Health Law PA News

Newsletter of the Pennsylvania Health Law Project

Harrisburg Philadelphia Pittsburgh

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

On the Internet: www.phlp.org

Volume 11, Number 3 May 2008

Feds Approve PA Autism Waiver

On May 14, 2008, the Centers for Medicare & Medicaid Services ("CMS") approved Pennsylvania's request to use federal Medicaid funds to establish a program that provides home and community based services for adults with autism. This program is known as the Autism Waiver and is the first such program for adults in the nation to receive federal approval. The $20 million-a-year waiver program will serve up to 200 individuals initially. Waiver eligibility is limited to people who:

- Have a diagnosis of Autism Spectrum Disorder (ASD) (such as Childhood Disintegrative Disorder, Pervasive Developmental Disorder-Not Otherwise Specified, Rett Disorder-as determined by a licensed psychologist or physician);
- Are 21 years old or older;
- Have significant functional limitations; and
- Have countable monthly income below $1,911 (for 2008) and assets (not including a house, a car or other "exempt" assets) below $8,000. The income and assets of the consumer's parents do not count.

The Autism Waiver is designed to provide community-based services and supports to meet the specific needs of adults with ASD. The participant will choose a Supports Coordination Agency which will then conduct state-specified assessments and work with the participant, and other individuals he or she chooses, to develop an Individual Support Plan (ISP). Services available under the waiver include Day Habilitation, Respite (for caregiver family members), Supported Employment, Therapies, Assistive Technology, Behavioral Specialist, Community Inclusion, Community Transition, Environmental Modifications, Family Counseling, Family Training, Job Assessment, Nutritional Consultation, Temporary Crisis, and Transitional Work. See our website for a description of these various services that will be provided by the waiver (www.phlp.org).

The waiver offers only agency-managed

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services at this time. The Department of Public Welfare (DPW) intends to submit a waiver amendment to add participant-directed services at a later date.

Distribution of Waiver "Slots"
The Bureau of Autism Services will allocate waiver slots on a regional basis to ensure access across the Commonwealth. The Bureau will allocate the number of waiver slots for each region based on the percentage of Pennsylvania's population age 20 or older in each region, according to the U.S. Census Bureau's 2006 Current Population Estimates. The regions are divided as follows:

- **West**: Allegheny, Armstrong, Beaver, Butler, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Venango, Warren, Washington, and Westmoreland Counties
- **Central**: Adams, Bedford, Blair, Cambria, Centre, Clinton, Columbia, Franklin, Fulton, Huntington, Juniata, Lebanon, Lycoming, Mifflin, Montour, Northumberland, Perry, Snyder, Somerset, Union, and York Counties
- **Southeast**: Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties
- **Northeast**: Berks, Bradford, Carbon, Lackawanna, Lehigh, Luzerne, Monroe, Northampton, Pike, Schuylkill, Sullivan, Susquehanna, Tioga, Wayne, and Wyoming Counties
- **Capitol**: Cumberland, Dauphin, and Lancaster Counties

Initial Application Process
Beginning July 1, 2008, individuals may apply for the Autism Waiver by calling the DPW Bureau of Autism Services at 1-866-539-7689. Applications will only be accepted by phone. Callers will receive a voice mail message asking for basic information about the caller and the person for whom services are requested. The Bureau will determine whether the applicant meets basic program eligibility requirements (such as age and diagnosis). If that is the case, the Bureau will then check the DPW information systems to determine whether the applicant is currently receiving state or federally funded "long- term care services" through another waiver (e.g. PFDS, Consolidated, OBRA) or as a resident of an an ICF-MR. If so, that individual will be eligible for a waiver slot- if any remain- only after all other applicants without services are given slots.

During the initial 6 weeks of the waiver's operation, applicants without services will be randomly assigned a place on their region's intake list and applications will be processed in that order. If there are any slots left at the end of the 6 week period, applicants already receiving long-term care services will be randomly assigned a place on their region's "Priority 2" intake list and the remaining slots will be distributed in that order. The application process will include a "level of care assessment" as the waiver is limited, under federal law, to persons with significant care needs.

