth Court is allowing former recipients of the adultBasic health insurance program (adultBasic) to proceed with their lawsuits against Governor Corbett, Budget Secretary Charles Zogby and the state Treasury over the redirection of tobacco settlement funds away from the program.

AdultBasic was a low-cost health insurance program for adults who were uninsured, ineligible for other publicly funded programs like Medicaid and Medicare, and had incomes below 200% FPL. Funding for adultBasic partially came from proceeds of a 1998 settlement between several tobacco companies, Pennsylvania, and 46 other states. Pennsylvania created the Tobacco Settlement Act to handle and distribute this funding. Subsequent Acts—passed by the General Assembly and signed into law by former Governor Ed Rendell and current Governor Tom Corbett—redirected money away from the adultBasic program and into the state's general fund. As a result, more than 40,000 Pennsylvanians lost health insurance when the program ended in February 2011. Several former adultBasic recipients (plaintiffs) filed lawsuits shortly thereafter.

In both cases, plaintiffs argue that Governor Corbett violated the Tobacco Settlement Act and the Pennsylvania Constitution by moving the funding marked for adultBasic. They seek a court order directing all future tobacco settlement funds to be deposited in accordance with the Tobacco Settlement Act, and all redirected funds to be repaid to the Tobacco Settlement Fund. The plaintiffs also seek to have the adultBasic program reinstated retroactively to March 2011, and an injunction imposed requiring the state Treasury to keep in its accounts any tobacco settlement money until the case is closed.

The entire Commonwealth Court heard the case, and voted 5 to 2 that the plaintiffs stated a valid claim, because there is reason to believe there was unlawful redirection of Tobacco Settlement Act funds and that statutes accomplishing this redirection may have violated the Pennsylvania Constitution. Now that the court has largely dealt with the state defendants' preliminary objections, and the plaintiffs' challenges still largely stand, the cases can move forward to a trial on the merits—whether the redirecting of adultBasic funds was unconstitutional. We will keep readers updated about future rulings.

Do you currently get the Health Law PA News through the mail? Would you like to get these newsletters by e-mail?

If so, contact staff@phlp.org to change the way you get your PHLP newsletters!

Alert! Proposed Changes to Employability Assessment Form Cause for Concern

Recently, DPW issued a draft revised Employability Assessment Form (EAF) and a draft policy about how the form will be used to the County Assistance Offices. The EAF is currently used to help people qualify for Medical Assistance who are not receiving disability benefits from Social Security (either SSDI or SSI), but who have a health condition that can be considered temporarily or permanently disabling. Depending on the individual's situation, the form can help someone qualify for General Assistance (GA) categories of Medical Assistance (MA) as well as Healthy Horizons and Medical Assistance for Workers with Disabilities (MAWD).

The draft revised EAF asks health care providers to answer twelve impairment-related questions and requires them to supply supporting documentation. Currently, providers who complete the EAF provide information about an individual's diagnosis and check one of 4 boxes detailing whether someone is permanently disabled, temporarily disabled 12 months or more, temporarily disabled less than 12 months, or employable. The proposed changes will make the form more burdensome for providers to fill out and may result in people no longer meeting the disability standard required to qualify for Medical Assistance benefits.

Advocates and providers have expressed concerns about these proposed changes. As of the publication of this newsletter, the policy and form are still marked "draft". Yet, they have been given to local County Assistance Offices, some of which have begun to train staff on the new policy. Although the revised form should only be used for determining eligibility for GA-related categories of Medical Assistance under the draft policy, it is likely that it would inappropriately be given to applicants for other categories, such as MAWD or Healthy Horizons.

Another concern is that the revised draft EAF primarily requests information about physical limitations and does not adequately capture information about mental health limitations or intellectual disabilities. Also, some providers have asserted that a limited set of impairment-related questions cannot accurately replace a treating physician's judgment of disability based on a person's overall health status.

Consumers who are given the revised EAF by the County Assistance Office, and health care providers who are asked to complete this new form, are encouraged to call PHLP's Helpline-1-800-274-3258. PHLP will provide an update should the draft form and policy be made final. Interested individuals can also check our website for updates-www.phlp.org.

Please support PHLP by making a donation through the United Way of Southeastern PA.

Go to www.uwsepa.org and select donor choice number 10277.

MA Co-Pays to Start in October for Certain Kids with Disabilities

As of October 1, 2012, children who are newly approved for Medical Assistance under the PH-95 category (this is for children with a severe disability whose families' income does not count when determining MA eligibility) will have to start paying MA co-pays when they receive services if their families' income is above 200% FPL ($46,100 for a family of 4). Current PH-95 recipients whose family's income is above the 200% FPL will start paying co-pays in November. Notices will be sent 30 days before the co-pays start. We will provide more details about this in our September Health Law News.

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