Health Law PA News

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Pennsylvania Intends to Operate Health Insurance Exchange

Pennsylvania is moving forward in planning for a state-run health insurance exchange which has to be operational by January 2014 as required by the Affordable Care Act. In November, Governor Corbett announced his decision to establish a state-run health insurance exchange rather than defer to an exchange run by the federal government. The exchange will be a marketplace where consumers can comparison shop for health insurance coverage based on their needs and budgets. The exchange will also manage the available subsidies and tax credits to help low and middle-income consumers buy insurance.

Pennsylvania was awarded a Level One Establishment Grant from the federal government that will be used to support a plan for the new marketplace and decisions regarding its development and design. The Pennsylvania Insurance Department will be the lead agency for the grant; however, the Department is creating workgroups with other agencies that will be significantly impacted by the establishment of the exchange (e.g., the Department of Public Welfare). The state is also establishing several non-governmental advisory groups to provide input and feedback during the exchange planning and development process. The advisory groups, which have not been finalized, will address: administrative simplification, public program integration, wellness and healthy behaviors, enhancing quality outcomes, exchange access, information infrastructure, insurance market reforms and risk adjustment. Appointees to the non-governmental advisory groups have not yet been determined.

Prior to applying for the federal funding, the Insurance Department released an in-depth report which estimates that 2 to 2.5 million Pennsylvanians will participate in the health insurance exchange in 2014 (excluding individuals eligible for Medicaid or CHIP). The Department also released the results of a Fall 2011 survey of Pennsylvanians between the ages of 18-65 and small business owners. The survey asked about their current experiences in the Pennsylvania insurance market as well as their understanding and perceptions regarding a possible exchange. The survey concluded that for a state-based exchange to be successful in Pennsylvania it should: 1) provide a way for consumers to ask questions and get the correct information; 2) ensure all language and information on the exchange web site can be easily understood and acted upon;

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(Continued from Page 1) and 3) provide a comprehensive list of quality measures. Readers can view the report at this link: http://www.portal.state.pa.us/portal/server.pt/community/health_insurance/9189/health_insurance_exchange_-_archived_exchange_information/1075404. Information about the federal grant can be found here: http://www.portal.state.pa.us/portal/server.pt/community/health_insurance/9189/health_insurance_exchange/1064758.

Pennsylvania is expected to position itself to apply next year for a Level Two Establishment Grant (designed to fund exchange development through 2014). In order to do that, the state must establish a governance structure for its exchange and show it has the necessary legal authority to run the exchange. Two pieces of enabling legislation have been introduced independently by lawmakers in Pennsylvania's General Assembly—HB627 and SB940—but, they have not seen any movement during the current session. The proposed bills can be viewed at www.legis.state.pa.us. Legislation consistent with Governor's Corbett's vision is expected to be introduced soon. PHLP's future newsletters and other publications will provide updates about the design and content of the exchange.

DPW Planning to Impose MATP Co-Pays on April 1st

The Department of Public Welfare (DPW) plans to impose a $2 co-pay on MATP riders for each one-way paratransit trip ($4 for a round trip) beginning April 1, 2012. DPW recently issued a Draft Ops Memo and Consumer Notice regarding the MATP co-pays and sought comment from the Consumer Subcommittee of the Medical Assistance Advisory Committee, county MATP programs, and other interested parties.

According to DPW, the following individuals will be **excluded** from the co-pay requirement:

- Consumers under the age of 18
- Pregnant women (this exclusion will last through their 60 day post-partum period)
- Women on Medical Assistance through the Breast & Cervical Cancer Prevention and Treatment Program (BCCPTP)
- Consumers who live in personal care homes that do not provide transportation to their residents
- Consumers in hospice care

All other MATP consumers who use paratransit or taxi services will be subject to the $2 co-pay per one-way trip. Those escorting a consumer to their medical appointments are not subject to the co-pay. The county MATP programs will send out a written notice to all current MATP paratransit riders at least 33 days in advance of the co-pay policy going into effect. The draft policy specifies that the county may not deny transportation to a consumer who is unable to pay the co-pay. However, the policy goes on to say that the consumer is still responsible for the co-pay and that the county can attempt to collect outstanding co-pays from the consumer.