If the waiver slots in a region are filled, individuals requesting waiver services will be placed on a waiting list. Once waiver slots become available in a region, persons on the waiting list will then be assessed for level of care and financial eligibility.

After the initial 6 weeks of the application process (ending August 11, 2008), slots will be given to applicants without other services on a first-come first-serve basis. Any remaining slots will then be offered to persons who have other long-term care services.

Please call our HELPLINE at 1-800-274-3258 (voice) or 1-866-236-6310 (TTY) if you have further questions about the autism waiver and about the application process.

The Impact of Economic Stimulus Payments on Eligibility for Public Health Programs

Some low-income consumers may be eligible for the economic stimulus payments currently being sent to qualified individuals by the IRS. Consumers who received at least $3,000 in income in 2007 from sources such as Social Security (retirement, survivor, or disability benefits) or the Veterans Administration can qualify if they file a 2007 tax return by **October 15, 2008**. The deadline to qualify for a stimulus payment has been extended beyond April 15, 2008 because of concerns that many eligible consumers who do not usually have to file tax returns were unaware of the need to file a tax return in order to get the payment. Qualified individuals will receive a one-time payment between $300 and $600.

Those who receive the economic stimulus payment need to understand how the payment will affect their eligibility for public healthcare programs. The short answer is that the payment will not immediately affect eligibility for Medical Assistance (MA) or the Medicare Part D Low-Income Subsidy (LIS).

The rebate check will not be treated as countable *income* for MA or the LIS. The rebate check might be treated as a countable *resource* for MA or the LIS **if and only if** the rebate is not spent by the end of the 2nd month following receipt of the check. For example, if an individual gets a rebate payment in May 2008, and decides to keep it or invest it, it would not count as a resource for May, June, or July 2008. If any funds remain unspent after July 31, 2008, the amount remaining is counted as a resource and may affect someone's eligibility for MA or the LIS. Countable resources include money in bank accounts, investments, and cash at home or elsewhere.

Please call our HELPLINE at 1-800-274-3258 (voice) or 1-866-236-6310 (TTY) if you have any further questions about these payments.

Assisted Living Update

The Department of Public Welfare's Assisted Living Workgroup met for the last time in April. The Workgroup, which includes consumer representatives and provider representatives, met regularly with state officials to provide input on the development of the proposed regulations to implement the assisted living licensure statute enacted in July 2007. The proposed regulations are expected to be published in the PA Bulletin in the near future. A 30-day public comment period will follow publication of the proposed regulations. If you are interested in following the regulations' progress, we encourage you to join the mailing list of the PA Assisted Living Consumer Alliance (see below).

The PA Assisted Living Consumer Alliance (PALCA) was created earlier this year to make sure that the consumer voice gets heard in the development of Assisted Living Regulations for Pennsylvania. The Consumer Alliance is a coalition of organizations committed to ensuring quality assisted living options for consumers. **Consumers and consumer advocates are encouraged to join the Alliance and may do so by contacting Alissa Halperin at ahalperin@phlp.org.**

Medicare's Coverage of Durable Medical Equipment and Supplies Changing July 1, 2008

Starting July 1, 2008, consumers with **Original Medicare** in certain zip codes in Western PA will have to get their Medicare-covered durable medical equipment (DME) and supplies through a limited network of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) contractors who have been approved by Medicare. This new program, called the Competitive Bidding Program, is being rolled out in phases. There are 10 locations throughout the country, including a Pittsburgh-area location, which will start using this new program on July 1, 2008. The program will be expanded to 70 other areas in 2009 and then nationwide after that.

Who is impacted by these changes?
The Pittsburgh Competitive Bidding Area (CBA)includes:

- all of Allegheny and Washington Counties;
- most of Armstrong, Beaver, Butler, Fayette, and Westmoreland Counties; and
- small areas in Clarion, Greene, Indiana, Jefferson, Lawrence, Somerset, and Venango Counties.

