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DPW Announces HealthChoices Expansion Changes; Updates on the New HealthChoices Zones

The Department of Public Welfare (DPW) will eliminate ACCESS Plus rather than have it compete with Medicaid managed care plans when HealthChoices expands to 42 counties over the course of the next year. HealthChoices refers to mandatory managed care for Medicaid consumers and currently exists in 25 heavily populated counties in the Southwest (Allegheny and surrounding counties), Lehigh-Capital area (counties in the central and eastern part of the state) and Southeast (Philadelphia and surrounding counties). Medicaid managed care companies receive a per member per month payment from DPW to cover physical health services and medications for their members.

Originally, DPW planned to have ACCESS Plus continue to operate in the new HealthChoices zones it was creating allowing consumers in these zones to choose between ACCESS Plus and managed care. In April, however, DPW changed its mind and announced that when HealthChoices is implemented in a county, all Medicaid consumers (unless they fall into an exempt group—see the next page) will be required to enroll into a physical health managed care plan and ACCESS Plus will no longer be an option. Please note that coverage for behavioral health services in these counties is **not** changing—most Medicaid recipients across the state have been in managed care for behavioral health services since 2007.

Timeline for HealthChoices Expansion

HealthChoices expansion has already begun. In May, DPW sent notices to Medicaid consumers in seven south-central counties telling them that HealthChoices was expanding into their county on July 1st and that they needed to enroll into a physical health managed care plan by **June 14th** (see page 3 for more information). Bedford, Blair, Cambria and Somerset counties are joining the existing **HealthChoices-SW Zone**. Residents in those counties have a choice of four plans: Coventry Cares, Gateway Health Plan, United HealthCare Community Plan and UPMC for You.

Franklin, Fulton and Huntingdon counties are joining the existing **HealthChoices-Lehigh/Capital Zone**. The residents in those counties have a choice

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of five plans: Aetna Better Health, AmeriHealth Mercy Health Plan, Gateway Health Plan, United Healthcare Community Plan and UPMC for You.

New West Zone

On September 1, 2012 DPW is implementing a new HealthChoices zone known as the **New West Zone**. It will be made up of 13 counties: Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango and Warren. DPW is planning to mail out enrollment information to the Medicaid consumers in these counties in July. The consumers in these counties will be able to choose between four managed care plans: Coventry Cares, Gateway Health Plan, UPMC for You and AmeriHealth Mercy.

New East Zone

The final phase of HealthChoices expansion will be the implementation of the **New East Zone**, which DPW is planning for March 1, 2013. This new zone will consist of 22 counties: Bradford, Carbon, Centre, Clinton, Columbia, Juniata, Lackawanna, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne and Wyoming. DPW announced in April that three plans had been chosen to do business in the New East Zone: Coventry Cares, Geisinger Health Plan and AmeriHealth Mercy Health Plan. DPW is currently working through bid protests filed by unsuccessful bidders in this zone.

Consumers Exempt from HealthChoices

Certain Medicaid consumers are exempt from Medicaid managed care and will **not** be affected by the expansion of HealthChoices. As a result, consumers who fall into one of the following groups will stay in Medicaid Fee-for-Service (ACCESS) and will not be enrolled into a physical health plan:

- **Full Dual Eligibles**- individuals who have Medicare and also full Medicaid health insurance through their ACCESS card
- **Aging Waiver participants-** older adults who receive services through the Aging (PDA) waiver
- **LIFE program participants**- adults on Medicare and Medicaid who receive services through the LIFE program
- **HIPP participants-** consumers for whom Medicaid is paying a premium so that they are enrolled in an employer-sponsored health insurance program
- **Women in the BCCPT Program-** women who are eligible for Medicaid under the Breast and Cervical Cancer Prevention and Treatment Program

No MATP Co-Pays for Shared Ride Services

The Department of Public Welfare (DPW) decided **not** to implement co-pays for the Medical Assistance Transportation Program (MATP). As we reported in our March newsletter, co-pays of $2 each way for shared ride services were to begin May 1st as part of DPW's cost-savings initiatives to make up for a $26 million cut to MATP funding in the FY 2011-2012 budget. However, the Department received a number of comments back from various stakeholders about the MATP co-pays after regulations were issued in February. As a result, DPW has decided it will not go forward with imposing co-pays for shared ride services under MATP.

