Health Law PA News

Newsletter of the Pennsylvania Health Law Project

Harrisburg Philadelphia Pittsburgh

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Update on Final DPW 08-09 Budget-Challenges Ahead

The current Fiscal Year (FY) 2008-09 budget that passed in July contained no cuts to Medical Assistance (MA) enrollment or services. Yet, DPW failed to get legislative approval for its proposed pharmacy carve out, a major cost-saving initiative that was designed to put the Department in an improved fiscal position to face the anticipated challenges in future budgets due to a decline in state tax revenues and an uncertain national economic outlook. Contributing to the fiscal challenges ahead is the fact that several federal funding streams have been cut off at a time when health care costs and MA enrollment have been growing exponentially.

Although the outlook for FY 2009-10 and beyond is uncertain, the current budget represents an ongoing commitment to DPW's "Core Principles" outlined as (1) No one currently receiving services will lose eligibility; (2) Children will not experience any reduction in services; (3) Pennsylvania will provide coverage for the growing number of vulnerable individuals and families that need assistance. The current MA budget anticipated an increase in eligibility; DPW expects MA to serve 1.96 million consumers by the end of this fiscal year. Here is a re-cap of a few initiatives that were incorporated into this year's budget:

- New autism legislation mandates private insurers to provide coverage for diagnosis and treatment of Autism Spectrum Disorders (up to $36,000 per year) for children under 21.
- Enhancement of managed care quality and access initiatives, such as a revision of network adequacy standards to improve access.
- Improvement of care coordination and continued focus on community-based care management.
- Refinement of pharmacy services, such as preauthorization of early refill requests and refining prior authorization requirements based on changing health and safety standards.
- Increased funding for Home and Community Based Services Waiver programs to allow for the addition of 2,100 Aging Waiver slots and 1,500 slots for Waiver programs serving adults with physical disabilities.

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Several of DPW's proposed initiatives were **not enacted.** They include:

- Department of Public Welfare's Management of pharmacy benefit ("carve out");
- The addition of a pharmacy benefit for Medically Needy Only (MNO) recipients; and
- Creation of Health Choices Plus Zone in Northwestern and Central PA.

More detail about the initiatives that were included in the proposed budget but that did not make it into the final budget can be found in our March 2008 edition of this newsletter available on www.phlp.org.

PHLP Submits Comments on Responsible Pharmacy Administration

The Department of Public Welfare (DPW) failed to implement a "pharmacy carve out" in this year's budget as discussed in the previous article. The pharmacy carve out would have taken the pharmacy benefit away from the Pennsylvania's Medical Assistance (MA) managed care organizations (MCOs) and would have had DPW administer this benefit for all MA recipients. Since this did not happen, DPW invited Medical Assistance consumers to provide comments on how to improve the MCO pharmacy benefit.

On behalf of the Consumer Subcommittee of the Medical Assistance Advisory Committee, PHLP submitted comments with suggestions designed to improve the MCO pharmacy experience for consumers. All too often, consumers have difficulty when their MCO denies a medication particularly in navigating the system to try and get their medication covered. PHLP's comments make numerous suggestions to make the process more open, understandable, and easier for consumers.

For example, PHLP recommended that DPW require MCOs to openly and clearly explain the status of drugs covered on their medications lists called "formularies". This way, consumers and their doctors can be sure to know which medication are likely to be covered at the pharmacy and which others will need extra documentation submitted by the doctor in order to be approved. PHLP also recommended that MCOs be required to have a more open and inclusive process, with consumer involvement, for creating and managing their drug formularies. This will help consumers understand why certain drugs are not on the formulary, how the formulary is used, and how to request exceptions.

Another recommendation made to DPW was that MCOs be required to provide regular public reports about what drugs they are denying and with what frequency. PHLP believes this public accountability will lead to more transparent decisions about coverage. Finally, PHLP recommended that the MCOs be required to do more to analyze their pharmacy data and assure the safest possible prescribing practices are followed. PHLP believes that all of these suggestions will lead to a more open and consumer-friendly pharmacy experience, and ultimately, better health outcomes for MA consumers. Stay tuned to future newsletters for updates about any changes made to MCO pharmacy administration as a result of these and other comments submitted to DPW.

Thousands of Consumers Impacted by KMHP Contract Termination with Temple University Physicians

Members of Keystone Mercy Health Plan (KMHP) who have a primary care physician or who see a specialist at Temple University Physicians (TUP) are advised that KMHP and TUP have terminated their contract effective September 1, 2008. This means that Medicaid consumers enrolled in KMHP who were receiving care from a primary care physician (PCP) or a specialist at TUP must change their health plan if they want to continue to see their TUP physician OR select a new PCP/specialist within the KMHP plan network. This contract termination affects 15,586 KMHP members who were using TUP physicians. Of these, approximately 7,742 had a PCP at TUP.