A complete list of zip codes in the Pittsburgh CBA can be found at: www.dmecompetitivebid.com.

The changes will affect any Medicare beneficiary in **Original Medicare** (uses red, white, and blue card) who either:

- Has their permanent residence in a zip code in the Pittsburgh CBA, or
- Travels to a zip code in the Pittsburgh CBA and needs certain Medicare-covered equipment and supplies.

Beginning July 1, these individuals will have to use a Medicare-contracted supplier to get certain equipment and supplies (see next page).

Note: Individuals living in these areas in a Medicare managed care plan are <u>not</u> impacted by this change.

How does the new Competitive Bidding Program Work?
Currently, Medicare beneficiaries who have a prescription for DME or supplies can use any Medicare-approved supplier to fill their prescription. If the Medicare-approved supplier is a "participating" supplier, they have to accept the Medicare-approved amount for the item and they can only charge someone the 20% Medicare coinsurance (or the Part B deductible amount if that has not yet been met). However, if the approved supplier is "not participating", there is no limit on how much they can charge the individual consumer. In addition, non-participating suppliers can require that the consumer pay for the item up front and wait for reimbursement from Medicare for its portion of the bill.

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Under the new Competitive Bidding Program, Medicare beneficiaries in need of certain DME or supplies (listed on page 5) will generally have to use suppliers that were awarded contracts by Medicare. Suppliers had to submit bids to Medicare for the various items included in the program. Medicare awarded contracts to suppliers that offered the best price for the equipment or supplies and that met other standards.

Generally, only contract suppliers will be able to provide Medicare consumers with the DME and supplies listed below and be able to bill Medicare for these items. Contract suppliers cannot charge more than the single payment amount set by Medicare based on the bids received for a particular item and the price cannot be higher than the current Medicare fee schedule allowed amount. The contracted suppliers can only charge the consumer a 20% coinsurance (and any portion of the Part B deductible that has not yet been paid). Medicare announced the approved suppliers on May 19, 2008. Individuals can find a list of providers by going to www.medicare.gov/suppliers or calling MEDICARE at 1-800-633-4227 (voice) or 1-877-486-2048 (TTY).

Suppliers who were not awarded contracts can become "grandfathered" suppliers and continue to provide items through current rental agreements to Medicare beneficiaries in the Pittsburgh CBA **if** the supplier had been renting the item to the person prior to July 1, 2008. Suppliers are not required to become a “grandfathered supplier”, and if they do not become one, their Medicare consumers will have to change to a contracted supplier to continue getting the equipment and supplies after July 1st. Suppliers must notify their consumers prior to July 1, 2008 to let them know whether they will be a grandfathered supplier or not. Grandfathered suppliers can also only charge the 20% coinsurance (and any Part B deductible still owed) for items included in this new program (listed below) that they have been providing to individuals prior to July 1st. If a consumer is later prescribed something new, the consumer will need to use a Medicare-contracted supplier under the new program to get the new piece of equipment or item needed.

Are all types of durable medical equipment, prosthetics, orthotics, and supplies included in the Competitive Bidding Program?

No. Only the following types of equipment and supplies are included in the program beginning July 1st:

- Oxygen supplies and equipment;
- Standard power wheelchairs, scooters and related accessories;
- Complex rehabilitative power wheelchairs and related accessories;
- Mail-order diabetic supplies;
- Enteral nutrients, equipment, and supplies;
- Continuous Positive Airway Pressure (CPAP) devices and Respiratory Assist Devices (RADs) and related supplies and accessories;
- Hospital beds and related accessories;
- Negative pressure wound therapy pumps and related supplies and accessories; and
- Walkers and related accessories

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A Consumer Victory

Most consumers know that when a drug is available in generic and brand name versions, the generic version is usually the preferred drug, whether it is on the DPW Preferred Drug List (PDL) or on the Medical Assistance managed care plans formularies. Occasionally, however, DPW's PDL lists a brand name drug as "preferred" over a generic. This is because, in certain situations, a brand name drug company will offer to sell the brand name drug to the state at a lower price than the generic. Because the drugs are equivalent, Pennsylvania will choose the better price and put the brand name on the PDL as the preferred medication.

