Health Law PA News

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Health Reform Passes, Focus Shifts Toward Implementation

After more than a year of vigorous debate on both the floor of Congress and in the media, the Patient Protection and Affordable Care Act (the Act) was passed by the House of Representatives on March 22, 2009, and signed into law by President Obama the next day. A week later, the President signed into law amendments to that bill that were passed by the House and Senate through the process known as budget reconciliation (described in our January newsletter). The passage of the bill is a major victory for the Obama administration and is the most sweeping healthcare legislation enacted since President Lyndon Johnson signed Medicare into law.

The goals of the health care reform efforts in Congress were three-fold: to expand insurance coverage, to cut costs, and to improve quality of care. The Act contains provisions designed to address each of those issues. Key provisions include an insurance mandate, an expansion of Medicaid, insurance subsidies, the creation of insurance exchanges to spread cost and risk in individual plans, and an increase in Medicaid payment rates to providers. The Act also addresses concerns with Medicare, particularly the "donut hole" gap in Part D prescription drug coverage.

Here are some of the highlights of the health reform legislation and its impact on Pennsylvanians. Future PHLP newsletters and our website (www.phlp.org) will feature additional analysis as PHLP continues to read and analyze the 2,700 page bill and its amendments:

Insurance Reforms Aimed at Expanding Coverage and Reducing Costs

The Act mandates that most Americans carry insurance coverage beginning in 2014 or pay a penalty for going without insurance. Currently, there are 1.3 million Pennsylvanians without insurance. The mandate is necessary to spread both cost and risk in the insurance pool, and should result in individuals paying lower premiums for coverage. Currently, insurance premiums continue to rise because healthier people drop out and gamble that they will not need coverage. As a result, the insurance pool is made up of a higher percentage of people who are sick or who have health conditions that require costly medical care. A mandate

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that everyone carry insurance coverage ensures that costs are sufficiently spread out which should help control insurance premiums. It should also drastically reduce the costs society ultimately pays for uninsured individuals who end up seeking expensive emergency treatment.

The Act contains a number of provisions that allow the implementation of a mandate without creating an undue burden on low income individuals and families. These provisions include an expansion of Medicaid (discussed later), subsidies to help pay the costs of private insurance and, beginning in upcoming months, a stipulation allowing 1.2 million young adults in Pennsylvania to stay on their parents' health insurance until age 26.

The insurance subsidies will be available to people who earn up to 400% of the federal poverty level (FPL) to help them purchase private insurance through health insurance exchanges that will either operate on a state or a regional basis. Currently, 400% FPL is approximately $88,200 for a family of four. The Act also includes tax credits for small businesses to purchase insurance for employees through the exchanges. These credits could benefit 151,000 Pennsylvania businesses.

Insurance plans will also be prohibited from denying coverage or charging higher premiums based on an applicant's pre-existing conditions (health conditions that were treated or diagnosed previously). Currently, most private insurance plans decline to pay for treatment for any pre-existing condition for some period of time, and some plans refuse to cover a person at all based on their pre-existing conditions. The prohibition on pre-existing conditions goes into effect for children in September 2010. For adults, the prohibition begins in 2014 when the insurance exchanges are in place. Currently, over 140,000 adults in Pennsylvania are denied insurance due to pre-existing conditions.

Before the exchanges begin operation, adults with preexisting conditions will be able to enroll in a special "high-risk" insurance pool. This pool will ensure that adults who have been denied by private plans in the past because of their pre-existing conditions will be able to access insurance. The high-risk pool will be a national pool, so the number of applicants should help keep down premium costs.

Reforms Aimed at Expanding Medicaid and Improving Medicaid and Medicare

Beginning in 2014, states will be required to extend Medicaid coverage to all individuals under 65 years old whose income is less than 133% of the federal poverty level. Increasing the income guidelines will result in over 637,000 additional Pennsylvanians becoming eligible for Medical Assistance. In addition, states are barred from changing their eligibility requirements in a way that restricts enrollment for CHIP or Medicaid before 2014.

In 2013, Medicaid payment rates to providers will be increased to match Medicare rates. This should result in more doctors accepting Medicaid and may also help resolve issues involving the balance billing of "dual eligibles" (individuals who have both Medicaid and Medicare).

