Health Law PA News

Newsletter of the Pennsylvania Health Law Project

Harrisburg Philadelphia Pittsburgh

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On the Internet: www.phlp.org

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Medical Assistance Program to Deny Hospital Payments for Preventable Serious Adverse Events

DPW has notified acute care general hospitals that it will not pay for serious adverse events that were determined to have been preventable, under the fee-for-service program. The policy was announced in a Medical Assistance Bulletin on January 14, 2008, and was effective immediately. A "serious" event is one that results in death or loss of a body part, disability or loss of bodily function lasting more than seven days or still present at the time of discharge. In order for the policy to apply, the event must have occurred during an inpatient hospital visit and have been within the control of the hospital. The Bulletin directs health care organizations to the National Quality Forum's (NQF) work on serious reportable events in health care as a starting point for improving patient care.

Among the NQF list of serious reportable events are surgical events such as surgery on the wrong body part, surgery on the wrong patient, or the unintended retention of a foreign object in a patient; product or device events such as serious disability associated with the use of contaminated drugs, devices or biologicals; care management events such as medication errors; and environmental events such as patient falls.

The Bulletin only governs the fee-for-service program, with DPW leaving it up to the individual Medical Assistance (MA) HMOs to determine whether to apply the policy to their network hospitals. Consumers and advocates should be on the lookout for hospitals trying to shift costs to MA recipients where payments have been denied under this policy by DPW.

INSIDE THIS EDITION

New *Select Program for Women* Offers Family Planning Services

Starting February 1, 2008, women who are not eligible for Medical Assistance may be eligible to receive family planning services under a new program called ***Select Program for Women***. This program is available to uninsured and underinsured* women who meet the following criteria:

- Are between the ages 18-44;
- Are Pennsylvania residents and U.S. Citizens;
- Have incomes up to 185% of Federal poverty level; and
- Lack family planning coverage.

*Underinsured women are eligible if they meet these requirements and have health insurance that does not cover prescriptions.

The program does not provide full medical assistance coverage, but it does cover family planning office visits plus Pap smears and testing and treatment for sexually transmitted infections. It also provides coverage for all FDA approved contraceptives.

An eligible woman can access this program by going to any Pennsylvania Medical Assistance practitioner who currently provides family planning services. The woman can ask the practitioner's office to enroll her immediately, online, via special screens in COMPASS. She should be able to be seen that day, and the practitioner can receive payment for the visit, on a fee-for-service basis. This is true even in HealthChoices areas. Paper applications will also be available at participating physician offices and clinics. If the woman does not have all the necessary verification documents (such as a birth certificate and pay stubs) at the time of her visit, she will have 30 days to submit the necessary information via mail. She will not need to go to a County Assistance Office to apply for this program.

Pennsylvania's Department of Public Welfare hopes that this program will provide family planning coverage to 100,000 women each year who do not qualify for Medical Assistance. More information about the program will be available at a new website, www.selectplanforwomen.state.pa.us. Consumers can also find information regarding family planning services across the state at www.familyplanning.org, the website of the Family Planning Council of Southeastern Pennsylvania.

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Having Problems Finding an Agency to Fill Home Health Aide Hours Approved by MA HMO?

PHLP may be able to assist families with children who have been authorized for home health aide services (not nursing) **by a Medical Assistance HMO**, but who are having problems getting reliable aides to staff those hours. In recent months, PHLP staff was successful in getting the Department of Public Welfare's Office of Medical Assistance Programs (OMAP) and Keystone Mercy Health Plan (KMHP) to allow one family in this situation to hire their own aide (at a higher salary than paid by most home health agencies) without having to go through a home health agency. It worked so well that OMAP is now willing to try this with some more families with the ultimate goal of adding this model as an option for all families with kids receiving Medical Assistance (MA) benefits who are in need of home health aide services.

PHLP is looking for families that meet the following criteria:

- home health aide services have already been authorized for child under 21 by a MA HMO;
- family has not been able to get authorized hours staffed on a consistent basis;
- family has gone through at least 2 different home health agencies trying to get their authorized hours staffed;
- family is willing and able to take on the responsibility of recruiting and supervising their child's aide; and
- the child's physician supports the family supervising the aide without the involvement of a home health agency and is willing to write a new request for a "personal care aide".

If you are in this situation or know of a family in this situation, please contact the PHLP Helpline at 1-800-274-3258 or 1-866-236-6310 (TTY).

Some Medicaid HMOs Earn Extra Payments for Quality Care

In the second year of DPW's "Pay for Performance" program, some HMOs earned far more than others in bonus payments for meeting quality measures. The PA Medical Assistance Program pays a bonus to physical health HMOs that improve or sustain quality care in one or more of 12 areas. The measures include controlling high blood pressure and diabetes, screening for breast and cervical cancer, using appropriate medications for asthma, delivering prenatal and adolescent care, and blood lead screening.

