Health Law PA News

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Medical Assistance Pharmacy Benefit to be Capped Monthly

Most adults on Medical Assistance (MA) will soon have their coverage limited to **six prescription drugs per month**. The Corbett Administration is implementing this benefit reduction, among others, in an attempt to reduce MA program spending and to make benefit recipients more personally responsible for their health care. This benefit change will **not** apply to MA recipients who are under age 21, pregnant, or residents of a nursing home or intermediate care facility.

The limit of six drugs per month will be **effective January 3, 2012** for MA consumers in "fee-for-service" (consumers who use the ACCESS card to get their prescriptions). For consumers enrolled in a physical health managed care plan, their individual managed care plan controls whether, and when, the reduction will go into effect. As of November, the managed care plans have announced their intent to adopt the six prescription/month benefit limit as follows:

Managed Care Plan	Effective Date/Decision
UnitedHealthcare UPMC For You	January 3, 2012 February 1, 2012
Keystone Mercy AmeriHealth Mercy Gateway	plan to implement, date to be determined
HealthPartners Coventry Cares Aetna Better Health	to date, no plan to implement

A managed care plan can decide to implement the benefit reduction at any point in the future. If a plan decides to go forward with the reduction, it is required to provide written notice to consumers at least thirty days before the changes start. DPW has already begun mailing the notice of benefit change to practically all adult MA consumers with a pharmacy benefit. Consumers in a managed care plan who receive this letter should contact their plan to see if and when this reduction will apply to them.

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Exceptions

Some drugs will be automatically exempt from the '6 per month' policy. DPW has determined that providing these drugs is either cost-effective or necessary to prevent serious harm to a consumer's health. As examples, DPW has indicated that medications to treat hemophilia, diabetes, cancer, and angina will be automatically exempt. Some medications will be exempt from the limit only for consumers who have a certain diagnosis; for example, anti-infective medications will only be exempted for consumers with HIV/AIDS, cancer, organ transplant, sickle cell anemia, or diabetes. The complete list of drugs that will be automatically exempt from the limit is included in the advance notice DPW is mailing to affected consumers.

For drugs automatically exempt from the '6 per month' policy, a pharmacist should be able to fill the prescription without needing to take further action, regardless of how many medications the consumer has already filled that month.

For drugs not automatically exempt from the '6 per month' policy, a consumer's doctor or health care provider will be able to request an individual exception to the monthly cap. To request this "benefit limit exception," the prescriber will need to supply clinical information showing that the exception will be either cost-effective or necessary to avoid jeopardizing their patient's life or risking serious deterioration of their health. This clinical information can be provided by phone. DPW and the managed care plans who are implementing the change are required respond to such requests within 24 to 72 hours. If DPW/the managed care plan denies the request, it must issue a written notice explaining the denial and applicable appeal rights.

Emergency Supply

A consumer denied a medication because of the '6 per month' policy can receive a five day emergency supply from the pharmacist. Issuing the emergency supply is at the pharmacist's discretion. Coverage denials at the pharmacy due to the '6 per month' policy will show denial code "76; plan limitations exceeded." Consumers are encouraged to request an emergency supply from their pharmacist, many of whom may not be aware of this policy.

Medical Assistance consumers and advocates with questions about this benefit change can contact PHLP or the Medical Assistance Recipient Service Center at 1-800-657-7925.

IMPORTANT REMINDER TO MEDICARE BENEFICIARIES

The Medicare Annual Open Enrollment Period ends December 7th! Individuals wanting to make a change to their Medicare Advantage or Medicare Prescription Drug Plan for 2012 need to take action by December 7th to join a new plan.

Plans can change their costs and their coverage each year. Everyone on Medicare should review their current plan to decide if it will still meet their needs next year.

Individuals can call APPRISE (1-800-783-7067) or Medicare (1-800-633-4227) for help.

State Takes Next Steps to Implement Health Insurance Exchange

At the end of November, the Pennsylvania Insurance Department announced it will proceed with implementation of a state-based health insurance exchange (www.pahealthoptions.com).