Individuals in South Central PA Have Until 6/14 to Pick a Managed Care Plan!

Individuals currently enrolled in ACCESS Plus who live in Bedford, Blair, Cambria, Franklin, Fulton, Huntingdon, and Somerset counties will be enrolled in Medicaid managed care for their physical health coverage and all prescription medications as of July 1st. As discussed previously, their behavioral health care coverage is **not** changing.

ACCESS Plus enrollees in these counties must enroll in a physical health managed care plan by **June 14th** or they will be auto-enrolled into one. Auto-enrollment will be split evenly among all available plans, and it is done randomly with no consideration of a person's providers or medications. When choosing a plan, an individual should:

- Make a list of all their physical health care providers (this includes primary care doctor, any specialists she sees, hospital(s), dentists, and medical suppliers). Once the list is ready, individuals can:
  - ⇒ Contact their doctors and other providers and find out what plans they will take.
  - ⇒ Contact PA Enrollment Services (800-440-3989 or www.enrollnow.net) for help checking to see which plans work with their doctors and hospital.
- Make a list of **all** their medications. Once the list is ready, they should contact the plan(s) that work with their doctors to check that their medications are covered.

Individuals living in these seven counties who are currently enrolled in a voluntary managed care plan can remain in their plan if they are satisfied. Since there are new plan options available, these individuals can explore their options and join a different plan if they so choose. If someone wishes to change plans for July 1st, they should contact PA Enrollment Services by June 14th to enroll in the new plan.

Important Things to Know:

- If someone misses the June 14th deadline, she can still choose her own plan (it just won't start until August 1st or later depending on when she joins)
- People can change their plan and/or PCP at any time
- Pregnant women can continue to see their OB/GYN (even if their doctor is not in their new plan's network) throughout their pregnancy until the end of their postpartum period
- The new plan must continue to cover prior authorized services until the end of the authorization period (for children under 21 years old) or up until 60 days (for adults) and must continue to cover services/providers for 60 days for individuals who are in a course of treatment (i.e., planned series of medical/surgical/dental procedures; prescription for a particular medication; prescription for use of a particular medical equipment or supply)
- This HealthChoices expansion will have no affect on special education services provided by schools & IUs that are billed to Medical Assistance (known as the School Based ACCESS program).

Please contact PHLP's Helpline (800-274-3258) with questions or for assistance. Individuals who are having problems getting their needs met after July 1st are also encouraged to call us. Visit our website (www.phlp.org) to see a fact sheet with tips about choosing a plan for both the Southwest Zone and the Lehigh/Capital Zone and for information about appeal rights available in managed care.

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2 More Medicaid MCOs To Limit Prescriptions Starting July 1st!

Keystone Mercy Health Plan (operating in the HealthChoices Southeast Zone) and AmeriHealth Mercy Health Plan (operating in the HealthChoices Lehigh/Capital Zone) will start to limit the prescription coverage for adult members to six prescriptions per month on July 1st. Members of these plans should have already received notice about the changes.

These two plans join three other Medicaid managed care plans who have already started prescription limits for adults. To date, only Aetna Better Health (Lehigh/Capital Zone), Coventry Cares (Southwest and Southeast) and HealthPartners (Southeast) have decided not to adopt prescription limits at this time.

MCO/Delivery System	Prescription Limits
Fee-for-service (ACCESS)	January 3, 2012
Aetna Better Health	Not adopting
AmeriHealth Mercy/Keystone Mercy	July 1, 2012
Coventry Cares	Not adopting
Gateway Health Plan	May 2012
Health Partners	Not adopting
United HealthCare Community Plan	March 2012
UPMC for You	May 2012

As a reminder, individuals who are subject to the six prescription limit may be able to get some of their medications automatically after they reach the monthly limit. Otherwise, their doctors will need to request a Benefit Limit Exception from the plan. Individuals should ask their pharmacy for an emergency supply if they are out of medications before their doctor has requested an exception or before an exception has been granted.

Medicaid's "Six-Drugs Per Month" Policy Leads to Recurring Delays

In recent months, adult Medicaid consumers in the Fee-for-Service system (using the ACCESS card) who take more than six prescriptions per month have faced recurring delays waiting for a response from DPW following their doctor's coverage request. At the end of April, DPW confirmed that its pharmacy unit was taking ten days or longer to process benefit limit exception requests. According to policy, pharmacy benefit limit exception requests should be processed within 72 hours. At the end of May, DPW reported that it had resolved its backlogs and was responding to requests within 72 hours.