The big winners were Gateway Health Plan and Health Partners. Gateway got bonus payments for 9 of the 12 measures, including the only payout for cervical cancer screening. Gateway earned 71% of the bonus funds that were available to it. Second was Health Partners, which got 41% of the funds available to it, by partially or fully meeting goals for 7 measures. Keystone Mercy only met one goal, adolescent well-care visits. UPMC partially met only one goal, blood lead screening for 3 year olds. Unison, which only received 1.32% of the funds available to it, qualified for a 50% payout on only one measure, blood lead screening for 19 month olds.

State Holding Listening Sessions on Attendant Care Waiver and Aging Waiver Renewals

The Attendant Care Waiver and the Aging Waiver are up for renewal this year. The Office of Long Term Living is currently holding Listening Sessions around the State to outline some of its proposed changes to the waivers and to get input from the public and interested stakeholders about the proposed changes, how the waiver programs are working and how the programs can be improved.

The state plans to submit the waiver applications to the Centers for Medicare & Medicaid Services (CMS) in April 2008 and hopes to get approval by the end of June, when the current waivers expire. According to the state, CMS is requiring much more detailed information in the current waiver applications than it has in the past. CMS has also raised concerns about the consistency of waiver eligibility determinations and service delivery across the state and is seeking assurance that freedom of choice is guaranteed for participants in the waiver programs. In addition, CMS has indicated that the state must develop a comprehensive strategy for Quality Management of its waiver programs.

Some of the proposed changes are more fleshed out than others. Of particular interest to consumers are the following proposed changes to the waivers:

Attendant Care:

- Allowing waiver participants to have a choice of providers for each ***service*** they receive (currently, waiver participants have a choice of providers, but must get all their services from the same provider);
- Offering a new model of service called “Services My Way” as a pilot program. This would be in addition to the Agency Model and Consumer Employer Model. “Services My Way” is the name for PA’s cash and counseling program that allows consumers the option to direct and control their non-medical services through the waiver. Individuals get a budget based on their needs and then use that budget to hire workers to provide services and purchase other goods and services.
- Developing and implementing a Peer Review Committee to help with the Individual Service Plan review process.

Aging Waiver:

- Offering consumers a choice of whether they want care management services and whether they want these services through the local Area Agency on Aging;
- Changing how the Level of Care determination is done to give the state a greater role in the process;
- Proposing standardization of the definition of Personal Assistance Services (PAS) and delivery of PAS across the counties. Currently, there is no standard definition in the waiver and these services are not offered statewide.
- Including TeleCare services as an available service under the waiver and standardizing the delivery of these services across counties. TeleCare services use

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innovative technologies to promote and sustain independence and quality of life through services that include Health Status Measuring and Monitoring, Activity and Sensor Monitoring, Medication Monitory System, and Personal Emergency Response System (PERS).

There are two remaining listening sessions scheduled on February 1st in Nanticoke and February 6th in Norristown. Please go to this link for more detailed information: http://www.dpw.state.pa.us/Resources/Documents/Pdf/LongTermCare/ListeningTourSaveTheDate.pdf.

Individuals who are not able to attend the sessions or who still want to provide comments can do so via e-mail at RA-acwrenewal@state.pa.us or by sending their written comments to: Office of Long Term Living, Attention: Listening Sessions, P.O. Box 2675, Harrisburg, PA 17105.

PHLP Receives Funding to Increase Awareness and Improve the Effectiveness of HCBS Waiver Programs in Southwestern PA

PHLP has received funding from FISA Foundation (www.fisafoundation.org) for a two-year project aimed at increasing awareness and improving the effectiveness of Home and Community Based Service (HCBS) programs for individuals in Southwestern PA with physical and developmental disabilities. This project includes conducting education and outreach to both professionals and consumers about eligibility for the various programs as well as how to access these programs.

In addition to doing community education and outreach, PHLP will be creating consumer education material and engaging in individual and systemic advocacy to eliminate the barriers consumers and family members face in accessing these programs and to improve the effectiveness of the waiver programs.

If there are any groups of professionals and/or consumers/family members in Southwestern PA who are interested in scheduling a training on HCBS Programs in PA, please contact PHLP's HELPLINE at 1-800-274-3258 (voice) or 1-866-236-6310 (TTY). Furthermore, individuals, family members, and/or professionals in Southwestern PA who have questions about the HCBS waiver programs or who are experiencing problems in terms of eligibility and/or accessing services under the waiver programs are encouraged to contact our HELPLINE.

2008 Part D LIS Income and Resource Limits Announced

To qualify for a Medicare Part D Low-Income Subsidy (also called "extra help with Medicare prescription drug costs") in 2008, individuals have to meet the following guidelines:

Full Subsidy

- ***Individual***: Income less than $1,170/month ($14,040/year); Resources less than $7,790.
- ***Married Couple***: Income less than $1,575/month ($18,900/year); Resources less than $12,440.