In the past, pharmacists sometimes incorrectly denied consumers these brand name drugs insisting that a generic had to be substituted (because PA has a mandatory substitution law). This issue was raised by the consumer representatives on DPW's Pharmacy and Therapeutics Committee and by PHLP. We are happy to report that DPW has been able to adjust its computer message to pharmacists. From now on, when a brand name is "preferred" over a generic on the PDL, pharmacists will see this on the computer and consumers should not be denied a medication at the pharmacy in this situation.

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What else is important to know about the Competitive Bidding Program ?

- This new program only impacts certain durable medical equipment and supplies that are listed above; it does not affect the doctors, hospitals, or other healthcare providers an individual can see.
- Medicare-contracted DMEPOS suppliers may not charge more than the 20% coinsurance (and any applicable Part B deductible).
- If someone has insurance primary to Medicare (for example, if someone is still working and receiving coverage through their employer, this coverage may be primary to Medicare) and that primary insurance requires that they use a non-contracted supplier, Medicare may still pay its share for equipment and supplies as long as the supplier meets Medicare standards.
- If a person travels to a non-Competitive Bidding Area and needs any of the items listed above, she can use any Medicare supplier (even if she lives in a CBA).
- If someone has been receiving equipment or supplies from a non-contracted supplier, they may be able to stay with the supplier and continue receiving those items (if the supplier decides to be a grandfathered contractor).
- If someone owns equipment purchased before July 1, 2008, they can use any Medicare-approved supplier for repairs or replacement parts.

Medicare will be notifying beneficiaries living in the Pittsburgh CBA about the changes via mail in June. In addition, a statement about the Competitive Bidding Program will be included in the Medicare Summary Notices beneficiaries receive for months in which they have received healthcare services billed to Medicare. If you have any questions about these changes, please contact our HELPLINE at 1-800-274-3258 (voice) or 1-866-236-6310 (TTY).

SPBP for Individuals with Schizophrenia Has Funding That Must Be Spent By June 30, 2008

The Special Pharmaceutical Benefits Program (SPBP) for individuals diagnosed with schizophrenia and in need of atypical antipsychotic medications currently has funding that must be spent by June 30, 2008 (the end of the state's fiscal year). The SPBP Program for mental health drugs is funded entirely through state funds. The Program will continue into the next fiscal year but unspent funds for this year will not be carried over. Because of this, we wanted to remind people about what SPBP covers and how to qualify in case you or someone you work with could benefit from the program.

The Department of Public Welfare's Office of Mental Health and Substance Abuse Services (OMHSAS) provides qualifying individuals with certain medications for the treatment of schizophrenia . The only medications currently covered by SPBP for people with schizophrenia are: Abilify, Clozaril, Clozapine, Geodon, Risperdal, Seroquel and Zyprexa. The SPBP also covers Clozaril Support Services.

To be eligible for SPBP for atypical antipsychotics, an individual must:

- Be a resident of Pennsylvania;
- **NOT** be on Medical Assistance;
- Have an annual income of $30,000 or less (plus $2,480 for each additional family member); and
- Have a diagnosis of schizophrenia.

For persons enrolled in Medicare Part D, the SPBP may help pay their Part D plan premium (depending on which plan they are enrolled in). In addition, SPBP helps with the Part D co-payments and deductibles for the medications listed above. SPBP will also cover the above medications for those with Medicare Part D if they hit the "donut hole". Individuals who are eligible for Medicare Part D, but who have not yet enrolled, will get a Special Election Period to join Part D if they are approved for SPBP.

