

Health Law PA News

Newsletters of the Pennsylvania Health Law Project

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Dental Limits for Adults on Fee-for-Service Medicaid Start September 30th

Effective September 30, 2011, adults who receive their Medical Assistance (hereafter referred to as Medicaid) coverage through the ACCESS card (this is known as “fee-for-service”) are having their dental benefits changed 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 seven 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.

Affected recipients received notice about these changes in past weeks. The changes **do not apply to**:

- recipients under 21 years old;
- recipients who live in a nursing home or intermediate care facility (ICF)
- recipients enrolled in Medical Assistance managed care plans (see next page)

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.

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Two Medical Assistance Managed Care Plans Announced Dental Limits

Medical Assistance managed care plans can decide whether they will implement changes to their dental benefits and whether the changes will be the same as the limitations for those using their ACCESS card as described previously. As of the publication of this newsletter, the following managed care plans are also making changes to their dental benefits:

- ◆ United Healthcare Community Plan-starts October 3, 2011(notices have been sent to their members)
- ◆ Gateway Health Plan-starts November 1, 2011 (notices will be sent to members by October 1st)

Both of these plans are changing their dental benefits in the same way that the fee-for-service program is changing its coverage of dental services (described on page one).

Coventry Cares has announced that it does not plan on changing its dental benefits for adults. It is not yet known whether the other Medical Assistance managed care plans (Aetna Better Health, AmeriHealth Mercy Health Plan, Health Partners, Keystone Mercy Health Plan, and UPMC for You) will be making any changes to their dental benefits. If any of these plans decide to make changes, they have to send written notice to members 30 days in advance of when the changes start. The notice will describe the changes to their dental benefits and when the changes will go into effect.

Plans who decide to make changes to their dental benefits will have a benefit limit exception process that cannot be stricter than the one used by the Medicaid fee-for-service system. Any denials of a benefit limit exception request can be appealed through the plan grievance process and the fair hearing process available to all Medicaid recipients.

DPW Going Ahead With MATP Mileage Reimbursement Reduction

Individuals who use their own vehicle (or someone else's) to get to and from their medical appointments and who are registered with the local Medical Assistance Transportation Program (MATP) for mileage reimbursement will see their reimbursement reduced to 12 cents per mile (plus parking and tolls) starting **October 15th**.

In early September, the county MATP programs mailed written notices of this change to all consumers registered with MATP. This significant change could create a hardship for many MATP consumers. Up until now, every county MATP could determine its own mileage reimbursement rate. The lowest rate was 25 cents per mile, while some counties paid over 40 cents per mile. If, as a result of this mileage reduction, a consumer no longer has a vehicle available to get to medical appointments (for example, her neighbor has been driving her to appointments but is no longer willing to do so for only 12 cents a mile), the consumer can request to change their MATP service (to a bus pass, shared ride, taxi, etc). The county is responsible to provide a consumer with the least costly, most appropriate transportation available to meet the consumer's needs. If the county denies the consumer's request for other transportation, she has the right to appeal the decision.

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DPW estimates it will save \$5.8 million by implementing the reduction in mileage reimbursement; ultimately, it needs to find savings to address the \$26 million cut to the MATP budget in the 2011-12 fiscal year. At this time, DPW has decided to delay implementation of the \$2 co-pay for each one way shared ride or taxi trip provided by MATP while it works out issues and problems related to that change (these co-pays were previously discussed in the June/July 2011 Combined Newsletter). DPW is asking county MATP programs to come up with other cost-saving ideas to achieve the necessary savings. Possibilities of additional changes that may be made by county MATPs include: revising the “no show” policy and limiting out of county trips to certain days of the week. Stay tuned to future newsletters for additional information and updates.

