Health Law PA News

and

Senior Health News

Newsletters of the Pennsylvania Health Law Project

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This newsletter is a combined issue of PHLP's two bi-monthly newsletters. We plan to return to our regular schedule of monthly newsletters in August.

Final Budget Brings Significant Changes to MA Program

The final budget approved by the General Assembly and signed into law on June 30th includes substantial cuts to DPW's budget from the previous year. Governor Corbett introduced his 2011-12 budget proposal in March. To meet his goal of balancing the budget without raising taxes, the Governor proposed cuts to DPW's budget along with cuts to many different programs including basic and higher education. In May, the House Republicans introduced their version of the state budget which cut the Department of Public Welfare further while restoring some education funding.

The final budget relies heavily on the Department of Public Welfare (DPW) achieving major savings through eliminating waste, fraud and abuse in its programs. That raises a question about what happens if those savings are not found. Adding to the pressure, DPW may not be able to request additional funding mid-year, as it often has in the past, through a process called "supplemental appropriations." One answer to the question of what happens if substantial savings are not achieved by eliminating waste, fraud and abuse may lie in Act 22 of 2011.

DPW Granted Extraordinary Power

Act 22 of 2011 passed as part of the budget process. It amends the Public Welfare Code to give DPW authority to make sweeping changes without legislative approval and without going through the normal administrative rulemaking process. This allows DPW to make changes more quickly. Act 22 mandates that DPW "take any action" needed to stay within its budget.

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DPW can now unilaterally (i) change eligibility standards, (ii) mandate co-pays and direct providers to stop services if those co-payments are not received, (iii) modify benefits, and (iv) change provider reimbursement rates.

Although the General Assembly has given DPW this extraordinary new authority under state law, the state cannot override existing protections in federal law. For instance, DPW must follow federal rules as it implements the reduced pharmacy and dental benefits or any changes related to co-pays for Medicaid services. At the very least, DPW needs to seek the federal government's approval for these changes by amending Pennsylvania's Medicaid state plan.

Ongoing Concerns and Need for Continued Advocacy

DPW has to find significant "savings" in the Medical Assistance program. Even with the benefit changes described in the following articles, the Office of Medical Assistance Programs (OMAP) still needs to reduce program spending by another $200 million. Consistent with the message conveyed by the PA General Assembly, DPW officials have asserted that their initial, primary focus will be on identifying and addressing waste, fraud, and abuse within their programs. At the same time, these officials concede that they are analyzing **all** areas of the Medicaid program to find ways to reduce spending.

Regarding waste, fraud, and abuse, DPW officials have stated that DPW wants to focus on the "front door" –that is, the County Assistance Offices. The CAOs are where most consumers apply for benefits, and the state wants to ensure that these offices follow all of all of DPW's existing rules when determining eligibility.

Because of a federal requirement that prevents states from reducing their Medicaid rolls before the Medicaid expansion that occurs as part of health care reform in 2014, DPW can only enforce existing eligibility rules, and cannot tighten eligibility standards or impose additional eligibility procedures for most categories of Medical Assistance. Under this "maintenance of effort" requirement a state cannot alter its state plan to implement "eligibility standards, methodologies, or procedures" that are more restrictive than those in place on March 23, 2010.

DPW is currently analyzing how to achieve cost savings through a variety of means including reducing benefits, reducing provider rates, and imposing co-payments in light of the federal rules and consumer protections that apply in each of these areas. It is a near certainty that DPW will pursue a variety of cost-containment initiatives in coming months in its efforts to achieve the savings that the final budget demands.

In this publication, we describe what is currently known and encourage readers to visit our website and read future editions of *Health Law News* for more information as developments occur.

DPW Limits Adult Dental Benefits Starting in September

In August, DPW will be sending out notices to adults* on "fee-for-service" Medical Assistance (those who use an ACCESS card for medical services) informing them that **effective September 30, 2011** their dental benefits are changing in the following ways:

- 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 7 years to **one upper denture (partial or full) and one lower denture (partial or full) per lifetime**. If DPW already paid for a partial or full upper or lower denture for the consumer since March 1, 2004, that person will only be able to get a replacement denture under this policy if DPW 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 DPW approves the dentist's request through a benefit limit exception**. Previously, these services could be obtained if specific criteria were met and DPW prior authorized the service as medically necessary.

*Please note: The changes **do not apply to:**

- recipients in any of the state's Medical Assistance Physical Health managed care plans (These managed care plans may decide to limit their benefits at a later date in a similar way, but they are required to send a notice to members 30 days in advance of any benefit changes);
- recipients under 21 years old;
- recipients who live in a nursing home or intermediate care facility (ICF).