One of the biggest changes to the Medicare program is the eventual elimination of the "donut hole," or the coverage gap that kicks in once a Medicare beneficiary has received $2,830 in prescription drug benefits for the year. Currently, all prescription drug costs between $2,830 and $6,440 have to be paid out of pocket by the consumer (unless the individual gets extra help from Medicare or is eligible for help through a program like PACE/PACENET). Although the Act will not eliminate the donut hole coverage gap until 2020, some assistance will be provided sooner. Later In 2010, Medicare consumers who reach the donut hole will receive a $250 rebate, and in 2011, consumers who reach the donut hole will receive a 50% discount on brand name drugs while they are in the coverage gap. The elimi-

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-nation of the donut hole will benefit hundreds of thousands of Pennsylvania seniors.

The Patient Protection and Affordable Care Act is a first step toward ensuring that access to affordable health care is a right all Americans can enjoy. The details of implementation will be developed over upcoming months and years and there will likely be successes and setbacks along the way. Stay tuned to future newsletters for updates on the implementation of health care reform.

PA Health Access Network (PHAN) is hosting *Where Do We Go From Here? A Conference on Health Care Reform* on April 25th and April 26th at the Crowne Plaza in Harrisburg. The conference begins Sunday evening and continues with keynote speakers and workshops throughout the next day. To learn more and register, visit PHAN's website (www.pahealthaccess.org).

Proposed 2010-2011 Budget Increases MA Funding

Governor Rendell's proposed FY 2010-2011 budget released in early February 2010 relies heavily on the assumption that Congress will extend the increased Federal Medicaid Assistance Percentages (FMAP) beyond 2010 until June 30, 2011. Consequently, the proposed budget does not include any major cuts or other changes to Medicaid/Medical Assistance (MA) programs. If that assumption does not hold true, and Congress does not extend FMAP, there will be significant budget shortfalls. Last month, the US Senate passed the American Workers, State, and Business Relief Act of 2010 (HR 4213), which includes an FMAP extension, by a vote of 62 to 36 . The Senate bill is now in the US House. The House previously passed a bill in December 2009 that included FMAP extension, but this Senate bill has additional provisions requiring action by the House.

Medical Assistance spending in PA is expected to increase to $5 billion dollars (up from $4.6 billion in the current fiscal year). The proposed budget builds in funding to cover an expected 3% increase in MA enrollment. This may be a conservative estimate given that Medicaid enrollment increased by 5% in the last calendar year. Currently, 2.1 million Pennsylvanians are receiving benefits through Medicaid. Recently released enrollment figures show that 14 counties in PA have 20% or more of their population on Medicaid.

"Smart Pharmacy" is not included in the proposed budget—it had been a component of previous budgets but consistently failed to pass the legislature. Instead, the budget assumes the federal government will pass legislation that allows the state to collect federal rebates for managed care pharmacy benefits. The recently enacted Health Reform legislation appears to allow Medicaid managed care plans to take advantage of drug rebates that are currently only available to state Medicaid programs. The amount of savings the Commonwealth will receive from the health care reform provision or additional legislative action, if any, remains to be determined.

The PA House of Representatives passed the proposed budget and it has been sent to the Senate for action. See articles on the following pages for information about the OMHSAS and Long-Term Living budgets. We will keep you informed about budget issues in upcoming newsletters.

Proposed OMHSAS Budget Level Funded for 2010-2011

At a March 4, 2010 Advisory Committee meeting, Deputy Secretary Joan Erney shared an overview of the Governor's proposed 2010-2011 budget for the Office of Mental Health and Substance Abuse Services (OMHSAS). As proposed, the OMHSAS budget would remain relatively level to the 2009-2010 budget. The OMHSAS budget includes county or "base" funding for mental health and drug and alcohol services for individuals who are not MA eligible and who are uninsured or underinsured. It also includes Medicaid funding for the Behavioral HealthChoices Program and the Medicaid Fee-For-Service (FFS) system as well as funding for state mental health facilities. The OMHSAS proposed budget for 2010-2011 is over 4 billion dollars. Of that amount, 70% is allocated to the Medicaid Behavioral HealthChoices Program, 15% to county-based funding, 10% to state mental health facilities, 3% to MA FFS and 2% to Behavioral Health Services Initiative (BHSI) and Act 152 drug & alcohol funding.