Keystone Mercy Health Plan Closes PCP Panels at Popular Hospitals

On September 1st, Keystone Mercy Health Plan (KMHP), the largest Medicaid managed care organization in the Southeastern region, closed enrollment into health system-owned primary care provider (PCP) panels at the University of Pennsylvania, Jefferson, and Crozer-Keystone Health Systems. KMHP members currently enrolled in these PCP practices will not be affected by this action, which the managed care plan explained as necessary in advance of upcoming contract negotiations between KMHP and these health systems. KMHP reports that this PCP panel closure will last no longer than six months. It will not apply to KMHP consumers who have a household member already enrolled in one of the affected practices, or to KMHP members currently enrolled in these PCP practices who lose and regain Medicaid eligibility within six months.

The Consumer Subcommittee (Consumers) of the Medical Assistance Advisory Committee raised a number of concerns regarding the panel closure. Specifically, the Consumers:

- questioned whether KMHP continues to meet the provider access requirements, especially in Chester and West Philadelphia. Medicaid managed care organizations in urban areas are required to have at least two open PCP panels available for members within a thirty minute travel time (including traveling by public transit).
- expressed their concern that closing only PCP practices when KMHP has a current contract with the remainder of a health system could confuse both KMHP members and new Medicaid consumers looking to enroll in KMHP in terms of the plan’s provider network.
- objected to Medicaid consumers being used as leverage in contract negotiations between a Medicaid managed care plan and a hospital/health system.

Medicaid consumers wanting to enroll in a PCP practice owned by the University of Pennsylvania, Jefferson, or Crozer-Keystone Health System can still do so; however, they will need to choose a managed care plan other than KMHP. Each of the affected hospital systems contracts with at least two Medicaid managed care plans in addition to KMHP. To find out which plans contract with these health systems, contact PA Enrollment Services at (800) 440-3989 or <http://www.enrollnow.net>.

DPW Proposes Expanding Medicaid Managed Care

On August 23, the Department of Public Welfare (DPW) announced plans to expand HealthChoices to the remaining 42 of the Commonwealth's 67 counties. DPW currently requires most Medicaid recipients living in heavily populated counties to enroll in a managed care plan (this is known as HealthChoices). Currently, there are 25 HealthChoices counties which are in the Southwest (Allegheny and surrounding counties), Lehigh-Capital area (counties in the central and eastern part of the state) and in the Southeast (Philadelphia and surrounding counties). The Department is proposing to expand HealthChoices to the other 42 counties that currently have ACCESS Plus and may have voluntary managed care plan options.

Consumers in these 42 counties will choose between ACCESS Plus and HealthChoices. ACCESS Plus is a primary care case management program that requires recipients to use primary care physicians to coordinate their health care needs. Otherwise, they can see any medical provider that accepts the ACCESS card. Under the HealthChoices program, managed care organizations (MCOs) contract with health care providers to serve their enrolled population. MCOs require that individuals have primary care physicians to coordinate care and stay within the plan's network of providers.

The federal government has established various requirements for mandatory Medicaid managed care programs like HealthChoices, including the right to appeal or file grievances to address particular health care needs and provider network adequacy requirements to ensure that Medicaid recipients have reasonable geographic and timely access to health care.

As proposed, DPW intends to establish two new zones:

- **New West Zone** that would encompass 19 counties (Erie, Crawford, Mercer, Venango, Warren, Forest, Clarion, Jefferson, Elk, McKean, Cameron, Clearfield, Cambria, Somerset, Blair, Bedford, Fulton, Huntingdon and Franklin) and approximately 270,000 Medical Assistance beneficiaries
- **New East Zone** that would include the remaining 23 counties (Potter, Tioga, Bradford, Susquehanna, Clinton, Lycoming, Sullivan, Wyoming, Lackawanna, Wayne, Pike, Monroe, Carbon, Luzerne, Columbia, Montour, Union, Centre, Mifflin, Juniata, Snyder, Northumberland and Schuylkill) covering 295,000 beneficiaries.

DPW is operating under an accelerated timeframe. Implementation in the New West Zone would start on September 1, 2012, and in the New East Zone would start March 1, 2013. DPW has sought feedback from stakeholders on their proposal. Stay tuned for updates as details become available.