Individuals who fall into one of these three categories and who receive the notice should file an appeal. Appeal instructions will be included in the notice.

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. DPW 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 not granted; *or*
- it would be against federal law for the Department to deny the exception to the consumer.

If the request for a benefit limit exception is denied, the consumer will be sent a written notice and can appeal and request a Fair Hearing on the matter.

DPW is making these changes as a cost saving initiative to help the Department stay within its appropriation for FY 2011-12. The changes are anticipated to save the state $25.2 million.

Major Changes Ahead For Consumers Who Use the Medical Assistance Transportation Program

DPW recently announced two cost-savings measures for the Medical Assistance Transportation Program (MATP) that it plans to put into effect this Fall**.** The MATP provides or pays for rides for Medical Assistance (MA) consumers to get to and from medical appointments and other MA-covered services. DPW had hoped the MATP budget would be level-funded in FY 2011-2012. Instead, the final state budget passed by the legislature and approved by the Governor reduced funding for MATP by $26 million.

Co-pays for Shared Ride

The MATP provides medical transportation for consumers in various ways including public transportation (like the bus or train), shared ride (paratransit vans), or taxi service. Consumers are entitled to the least costly, most appropriate transportation service that meets their needs.

Beginning this Fall, consumers who receive shared ride or taxi service from MATP will be required to pay a $2 co-pay for each one way trip ($4 for a round trip). The co-pay will be paid to the driver at the time of pick-up. This co-pay applies to all MA consumers using MATP except:

* those who are under age 18
* women who are pregnant

Reduction in Mileage Reimbursement

MA consumers who have a car (or have access to someone else's car) but who need help getting to and from their medical appointments can receive mileage reimbursement (including parking and toll costs) from their county MATP. Up until now, the state allowed each county to decide its own mileage reimbursement rate and the rates fluctuated from 25 cents per mile in some counties to over 40 cents per mile in others.

Beginning this Fall, DPW has decided to reduce the mileage reimbursement rate across the state to 12 cents per mile (plus parking and toll costs) and no county will be able to pay a higher rate. This reduced mileage rate applies to **all** MA consumers regardless of their age.

Notice of Changes and Appeal Rights

MATP consumers must be given notice of these changes 30 days before they go into effect. A written notice will be sent out by each county MATP program notifying their registered consumers of the new co-pay requirement and mileage reimbursement rate. Consumers cannot appeal the change itself but can appeal if the change should not apply to them (that is, that they are not subject to co-pays because they are pregnant or under age 18).

Medical Assistance Pharmacy Benefit to be Capped for Adults

Beginning in January 2012, adults on Medical Assistance will have their coverage limited to six prescription drugs per month. The Corbett Administration is implementing this benefit reduction, among others discussed previously, in an attempt to reduce Medicaid program spending and to make recipients more personally responsible for their health care. This benefit change will not apply to children under age 21, pregnant women, or residents of a nursing home or intermediate care facility.

For consumers who access care through "fee-for-service" (those who use the ACCESS card to see their doctors), the reduction is scheduled to go into effect January 1, 2012. For consumers enrolled in a managed care organization (MCO), their individual MCO controls whether, and when, the reduction will go into effect. While DPW is reducing the capitation rates to the MCOs to reflect the prescription drug limit, it is unknown at this time whether the MCOs will implement the reduction. DPW and the MCOs are both required to provide written notice at least thirty days in advance to any consumers whose pharmacy benefit is being reduced. The notice will detail the changes and an individual's right to appeal.

DPW is still finalizing the list of approximately thirty drug classes that will be exempt from the monthly cap. These drug classes will be exempt based on a determination that providing the drugs is either cost-effective or necessary to avoid jeopardizing a consumer's life or risking serious deterioration of health. As examples, DPW has indicated that medications to treat hemophilia, diabetes, cancer, HIV/AIDS, and angina will be automatically exempt. Other medications will be exempt only for consumers who have a certain diagnosis; for example, anticonvulsants will be automatically exempted only for consumers with a diagnosis of seizure disorder or bipolar illness. A pharmacist should be able to fill a prescription for medications that are automatically exempt from the '6 per month' limit without needing to take further action, regardless of how many prescriptions the consumer has filled that month.

In addition to exempting certain drugs from the cap, DPW is developing a policy that will allow prescribing physicians to request an exception to the benefit limit for a specific patient. We'll provide more details about this in future newsletters.

Do you currently get the Health Law PA News and/or Senior Health 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!