Children Hit Especially Hard by Pennsylvania's Medicaid Review

The reviews of Medicaid eligibility that started this past summer have particularly affected children. As discussed in previous newsletters, DPW officials ordered local County Assistance Offices to process a backlog of Medicaid cases that were overdue for renewal resulting in more than 700,000 eligibility reviews.

Medicaid enrollment data for children shows a drop of 88,000 – half of that in December alone – since August 2011. These numbers do not include an additional 23,000 children whose benefits were cut but eventually restored retroactively. Given that virtually all Pennsylvania children without insurance are eligible for either CHIP or Medicaid, it is particularly troubling that the CHIP enrollment did not see a corresponding increase. According to program rules and procedures, when a child's family income is too high for Medicaid, they are automatically referred to the CHIP program. However, even as 88,000 children lost Medicaid coverage, CHIP program enrollment remained virtually flat, growing by only 309 children in the same August to December 2011 period.

Reminder:

The CAOs are required to send individuals a 15-day advance written notice before closing a Medicaid case. If individuals receive a termination notice but believe they might still be eligible for Medicaid, they should file an appeal within 15 days of the mailing date on the notice.

Social service agencies, healthcare providers and legal aid programs across the Commonwealth all report an increase in individuals terminated from Medicaid due to alleged failure to furnish renewal documents. Many of those terminated not only continued to be eligible for Medicaid, but turned in the required paperwork in a timely fashion and had proof that they faxed, mailed or hand delivered the requested documents. However, their paperwork was apparently lost or was not properly attached to their case record by the County Assistance Office, and their benefits ended.

Individuals who receive MA termination notices and think they are still eligible can contact our Helpline for assistance at 1-800-274-3258.

DPW Changes Methodology for Calculating Medicaid Enrollment

While the total number of children enrolled in Medicaid has gone down significantly, the most recent data for adults (age 21 and older) shows the opposite. Since November 2011, DPW has begun using a new method for calculating Medicaid enrollment; a method that makes comparisons with previous enrollment numbers unclear. Surprisingly, the new data shows adult enrollment is up by 23,000 since August – the same time DPW officials agree that tens of thousands of people lost benefits after overdue reviews found they were ineligible.

Most Medicaid Managed Care Plans Adopt the Fee-for-Service Dental Limits for Adults

Most of the Medicaid managed care plans either have, or are planning to, impose the same dental limits that the Fee-For-Service system (ACCESS) started September 30, 2011. All plans implementing the dental changes must provide written notification to their members at least 30 days in advance of the changes.

The plans' dental changes (which are the same as those in the Fee-For-Service system) include:

Managed Care Plan	Effective Date/Decision
UnitedHealthcare	October 3, 2011
Gateway	November 1, 2011
Keystone Mercy	January 8, 2012
AmeriHealth Mercy	January 8, 2012
Aetna Better Health	February 15, 2012
UPMC For You	Sometime in February, 2012
Health Partners	March 1, 2012
Coventry Cares	to date, no plan to implement

- Coverage for oral exams and cleanings is increased from once every year to once every six months;
- Coverage for dentures is reduced from one full or partial denture every seven years to one upper denture (partial or full) and one lower denture (partial or full) per lifetime. If DPW or a managed care plan already paid for a denture for the consumer since March 1, 2004, that person will only be able to get a replacement denture under this policy if the plan approves the dentist's request through a benefit limit exception (see below);
- Coverage for crowns, root canals and periodontal services will be limited and only covered if the plan approves the request through a benefit limit exception.

The dental limits **do not apply to**:

- Plan members who are under 21 years old; *or*
- Plan members who live in a nursing home or Intermediate Care facility (ICF) (Note: the limits **do** apply to members who live in personal care homes.)

Benefit Limit Exceptions: Only a dentist can ask for this. The request can be made before the services start or up to 60 days after they are finished. The plan can grant a benefit limit exception and approve the requested dental service if:

- The consumer has a serious illness or health condition and their life would be in danger, or their health would get much worse, without the dental service; *or*
- The consumer would need more expensive services if the exception was granted; *or*
- It would be against federal law for DPW or the health plan to deny the exception to the consumer.