Temple University Physicians (TUP) is a group of 54 PCPs and 300 Specialists. It consists of full-time and part-time faculty members of the Temple University School of Medicine. *Please note that Temple Hospital (TH) and Temple Physicians Inc. (TPI) are separate from TUP. KMHP members with doctors at TH and/or TPI can continue to see those providers at this time. TH and TPI are still in negotiations with KMHP and have extended their contract to November 30, 2008.*

PHLP is concerned that consumers did not receive adequate notice from KMHP or the Department of Public Welfare about this contract termination. KMHP sent out a letter dated July 28, 2008 to its members who have PCPs or specialists at Temple University. The notice includes a list of TUP physicians who would no longer take KMHP effective September 1, 2008. The letter told members that if they had a PCP at TUP they had until August 15, 2008 to contact the Plan and pick a new PCP. If consumers did not respond, KMHP chose a new PCP within the plan for the member. Members who were using TUP specialists were told to consult with their PCP and choose another specialist in the KMHP network.

The Keystone Mercy notices did not adequately explain that a consumer had a choice other than changing doctors. It was only on the second page of the letter that members were told they could change health plans if they wanted to stay with their current PCP or specialists. Consumers who want to continue to receive care from their TUP PCP or specialist should check with these physicians to see if they take Health Partners and/or AmeriChoice. If someone decides to change health plans to keep her PCP and/or specialists, she should call the Health Choices Hotline to make this change immediately to ensure that it is effective November 1, 2008. The number is 1-800-440-3989 (1-800-618-4225/TTY).

PHLP recently learned that approximately 1,150 consumers impacted by this contract termination picked a new Keystone Mercy PCP. Another 1,200 consumers changed to another health plan while 5,400 consumers were auto-assigned by KMHP to a new PCP via a letter dated August 18, 2008.

Consumers who decide to remain in KMHP should know that they have a right to continue seeing their TUP physicians so that they can have continuity of care, to receive services that were prior authorized, and to continue an ongoing course of treatment for 60 more days (until November 1, 2008). 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 TUP physician beyond this 60 day period and, in some cases, through postpartum care.

PHLP continues to advocate with the Department of Public Welfare to ensure that consumers transition properly to a new doctor or a new plan, and in the meantime, continue to receive all medically necessary treatments. Please call our helpline at 1-800-274-3258 or 1-866-236-6310 (TTY) if you are having problems accessing care or services because of this major contract termination.

DPW Increases EPSDT Fees and Requirements

Effective September 1, 2008, the Department of Public Welfare increased fees for all EPSDT* well-child visits in the Medical Assistance Fee-for-Service system. The new fees range from $80 to $125, a substantial increase from the $65 previously paid for all well-baby and well-child visits. The new fee increases recognize the different elements required for each age-related visit with the largest fee for the child's 18-month visit.

Accompanying the fee increases are new requirements for "developmental surveillance" (observing children over time to determine whether they are at risk for developmental delays), psychosocial and behavioral assessments at each visit, and structured developmental screenings at the 9 month, 18 month and 30 month visits. A requirement for autism screening has been added to the 18 and 24 month visits. There are also new requirements for metabolic screening for newborns, dental risk assessment or referral, anemia screening, cholesterol screening for youth over 18 years old, and alcohol and drug risk assessments for those over 11 years old. These new screening requirements apply to all MA providers who see recipients in MA Fee-For-Service as well as MA Managed Care.

There is overwhelming evidence that identifying and addressing a child's needs early in life yields substantial gains for the child, the family and the community at large. Research shows that using a scientifically validated developmental screening tool can improve early identification dramatically. Screening improved the identification of developmental problems from 30% without a tool to 70-80% with a tool and identification of behavioral health issues from 20% without a tool to 80-90% with a tool.

However, a survey conducted by PHLP's Room to Grow project (previously discussed in our September 2007 newsletter) shows that only about 1 in 5 pediatricians responding to the survey uses a scientifically validated developmental screening tool for well-baby/well-child visits. In the Medical Assistance bulletin announcing the new fees and new requirements, DPW does not include a definition of the structured developmental screening or a list of recommended screening tools, leaving the providers to make their own choices. To view the MA bulletin, go to: http://www.dpw.state.pa.us/PubsFormsReports/NewslettersBulletins/003673169.aspx?BulletinId=4391.

To ensure high quality care, defining the structured developmental screening will be a critical task. Other states (Connecticut, Iowa, Illinois, North Carolina, and Minnesota) define the requirements for developmental screening in their provider manuals and/or billing procedures. Through comments to the PA Bulletin, policy and state budget recommendations, PHLP will urge the Office of Medical Assistance Programs to implement similar standards of care both for the fee-for-service system and for the managed care plans.

Stay tuned to future newsletters for updates about the Room to Grow project and its work.