Update on Federal Court Review of the Affordable Care Act

Before the signature ink dried on the Patient Protection and Affordable Care Act (ACA) states and individuals alike began legal challenges to overturn the law. To date, more than two dozen lawsuits have been filed in federal courts. For example, in Pennsylvania, a federal district court recently decided that the individual mandate is unconstitutional (see [Goudy-Bachman v. Sebelius](#)). This decision has already been appealed to the Third Circuit Court of Appeals. This case and other similar legal challenges likely mean that the U.S. Supreme Court will soon grant review to consider the ACA's constitutionality (possibly as early as June 2012). The Obama administration recently asked

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the Supreme Court to hear at least one case, making it all but certain to most commentators and legal scholars that the Court will accept briefs with arguments by the spring and issue a decision by June, in time to land in the middle of the 2012 presidential campaign.

The decisions by lower federal courts on the constitutionality of the ACA that the Supreme Court is most likely to consider include:

- A June 2011 decision by the Sixth Circuit Court of Appeals ([Thomas More Law Center v. Obama](#)), finding that the ACA's requirement that all Americans obtain health insurance (known as the individual mandate) was constitutional;
- An August 2011 decision by the Eleventh Circuit Court of Appeals ([Florida v. HHS](#)), a case brought by 26 states, including Pennsylvania, which found that the individual mandate was unconstitutional because it was an improper use of Congress' power. However, the court did uphold the ACA's use of Medicaid to cover a greater number of uninsured Americans;
- One of two recent Fourth Circuit Court of Appeals decisions dealing with the ACA; neither decision was about the constitutionality of the law, but instead focused on whether the state of Virginia had standing to bring the lawsuit. However, a majority of the court wrote that they would find the individual mandate constitutional.

For more in-depth analysis, visit <http://healthlawandlitigation.com/>, a website run by the National Health Law Program and Georgetown University.

U.S. Supreme Court Will Decide Whether Medicaid Recipients Can Sue State

One of the first matters the U.S. Supreme Court will hear when it sits for its 2011-12 term is whether Medicaid recipients should have the right to sue their state to enforce federal Medicaid requirements.

In [Douglas v. Independent Living Center of Southern California](#), Medicaid providers and recipients challenged California's cutbacks in reimbursements to providers enrolled in the state's Medicaid program. The providers and recipients argued that these cuts were a violation of federal Medicaid law which says Medicaid rates "must be sufficient to enlist enough providers" so that Medicaid recipients have access to care to the same extent as the general population in an area. The plaintiffs asserted the cuts would reduce the number of providers who participate in the program, and therefore prevent Medicaid recipients from accessing care at the same rate as others in the general population. Although courts have said in the past that recipients do not possess a private right to sue the state if Medicaid services become limited, the Ninth Circuit Court of Appeals determined that the Medicaid recipients could sue in this case saying the federal Medicaid law requiring equal access preempts the state's authority to cut provider reimbursements.

The U.S. Supreme Court is not deciding the merits of the case (whether California violated federal law by reducing reimbursement rates to certain Medicaid providers); rather, it will be ruling on whether Medicaid recipients can sue states that enact laws which conflict with federal Medicaid requirements. The Obama Administration supports California's position that individuals should not have this right and that the federal government can enforce Medicaid requirements. Many states have filed briefs supporting California saying that it costs too much money for states to comply with federal law. Consumer advocates and others (including influential members of Congress and former federal officials) have filed briefs supporting Medicaid recipients right to sue states when they violate federal Medicaid law.

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.

Report Details Number of Pennsylvanians with Chronic Conditions Who Depend on Medicaid for Treatment

Tens of thousands of Pennsylvanians depend on Medicaid for regular treatment for medical conditions such as cancer, diabetes, chronic lung disease, heart disease, and stroke. Without Medicaid, many of these seriously ill Pennsylvanians would no longer be able to fill essential prescriptions or see a doctor for treatment.

The importance of Medicaid to Pennsylvanians is detailed in a report recently released by the American Cancer Society Cancer Action Network, the American Diabetes Association, the American Lung Association, and Families USA (a health care consumer group).