For an application or more information on the Special Pharmaceutical Benefits Program, go to: www.dpw.state.pa.us/ServicesPrograms/MentalHealthSubstanceAbuse. ***Be sure to select the application for atypical antipsychotics since there is also an application online for the SPBP for individuals with HIV/AIDS.***

Mail the completed application with copies of documentation of income, Social Security card, proof of residence, and a prescription for one of the above medications with DSM IV diagnosis of schizophrenia including ICD-9-CM written on the prescription to:

Department of Public Welfare
SPBP MH
P.O. Box 2675
Beechmont Building #32
Harrisburg, PA 17105

If you have questions or need assistance completing the application, call 1-877-356-5355. Applications are usually processed in 7-10 days. For faster processing, fax the application with documentation to ATTN: SPBP MH at 717-772-7964.

Review of Dual Eligible Billing Protections

In recent months, PHLP has gotten a high volume of calls to our Helpline from dual eligibles (people who get both Medicare and Medical Assistance (MA)) with medical billing problems. Therefore, we wanted to review the dual eligible protections included in the law to help consumers and their family members avoid and/or resolve billing problems and prevent them from making unnecessary payments to providers.

First and foremost, it is against the law for a Medicare provider to bill a dual eligible for Medicare cost-sharing. This is true even if the Medicare provider does not accept Medical Assistance. All dual eligible consumers need to show their ACCESS card along with their Medicare card (either the red, white, and blue card or a Medicare managed care plan identification card) ***each time*** they receive services. The ACCESS card that dual eligibles will show to the providers will either be yellow (if they only get Medical Assistance) or green (if they get food stamp benefits in addition to their Medical Assistance). A provider can refuse to treat an individual if the provider does not want to take the ACCESS card; however, if the provider treats the individual, he cannot bill her for ***any*** Medicare cost-sharing. Providers are not allowed to accept dual eligibles as "private pay" in order to bill the consumer directly.

Any Medicare provider can register with the state to be a MA provider. In that case, the provider bills Medicare (or a Medicare managed care plan like a Special Needs Plan) first and then bills any remaining balance to Medical Assistance (MA). MA is always the payer of last resort, which means that after the provider bills Medicare, MA can cover any amounts not covered by Medicare, such as deductibles and co-insurances normally charged to Medicare consumers who do not have any other insurance.

Providers must accept payment from MA as payment in full. In general, MA pays up to the applicable MA fee schedule amount for the particular service provided. That means Medicare providers may not receive payment from MA for the entire amount of Medicare cost-sharing from MA. Sometimes, the provider may receive no additional payment from MA beyond what Medicare paid. Nonetheless, providers cannot bill dual eligibles for any of the Medicare cost-sharing or any remaining balance (this is called "balance billing" and it is not allowed). Providers who bill dual eligibles for the Medicare cost-sharing are subject to federal sanctions.

Dual eligibles who receive a bill from a provider for their Medicare cost-sharing should call or write a letter to the provider to make sure that the provider has their correct insurance information on file. They should tell the provider to bill MA for any Medicare cost-sharing if they have not yet done so and give the provider their Recipient Identification number from the ACCESS card if needed. Dual eligibles who are having billing problems can call the PHLP's Helpline at 1-800-274-3258 or 1-866-236-6310 (TTY) for assistance.

PHLP staff are available in Southeastern PA to conduct trainings on Medicare 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 Medicare 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 visual impairments.

Stories of the Uninsured

Beginning this month, the Health Law News will include a regular feature of stories about the uninsured. As part of PHLP's Refer the Uninsured Project (originally discussed in our July 2007 newsletter), we have been: counseling uninsured and underinsured individuals who call our HELPLINE; representing individuals who have been wrongly denied publicly funded health programs; and helping to raise the visibility of the uninsured in the public eye.

Clara's Story

"This is how they treat you, at your age, after Daddy worked all his life?" That's what Clara's grown daughter said, in disbelief, as she tried to help her find health insurance by going on the Internet and giving her numbers to call.

Clara was a homemaker, raising two children in the Kensington neighborhood of Philadelphia. Her husband worked for the City of Philadelphia. In February of 2006, he was diagnosed with cancer. By January 2007, he had passed away. In February of 2007, Clara, age 61, no longer had health insurance through her husband. She was living on $1,000/month survivor's benefits from her husband's Social Security.