Requests for exceptions to the six-drug limit spike at the end of each calendar month, and DPW has struggled to consistently meet its 72 hour response timeframe since the limit began in January. It cites physician's requesting exceptions for all of a patient's medicines, rather than just those denied at point-of-sale, as a major reason for the backlog.

In addition to the increase in coverage requests as a result of the monthly limit, new prior authorization rules for certain medications (such as for antipsychotics for children) have

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(Continued from Page 4) increased the volume of requests submitted to DPW's pharmacy unit. There had also been delays in processing these requests as well, though DPW stated that, as of April, they were meeting the required 24 hour timeframe for prior authorization requests.

Individuals who are unable to get a medication at the pharmacy because it needs prior authorization or because they've already reached their monthly limit are encouraged to **request an emergency supply** from their pharmacist, many of whom are not aware of this policy. Individuals can receive **one or multiple** five-day emergency supplies from the pharmacist. Multiple supplies are appropriate where DPW has not issued a response before the first supply is exhausted. Issuing the emergency supply is at the pharmacist's discretion, and is discussed more in DPW's Provider Quick Tip #133 available here http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/communication/p_012511.pdf.

A Continuing Concern: Pennsylvania's Children Still Losing Medicaid

Children who have health insurance are more likely to be immunized, receive regular checkups and get prompt treatment for common childhood ailments, such as ear infections or asthma. In other words, insured kids are able to be healthy kids —and that helps them be successful kids.

Despite the benefits of keeping kids insured, Pennsylvania—a state with near universal health care available for children—continues to remove children from Medicaid due to bureaucratic inefficiencies. More than 4,000 children lost Medicaid coverage in April alone. Enrollment in Pennsylvania's Children's Health Insurance Program (CHIP) has remained relatively unchanged with no corresponding increases to enrollment. In fact, between August 2011 and April 2012, CHIP enrollment declined slightly (by about 240 children).

As reported in past PHLP newsletters, last summer, DPW reviewed all Medicaid cases overdue for annual renewal. In the months following that review, adults and children both lost ground: in September and October, adult enrollment dropped by 9,400 but recovered slightly in November with a further gain of about 29,000 in December. Children's enrollment in Medicaid also dropped in September and October by almost 31,000, however, unlike the adult data, the downward trend for children's enrollment continued in November and December; December's drop was especially alarming with over 44,000 children losing Medicaid. There appeared to be some stabilization in January, February, and March; in fact, enrollment increased by about 4,550 in February and March. However, that increase was almost completely reversed in April as 4,000 children were disenrolled from Medicaid.

Some of the problems can be attributed to overwhelmed caseworkers unable to keep up with the paperwork, so benefits get stopped and kids lose coverage, even though many families did everything required to continue Medicaid coverage.

PHLP continues to work with DPW and with the Centers for Medicare and Medicaid Services to understand and address the substantial number of children losing coverage. We remain interested in hearing about cases where children have lost coverage. Please contact PHLP's Helpline (800-274-3258) with questions or for assistance.

Health Care Reform Update

As the nation awaits the U.S. Supreme Court decision on several legal challenges to the Affordable Care Act, the implementation of the health care reform law continues to move forward.

At this writing, Pennsylvania successfully obtained federal Exchange planning funds as well as additional funding to work on implementing key provisions of the Affordable Care Act such as establishing Exchanges, health care quality improvement, expansion of the health care workforce and school-based health clinics, and outreach to Medicare beneficiaries and families with children with special health care needs.

The state, however, has not passed legislation authorizing an Affordable Health Exchange or appropriating significant portions of the Exchange planning funds. Predictions are that the General Assembly will wait until after the Supreme Court decision before continuing to work on Exchange issues in the fall.

Federal guidance, issued May 16, 2012, describes the criteria and methodology for submission of state plans for operating an Exchange. The guidance gives states three options: a fully state-run Exchange, a state-federal partnership Exchange with the federal government assuming some tasks, or a fully federally-facilitated Exchange with the federal government solely responsible for the operations of the Exchange. State plans are due in November 2012 with responses from the federal government by January 2013.