Partial Subsidy

- ***Individual***: Income less than $1,300/month ($15,600/year); Resources less than $11,990.
- ***Married Couple***: Income less than $1,750/month ($21,000/year); Resources less than $23,970.

Certain income disregards apply when determining eligibility for the LIS (i.e., $20 disregard for unearned income and significant disregards for earned income). Also, only certain resources are counted when determining eligibility (i.e., a home and car are not counted).

As a reminder, individuals can get applications at the local County Assistance Office or local Social Security Office. Online applications can be submitted at www.ssa.gov/prescriptionhelp. There is no deadline for applying for this help. LIS applications that were filed in late 2007 that did not meet the 2007 income guidelines were held by SSA to be evaluated by the 2008 guidelines.

Medicare Advantage Open Enrollment Period Runs from 1/1/08-3/31/08

Although the Medicare Annual Open Enrollment Period ended December 31, 2007, Medicare beneficiaries have another opportunity to change plans in 2008 Every year from January 1st until March 31st, Medicare beneficiaries who are enrolled in a Medicare Advantage plan can change their plan or go back to Original Medicare. Similarly, individuals in Original Medicare can join a Medicare Advantage plan during this period.

During this Medicare Advantage Open Enrollment Period, Medicare beneficiaries can only change from "like plan to like plan". This means that if someone is currently in a Medicare Advantage plan with prescription drug coverage (MA-PD), they can only change to another MA-PD or go back to Original Medicare and join a stand-alone Prescription Drug Plan (PDP). Individuals who are enrolled in Medicare Advantage Only plan (with no drug coverage) would be limited to joining a different Medicare Advantage-only plan or going back to Original Medicare. These individuals would not be able to pick up Part D coverage through an MA-PD or a PDP during this enrollment period.

Not all Medicare Advantage plans accept enrollments during this Open Enrollment Period. Individuals who wish to change their plan can enroll in the new plan and do not need to disenroll from their current plan. Joining a new plan will automatically disenroll someone from their current plan. Any enrollments during this period should become effective the first of the following month.

Update on Wellpoint Process as a Back-Up Part D Plan for Dual Eligibles and Others with the Low-Income Subsidy

The Wellpoint process, also called the Point of Service (POS) facilitated enrollment process, is still available to dual eligible individuals who do not have Part D coverage and need medications. In the past year, it has been clarified that this process can be used by both full benefit dual eligibles **and others who receive the Part D low-income subsidy (LIS).** Prior to using the Wellpoint process, pharmacies have to confirm dual eligibility or LIS status by checking for Medicaid card, asking to see an LIS award letter, or confirming eligibility through state system (like EVS). In addition, they also have to verify someone's Medicare eligibility and check the Medicare system for any active Part D plan enrollment.

Pharmacies still use the following information to bill Wellpoint for eligible individuals:

Bin: 610575
PCN: CMSDUAL01
Cardholder ID: Medicare HICN (on red, white, and blue card)
Patient ID: Medicaid number (if applicable) from ACCESS card (either green or yellow)

Starting in 2008, CMS has a new process to recover funds from Medicare beneficiaries who use the Wellpoint process but who are not eligible for Medicaid or LIS. In the past, pharmacies were held responsible for claims submitted on behalf of beneficiaries who later turn out to be ineligible for the Wellpoint process. In cases where someone uses this process but is not a dual eligible or eligible for the LIS, Wellpoint will send a notice (called an "Evidence of Eligibility" letter) asking for proof of Medicaid or LIS eligibility and telling the individual she has to reimburse Wellpoint for the amount billed through the Wellpoint process if no proof is submitted. If documentation is not provided in 60 days, Wellpoint will seek reimbursement from the beneficiary.

Individuals who are dual eligible or those who otherwise qualify for the LIS can contact our HELPLINE at 1-800-274-3258 or 1-866-236-6310 (TTY) if they're having problems accessing medications under the Wellpoint process. For more information about the Wellpoint process, please see: http://www.cms.hhs.gov/States/065_Backgrounders.asp.

PHLP staff are available in Southeastern PA to conduct trainings on Part D to help social service agencies and their clients navigate the Part D system. Trainings focus on the rights that dual eligibles have under Part D and the appeals and grievance processes that are available to all Part D enrollees.

To learn how to help get your clients' needs met through Medicare Part D, contact the PHLP HELPLINE to schedule a training (1-800-274-3258 voice or 1-866-236-6310/TTY). Please let us know if you require any special accommodations for persons with hearing and/or vision needs.