The state hospital allocation includes approximately $14 million dollars to support community based services for 155 persons to be discharged from state hospitals, including the 110 discharges from the closure of Allentown State Hospital (the previous edition of this newsletter includes details about this closure). The remaining 45 slots are allocated for 30 people who are to be discharged from Norristown State Hospital and 15 people to be discharged from Wernersville State Hospital.

The Medicaid Behavioral HealthChoices Program funding allows for a slight rate increase to the managed care plans and some growth in eligibility. The HealthChoices budgets counts on an estimated savings of $30 million from the state's implementation of Act 62 autism legislation requiring commercial plans to pay for autism services for their members. The proposed budget also relies on the return of uncommitted and unspent HealthChoices reinvestment funds from counties, as well as a cap on reinvestment and risk and contingency funds that will yield an anticipated $3 million in savings.

In addition, the budget relies on an estimated $354 million to be collected from Medical Assistance managed care plans through taxes on their revenues. A portion of this money will be allocated to OMHSAS.

The PowerPoint presentation on the 2010-2011 OMHSAS budget shared by Deputy Secretary Erney at the March 4th Advisory Committee meeting can be viewed at http://www.parecovery.org/advisory_materials/march_2010_handouts/Joint_OMHSAS_10-11_Budget_Briefing.pdf

Proposed Budget Increases and Expands Long-Term Living Services

The following are highlights from Governor Rendell's proposed budget affecting Pennsylvania's long term living services.

Merging the Department of Aging and the Office of Long Term Living: The Governor is again proposing legislation to merge the existing Department of Aging and the Office of Long Term Living (OLTL) into a new Department of Aging & Long Term Living. OLTL was created in 2007 and is managed by both the Department of Public Welfare (because it oversees many Home and Community Based Services Waivers programs and the MA nursing facility program which are the ultimate responsibility of DPW as the single state Medicaid agency) and the Department of Aging. Similar legislation was introduced and passed by the House last year but was never acted on by the Senate.

Additional Slots Added to Several HCBS Waivers and Other Programs: The proposed budget contains funding to allow modest growth in the Home and Community Based Services (HCBS) waiver programs administered by OLTL. The following are the number of additional slots proposed

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for the next FY:

- Aging (PDA) Waiver - 1,692
- Attendant Care - 660
- LIFE - 680
- CommCare - 108
- Independence - 636
- Act 150 - 120

Expenditures Related to Assisted Living Residences: Final regulations that will govern the licensing of assisted living residences in the state have yet to be issued by OLTL. Once those regulations become final, OLTL plans to seek approval from the Centers for Medicare & Medicaid Services (CMS) for an assisted living waiver that would allow the state to pay for some services assisted living residents receive. The proposed budget includes 279 slots for a new assisted living waiver as well as funding to hire eight additional staff to support assisted living licensure activities.

Changes Ahead for Michael Dallas Waiver Recipients

Pennsylvania's Office of Long Term Living (OLTL) recently announced that it will not renew the Michael Dallas Waiver which is due to expire on June 30, 2010. Instead, the state plans to move all individuals currently in Michael Dallas into the Independence Waiver.

The Michael Dallas Waiver provides home and community-based services to eligible persons of any age who are technology-dependent (that is, dependent on technology to replace a vital bodily function or to sustain life). Most individuals on this waiver are ventilator dependent and receive private duty shift nursing. In order to have the waiver renewed and approved by the Center for Medicare and Medicaid Services (CMS), OLTL would need to show that it can serve the current waiver participants (approximately 88 people) in the community for a lower cost than the same population can be served in an institutional setting (i.e., a nursing home). Given the extensive medical needs of the individuals receiving Michael Dallas waiver services and the high cost of shift nursing, the state is no longer able to meet this federal requirement.