Exchanges are marketplaces where individuals and small businesses (those with less than 100 employees) can shop for health coverage and expect to obtain easy-to-understand information about their insurance options. Available online and by phone, exchanges will make it easy to shop for quality, affordable health-insurance coverage. As easily as Cyber Monday shoppers compared retail offers, anyone in the market for health insurance as of 2014 will be able to see how insurers' policies stack up against the competition on price and coverage. The Insurance Department estimates two million people could participate in the Pennsylvania health insurance exchange. The exchange will also be the entry point for low income residents to apply for government help to purchase health insurance under the federal health-care overhaul.

Exchanges are mandated by the Patient Protection and Affordable Care Act (ACA), but states have the option to design their own exchanges or default to a federal system. Pennsylvania's exchange must be operational by January 1, 2014. That will require legal authorization; a governance structure; a budget and sustainability plan; and designing and developing the information technology systems that will be needed to support the exchange. The next steps for the state are: to apply for a "federal establishment grant" that will help finance the development of the exchange's infrastructure; and to work with the General Assembly on drafting legislation that will allow for the operation of the exchange.

More Cost-Saving Measures Being Implemented by MATP

DPW continues to look for cost-saving measures within the Medical Assistance Transportation Program (MATP) and is encouraging county MATP programs to make changes that will save the program money. As a reminder, DPW's budget for the MATP was cut by $26 million for the 2011-12 fiscal year. In response to these cuts, MATP has already reduced mileage reimbursement across the state to 12 cents per mile (plus parking and tolls). This change is expected to save the program $5.8 million over the year.

Another cost-savings change that DPW has been encouraging county MATP programs to make is coordinating or "grouping" the shared ride trips they make to out of county locations to certain days and times. If counties do this, they must seek DPW approval first, and then send a 45 day advance written notice to all registered consumers providing them with the revised schedule for out of county trips. The notice also informs consumers that if they cannot make their appointments to fit within the dates and times of the county's schedule, they should contact the MATP program who will help them find another ride. So far, DPW has approved coordinating trips by these county MATP programs: Bedford, Blair, Huntingdon, Indiana, and Union/Snyder.

Congressional Super Committee Fails to Reach Budget Agreement

The bipartisan panel established by President Obama and Congress in August as part of the agreement to raise the federal debt ceiling (Budget Control Act of 2011) has failed to reach a deal on deficit reduction. The 12 person bipartisan congressional committee known as the "Super Committee" failed to reach agreement on new tax revenues and spending cuts by their Thanksgiving deadline. Under the debt limit deal, this failure triggers an automatic cut of $1.2 trillion in federal spending over the next ten years, beginning in January 2013.

Medicaid, as well as many other mandatory programs such as CHIP, Social Security, and SNAP (food stamps), are exempt from the $1.2 trillion automatic spending cuts. Medicare cuts are limited to 2 percent of payments to providers and insurance plans per year. Medicare premiums and cost-sharing were exempt from the spending trigger, though cuts to Medicare Advantage plans could result in higher costs for their members starting in 2013. The $1.2 trillion across-the-board spending reduction is divided evenly between defense spending and non-defense spending (comprised of both discretionary and non-exempt mandatory programs). This constitutes a 9% reduction for defense and non-defense discretionary spending, which includes, among other things, education, medical research, housing subsidies, FBI, and EPA funding. This triggered reduction is in addition to the $900 billion in federal spending reductions announced as phase one of the Budget Control Act (Medicaid and Medicare are not affected by the phase one reductions).

The Super Committee had been expected to include extensions of the payroll tax holiday and unemployment benefits in any agreement reached. Now Congress and the Obama Administration will consider these items individually, both of which have significant implications for the economy. The Super Committee had also been expected to decide the fate the Bush tax cuts, which expire at the end of 2012 and are worth an estimated $3.8 trillion over ten years. President Obama has called for the Bush tax cuts to be continued only for those with annual income under $250,000.