* Early and Periodic Screening, Diagnosis and Treatment (otherwise known as "EPSDT") is a federal mandate that applies to all MA recipients under the age of 21. Under EPSDT, all children on MA are entitled to regular screenings and check-ups to identify health and developmental problems. EPSDT goes on to require that these children get all "medically necessary" services and treatment for any problems or conditions identified.

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Consumer Subcommittee Works to Improve ACCESS Plus

We reported in our July Newsletter that the Department of Public Welfare released a Draft Request for Proposal (RFP) seeking comments regarding the operation of the ACCESS Plus Program. The current contract (held by McKesson Health Solutions) expires on June 31, 2009 and DPW intends to release its final RFP this Fall seeking bids from companies interested in getting the ACCESS Plus contract.

PHLP submitted comments to the Draft RFP on behalf of the Consumer Subcommittee of the state's Medical Assistance Advisory Committee. We are happy to report that DPW agreed to almost all of the Subcommittee's comments and recommendations and will incorporate them into the final RFP document.

Regional Advisory Committees

The Access Plus Program has a Regional Advisory Committee in each of its four regions that meets quarterly to discuss issues regarding how the Program is run. The Consumer Subcommittee has been urging the Department to increase consumer participation in the Committees (known as RACs) and to enhance the role of the RACs. To that end, DPW agreed to the following changes in the RFP:

- All bidders must describe how they will provide information to the RACs, solicit their input and incorporate their feedback into the running of the ACCESS Plus Program;
- All bidders must identify how they will recruit and increase consumer participation in the RACs;
- The Contractor (whoever wins the bid) must seek input from the RACs in developing and implementing any Consumer Incentive programs and provide regular updates to the RACs on these programs; and
- The Contractor must ask the RAC for feedback and recommendations prior to proposing any Program Innovations for funding by DPW.

Integrating and Coordinating Behavioral Health Services

Though the ACCESS Plus Program only delivers physical health services to MA recipients, the Consumer Subcommittee agrees with DPW's efforts to improve the coordination of physical health services and any behavioral health services consumers may need. The Subcommittee made additional suggestions to strengthen this section of the RFP which DPW agreed to:

- All bidders must describe how they would ensure Primary Care Practitioners (PCPs) are ident-

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PHLP Welcomes New Staff Attorney

Earlier this month, PHLP welcomed Kyle Fisher as a new staff attorney in our Philadelphia office. Kyle is funded by the Skadden Fellowship Foundation to provide direct representation to low-income veterans having difficulty accessing health care in the Veterans Hospital Administration (VHA). This work will include advice, advocacy and/or representation in appeals of eligibility denials and possibly appeals of delays in the provision of care. As part of this project, Kyle will be creating community education materials, conducting outreach, and providing trainings in Southeastern PA on appeals within the VHA system. If you know of a low-income veteran in Pennsylvania having problems accessing healthcare, please contact our HELPLINE at 1-800-274-3258 or e-mail Kyle at kfisher@phlp.org.

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-ifying substance abuse as well as mental health problems, how they would coordinate care for both types of conditions, and how they would follow up to assure consumers were able to access BH providers/services;
- To coordinate care the Contractor must collaborate not just with BH-MCOs but also with county MH offices and Single County Authorities (SCAs run the county D & A programs);
- The contractor must include in its agreements with PCPs all requirements imposed on the PCPs to identify BH issues and to respond to behavioral health issues of their patients; and
- Care coordination for BH issues must specifically include informing consumers about the Medical Assistance Transportation Program and helping them access those services.

Enrollees With Special Needs

To ensure that consumers who have special needs or who are at "high risk" are well served by the ACCESS Plus Program, DPW agreed with the Consumer Subcommittee that:

- All bidders must describe how they would identify and outreach to consumers with special needs as well describe what process they would use to refer the consumers to DPW's Intensive Case Management Unit;
- The Contractor must make all written materials available in alternative formats like Braille, large print, etc; and
- Clarification be provided in the following areas: defining "high risk enrollees" and special needs enrollees; outlining the responsibilities of the Call Center staff to assist each group; and explaining how, and by whom, care management is provided.

PCP Provider Network

The Consumer Subcommittee is very supportive of DPW's efforts to assure the adequacy of the ACCESS Plus PCP Provider network, including establishing access standards that mirror those used by HealthChoices (a choice of at least 2 PCPs within a travel time of 30 minutes/urban areas; 60 minutes/ rural areas). In addition, DPW agreed with the Consumers that:

- The Contractor must keep a record of whether or not PCP offices are accessible and provide that information to enrollees with accessibility needs as well as to Call Center staff;
- PCPs whose patients are consistently going over the 18 visit limit would be identified and targeted information and education will be provided to the PCPs to address this matter.