If the dentist's request for a benefit limit exception is denied, the consumer will be sent a written notice and can appeal and request a grievance with the managed care plan and/or ask for a Fair Hearing on the matter.

New Law Limits Transportation to Methadone Treatment

A recently-enacted law limits where people in methadone treatment can go for this service when using the Medical Assistance Transportation Program (MATP). Act 121 passed the General Assembly and was signed into law by Governor Corbett on December 22, 2011.

Under the new law that will go into effect on March 1, 2012, consumers who use MATP to get to and from their methadone treatment will be subject to these limits:

- Consumers who use a private vehicle and receive mileage reimbursement from MATP will have their mileage limited to the distance from the consumer's home to the closest methadone clinic.
- Consumers using MATP paratransit can only use those services if they are receiving treatment at the methadone clinic closest to their home.

Counties will be sending out a written notice at least 30 days in advance to all consumers who use MATP mileage reimbursement or paratransit services to go to methadone treatment informing them of the new limits. If a consumer is currently using MATP services to go to a clinic that is not the closest to their home, the notice they receive from the county will tell them to contact their Behavioral Health Managed Care Plan to find out how to get treatment at the closer clinic.

Any consumer can request an exception to the rule and explain their need to go to a methadone clinic that is not the closest to their home. The county should grant an exception for the following reasons:

- the closest clinic is not accepting new patients
- the consumer does not meet the intake criteria of the closest clinic
- medical reasons
- safety issues
- medical emergency

Consumers experiencing difficulty getting an exception or using MATP to get to their methadone treatment can call PHLP's Helpline at 1-800-274-3258.

DPW To Change Consumer-Directed Support Services

Currently, most people with disabilities who receive services under DPW's home and community based service waiver programs can hire and fire their own support staff if they choose the consumer or participant directed model of services. Under this model, once a consumer chooses his or her support staff, the state pays an organization to write the checks to pay that staff and to pay the required taxes, unemployment comp and workers' comp. This is called Financial Management Services or "FMS". PA currently has 37 organizations that perform this Financial Management Service function in various parts of the state for persons in certain home and community based service waivers. These include "vendor-fiscal agent" (Acumen) and "agency with choice" organizations.

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On January 5th, DPW announced it intends to only contract with up to three organizations — one for each of three geographic regions of the state — to perform the Financial Management Services function. The waivers affected include the Aging, Attendant Care, CommCare, Consolidated, Independence, OBRA, and PFDS. Organizations can apply to perform Financial Management Services for one, two or all three regions so, depending on DPW's decision, there could be just one agency chosen to serve the entire state.

DPW maintains that reducing the number of Financial Management Service organizations from 37 to 3 or less, will reduce costs and increase efficiencies. Consumer advocates are concerned because waiver recipients will lose their ability to choose their Financial Management Service organization as there will be only one FMS organization per region. Additionally, several of the existing organizations that currently provide Financial Management Services are consumer-run organizations, such as the Centers for Independent Living. Losing that funding will not only affect the consumers that use those organizations, but will likely result in layoffs of people employed by those organizations, many of whom are people with disabilities.

We have not yet heard a timeline for these changes. We'll update readers about these developments.

Update on When Managed Care Plans will Start Rx Limits for Adults

The dates that some Medicaid Managed Care Plans will start to limit adults to six prescriptions per month have changed since our previous newsletter was published.

- **United Healthcare Community Plan** will start the limits on **March 1st.** The notice they are sending to members about the change has been approved by DPW and is currently being mailed.
- **UPMC for You** plans to start the limits on **April 1st**. *This is a target date* and may be changed. DPW has not yet approved the notice UPMC will send to members and that must happen before notices are printed and mailed. In addition, the notice must be mailed to plan members at least 30 days before the changes start.

Keystone Mercy and AmeriHealth Mercy are still undecided about when they will start the limits. Again, if they decide to impose the limits they must first have their notices approved by DPW and then send written notice to members at least 30 days before the limits start.

Aetna Better Health, Health Partners, and Coventry Cares still have no plans to impose the limits on their members.