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DPW to Purge More Medical Assistance Recipients

The Department of Public Welfare (DPW) continues to review current Medical Assistance recipients to make sure they continue to qualify for coverage. In recent months, DPW has purged over 100,000 Medical Assistance recipients from the program. Advocates believe that many of those who have lost their coverage are still eligible.

DPW's latest reviews focused on adults age 21 or older who are still coded as children in the system. In a recent DPW Operations Memorandum, the Department required County Assistance Offices (CAOs) to review these cases by November 10, 2011.

This means if a person was on MA prior to turning 21 and is still coded in the MA system as a child despite having turned 21, that person's case will be reviewed. If the CAO determines this person does not continue to qualify in an adult MA category, then an MA termination notice will be sent. The CAOs are required to provide individuals with a 15-day advance written notice before closing their case.

If individuals receive a termination notice but believe they might still be MA eligible as an adult, they should file an appeal within 15 days of the mailing date on the notice (or prior to the date their benefits will end). For example, women who are pregnant, adults with disabilities, adults with very low incomes who require health sustaining medications, or those who are receiving drug and alcohol treatment that precludes them from working, could all still qualify for MA.

Individuals who receive MA termination notices and think they might be eligible under an adult category can contact our Helpline for assistance at 1-800-274-3258.

Geisinger Health System & United Contract to End

Geisinger Health System and the Medical Assistance managed care plan United Healthcare Community Plan will terminate their contract on January 1, 2012. This termination would affect three hospitals: Geisinger Medical Center in Danville; and Geisinger South and Geisinger Wyoming Valley, both in Wilkes-Barre. United Healthcare is required to provide its members written notice of the termination by December 1st.

This contract termination affects 9,206 United Healthcare members who use Geisinger, including more than 6,000 members who use a Geisinger primary care provider (PCP). These members have the option of remaining with their Geisinger providers by switching from United Healthcare to ACCESS Plus. ACCESS Plus provides members with a primary care provider, but members use the ACCESS card to access all their specialty and other health care.

Geisinger mailed a letter to its affected patients in early November advising them, **in error,** to contact their County Assistance Office to enroll in ACCESS Plus. United Healthcare members who wish to switch to ACCESS Plus should instead contact PA Enrollment Services at www.enrollnow.net or 1-800-440-3989. Note that it can take up to four weeks for someone to be switched from United to ACCESS Plus.

United Healthcare members using a Geisinger PCP who wish to stay with United should contact member services to choose a new PCP in United's provider network. Under "continuity of care" rules, members who are pregnant or in an ongoing course of treatment can stay with their Geisinger provider for up to 60 days past the termination date and still remain with United Healthcare.

Possible Co-Payments for Children with Disabilities

The Department of Public Welfare (DPW) is planning to ask families with children under age 18 on Medical Assistance due to their disability and whose income is more than 200% of the federal poverty guidelines ($44,700 for a family of 4) to pay part of the cost of services. These co-pays are a result of the State Budget for 2011-12 which included cost-savings based on the implementation of co-pays for these families. However, the Department has not yet decided how much the co-payments will be, when they will start, or how they will be paid. Because DPW is still deciding how this should work, families and providers have an opportunity to comment on this. **Several advocacy and provider organizations have developed the following recommendations for the Department to consider:**

1. Out-of-pocket costs should be counted

Most families already pay some out of pocket expenses for their child with disabilities. Many pay private health insurance premiums for their child, asking Medical Assistance only to cover what their private insurance does not. Other payments may be for therapists or other providers that don't accept the child's insurance, or for home modifications and/or equipment needed to continue to care for the child at home.

DPW gets to decide how family income is counted when determining who will pay these copays. DPW should deduct the family's out-of-pocket costs related to their child's disability or medical condition and/or the premium paid for covering the child under the parent's insurance policy from family income. For some families, these deductions may bring their countable income under 200% FPL and therefore exempt them from the copayments altogether. Deducting these costs from family income will ensure that families' copayments are based on actually available income.

