# Health Law PA News

Newsletters of the Pennsylvania Health Law Project

Harrisburg Philadelphia Pittsburgh

Statewide Help Line: 1-800-274-3258 / TTY: 1-866-236-6310

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## Independence Blue Cross Drops Medicare Plans for Low-Income Beneficiaries

The Philadelphia region's largest health insurer, Independence Blue Cross (IBC), will no longer offer three health plans for older adults and people with disabilities that make up its Keystone 65 Medicare Advantage Plans in 2010. Almost 40,000 Medicare beneficiaries living in Bucks, Chester, Delaware, Montgomery and Philadelphia Counties currently enrolled in these plans will lose their coverage on December 31, 2009 and will need to make new choices about how to receive their Medicare benefits in 2010.

Medicare Advantage plans provide, through managed care networks, services covered by Medicare Parts A, B (and often Part D) and may offer additional benefits such as dental care, fitness reimbursement, preventive care, and wellness programs. The three IBC plans being terminated (*Keystone 65 Complete*, *Keystone 65 Value Medical Only*, and *Keystone 65 Value Rx*) principally affect low-income Medicare beneficiaries. IBC says it can no longer afford the programs citing "unprecedented" funding cutbacks regionally and nationally for Medicare Advantage plans and increased medical costs.

*Keystone 65 Complete* is a Medicare Special Needs Plan (hereinafter "SNP") with no monthly premium that only enrolls low-income consumers who have both Medicare and full Medical Assistance (known as "dual eligibles"). *Keystone 65 Value Medical Only* is a zero-premium Medicare Advantage plan that covers medical services but does not provide prescription drug (Medicare Part D) coverage. *Keystone 65 Value Rx* covers medical services and provides Medicare Part D prescription coverage. Enrollees in Keystone 65 Value Rx currently *(Continued on Page 2)*

## PA Budget Update

Pennsylvania finally has a state budget. The House and Senate passed a $27.8 billion spending plan that Governor Rendell signed into law on October 9th. It will take some time to read and analyze the budget to determine how it impacts the state's Medical Assistance Program as well as other state–funded public health and human service programs. Please check our website, www.phlp.org, in a few weeks for more information on how the budget will affect low-income Pennsylvanians.

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pay a monthly premium of $23.90; however, individuals in this plan who qualify for the full low-income subsidy pay no premium (the subsidy fully covers the premium). There are 19,870 members in *Keystone 65 Complete* and 18,800 members in the *Value Medical Only* and the *Value Rx* plans combined.

Toward the end of the summer, IBC sent initial cancellation notices to members enrolled in these three plans. Final notification letters were then sent in early October explaining in more detail the Medicare coverage options available. Plan changes need to be made by the end of the year to ensure coverage is in place on January 1, 2010.

The dual eligibles, those having both Medicare and Medical Assistance coverage, enrolled in the *Keystone 65 Complete* plan must decide whether to join another Medicare Advantage SNP (if there is one available in their area) or go back to original Medicare (using their red, white and blue Medicare card) and enroll in one of the 2010 zero premium, stand-alone prescription drug plans. According to information released by the Centers for Medicare & Medicaid Services on October 1, 2009, there will only be two SNPs for dual eligibles living in Bucks, Montgomery and Philadelphia counties in 2010: *Bravo Select* and *Senior Partners Silver*. There will be no dual eligible SNP option in Chester County in 2010, and Delaware County will only have the *Bravo Select* SNP option available for dual eligibles next year.

Those enrolled in either of the two *Keystone 65 Value* plans have the following choices:

- enroll into another Medicare Advantage plan with or without Medicare Part D coverage (individuals who do not have other creditable prescription coverage such as PACE/PACENET should enroll in a plan **with** drug coverage);
- go back to original Medicare (using their red, white and blue Medicare card), buy a Medigap (Medicare Supplement) policy, and enroll in a stand-alone prescription drug plan (PDP); or
- go back to original Medicare and just enroll into a stand-alone prescription drug plan (PDP). Those who choose this option and who do not have secondary insurance (*i.e.*, Medical Assistance) will only have basic Medicare Part A and B coverage and will have to pay significant deductibles and co-pays for their Medicare-covered medical services.