Increase in Medicaid Physician Payment

The Department of Health and Human Services has released proposed rules on implementing an increase in primary care reimbursement under Medicaid. In 2013 and 2014, Medicaid will increase reimbursement fees for primary care providers to match what Medicare pays these providers. The federal government will cover 100% of the difference between the Medicare rate and the Medicaid rate in place on July 1, 2009. States that have reduced primary care reimbursement rates since that date will have to restore those cuts before the federal funds can be drawn down.

This is a substantial increase in Medicaid payment rates which have averaged about 66% of the Medicare rate. The increase is designed to encourage more primary care providers to participate in the Medicaid program as the program expands to cover adults and children whose income is less than 133% of the federal poverty guidelines in 2014 .

Family medicine, general internal medicine, and pediatric primary care providers including nurse-practitioners and physician assistants will qualify for the increased payments as will subspecialty providers who act as primary care providers for their patients.

The proposed rules require states to address how the increased payments will be implemented in managed care settings. States will have to show how the increased payments will be implemented uniformly and that the primary care providers will receive the full increase.

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(Continued from Page 6) This will include modifying contracts between the states and the managed care plans as well as modifying contracts between the plans and the providers.

Children's Principles for Health Care Reform

PHLP has partnered with Community Legal Services, the Pennsylvania Chapter of the American Academy of Pediatrics, Pennsylvania Partnerships for Children and Public Citizens for Children and Youth to promote a set of Principles that address the impact of health care reform on children in Pennsylvania. These Principles have now been endorsed by 22 organizations ranging from children's hospitals to physical and behavioral health providers and consumer advocates. To view the Principles, please visit our website at http://www.phlp.org/wp-content/uploads/2011/08/PA-Principles-for-PPACA-final.pdf.

For a list of the endorsers or to add your organization's name to the list, contact Ann Bacharach, abacharach@phlp.org.

Health Care Reform is already making a difference in Pennsylvania:

- 64,798 more young adults have health insurance on their parent's plan.
- 235,820 Medicare beneficiaries have saved an average of $662 on the cost of their prescription drugs as a result of discounts during the coverage gap. And everyone on Medicare can get preventive services like mammograms for free.
- Insurance companies must spend at least 80% of your premium dollars on health care and not overhead. They can no longer raise your premiums by 10% or more without any accountability. Pennsylvania has received $5.3 million under the new law to fight unreasonable premium increases.
- The law bans insurance companies from imposing lifetime dollar limits on health benefits – freeing cancer patients and individuals suffering from other chronic diseases from having to worry about going without treatment because of their lifetime limits. Already, 4,582,000 residents, including 1,769,000 women and 1,136,000 children, are free from worrying about lifetime limits on coverage. The law also restricts the use of annual limits and bans them completely in 2014.
- Health centers in Pennsylvania have received $34.2 million to create new health center sites in medically underserved areas, enable health centers to increase the number of patients served, expand preventive and primary health care services, and/or support major construction and renovation projects.
- $5.2 million for Maternal, Infant, and Early Childhood Home Visiting Programs. These programs bring health professionals to meet with at-risk families in their homes and connect families to the kinds of help that can make a real difference in a child's health, development, and ability to learn - such as health care, early education, parenting skills, child abuse prevention, and nutrition.

More information about Health Care Reform can be found on our website at http://www.phlp.org/home-page/reform.

Update on the State 2012-2013 Budget

The Legislature is working to reach agreement and pass the 2012-2013 budget and send it to Governor Corbett for his signature before the end of the current fiscal year (June 30th). The Senate passed its budget bill (SB1466) on May 9th that restores some of the funding cuts to education and human services that were part of the Governor's proposed budget issued in February.

As a reminder, one of the more controversial proposals in the Governor's budget was block granting human services funds (a main source of funding for county-based mental health and intellectual disabilities services) and then reducing the funding by 20% (discussed in greater detail in our March 2012 Health Law PA News). The Senate's budget bill restores $84 million of the $168 million cut. Representative Gene DiGirolamo (R-Bucks County), Chairman of the House Human Services Committee, has introduced an Amendment to the State Senate's Budget Bill that restores all of the funding cuts under the Human Services Block Grant proposal and prevents the block grant from occurring. The House still needs to approve a spending plan. House and Senate leaders will be negotiating a budget with Governor Corbett in early June.

Stay tuned to our website and upcoming newsletters for information about the final budget that is passed.

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