Her college-educated daughter tried to help her find insurance. Clara called Independence Blue Cross, Aetna, and other local insurers. She never even got to the point of finding out if they would have accepted her or covered her pre-existing conditions because all the plans she could find cost more than half of her monthly income. She couldn't afford the coverage and still buy food and pay her gas and electric bills.

She tried to continue to take care of herself. "I found a place that was giving free mammograms. I went, but I was totally embarrassed, because all my life I had insurance." Clara was lucky because her physician of 40 years was willing to continue to see her. However, she didn't want to see him when she didn't have health insurance, so she put off going to the doctor even when she didn't feel well. When she did see her doctor, he wanted to order diagnostic tests; but, they agreed together that she couldn't afford them.

Clara saw her biggest need as prescription coverage. She has degenerative arthritis "all over my body" but medications to help the pain upset her stomach. Even over-the-counter medications to treat these conditions are costly. She went into a depression after her husband's death and her physician gave her medication samples that helped, but she couldn't afford to continue the medications. Her cholesterol is high, but that too remains untreated because she can't afford the medications.

Clara called the Pennsylvania Health Law Project for help. PHLP staff referred her to the adultBasic health insurance program and to patient assistance programs for her medications. At the time she applied for adultBasic in the spring of 2007, the program had a waiting list of 85,000. Most persons have a wait of 12 months before they are able to purchase the adultBasic insurance at the subsidized rate of $33/month. Clara was too afraid to continue to go without any insurance, so she chose to purchase adultBasic at its full cost of $305/month, despite the hardship this imposed – spending 1/3 of her monthly income on health insurance that does not include any prescription coverage!

Clara keeps busy. She is a giving person. She is a committeewoman for her area, and works with Aid for Friends, an organization that helps older persons who cannot leave their homes. She volunteers with her church. She never thought, before it happened, that her husband's unexpected death would leave her without health insurance. Now she knows it can happen to anyone.

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Tracy and Vito's Story

Tracy and Vito thought they had done everything right. Vito ran a small business – he owned a restaurant in Northampton County, Pennsylvania. Despite the cost for small businesses, he provided health insurance for himself and his employees because once he and his wife decided to have a family, he knew it was too risky to go without. He worked 80 hours/week in the restaurant business. His wife worked outside the home only part-time- 38 hours per week – in order to care for their three children under age 6. Her company did not offer her health benefits.

Vito became sick with a mysterious illness finally diagnosed as leukemia. "We had $20,000 worth of medical bills before they knew what was wrong with him," Tracy remembers. He required chemotherapy, and he could no longer work full time. The contract his health insurer had with his business required that he be employed full-time. As a result, he lost his health insurance and so did his wife and children.

His health care needs forced Tracy to leave her job combining serious financial problems with their lack of health insurance. "We sold everything but our house and minivan," Tracy recounts. This was the first time Tracy called PHLP desperate for health coverage for her critically ill husband, herself and her children. Lawyers at PHLP determined that Vito was eligible for MAWD, or Medical Assistance for Workers with Disabilities, and that Tracy and the children were also eligible for Medicaid.

Vito died in January 2007. Two weeks later, Tracy received notice that her husband was approved for Medicare, following the required two year waiting period after receiving cash benefits from Social Security disability. That was two years too late for Vito. But neither Tracey's story, nor the health insurance story, ends here.

Two months later, Tracy developed chest pain while picking up her children from school. By the evening, she felt extremely dizzy and as though someone was standing on her chest. She was admitted to the hospital with a diagnosis of a blood clot to her lungs. Tracy believed she and her children were still covered through Medical Assistance. However, hospital staff informed her that she no longer had health insurance. She already had stacks of unpaid medical bills as well as funeral costs to cover. Fearful of increasing medical bills, she left the hospital against medical advice.

Tracy lost health insurance the first time because her husband could no longer work full time. She lost health insurance the second time because her Social Security survivor benefits of $2,700/month for her family of four put her over the income limit for Medical Assistance.