2. DPW should bill families monthly for their co-pays rather than have families pay the provider every time their child receives a service

Federal law limits the total amount of Medical Assistance copayments to no more than 5% of monthly or quarterly family income. Families with more than one child with disabilities should have all of their co-payments count toward the 5% limit.

Establishing a simple and easy process for how the MA co-pays will be collected is also important. If families have to pay the provider every time their child receives a service, the provider won't know when the family has reached its monthly or quarterly limit, especially if the child uses more than one provider. This means the family may end up paying more in copayments than necessary. DPW would have to reimburse the family- but that could take months, and the family would have to wait. Instead, DPW should collect information on the services provided to the child (or children) in each month, add up the total amount of copayments owed, compare that amount to the family's limit, and then bill the family once a month for the total or the limit, whichever is less. This way, the family would never have to pay more than their limit and would pay only once a month.

If you support these recommendations, PHLP has developed a postcard template that can be downloaded and sent to DPW. You can find it here: http://www.phlp.org/wp-content/uploads/2011/11/Postcard-to-Leesa-Allen.pdf

For more information, contact David Gates at the PA Health Law Project at dgates@phlp.org

RFP Issued for HealthChoices Expansion

Earlier this month, DPW issued a Request for Proposal (RFP) for two new managed care zones- New West Zone and New East Zone. Managed care organizations (licensed in PA) wishing to contract with DPW and provide physical health care coverage for Medicaid recipients in these new areas must respond to the RFP for consideration. MA recipients in these zones are already receiving their behavioral health services through behavioral health managed care plans operating in all the counties throughout the state.

As discussed in our September newsletter, DPW wants to expand HealthChoices to the 42 counties that currently have ACCESS Plus (a MA health care delivery program that requires individuals to have a primary care provider to coordinate their health care needs but otherwise allows the individual to see any medical provider who acceps the ACCESS card). However, HealthChoices will work a bit differently in the two new zones. In these zones, consumers will be able to choose between ACCESS Plus and enrolling into one of the HealthChoices plans. By contrast, in the 25 counties where HealthChoices has operated for years consumers are not given the choice of opting out of managed care. Instead, they must enroll into one of the available HealthChoices plans or they will be auto-enrolled into a plan by DPW.

Since our last newsletter, there have been some updates on which counties will be included in the new zones.

The **New West Zone** will be **implemented September 1, 2012**. It includes thirteen counties (Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango and Warren) and 174,000 Medical Assistance recipients (124,000 of whom are currently enrolled in either ACCESS Plus or a voluntary managed care plan).

The **New East Zone** will be **implemented March 1, 2013**. It includes 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) and 290,000 Medical Assistance recipients (210,000 of whom are currently enrolled in ACCESS Plus or a voluntary managed care plan).

Proposals are due January 18, 2012. Plans can submit proposals for one or both zones. Selected plans must provide services to consumers in all counties of each zone. The RFP can be viewed here: http://www.emarketplace.state.pa.us/GeneralEdit.aspx?SID=RFP 20-11.

The remaining seven counties will join existing HealthChoices Zones and are not included in the scope of the RFP. Blair, Bedford, Cambria, and Somerset Counties will be incorporated into the existing HealthChoices Southwest Zone. Franklin, Fulton, and Huntingdon Counties will be incorporated into the existing HealthChoices Lehigh Capital Zone. There are no dates yet for when these seven counties will be transitioned into HealthChoices.

Stay tuned to future newsletters for updates.

No Medicare Part D Co-Pays for Waiver Recipients Starting in 2012!