Before making any enrollment decisions for 2010, all affected Keystone 65 members should wait until they receive a "Medicare & You 2010" Handbook in the fall to learn about their plan choices (both Medicare Advantage plans as well as stand-alone Part D plans). The Handbook will have information about each plan's premiums, deductibles and co-pays in 2010. **Those enrolled in one of the three plans being terminated by IBC need to choose coverage they can afford and that will best meet their needs. New enrollments must be done by December 31st to ensure continuing coverage in January 2010.**

Anyone enrolled in one of the three affected plans who is a dual eligible or who has the Medicare Low Income Subsidy (LIS) and who fails to act by the end of the year will be automatically changed to original Medicare and randomly assigned to a stand-alone, zero premium Part D plan for 2010. Persons who are not dual eligibles, do not have LIS**,** and who fail to act by the end of the year will also be changed to original Medicare but they will not be assigned to a Part D plan and will find themselves without Medicare prescription coverage. Approximately two-thirds of those enrolled in the *Keystone 65 Value* plans do not have an LIS and must take action before the end of the year to continue drug coverage in 2010.

If you have questions about IBC's plan terminations or need help understanding the process for enrolling into a new plan by Dec. 31st, call APPRISE at 1-800-783-7067, PHLP's Helpline at 1-800-274-3258 or Medicare at 1-800-633-4227.

# HealthChoices Plans Illegally Deny Home Health Aide Services As "Non-Covered Services"

Over the summer, PHLP received numerous distress calls from families of children denied coverage of home health aide (or personal care) services by their HealthChoices physical health Managed Care Organizations (MCOs). The reason given for many of these denials was that the request was for "a non-covered service." PHLP immediately notified the Department of Public Welfare (DPW) about this problem: home health aide (HHA) services are a covered service under Medical Assistance for all children (and some adults).

In many PHLP cases, the physical health MCOs denied the HHA services because the child/consumer in question had a behavioral health *diagnosis*. While it is true that the physical health MCO is not responsible for covering behavioral health treatments, home health aide services are a physical health service, just like an anti-biotic prescription or a routine check-up. The fact that a consumer has a behavioral health diagnosis does not negate the child's need for HHA services to treat a physical health need. A physical health MCO can only deny home health aide services as a non-covered service if these services were, in fact, prescribed only to treat a behavioral health need.

Not only was it problematic that the physical health MCOs were denying HHA services incorrectly (on the basis of them being a "non-covered service" under Medical Assistance), but the problem was compounded in that the MCOs labeled the appeals of these HHA denials as "complaints" rather than grievances. Under DPW rules, an appeal from an MCO's denial of a service as not "medically necessary," is a *grievance*. An appeal from a MCO's denial of a service because it is not a covered service is a *complaint*. Consumers have different rights and protections under each type of appeal.

DPW has since investigated, reviewed their denials data, and determined that three out of the seven HealthChoices MCOs issued improper denials. DPW put the three MCOs on a Corrective Action Plan requiring them to stop issuing the erroneous denials, review these cases, and correct the previous denials sent. DPW will monitor this issue and will also be reviewing these cases. Please contact PHLP's HELPLINE (1-800-274-3258) immediately if you learn of any new cases of home health aide services being denied by a physical health MCO as a "non-covered service."

**Do you currently get the Health Law PA 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!**

# Update on Medical Assistance Contract Terminations in Southeastern PA

News of premature contract terminations between Medical Assistance Managed Care Organizations (MCOs) and hospitals/health systems in Southeastern PA continue at an alarming rate, potentially disrupting care for thousands of consumers. In the past six months, contact terminations have reached the potential breaking point between Keystone Mercy Health Plan (KMHP) and Tenet Health System as well as between Abington Memorial Hospital (Abington) and two MCOs, Health Partners and Keystone Mercy.