Please see our November Health Law News for more information about the limits, drugs that are automatically exempt from the limits, and the Benefit Limit Exception Process. We also created a consumer fact sheet about the prescription limits and this can found on our website at www.phlp.org.

Co-Payments for Certain Children in Medicaid To Start in September

DPW announced that it plans to ask families with children under age 18 on Medicaid due to their disability, and whose family income is more than 200% of the federal poverty guidelines ($44,700 for a family of four), to pay part of the cost of services starting September 2012. These co-pays are a result of the state budget cost-savings mandated by Act 22 of 2011 and will affect approximately 38,000 children. The Office of Medical Assistance Programs (OMAP) is in the process of finalizing policies and procedures regarding the co-pays. Notices will be sent to affected families 30 days prior to implementation.

Medical providers will be responsible for collecting co-payments and may do so at the time of service or make other arrangements for payment. The total amount of co-payments for all Medical Assistance services the child (or children, if more than one child in the family is on Medical Assistance) receives can not exceed the federal legal limit of five percent of the family's income, counted on a monthly or quarterly basis. So, for example, if the family's income is $48,000 a year, the total amount of all Medical Assistance copays for which they would be responsible could not exceed $200 a month ($4000 a month income x 5%) or $600 for three months if DPW decides to calculate this quarterly. Each copay can not be in excess of 20 percent of the cost of the service. Reportedly, co-payments will not be applied to school-based services, preventative services, and other items or services that are currently excluded from MA co-payment under federal rules.

It is not known whether DPW will deduct a family's current out-of-pocket costs for their child's health care when calculating family income. Other questions include: how will DPW track their co-pays paid to all providers to determine when a family can stop paying co-pays? How will DPW notify providers when the family no longer has to pay co-pays?

It is unclear whether providers will be required to provide services if the co-payment is not paid. More clarity will be needed, as these rules are under the Deficit Reduction Act, which is different from co-payments under traditional Medicaid rules.

PHLP will continue updates as new information is received.

HealthChoices Southwest Zone to Offer New Managed Care Plan Option

Beginning in April, Medical Assistance recipients in the HealthChoices Southwest Zone (currently, Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Indiana, Lawrence, Washington and Westmoreland counties) will have a new physical health plan option available. ***Coventry Cares*** will be offered along with the current plans-Gateway Health Plan, United Healthcare Community Plan, and UPMC for You. Coventry Cares currently provides coverage in the HealthChoices Southeast Zone, which includes Bucks, Chester, Delaware, Montgomery and Philadelphia counties.

Individuals in the Southwest Zone who are new to Medicaid on or after April will be able to join Coventry Cares. Also, current Medicaid recipients who are in one of the other plans in the Southwest will have the option to change to Coventry Cares for their physical health coverage to start April 1st. Interested individuals can contact PA Enrollment Services (1-800-440-3989) for more information.

Corbett Nominates Leader for New Department of Drug and Alcohol Programs

This month, Governor Corbett announced the nomination of Gary Tennis to serve as Secretary of the Department of Drug and Alcohol Programs. This Department was established under Act 50 of 2010 when Governor Rendell was still in office and is charged with setting up a plan for the management and allocation of state and federal funds used to oversee alcohol and drug prevention, intervention and treatment services. Citing budget limitations, Governor Corbett did not take action to create the department last year; however, the administration appears to be moving forward at this time. It is not yet clear whether funding will be allocated to the new department in the 2012-2013 budget.

Mr. Tennis is retired from the Philadelphia District Attorney's Office where he held the position of chief of the legislation unit. In 1993, he served as executive director of the President's Commission on Model State Drug Laws.

Currently, drug and alcohol services in Pennsylvania are provided through a number of agencies including the Departments of Public Welfare and Health. Reports indicate that Tennis' first order of business will be to analyze the provision of drug and alcohol services. According to a press release about the nomination, Tennis has been charged with taking a "commonsense approach to streamlining and eliminating duplication of state drug and alcohol treatment and prevention efforts in Pennsylvania."

2012-2013 Budget

Governor Corbett plans to announce his 2012-2013 Budget Proposal on February 7th. DPW will hold a budget briefing later that same day.