Starting January 1, 2012, dual eligible consumers who receive services through a Home and Community Based Waiver Program will no longer have to pay co-pays at the pharmacy for their Part D covered prescription drugs. This change applies to all Medicare beneficiaries who are also enrolled in one of these waiver programs:

- Aging (PDA) Waiver
- LIFE Program
- Attendant Care Waiver
- Independence Waiver
- COMMCARE Waiver
- OBRA Waiver
- Person/Family Directed Support (PFDS) Waiver
- Consolidated Waiver
- AIDS Waiver
- Adult Autism Waiver

Currently, these beneficiaries are considered "full dual eligibles" which means they are automatically entitled to a full Low Income Subsidy (LIS) from Medicare and they pay small co-pays for their Part D covered drugs ($1.10 or $2.50 for generics; $3.30 or $6.30 for name brands, depending on their income). **Beginning in 2012, however, they should be able to get their Part D drugs at no cost.**

This change will now treat HCBS Waiver recipients (dual eligibles who receive long-term care services at home) the same as full benefit dual eligibles who receive long-term care services in a nursing home in terms of what they pay for their medications under Part D. These nursing home recipients have not had to pay co-pays for their Part D drugs since the program started in 2006.

How this change should work

Once Medicare receives information from the Department of Public Welfare that a Medicare beneficiary is also in a waiver program, it will inform the individual's Part D Plan that the person should be charged no co-pays for medications covered by the Plan. The Plan then changes their system so that when a pharmacy bills the Plan for a medication, it goes through without any co-pay being charged to the consumer.

If the consumer is not already in a Part D Plan, Medicare will auto-enroll the person into a zero-premium drug plan and inform the Plan that the consumer should be charged no co-pays.

PHLP and other Medicare advocates are concerned that consumers covered by this policy may still find themselves being charged co-pays by their Plan after January 1st. If that is the case, the consumer (or someone acting on their behalf) should give the Part D Plan proof that he is enrolled in a waiver program (i.e., a copy of their eligibility notice or a copy of the waiver service plan). The Plan must accept the proof and stop charging co-pays.

More information about this change can be found on PHLP's website (www.phlp.org) in a Fact Sheet entitled *No Medicare Part D Co-Pays for Waiver Recipients in 2012.* For help with waiver participants being incorrectly charged Part D co-pays in 2012, call PHLP's Helpline at 1-800-274-3258.

More Medical Assistance Managed Care Plans Decide to Implement Dental Limits

All but one of the Medical Assistance managed care plans (Coventry Cares) has decided to impose the same dental limits for adults that the fee-for-service system started on October 1st. As previously reported, DPW has imposed the following limits on the dental services provided to those age 21 and older who receive their Medical Assistance coverage through the ACCESS card*:

- Oral exams and cleanings once every six months
- One upper and one lower denture (partial or full) per lifetime. If DPW (or the managed care plan) already paid for a denture for the consumer since March 1, 2004, the consumer will only be able to get a replacement denture if DPW (or the managed care plan) approves a dentist's request for a benefit limit exception.
- Crowns, root canals and periodontal services will only be covered if DPW (or the managed care plan) approves the dentist's request for a benefit limit exception

*Note: the dental limits do not apply to Medical Assistance consumers who live in a nursing home or an Intermediate Care Facility (ICF).

United Healthcare Community Plan and Gateway Health Plan have already implemented these dental changes (October 1st and November 1st respectively). January 1, 2012 is the target date for Keystone Mercy Health Plan, AmeriHealth Mercy Health Plan, Aetna Better Health and Health Partners to implement the dental limits. UPMC for You plans to start the dental limits as of February 1, 2012. These plans must send written notice to their members 30 days before the changes start. As noted previously, Coventry Cares announced it currently has no plans to impose dental limits on its members.

The managed care plans will be applying the same benefit limit exception process being utilized by DPW. Only the consumer's dentist can request a benefit limit exception and it should be approved if the dentist can show:

- the consumer has a serious illness or health condition and his life would be in danger or his health would get worse without the dental service; *or*
- the consumer would need more expensive services if the request was not approved; *or*
- it would violate federal law 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 through the managed care plan and/or ask for a Fair Hearing on the matter.

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Pennsylvania Health Law Project
The Corn Exchange
123 Chestnut St., Suite 400
Philadelphia, PA 19106