Respite Funding Available for Families with Children with Behavioral Health Needs

Funding for respite services for families with children who have a serious emotional or behavioral health condition is available and must be used by June 30, 2008. The PA State Budget for 2007-2008 included a $500,000 allocation for these respite services, and every county was awarded a minimum of $5,000. The vast majority of counties were awarded between $5,000 and $15,000. The two exceptions were Allegheny County (which received $45,918) and Philadelphia County (which received $112,166). Counties were awarded funding based on the percentage of children receiving behavioral health services in the county relative to the total number served statewide. For example, if a county served 10% of the total number of children served in the state, that county received 10% of the $500,000. Each county received letters in September 2007 notifying them about the amount of funds they would receive.

The Office of Mental Health and Substance Abuse Services (OMHSAS) defines respite as short term care that helps a family take a break from the daily stress and routine associated with caring for a child with a serious emotional or behavioral disorder. Respite can be provided in the client's home or in a variety of out of home settings.

Families with children being served by the behavioral health system have long advocated for the availability of respite services. Both families and OMHSAS staff are pleased that respite funding is now available, but they also recognize that this modest allocation cannot meet the existing need.

In order to document the need for respite services and work towards the expansion of such services, counties are recording the extent to which respite services were made possible through the budget allocation as well as tracking other respite services previously available through the county. In addition, a Respite Development Group, comprised of families, advocates and county representatives, has been established. This Group will conduct surveys, hold focus groups, and utilize other methods to monitor the implementation of respite services throughout the Commonwealth, ensure the quality of services, and identify ways to expand and enhance respite services.

Families of children with serious emotional or behavioral disorders, in need of respite services, should contact their County Mental Health Office as soon as possible to find out about the availability of funds and how to access respite services.

Understanding the Medical Assistance For Workers With Disabilities (MAWD) Program

Although the MAWD Program has been in effect for a number of years, it is still a widely unknown and misunderstood program. PHLP gets numerous calls from individuals who either lost their Medical Assistance coverage because their income increased or who were denied Medical Assistance because their income was too high. In many of these cases, no one tells these consumers about the MAWD Program even though it may allow them to get Medical Assistance coverage when they are otherwise not eligible.

Under the MAWD program, a person with a permanent disability may buy into full Medical Assistance coverage at a cost of 5% of his countable monthly income. The average premium paid by participating individuals is currently $43/month.

Medical Assistance for Workers with Disabilities is available to single persons with disabilities who work even just one hour a month and have countable incomes in 2008 up to $2,167/month and married persons with incomes up to $2,917/month. Resources must be below $10,000 (not including a house or car). In addition to meeting these income and resource requirements, an individual has to meet the following eligibility guidelines to qualify for MAWD:

- Be between 16 and 64 years of age;
- Meet the Social Security Administration disability definition (this does not mean that someone has to be receiving SSDI benefits; someone can submit medical records and be determined disabled by the state's Medical Review Team); and
- Be employed and receiving compensation (there is no minimum work requirement, so even 1-2 hours of work per month would meet this requirement).

Please note: When the County Assistance Office reviews eligibility for Medical Assistance, they determine someone's countable income which includes a standard $20 deduction for unearned income and significant deductions for earned income (taking a $65 deduction and then only counting half of the remaining amount). For example, if someone's gross monthly income is $2,100 and it's all from earnings, their countable income for determining eligibility for MAWD and determining the MAWD monthly premium is $1,017.50 ($2,100 minus $65 which equals $2,035 and then counting half of this remaining amount).

MAWD insurance provides coverage in areas which may not be covered by other insurances, such as glasses, dental, chiropractic visits, prescription drugs, medical equipment, and rehabilitation services. MAWD can be someone's only insurance (if he has no coverage now), or it can be a secondary insurance (if someone already has Medicare or has some coverage through a job that does not cover all of his health needs).

For more information about the MAWD Program, please see the brochures on our website at www.phlp.org or call the HELPLINE at 1-800-274-3258 or 1-866-236-6310 (TTY). Individuals can obtain applications from their local County Assistance Office or can apply online at www. compass.state.pa.us.

2008 Federal Poverty Levels Announced

On January 23, 2008, the new federal poverty level (FPL) guidelines were announced. Although the new guidelines become effective once they are published in the Federal Register (73 Fed. Reg. 3971), each program that uses the FPL guidelines to determine eligibility decides when they will start to officially use the new numbers.

The use of these new guidelines may impact someone's eligibility for certain programs like Medical Assistance and the Part D low-income subsidy programs (see page 3). In 2008, 100 % FPL is $867/month ($10,400/year) for a single person and $1,167/month ($14,000/year) for a married couple. In 2007, these amounts were $851/month ($10,212/year) for a single person and $1,141/month ($13, 692/year) for a married couple.

To determine other FPL amounts (such as 135%), take the 100% amount and multiply it by the FPL you're trying to determine. For example, if you're trying to determine 135% FPL, you take the 100% FPL amount of $867/month and multiply that by 1.35 which equals $1,170 /month.

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