PHLP has learned that the contract between the Keystone Mercy Health Plan and Tenet Health System (which includes St. Christopher's and Hahnemann University Hospital), originally scheduled for termination at the end of July but extended to September, has been averted. Keystone Mercy will continue to contract with Tenet Health System.

The contracts between Abington and two MCOs, KMHP and Health Partners, have both been extended to November 4th and December 4th respectively.

However, PHLP has learned of another contract termination. **The contracts between Chester County Hospital and two MCOs, Keystone Mercy and AmeriHealth Mercy, have been terminated as of September 30th**. Notices were sent to approximately 6,000 affected members at the end of August. This is the second contract termination between Keystone Mercy Health Plan and providers since July 2008.

Other possible contract terminations include:

- AmeriHealth Mercy Health Plan and St. Joseph Medical Center (extended to November 30th).
- KMHP and Crozer Health System (originally discussed in our January 2009 newsletter) contract extended to December 31st.

We also learned of a potential breakdown between KMHP and Alfred I DuPont Hospital, but the issue has since been resolved.

As a result of frequent contract breakdowns, the Consumer Subcommittee of the Medical Assistance Advisory Committee is working with the Department of Public Welfare (DPW) to develop strategies to prevent the terminations from occurring. Also, the Consumer Subcommittee continues to work with DPW to improve the notice affected consumers receive when a provider contract is terminated and is advocating for the involvement of the HealthChoices enrollment broker, Maximus, to help members impacted by a contract termination understand their options and the continuity of care rules.

# PHLP Partners to Improve Services for Youth with Special Needs, Their Families & Caregivers

PHLP is partnering with the Pennsylvania Chapter of the American Academy of Pediatrics, the state's Department of Health, and the PEAL Center to integrate systems and services for Children and Youth with Special Health Care Needs (CYSHCN). The partnership, called the Pennsylvania Consortium for CYSHCN, addresses and promotes several goals:

- To hear the experiences of special needs youth transitioning to adulthood about how service systems do and do not work.
- To engage medical, education and human service providers to redesign service delivery so they are better coordinated and managed to meet family needs.
- To identify the strengths, areas of growth, and gaps in systems and service delivery for children and youth with special health care needs.
- To create culturally competent services for children and youth with special health care needs.

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**Upcoming Regional Forums**
The Pennsylvania Consortium is convening regional forums that will gather and record input from families of children and youth, young adults with special health care needs, community service providers and other important stakeholders.

If you are interested in joining your regional forum as a youth, a parent or caregiver or as a CYSHCN provider agency, please contact Ann Bacharach at abacharach@phlp.org or Grace Egun at gegun@phlp.org. Either Ann or Grace can be reached by phone at 1-800-274-3258.

## Parent, Youth, Professional Forums

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| **Northeast PA**<br>Date: Monday, November 16, 2009<br>Time: 9:15 am to noon<br>Location: to be announced<br><br>Contact: Linda Denault, SHCN: 570-826-2062, ldenault@state.pa.us | **North Central PA**<br>Date: Tuesday, November 3, 2009<br>Time: 9:00 am to noon<br>Location: 1000 Commerce Park Drive<br>Suite 109<br>Williamsport, PA 17701<br><br>Contact: Jessica Bower, SHCN: 570-327-3400, jesbower@state.pa.us |
| **Northwest PA**<br>Date: Tuesday, January 13, 2010<br>(with youth meeting January 12th, 6 to 9 pm)<br>Time: 9:00 am to noon<br>Location: to be announced<br><br>Contact: Lisa Snyder, SHCN: 724-662-6068, lisnyder@state.pa.us | **South Central PA**<br>Date: Monday, November 9, 2009<br>Time: 9:00 am to noon<br>Location: Giant Community Center<br>3301 Trindle Road<br>Camp Hill, PA<br><br>Contact: Carol Miller, SHCN: 717-787-8092, carolmille@state.pa.us |
| **Southwest PA**<br>Date: Wednesday, January 14, 2010<br>(with youth meeting January 13th, 6 to 9 pm)<br>Time: 9:00 am to noon<br>Location: to be announced<br><br>Contact: Carol Gettemy, SHCN: 412-565-5101, cgettemy@state.pa.us | **Southeast PA**<br>Date: December 4, 2009<br>Time: 9:00 am to noon<br>Location: Susquehanna Association for the<br>Blind and Vision Impaired<br>244 N Queen St.<br>Lancaster, PA<br><br>Contact Monika Antosy, SHCN: 610-378-4352, mantosy@state.pa.us |