To continue home and community-based services to current Michael Dallas Waiver recipients, OLTL has decided to move those individuals into the Independence Waiver effective July 1, 2010. The Independence Waiver is another home and community-based services program available to eligible persons with physical disabilities who are determined to meet a nursing facility clinically eligible level of care. The Independence Waiver is also up for renewal and OLTL is seeking to amend that waiver so that it will serve those now in the Michael Dallas Waiver. Among the Independence Waiver amendments OLTL intends to have in place prior to July 1st:

- Removing the current prohibition that those who are ventilator-dependent are not eligible for the Independence Waiver
- Adding continuous and ongoing shift nursing to the list of services available under the Independence waiver

Participants in the Michael Dallas Waiver will be able to continue using their current providers as long as the providers are enrolled Independence Waiver providers.

OLTL has sent notices out to all those on the Michael Dallas waiver who will be affected by these changes and has conducted several conference calls and Webinars for consumers and their family members to try and address their questions and concerns. In addition, OLTL has agreed to give Michael Dallas participants and their families an opportunity to provide input to the Independence Waiver amendments prior to their submission to CMS.

Consumers, family members and advocates with questions about the termination of the Michael Dallas Waiver and/or the amendment and renewal of the Independence Waiver can contact OLTL's Bureau of Individual Supports at (717) 787-8091.

New ACCESS Plus Vendor to Start May 1st

The Department of Public Welfare (DPW) has selected APS Healthcare (APS) to administer the ACCESS Plus Program starting May 1, 2010. ACCESS Plus is the Medical Assistance (MA) health care delivery system that operates in 42 Pennsylvania counties where HealthChoices (mandatory managed care for MA recipients) does not exist. McKesson Health Solutions (McKesson) currently holds the contract and has been the ACCESS Plus vendor since the program began in 2005. DPW initially planned to implement the new contract as of April 1, 2010. However, the start date was delayed because of a protest that McKesson lodged with DPW regarding the award of the contract. The new contract now has an effective start date of May 1, 2010. Notices advising ACCESS Plus enrollees of the change were mailed on or about March 26, 2010.

As a reminder, the ACCESS Plus vendor is responsible for the Disease Management program for ACCESS Plus recipients with certain conditions (currently, the only conditions that qualify for disease management are asthma, chronic obstructive pulmonary disease, diabetes, coronary artery disease, and congestive heart failure). In addition, the vendor also administers Primary Care Case Management (PCCM) services for consumers who need help coordinating their care or who have special needs.

Although the vendor for the program will change, the ACCESS Plus Program's provider network should **not** change. Consumers should be able to continue seeing their current providers even after the new contract is in place. In addition, the ACCESS Plus Helpline (1-800-543-7633) and website (www.accessplus.org) will **not** change.

APS and DPW are identifying and reaching out to consumers who are high risk and who have special needs to explain the transition and to ensure that their care is not disrupted. DPW is gathering data from McKesson about consumers who are already designated as having special needs. Additionally, special needs consumers will be identified via outreach to provider offices and through self-identification.

Starting July 1, 2010, ACCESS Plus enrollees will be experiencing additional changes to the ACCESS Plus program that will be put in place under the new contract (see the July 2008 Health Law PA News for more details about upcoming changes to the ACCESS Plus program). For example, under the terms of the new contract, the ACCESS Plus Disease Management program will be expanded to include many more health conditions including cardiovascular and respiratory diseases, gastrointestinal diseases, rheumatic disorders and neurological disorders. There are about 40,000 ACCESS Plus consumers enrolled in the current disease management programs. The expansion of the program is expected to double enrollment in Disease Management.

Consumers with questions about the new ACCESS Plus vendor or upcoming changes to the program should call the ACCESS Plus Helpline (800-543-7633) or visit the ACCESS Plus Web site (www.accessplus.org).

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Thousands of Consumers Impacted by KMHP Contract Termination with Crozer Health System

Keystone Mercy Health Plan (KMHP) is terminating its contract with Crozer Health System (Crozer), which includes Crozer-Chester Medical Centers (2), Delaware County Memorial Hospital, Crozer Hospice, and Taylor Hospital effective April 30, 2010. KMHP and Crozer had been working to resolve their contract differences since 2008 but were unable to reach any agreement.

This contract termination will affect tens of thousands of KMHP members. Approximately 10,000 KMHP members in Delaware County use a primary care doctor affiliated with Crozer and approximately 17,000 members have used a Crozer hospital or specialist in the past year. Notices regarding this termination were mailed out by KMHP to all affected members on Friday March 26, 2010.