PA Legislature Gives DPW Green Light for Co-pays

Act 22 of 2011 (described earlier) grants authority to DPW to charge co-pays, including co-payments for services to some children under 18 with disabilities. DPW is able to require providers to charge families a co-pay for services their children receive under Medical Assistance and to refuse services if the family doesn't pay the co-pay. The co-pays would not apply to children on SSI, families whose children receive cash assistance, or families whose household income is less than 200% of the federal poverty level. The co-pays could apply to children whose family income is **above 200%** of the federal poverty level (FPL) as set out below:

Household	Monthly income (200% FPL)	Annual income (200% FPL)
2	$2,452	$29,420
3	$3,090	$37,060
4	$3,725	$44,700
5	$4,362	$52,340
6	$5,000	$59,980
7	$5,635	$67,620
8	$6,272	$75,260

DPW must now make crucial policy decisions and address critical issues including:

- How much will co-pays be?
- On which services will co-pays be imposed?
- Will the amount of the co-pay be based on family income? How will income be determined?
- Will out of pocket medical costs be deducted from family income for co-pay purposes?
- Will co-pays be imposed if the child has other insurance coverage and Medical Assistance pays nothing for a service because the other insurance payment exceeds the Medical Assistance fee for the service?
- Will there be any exemptions (for example children on Medical Assistance waivers)?

Act 22 of 2011 appears to allow DPW to avoid the regulatory process and just publish a notice in the official state publication, the *PA Bulletin*, that will "set forth the co-payment schedule".

PHLP looks forward to working with family and advocacy organizations, as well as providers, to advocate with DPW for an open and inclusive process in which input from affected families is obtained and for a co-pay policy with limits and exemptions that recognize the financial pressures faced by families with children with disabilities.

For further information or to complete a survey about medical expenses that families of children with disabilities who are under 18 years old pay, please contact David Gates at dgates@phlp.org.

Medical Assistance Recipients at Risk of Losing Benefits in Upcoming Weeks

County Assistance Offices (CAOs) across the state are in the midst of reviewing approximately **68,000** Medical Assistance cases that are overdue for renewals (this includes those on MA in nursing homes and those receiving Home and Community-Based Waiver services). DPW ordered the CAOs to have these reviews completed by **August 12, 2011** in order to bring them into compliance with MA eligibility requirements.

The CAOs have been instructed to identify cases with overdue renewals, process those cases where verification has been received, and notify individuals if they no longer qualify and their benefits will be terminated. In cases where verification was not received by the CAO, the caseworker will immediately close the case and send an advance notice of termination. In cases where the CAO has not yet sent out the renewal packet, this will be done and individuals will be given 10 days to return the renewal form with verification. Individuals who do not return the information within this timeframe, or who do return the information but who are then determined no longer eligible for MA, will be sent an advance termination notice.

Advocates are very concerned that individuals who are in fact eligible for MA will lose their coverage as a result of these mass renewals. With CAOs operating at reduced staffing levels and already overwhelmed with applications and ongoing cases, this hurried review process could easily result in individuals who are still eligible for MA losing their benefits.

Individuals who receive an advance termination notice should:

- file an appeal within 13 days of the mail date on this notice. This will ensure that their benefits continue during the appeal process.
- Appeals should be mailed in a way that someone can prove mailing date (i.e., certified mail, return receipt requested).
- Individuals can also drop off their appeal requests at the CAO but should keep a copy of the appeal and get a receipt from the CAO.

Individuals whose benefits are being terminated as a result of these renewals are encouraged to call our HELPLINE (1-800-274-3258) or to contact their local legal aid office for advice and assistance.

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.

Final FY11-12 Budget's Impact on other DPW Offices

Office of Long-Term Living (OLTL)

OLTL's total budget for this fiscal year is approximately $300 million, which represents an 8% cut from the previous year. OLTL operates jointly within the Department of Public Welfare and Department of Aging and is responsible for administering programs for adults with certain disabilities and for older adults. This reduced funding will result in some program changes:

- Waiting lists for all Waiver Programs are likely. OLTL expressed concern about significantly increased enrollment in the Aging Waiver and the LIFE program. Due to a $26 million reduction in both the Attendant Care (which also includes the Act 150 program) and the Services for Persons with Disabilities (includes the OBRA, Independence and COMMCARE Waivers) portions of OLTL's budget, waiting lists will also likely be used for the Attendant Care and Independence Waivers (neither of these programs have ever had a waiting list). As a reminder, there is currently a moratorium on enrollment for the OBRA and COMMCARE waivers.

- OLTL will probably reduce rates for LIFE providers and may potentially reduce provider reimbursement in other programs.

- Individuals currently receiving services through the Act 150 program will be evaluated to determine their eligibility for the Attendant Care Waiver (the Act 150 program is solely funded by state dollars whereas the state receives a federal match for individuals enrolled in the Attendant Care Waiver).