Two millions Pennsylvanians are covered by Medicaid. Of this number:

- An estimated 43,750 Pennsylvanians with Medicaid have cancer, including 1,180 children, 27,590 adults, and 14,980 seniors;
- An estimated 150,420 Pennsylvanians with Medicaid have diabetes, including 5,200 children, 102,480 adults, and 42,750 seniors;
- An estimated 342,120 Pennsylvanians with Medicaid have chronic lung diseases such as asthma, chronic obstructive pulmonary disease (COPD), and cystic fibrosis, including 143,560 children, 163,960 adults, and 34,600 seniors;
- An estimated 378,270 Pennsylvanians with Medicaid have heart disease or stroke, including 18,890 children, 253,570 adults and 105,810 seniors.

These are people whose health care needs require regular medical attention. Often, these conditions can be managed, or sometimes even cured, if treated in a timely manner. Medicaid helps make it possible for these Pennsylvanians to see a doctor when they need to, fill prescriptions, and keep up with screenings and other preventive care so that they can act quickly if their illness gets worse or recurs. Without Medicaid, many of these seriously ill people would not be able to afford the care they need. For them, Medicaid coverage is critical. Federal or state cuts to the Medicaid program would be detrimental to people with serious chronic conditions. To access the report online visit www.familiesusa.org.

New Key Staff at DPW

Earlier this month, **Vincent Gordon** began his duties as the new **Deputy Secretary for the Office of Medical Assistance Programs (OMAP)**. He had previously been employed by AmeriHealth Mercy Health Plan in network development and has more than 20 years of experience in managing business relationships between Keystone Mercy Health Plan and the hospital physician network. He has served as a member of the school board in Upper Darby since 2005. DPW reports that earlier in his career, Mr. Gordon served in the US Marine Corps.

Kenneth J. Serafin was appointed **Chief Counsel to the Department of Public Welfare** in June 2011. Prior to his appointment, he served as the Workforce Policy Counsel for the U.S. House of Representatives, Committee on Education and the Workforce, in Washington, D.C. He has held a number of positions dealing with various health care issues. Mr. Serafin was the Deputy Chief Counsel for the Pennsylvania Insurance Department from 2002 to 2004, and was Chief Counsel to

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the Medical Professional Liability Catastrophe Loss Fund from 1999 to 2002. He received his Juris Doctorate from The Dickinson School of Law in 1992.

Bonnie Rose has been named the new **Deputy Secretary for the Office of Long Term Living (OLTL)**. She is replacing Kevin Hancock who had been Acting Deputy Secretary but who left the position earlier this month to become Chief of Staff for Brian Duke, the Secretary of the Pennsylvania Department of Aging. Rose will begin her duties October 3rd. She has worked with DPW for over 35 years and most recently served as the Director of the Bureau of Provider Support within OLTL.

Blaine Smith has been appointed **Deputy Secretary for the Office of Mental Health and Substance Abuse Services (OMHSAS)**. He will begin his duties November 15th. He is currently the Executive Director for the Central Pennsylvania Behavioral Health Collaborative in Blair County. His previous positions included Chief Fiscal Officer for Blair County Mental Health/Mental Retardation and Drug & Alcohol Offices.

33,450 Pennsylvanians Lose Medicaid Eligibility in July

As reported in our June/July newsletter, County Assistance Offices (CAOs) across the state were ordered to review nearly 70,000 Medicaid cases that were overdue for renewals, including those in nursing homes and those receiving Home and Community-Based Waiver services). Over 33,000 cases were closed in July due to failure to provide verification; this is more than double the average case closings for the last 18 months.

Advocates remain very concerned that individuals who are, in fact, eligible for Medicaid are losing 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 still qualify for Medicaid 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 the 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.

Medicare Annual Enrollment Period Starts Earlier This Year

Beginning this Fall, Medicare is moving up its Annual Enrollment Period (AEP) to run from **October 15th through December 7th**. Since the Medicare Part D Program started in 2006, the AEP had been November 15th through December 31st. However, the Affordable Care Act required Medicare to change the AEP by moving it up a month and extending the Enrollment Period from 47 days to 54 days.