# Stories of the Uninsured

*This is a regular feature of our newsletter highlighting stories of the uninsured in Pennsylvania.*

The vast majority of us are just one job away from being uninsured. Whether rich or poor, powerful or weak, high status or low, most Americans get health insurance through their employment. Unfortunately, the converse of that is not true, and not all working people have health insurance. Domenic is among the more than 800,000 Pennsylvanians with diabetes. He was employed, lost his job, could not afford COBRA, and became uninsured. He tried to manage living with diabetes and without insurance; but, he found that decision difficult, and he suffered medical consequences.

**DOMENIC'S STORY**

Domenic knew diabetes was a forever disease, and he knew that he had to take care of himself. When he was working full time, he had health insurance, regularly saw his doctor, and took medications to control his sugar and his blood pressure. But one day, at age 55, Domenic lost his job of 23 years and with it his health insurance. Three years later, he lost three toes, amputated because of infection and poor circulation from diabetes. How does this happen?

Domenic grew up in South Philadelphia. Now 58, he worked steadily for more than 40 years. For 23 of those years, until the business closed, he drove a bakery truck. But in Domenic's 23rd year, the business was sold, and 25 people lost their jobs. His union couldn't help. "I lost my health insurance, I lost my life insurance, I lost everything."

When Domenic lost his job, he began receiving unemployment compensation, about $256/week. Though he secured a part-time job at the airport, he continued looking for permanent work with benefits; but he had no success. His income stretched to meet food, transportation, and mortgage payments. He didn't have money left for doctor visits or medications, and he certainly couldn't afford to buy health insurance. He could not afford COBRA to stay in his former company's health plan, and he would surely be unable to afford other insurance. The lowest priced comprehensive plan available for a man Domenic's age is more than $400 per month, and it is likely that once an insurance company saw his medical history, they would raise that considerably, or more likely deny him insurance altogether because of his pre-existing condition of diabetes.

Without insurance, embarrassed to face his doctor, Domenic ran out of blood pressure and diabetes pills. "I knew I wasn't supposed to stop. But I didn't feel sick." He never tried to see his old doctor, or to ask for discounted care. He felt as if he was asking for handout. He thought about the city health clinics that offer free care to the uninsured. But there was a long wait for an appointment, and he was discouraged. He couldn't afford to see a podiatrist, a necessary part of diabetes care.

Domenic's part time job required standing on his feet 20 hours per week. That and the absence of routine medical care took its toll. Domenic's foot swelled. Soaking it in Epsom salts and warm water didn't improve his condition. He could not even cut his own toenails. Still he feared the costs of going to the hospital. He didn't understand Medicaid, but he went to the County Assistance Office to apply. He was turned down because as a working adult, without children and without a disability, he was simply not eligible.

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Finally, Domenic knew he had no choice. The foot was red, and looked infected. "I was nervous that I didn't have coverage, but I finally decided I had to go to the hospital. The pain was too much for me." He was admitted to the hospital, too late to save his foot. His big toe, and the second and third toes, were amputated. When he was in the hospital, someone came and helped him complete another Medicaid application. He asked the worker if her job was to help the patients. Her reply: "this is just so the hospital gets paid." He asked, "Doesn't anyone care about the patient anymore?"