- OLTL will also be reviewing "high cost" service plans and will likely be reducing services to individuals in an effort to "case manage" those individuals. Individuals whose services will be reduced have the right to appeal.

OLTL is also looking at other options for controlling costs but has not made any further decision about how to achieve this.

Office of Mental Health and Substance Abuse Services (OMHSAS)

OMHSAS' total FY 2011-2012 budget is $701 million. This office is responsible for administering behavioral health services (which includes mental health and substance abuse services). Noteworthy items within the final budget include:

- BHSI (Behavioral Health Services Initiative) funding is reduced by $4.3 million-this program provides mental health and drug and alcohol treatment for low income individuals who do not qualify for Medicaid.

- A 4% cap on the amount of reinvestment money counties can keep. Counties receive a per-person ("capitation") payment from the state to provide behavioral health services for MA consumers. If the county and its Behavioral Health MCO spend less than the state payment, they must reinvest that "profit" in services. Up until now, there had been no limit on the amount of profit counties could keep for reinvestment.

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- Continued focus on two cost containment initiatives affecting children. Specifically, OMHSAS is working with counties and MCOs on developing evidence-based therapies as alternatives to Residential Treatment Facilities (RTFs) and Behavioral Health Rehabilitation Services (BHRS) commonly called "wrap around".

OMHSAS may have to make additional cuts beyond those specified in the budget. Additional details should become available when OMHSAS holds a budget briefing scheduled for August 10, 2011.

Office of Developmental Programs (ODP)

ODP is responsible for overseeing programs for individuals with intellectual disabilities and autism. The Office is still determining how it will achieve cost savings in light of its 2011-12 budget allocations. Though few details are currently available, one item to note is that additional waiver slots will be available for dually diagnosed persons coming out of state psychiatric hospitals and state centers for persons with intellectual disabilities but otherwise no new waiver slots will be available for persons currently on the "waiting list" for the PFDS or Consolidated Waiver**.**

Oregon Medicaid Study Finds Medicaid Matters to Those Enrolled

In a first-of-its-kind study, researchers say Medicaid increases the use of health care, reduces financial stress, and improves health for its clients. A report by the National Bureau of Economic Research, the Harvard School of Public Health, Massachusetts Institute of Technology, and Providence Health and Services compared people who enrolled in Oregon's Medicaid program to those who did not.

What makes this study different from other reports on the effects of Medicaid enrollment was the unique opportunity to compare those who enrolled to a control group of similar people who did not enroll; a randomized controlled study. In 2008, Oregon held a lottery to fill 10,000 available openings for low-income uninsured adults in their Medicaid program. About 90,000 people applied for those 10,000 slots. The researchers collected information about the 10,000 who enrolled in Medicaid as well as information about those who did not obtain Medicaid coverage through the lottery process. Importantly, the two groups were similar in income, health status, and employment. And as a group, they were in poor health: 18% had been diagnosed with diabetes, 28% with asthma, 40% with high blood pressure and 56% screened positive for depression.

Looking at the first year of Medicaid coverage, the study found that those enrolled in Medicaid had statistically significant higher health care usage, including primary and preventive care, hospital care, and the appropriate use of prescription drugs. Those covered had lower out-of-pocket costs for their health care and lower medical debt. This decreased the likelihood of having to borrow money or skip other expenses to pay for health care. It also meant that providers were paid, decreasing the amount of uncompensated care. Those who obtained Medicaid coverage also reported better physical health and less depression than those who did not enroll in Medicaid.

As the debate regarding federal and state expenditures continues, this study provides critical and substantiated evidence: ***Medicaid works***.

Judge Orders IBC to Cover In-School Autism Services

Children and adolescents under 21 on the autism spectrum may now be able to get coverage for ABA (Applied Behavioral Analysis) or TSS (Therapeutic Staff Support) in school under certain Independence Blue Cross (IBC) insurance policies as a result of a recent court decision. Act 62, a state law also known as the Autism Insurance Law, requires certain health insurance policies to cover a variety of therapies and services for children and adolescents under 21 on the autism spectrum.

To our knowledge, all insurance companies except Independence Blue Cross provide coverage of autism therapy services in school under their policies that are governed by Act 62. PHLP filed a lawsuit against IBC on behalf of a boy denied coverage for ABA services in school because IBC excludes coverage of all services provided in school. On July 19th, the Philadelphia Common Pleas Court reversed that coverage decision and ruled that Act 62 requires health insurance policies subject to Act 62 cover autism therapy services in school.