From October 15th through December 7th anyone with Medicare can make changes to their Medicare coverage by enrolling into a Part D Plan (or switching their plan), changing from a Medicare Advantage Plan to Original Medicare, or moving from Original Medicare into a Medicare Advantage Plan. For anyone who makes a change during the AEP, their new coverage will start on January 1, 2012.

As a reminder, the Medicare Advantage Open Enrollment Period that had run from January 1st to March 31st every year has been eliminated and replaced by an **Annual Disenrollment Period** that runs from **January 1st through February 14th**. During this period, anyone in a Medicare Advantage Plan can disenroll from their plan and go back to Original Medicare. Individuals who take advantage of this option will also get a Special Enrollment Period that will allow them to enroll into a stand-alone Part D Plan (even if their Medicare Advantage plan did not include drug coverage).

Individuals who need assistance with 2012 plan choices should call APPRISE at 1-800-783-7067 or Medicare at 1-800-633-4227. PHLP will be conducting trainings in upcoming weeks about Medicare 2012 (see next page for more information).

PA Submits Letter of Intent to Implement a Demonstration Project to Integrate Care for Dual Eligibles

On September 19th, Department of Public Welfare (DPW) Secretary Gary Alexander submitted a letter of intent to the Centers for Medicare and Medical Services (CMS) to implement a demonstration to fully integrate care for dual eligibles (people with both Medicare and Medicaid). The state has proposed a project that evaluates both a capitated model and a fee-for-service model. The overall goal is to integrate primary, acute, behavior and long-term services and supports. The state is awaiting CMS's standards and conditions for the project before deciding whether to proceed. If it does, implementation will begin in early 2013. At a September Medical Assistance Advisory Committee meeting, the Department committed to keeping stakeholders informed. We will report on the state's planning and activities in upcoming newsletters.

Readers may recall that in February the state drafted and then withdrew an application to the Center for Medicare and Medicaid Innovation (CMMI) for up to one million dollars of funding for a strategic planning process about integrating care. In past years, the Commonwealth had extensively explored integrating care through the Medicare Advantage Special Needs Plans. These plans were to also provide Medicaid physical health and long-term supports and services, in addition to the Medicare services. However, implementation was delayed for logistical reasons and after criticism from dual eligible consumers and their advocates.

PHLP Trainings in SW PA To Highlight Medicare Part D Changes

In the month of October, PHLP will be holding information sessions to educate consumers and advocates on upcoming changes to Medicare Part D in 2012. Come to one of our trainings to learn more about:

- Home and Community Based Services (HCBS) Waiver recipients will no longer have Part D co-pays in 2012
- Special Enrollment Period to join a 5 Star Plan
- Changes to Part D plan options and costs
- Other developments affecting low-income Medicare beneficiaries (i.e., Medicaid changes affecting dual eligibles)

<p><u>Tuesday October 11, 2011</u> 10am-12pm Butler Memorial Library 218 N. McKean Street Butler, PA, 16001</p>	<p><u>Tuesday October 18, 2011</u> 9:30am-11:30am Westmoreland County Area Agency on Aging Conference Room 200 South Main Street Greensburg, PA 15601</p>
<p><u>Friday October 21, 2011</u> 9:30am-11:30am Allegheny General Hospital Snyder Auditorium 320 East North Avenue Pittsburgh, PA 15212</p>	<p><u>Monday, October 24, 2011</u> 9:30am-11:30am Presbyterian SeniorCare Hillview Chapel 835 S. Main Street Washington, PA 15301</p>

Please Call our Helpline at 1-800-274-3258 or e-mail staff@phlp.org to RSVP!

We plan to offer this training via webinar in early November for those who cannot attend one of the in-person trainings listed above. We will let you know about the webinars via an e-mail announcement once they are scheduled.

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Pennsylvania Health Law Project

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