When Domenic was discharged from the hospital, he was sent home on five medications. He was never asked if he would be able to fill the prescriptions. He paid $155 at the pharmacy, more than he expected, but he felt he had no choice. He had already lost three toes. His old doctor, who visited him in the hospital, agreed to "cut him a break" and see him for a discounted fee.

Domenic knows he will never again be able to drive a delivery truck, but he wants to return to work. His greatest fear is losing his home; although he can't afford health insurance so far he is up to date on his mortgage payments.

He called PHLP, uninsured and desperate, knowing that he was about to receive a large hospital bill. When he talks about what happened to him, he sounds worried, with anger and frustration bubbling up. He was not depressed, but he was demoralized. "I'm looking for a little bit of help, not a long term handout. It seems like they just shut the doors on me. I don't understand how they just throw people out in the cold. It seems like they are shutting the doors on me."

A PHLP attorney helped open those doors by getting Dominic eligible for a special category of Medicaid known as Medical Assistance for Workers with Disabilities (MAWD). He has over $110,000 in hospital and doctor bills. Some of these will be covered by Medicaid. Neither the hospital, nor the County Assistance Office gave Dominic adequate help or information. Like many other people, Dominic thought he would never need "government help" but that if he did, as a taxpayer, it would be there for him. It was a shock to discover that he, along with many others, was sick and on his own.

**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.**

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# Update On Federal Health Care Reform

Congress has been back at work for several weeks after the summer recess trying to finalize health care reform proposals and answer President Obama's call to lower health care costs and provide affordable insurance to 46 million uninsured Americans. To date, committees in each chamber of Congress released major proposals before the August recess: the House of Representative's America's "Affordable Health Choices Act of 2009 (H.R. 3200)," and the Senate HELP Committee's "Affordable Health Choices Act." Both proposals have been voted out of committee but neither have been brought to the floor of either chamber for debate. See PHLP's combined June/July Newsletter for information about each proposal.

More recently, another proposal known as the "Baucus Bill" has been introduced. The Senate Finance Committee is currently modifying the original proposed legislation to prepare it for a vote by the whole Committee. The Finance Committee is the fifth and last of the congressional panels to debate health care.

The Baucus Bill, like the other two congressional proposals, require Americans to have health insurance and imposes financial penalties for those who elect not to get coverage. Further, the Baucus proposal expands Medicaid coverage to all adults whose income is less than 133% of the Federal Poverty Level ($1,200/month for a single individual in 2009). Unlike the two other major proposals, however, the Baucus Bill does not have what is referred to as a "public option." The public option is a government-run health insurance plan (similar to Medicare) for people who cannot find affordable private insurance. Supporters of the public option hope that it will increase competition and drive down health care costs in the private market. Instead of creating a new government health plan, the Baucus Bill establishes non-profit, member-run, health insurance cooperatives in every state.

Other major differences between the Baucus proposal and the two proposals already released from committee are detailed below:

- It creates a new excise tax on insurance companies that sell high-end policies (known as "Cadillac plans") costing more than $8,000 for individuals and $21,000 for families in order to put downward pressure on health costs.
- It does not require employers to offer coverage to their employees, but it requires employers with more than 50 workers to reimburse the government for some or all of the cost of subsidies provided to their employees who must then buy insurance on their own.
- It increases CHIP eligibility to higher income levels (Pennsylvania already has the "Cover All Kids" programs, so this would not impact our state as much as others without a similar program).
- The Congressional Budget Office has estimated the total cost of the bill to be $829 billion over 10 years (less expensive than H.R. 3200).