KMHP is the only Medicaid managed care plan that had a contract with Crozer and it does not appear that Crozer will have a contract with any other plan in Southeast PA. Therefore, KMHP members who are impacted by this contract termination will have the following options:

- They can stay with their current provider <u>if</u> the provider has admitting privileges outside of the Crozer system with another hospital in KMHP's network;
- They can choose a new provider and stay in KMHP; or
- They can choose a new provider and choose a new MA plan.

Consumers who have a provider with admitting privileges to another hospital do <u>not</u> have to change their provider. However, these consumers will have to use a different hospital network for hospital-based services. Area hospitals in the KMHP network include: Mercy Fitzgerald Hospital, Riddle Memorial Hospital, Bryn Mawr Hospital, Lankenau Hospital, and Mercy Philadelphia Hospital.

<u>Consumers who have a provider who does not have admitting privileges elsewhere must change providers</u>. To choose a new provider within the KMHP network, consumers should call KMHP Member Services at 1-888-765-6354. To choose a new provider and choose a new MA plan, consumers should call PA Enrollment Services at 1-800-440-3989. **Please note: Due to a recent suspension of new enrollments into KMHP, consumers who leave KMHP to change MA plans may not be able to re-enroll into KMHP at a later date (see our January Newsletter for more information).**

Consumers who decide to remain in KMHP should know that they have a right to continue seeing their Crozer physicians to receive services that were already approved by KMHP and to continue an ongoing course of treatment for 60 days beyond the contract termination (until June 29, 2010). If necessary, consumers can ask KMHP to allow them to continue seeing these physicians beyond this 60 day period. KMHP will decide whether to approve the request based on clinical criteria. Pregnant women may continue to see their Crozer physician beyond this 60 day period through birth and their postpartum period.

All KMHP members who must switch their primary care physician (PCP) as a result of this contract termination should have a choice of at least two primary care physicians in KMHP's network whose offices are located within a 30-minute travel time of their home per Medicaid rules. Members who want a pediatrician as a PCP for their children should also have a choice of at least two in-network pediatricians within the same 30-minute travel time. Medical transportation arrangements can be made through the Delaware County Medical Assistance Transportation Program at 1-866-450-3766.

PHLP continues to advocate with the Department of Public Welfare (DPW) to ensure that KMHP members have adequate access to providers, transition properly to a new doctor or a new plan, and in the meantime, continue to receive all medically necessary care and treatment. Please call our Helpline (1-800-274-3258) if you or consumers you are working with have problems accessing care or services because of this major contract termination.

Contract Terminations Continue to Threaten Access to Care for HealthChoices Consumers in Central and Southeast PA

A contract termination between one Medical Assistance (MA) managed care plan and a vital hospital system in Central PA threatens the ability of HealthChoices consumers to access care from their current health providers. PHLP also recently learned of two potential contract terminations between MA managed care plans and hospital systems in Southeastern PA.

AmeriHealth Mercy Health Plan and Penn State Hershey Medical Center

The contract between AmeriHealth Mercy Health Plan (AMHP) and Penn State Hershey Medical Center (Hershey) will terminate April 14, 2010. At present, 1,615 AMHP members are assigned to a primary care physician (PCP) employed by Hershey. On March 5th, notices advising AMHP members of the change were sent to 700 members, and on March 13th, notices were sent to the remaining AMHP members with a Hershey-owned PCP. Notices to AMHP members with a hospital-owned specialist were also sent March 13, 2010.

Hershey currently accepts all of the other MA managed care plans in the HealthChoices Lehigh/Capital region. When AMHP's contract with Hershey terminates in April, impacted members will have the following options:

- They can stay with their provider and switch to another managed care plan in the region;
- They can stay in AMHP and choose a new provider in the plan's network; or
- They can choose a new provider and choose a new managed care plan.

Keystone Mercy Health Plan's and Albert Einstein Healthcare Network

The contract between Keystone Mercy Health Plan (KMHP) and Albert Einstein Healthcare Network (Einstein) ends May 31, 2010. The Einstein network includes Albert Einstein Medical Center, Belmont Behavioral Health, Einstein Center One, Einstein at Elkins Park, Germantown Community Health Services, MossRehab, and Willowcrest. Einstein and KMHP are negotiating new contract arrangements.