While this court decision applies to a specific child, PHLP is interested in assisting other families with children on the autism spectrum who have IBC policies subject to Act 62 and who need services in school. Act 62 applies to policies covering 51 or more employees that are not "self insured" and that are subject to Pennsylvania law. Families should check with their employer's human resources or benefits division to find out if their policy is subject to Act 62.

If the family's IBC policy **is** covered by Act 62, they should check whether their child's service provider participates in IBC. If so, they should ask that service provider to submit their child's psychological evaluation and treatment plan to Magellan, IBC's behavioral health contractor, for authorization.

Providers are required to seek authorization for autism services from IBC or other commercial insurance plans subject to Act 62 in order to also bill Medical Assistance as secondary insurance, or in the event that the commercial insurance denies coverage. Another reason families should seek coverage of their child's autism services from their commercial insurance, even if the child also has Medical Assistance, is to ensure that commercial insurance pays their fair share of autism treatment costs which will reduce the cost to Medical Assistance. With Medical Assistance and other DPW programs forced to find $200 million in additional savings in the next 12 months, savings from increased coverage by commercial insurance could avoid cuts in other areas later this year.

Families who are denied coverage for in-school autism services by Magellan under an IBC policy are urged to contact PHLP at 1-800-274-3258.

Bureau of Hearings & Appeals Selects New Vendor

Fair hearings involving an appeal of an action taken by a Medicaid managed care organization (MCO) will now be handled by a private entity named Federal Hearing & Appeals. DPW confirmed that it terminated its contract with the old vendor, Keystone Hearings & Appeals, at the end of June, and entered into a new contract with Federal Hearings & Appeals on July 17, 2011. With the change in vendors, DPW has indicated that there is a backlog of both consumer and provider appeals.

State regulations at 55 PA Code § 275.4 provide that fair hearings involving a Medical Assistance benefit must be heard and decided within 90 days from the date the appeal was requested. If that timeframe is missed because of DPW delay, a consumer can request and is entitled to receive the benefit under appeal until a final decision is rendered. This is called "interim assistance." As an example, if a consumer requests a fair hearing regarding an MCO denial of a medication, has a hearing 60 days later, but receives no decision by day 90, she can request "interim assistance" and receive the medication until the hearing decision is rendered. (Note: This rule does not apply to one-time items, like durable medical equipment.)

Consumers are encouraged to note the date they file a file hearing request. If a decision has not been rendered within 90 days, consumers are encouraged to request interim assistance. Requests for interim assistance should be made to the appeals unit of the consumer's managed care plan and be in writing, or made by phone and followed up in writing.

As a reminder, when someone is already receiving a benefit or service and then action is taken by their MCO to reduce or terminate that benefit or service, filing an appeal within 10 days of the notice mailing date allows the benefit or service to continue until a final decision is rendered. Paying attention to timeframes and acting quickly is always important when it comes to appealing denials, reductions and terminations of benefits.

Unique Housing Opportunity for Persons with Disabilities Opens

PHLP has been involved in the development of a unique subsidized independent housing model for persons with disabilities known as a "co-op". Under the co-op model, persons with disabilities have their own apartment, or share an apartment with a roommate of their choice. They also have a say in certain matters regarding how the project is run. A co-op is not a group home as services are completely separate from the housing. This enables residents to change service providers without losing their housing. After years in the planning, this co-op which is located in Bloomsburg finally opened in July and several residents have moved in. All apartments are fully accessible and the rent is subsidized. The co-op has several vacancies for its 2 bedroom units. Persons with disabilities interested in the Bloomsburg co-op should contact Jodi Braden of the Columbia County Housing Authority at 570-784-9373 x113.

Insurance Department Holding Hearings on Health Insurance Exchange

A key component of federal health care reform is the establishment of health insurance exchanges, which are marketplaces to purchase health insurance. States can develop their own exchange or default to the federal government in this matter.

The Pennsylvania Insurance Department is seeking input about who should operate its exchange and how it should be run. Three forums for **public comment** have been scheduled for the month of August.

All forums will run 9 a.m. to 3 p.m. **Prior registration is required.**
Visit the Insurance Department's website (www.insurance.pa.gov) to learn more or call 717-705-0008.

PITTSBURGH - Tuesday, Aug. 9, 2011
Doubletree Hotel Pittsburgh/Monroeville
Convention Center
101 Mall Blvd., Monroeville, PA

PHILADELPHIA - Thursday, Aug. 11, 2011
Crowne Plaza Liberty Convention Center
260 Mall Blvd., King of Prussia, PA

HARRISBURG - Tuesday, Aug. 23, 2011
Sheraton Harrisburg Hershey
4650 Lindle Rd., Harrisburg, PA

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