Pennsylvania's budget picture continues to look bleak as the state is likely facing a $1 billion deficit. The Department of Public Welfare is still trying to achieve the savings needed from the current budget (which has resulted in limiting dental and prescription benefits for adults and changes to the MATP program as discussed elsewhere in this newsletter).

In addition to the budget proposals and briefings, the PA Senate is holding a DPW budget hearing on February 28th at 9:30 am in Hearing Room 1, North Office Building. The PA House is holding its DPW Budget Hearing on March 7th at 9:30 am in Room 140 of the Main Capitol. These hearings are open to the public.

We'll update our readers about the proposed budget and its impact on Medical Assistance and other public health programs in our next newsletter.

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Dual Eligible HCBS Waiver Recipients Continue to be Charged Co-pays at the Pharmacy for Part D covered Medications

As of January 1, 2012, individuals receiving Medicare and full Medicaid benefits who receive services through a home and community-based services (HCBS) Waiver program are to get their Medicare Part D covered drugs at **no** cost. However, Medicare and the Part D plans are still in the process of updating their systems to identify the individuals to whom this change applies. As a result, many full benefit dual eligible waiver recipients are still being charged a small co-pay at the pharmacy this month ($1.10/$2.60 for generic drugs or $3.30/$6.50 for brand name drugs).

The reason for the delay is that Medicare did not require states to send data identifying full dual eligible Waiver recipients until January 2012; therefore, Medicare could not update their system or notify plans about who qualifies for zero co-pays prior to the data being received and processed. The systems should be updated soon, however, and once that happens, full dual eligible waiver recipients will no longer be charged a co-pay at the pharmacy for Part D covered drugs. The changes will be made retroactive to January 1st.

Important Things to Keep in Mind:

- This change applies to individuals receiving services through any of PA's HCBS Waiver programs including *Aging (PDA), LIFE Program, Attendant Care, OBRA, Independence, COMMCARE, Person/Family Directed Support (PFDS), Consolidated, AIDS*, and *Adult Autism*. Medicare did not send information to these individuals, their family members or advocates, so if you know someone who is a Waiver recipient, please make sure they are aware of this change.

- After Medicare and the Part D plans update their systems, the plans are required to reimburse full dual eligible Waiver recipients for any co-pays they paid in January or February. ***This reimbursement should happen automatically.*** Individuals can also contact their plan to request reimbursement.

- Individuals can try on their own to get their Part D Plan to update the system to reflect the zero co-pay by sending the Plan proof that the individual is enrolled in a Waiver program (i.e., an eligibility notice or an active service plan dated July 2011 or later). Part D plans are required to accept the proof and update their systems to reflect the zero co-pays at the pharmacy.

Please contact PHLP's Helpline at 1-800-274-3258 if you have questions or need assistance with submitting information to the Part D plan.

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.

HealthChoices Expansion Starts July 1st for Seven Counties

Beginning July 1, 2012, seven rural counties where ACCESS Plus currently operates will no longer offer ACCESS Plus but will instead be incorporated into existing HealthChoices zones. **Bedford, Blair, Cambria** and **Somerset** counties will join the HealthChoices **Southwest Zone**. **Franklin, Fulton** and **Huntingdon** counties will join the HealthChoices **Lehigh-Capital Zone**.

Current ACCESS Plus enrollees will be required to join a managed care plan for their Medicaid coverage and those currently enrolled in a Voluntary Managed Care Plan will also have to choose a HealthChoices Managed Care plan in their zone. If a consumer does not make a choice, the state will auto-assign them to one of the available plans. Open Enrollment in these counties begins in May 2012. Information about HealthChoices and plan choices will be provided to individuals before Open Enrollment starts.

As discussed in previous newsletters, DPW is expanding HealthChoices statewide. The remaining 35 counties in the state where ACCESS Plus will continue to do business will be split into two new zones-New West Zone and New East Zone. Consumers in these new zones will be able to choose between ACCESS Plus and one of the HealthChoices plans available. The target start dates are September 1, 2012 for the New West Zone and March 1, 2013 for the New East Zone.

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