KMHP members who have a PCP affiliated with a facility in the Einstein network, *but also affiliated with another non-Einstein facility in KMHP's network*, could stay with that PCP. However, as a practical matter, consumers often choose a PCP who is affiliated with a familiar hospital and one that is convenient for them. If the Einstein contract with KMHP is broken, a member in this situation who stayed with his PCP would not be able to use any facilities in the Einstein network for any physical health services including hospitalizations, lab tests or diagnostic tests (x-ray, ultrasound, etc.).

Facilities in the Einstein network currently accept the other Medicaid managed care plans in Southeastern PA-Health Partners, AmeriChoice Health Plan, Coventry Cares and Aetna Better Health.

Keystone Mercy Health Plan and Children's Hospital of Philadelphia

The current contract between KMHP and Children's Hospital of Philadelphia (CHOP) ends June 30, 2010. Negotiations to reach a new contract agreement are currently taking place.

CHOP currently accepts AmeriChoice but does not accept any other MA managed care plan in Southeastern PA.

As a reminder, when contracts are terminated, affected consumers must receive 30 days advance notice and plans must follow continuity of care rules for affected members in a course of treatment (including pregnant women).

An update about the status of KMHP's contract negotiations will be in our next newsletter.

Reminder-Medical Assistance Consumers in Central and Southeast PA have more physical health plan options as of April 1st!

In the Southeast Zone, consumers have the following choices:

- Aetna Better Health*
- AmeriChoice of Pennsylvania, Inc.
- Coventry Cares from HealthAmerica*
- Health Partners, Inc.
- Keystone Mercy Health Plan (new enrollments are currently suspended -some exceptions apply)

In the Lehigh/Capital Zone consumers have these choices:

- Aetna Better Health*
- AmeriHealth Mercy Health Plan
- Gateway Health Plan
- Unison Health Plan
- UPMC for You**

*These managed care plans are contracting with the state to provide Medical Assistance services for the first time.
**UPMC for You contracts with the state in the Southwest Zone and has expanded to the Lehigh/Capital Zone as of April 1st.

HealthChoices consumers always have the option to stay in their current Physical Health plan or switch to another plan operating in their area by calling PA Enrollment Services at 1-800-440-3989.

New Hurdle for Veterans Applying for Medicaid

Veterans applying for state-offered public benefits must now, as a condition of eligibility, pursue any potential entitlement to federal veteran's benefits. Through Act 54 of 2009, the General Assembly changed Pennsylvania's Public Welfare Code to require the Department of Public Welfare (DPW) to determine whether an applicant for Medical, Cash, or Energy Assistance is a veteran, and require applicants who are veterans to contact a Veterans Service Officer to determine their eligibility for veteran's benefits.

Act 54 requires DPW to create a standard form by which veterans can prove compliance with this new requirement. DPW is required to provide benefits to eligible individuals while they are in the process of verifying their veteran status. Though Act 54 became effective as of its enactment on December 17, 2009, PHLP is not aware of any action being taken by DPW to date to implement the Act. Advocates and applicants who know of applications or services being delayed because of this new requirement are encouraged to contact PHLP at 1-800-274-3258.

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.

DPW Launches New and Improved MATP Website

Over the past year, DPW has been working to improve the Medical Assistance Transportation Program (MATP) across the state and to increase its efficiency. Working with a group of consumers and providers, DPW updated and clarified uniform policies and procedures and worked to improve the communication of those policies and procedures to the county MATP programs, as well as to make them available to the public at large. One of the ways DPW has accomplished this is to develop a new and improved MATP website at http://matp.pa.gov.

This new website contains a great deal of useful information for consumers as well as their advocates and community organizations including:

- The Instructions and Requirements that govern the MATP Program
- All of the Operations Memos DPW has issued to update and clarify the MATP rules
- Contact information for each county MATP program
- Data Reports for each county that include the number of trips provided, the number of consumers served and total MATP expenses
- Frequently Asked Questions about MATP
- Information on Appeal Rights

If you or any of the consumers you are working with are experiencing problems using MATP services to get to medical treatment and services, please call PHLP's Helpline at 1-800-274-3258.

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