Tracy found out she had a heart condition and a possible blood disorder. She began paying for medications and an MRI with her credit card. She left an emergency room against medical advice because she could not afford another hospitalization. She tried to buy health insurance but was denied because of pre-existing conditions. Requiring frequent blood tests and visits to specialists at a university hospital, Tracy remained uninsured. This was the second time Tracy called PHLP. Lawyers helped Tracy qualify for Medical Assistance under a program where each month, if her medical bills are over $2500, she gets insurance to pay for the excess. But unpredictable medical expenses do not offer much security.

Tracy's three daughters are now all old enough to be in school. She has returned to work full-time for the same small business. This time, with Tracy's insurance troubles known to her employer, the employer chose to offer health insurance to his employees. The insurance is expensive for a widow with three children, but for the first time in two years, Tracy can breathe easier that no member of her family is uninsured. She hopes she can continue to afford the plan.

DPW Agrees to Expedited Fair Hearing Process If Pharmacy Carve-Out Goes Forward

As we previously reported in our March Newsletter, DPW is proposing to carve-out responsibility for prescription drugs from the Medical Assistance managed care plans and instead administer this benefit under the MA fee-for-service program. DPW plans to implement the change beginning in January 2009 and apply it first in the HealthChoices program in the SE and Lehigh/Capital zones as well as in the newly proposed Northwest Health Choices Plus zone (also discussed in the March newsletter and available at www.phlp.org).

One of the concerns that the Consumer Subcommittee of the Medical Assistance Advisory Committee raised regarding the carve-out was how it would impact affected consumers' appeal rights. Currently, when a HealthChoices Plan declines to cover a prescription medication, the consumer has a right to a quick appeal process from the Plan (who has to decide a grievance within 30 days) as well as a right to an expedited grievance and/or DPW Fair Hearing (with a decision in 72 hours) if their doctor verifies the consumer's life, health or functioning would be jeopardized if they had to wait longer for a decision. However, if prescription medications are instead handled by DPW through the MA fee-for-service system, the only appeal mechanism now available under that system is the normal Fair Hearing process where consumers can wait up to 90 days for a decision. The consumers urged the Department not to go forward with the pharmacy carve-out unless it established an appeal process that was similar to the process currently provided by MA managed care plans and that could be expedited depending on the urgency of the situation.

At the May 2008 Consumer Subcommittee meeting, DPW agreed to address the consumers' concerns. The Department provided a written proposal to create a grievance and fair hearing process that mirrors that of the MA managed care plans. It provides consumers affected by the carve-out with both a grievance process for DPW review of a medication denial as well as an expedited DPW Fair Hearing process for pharmacy services.

DPW intends to go forward with the pharmacy carve-out (and the proposed pharmacy services appeals process) unless the legislature intervenes to prevent the carve-out during the budget negotiation process. Stay tuned to our future Newsletters for updates on this matter.

Do you currently get the Health Law PA News through the mail? Would you like to get this newsletter by e-mail?

If so, contact staff@phlp.org to change the way you get the Health Law PA News!

The Pennsylvania Waiting List Campaign

As of March 2008, there are 21,225 people across PA waiting for waivers and other services through the Mental Retardation system. The Pennsylvania Waiting List Campaign is comprised of people with disabilities, parents, family members and providers whose purpose is to end the Waiting List for persons who are served by the Pennsylvania Office of Developmental Programs. Every year, 800 students with mental retardation graduate from school in need of services and supports to move on to the next phase of their lives. Thousands of adults with mental retardation live with aging parents who are less able to care for their loved one and more likely to need care for themselves.

The PA Waiting List Campaign is working to ensure access to care for all Pennsylvanians with mental retardation. The Campaign has an active website providing information on resources, facts and updates, as well as, state, county and legislative contacts. The website also includes an advocacy tool kit, letter writing tips and creative ideas for meeting with legislators. To review the website in its entirety, log on to www.pawaitinglistcampaign.org.

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