The Baucus Bill needs to be passed out of Committee before it goes to the floor for debate. Democratic leaders hope to hold votes on health care on the floor of the House and Senate within a few weeks. We'll continue to keep you posted in future newsletters. For more information about all three proposals, see http://finance.senate.gov/sitepages/baucus.htm, http://help.senate.gov, or http://edworkforce.house.gov.

# Are You Working on Issues Related to the Integration of Mental Health and Physical Health Services for Children and Adolescents?

The Healthy People 2010 initiative of the U.S. Department of Health and Human Services created a series of goals designed to bring better health to all people in this country. Specific to children and adolescents, Healthy People 2010 seeks family-centered, culturally-competent, comprehensive, and coordinated systems of services for all children and youth with special health needs, in every community, by the year 2010. EPIC-IC (Educating Practices in Community-Integrated Care), an initiative of the Pennsylvania Chapter of the American Academy of Pediatrics (PAAAP), is working toward the Healthy People 2010 goals for Pennsylvania's youth. Also known as the Pennsylvania Medical Home Initiative, the project focuses on assisting a group of pediatric practices in providing high quality care to children with special health care needs.

Earlier this year, the EPIC-IC Medical Home 2009 Spring Conference on Mental Health was held. Since then, a group of individuals from pediatric and family medical practices, mental/behavioral health providers, community organizations, behavioral health insurance organizations, state agencies and parents and caregivers of youth with mental health conditions formed the Pennsylvania Mental Health Workgroup. This Workgroup has met three times-twice via conference call and once in person in Harrisburg in September. The Workgroup seeks to coordinate its work with others already working in this field.

If you are part of a local, regional or statewide effort to improve the delivery of children and adolescents' physical health and mental health needs, please contact Janice Meinert at the Pennsylvania Health Law Project at jmeinert@phlp.org. Please share your name, the agency you work for, the project or committee you are involved with, and the goals and activities of that project. The Workgroup will use this information to share activities, lessons learned, and minimize duplication.

# Help PHLP Reduce Reliance on Institutional Care: Send Us Your Stories About Consumer Struggles to Become Financially Eligible for Home & Community Based Waiver Services

Individuals at risk of being placed in long-term care institutions such as nursing facilities or intermediate care facilities would prefer to receive services that would allow them to remain living in their homes and communities. Home and Community Based Services (HCBS) Waiver programs (such as the Aging Waiver, Attendant Care Waiver, AIDS Waiver, and Consolidated Waiver) provide alternatives to institutional care. The HCBS waiver programs in Pennsylvania recognize that many individuals at risk of being placed in institutions can be cared for in their homes and communities, preserving their independence and ties to family and friends, at a lower cost to the state than institutional care. However, many people who need the long term living services that HCBS Waiver programs offer do not qualify because their income is over the state's income limit for these programs.

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To be financially eligible for a HCBS Waiver program, an individual's monthly income has to be below $2,022 (for 2009). Just like in other Medical Assistance (Medicaid) programs, individuals whose monthly income are above the waiver limit can use medical bills and medical expenses to "spend-down" their excess income in order to qualify for the program. However, instead of spending excess income down to the waiver program income limit of $2,022 each month, a consumer seeking entry in an HCBS waiver program has to spend-down their countable income to $701 each month. Faced with the prospect of diverting so much of their income to meet this monthly spend-down, consumers rarely qualify for a waiver using a spend-down because they would not be able to meet their normal living expenses. Too many people, consequently, have no option but to leave their communities to receive long term care services in a more expensive and less preferred institutional setting.

To reduce the Medicaid long-term care system's reliance on institutional care, PHLP, along with other advocates, is trying to change this policy. Individuals whose incomes are too high to qualify for waiver services should be able to spend-down their excess income to the waiver program income limit of $2,022 a month rather than the current $701 spend-down limit noted above. PHLP is interested in hearing from consumers (as well as family members and professionals who work with consumers) who would benefit from such a change in policy. Individuals are encouraged to contact PHLP's HELPLINE at 1-800-274-3258 to discuss this further.

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