Recruiting Specialists and Dentists

The Consumer Subcommittee applauds the Department's proposal to have the ACCESS Plus contractor outreach to specialists and dentists and recruit them to serve ACCESS Plus as well as MA Fee-For-Service (FFS) consumers. Building on this, this Consumers recommended, and the Department agreed, that:

- When identifying dentists and specialists willing to accept MA, the contractor should track whether the dentists are willing to accept FFS patients (i.e. dual eligibles) as well as those on ACCESS Plus and share that information with DPW;
- The Specialist and Dentist Database should be updated monthly and the Databse should be shared with the Department to use in updating MA Call Center staff and MA Cares representatives at CAOs to provide MA consumers seeking help identifying local providers with up-to-date information;
- When identifying those who use Emergency Rooms on a regular basis to obtain dental care, the Contractor should also find out the reasons the consumer is using the ER, record any barriers the consumer has experienced trying to access services from dental offices, and share that information with DPW; and
- The Contractor will be required to assist consumers with accessing dental services even if dental services are not included in the person's MA benefit package (i.e. refer them to Community Health Clinics or other free or low cost dental programs).

DPW plans to issue the final ACCESS Plus RFP in October and choose a contractor early next year for the new contract to go into effect July 1st 2009.

Money Follows the Person Now Underway

As of July 1, 2008, certain individuals who have lived in an institution for six months or longer have the option to receive services and supports in a home and community based setting under the Money Follows the Person (MFP) program. During this initiative, 2,667 qualified individuals are expected to transition from an institutional setting to the community. This program is a joint effort of the Office of Mental Health and Substance Abuse Services (OMHSAS), the Office of Developmental Programs (ODP) and the Office of Long-Term Living (OLTL).

MFP is a federal initiative aimed at rebalancing the long-term care system and giving older adults, people with physical disabilities, people with mental retardation and developmental disabilities, and people with mental illness who have been living in certain types of institutions (see below) a choice of where they live and receive support services. PA hopes this initiative helps move the state closer to its goal of spending 50% of Medical Assistance funds on institutional care and 50% of those funds on home and community based services (currently, the state spends 80% of MA dollars to fund institutional care and 20% to fund HCBS).

Under this initiative, the state gets additional monies from the federal government to fund several of its Home and Community Based Services (HCBS) waiver programs. The state receives enhanced payments for the HCBS programs for 12 months after the qualified person transitions out of the institution and back to the community. One of the goals of the MFP program is to eliminate some of the barriers in the HCBS system by addressing areas such as personal assistance services, direct service worker shortages, transitions from institutions to the community, respite service for caregivers and family members, better transportation options, and quality assurance.

To be eligible for services under Money Follows the Person, individuals must:

- be residing in a nursing facility, an Intermediate Care Facility for the Mentally Retarded (ICF/MR), or a state hospital for at least six months;
- be receiving Medical Assistance benefits for at least 30 days prior to their discharge from the institution;
- be transitioning to a “qualified residence” that is either (1) a home owned or leased by the participant or her family member (2) an apartment with an individual lease or (3) a community-based residential setting (i.e., group home) with four or fewer unrelated people living there; and
- be eligible for services under one of the following waiver programs: Aging, Consolidated, Attendant Care, OBRA, Commcare, or Independence.

To get more information about Money Follows the Person, contact the Long Term Living Helpline at 1-866-286-3636 from 8:00 am-8:00 pm Monday-Friday or go to the Office of Long Term Living website, www.LTLinPa.com.

Gearing Up for Medicare Part D in 2009!

It’s that time of year again when Medicare is gearing up for the Annual Open Enrollment Period starting November 15, 2008 when all Medicare beneficiaries can change their Medicare Health Plans and their Medicare Part D plans. Over the upcoming weeks and months, all Medicare consumers will be receiving lots of information about Part D in 2009. Many dual eligibles will be receiving colored notices about whether they will have any changes in their situation (i.e., changes to their eligibility for the low-income subsidy, whether Medicare is going to be changing their Part D plan). Our October Senior Health News will have detailed information about the different mailings people will receive and what people need to know before the Open Enrollment Period starts on November 15, 2008. If you want to be added to the Senior Health Newsletter mailing list, please call our HELPLINE at 1-800-274-3258 or 1-866-236-6310 (TTY) or e-mail us at staff@phlp.org.

Stories of the Uninsured

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

Barbara's Story

Barbara knows about trying to take care of herself. Even though she has a full time job caring for a husband who is chronically mentally ill, she knows about preventive health care. She just paid $25 to get a flu shot. Last year, she managed to get a mammogram for free at a special screening program. At age 59, she knows she is supposed to have a mammogram every year. She also knows that having a colonoscopy to look for colon cancer is recommended. But no one is offering free colonoscopies, and the cost is a barrier.

Barbara doesn't have health insurance. It is not only preventive care that Barbara can't get. She lives in fear of becoming ill. She hasn't had health insurance for the last several years, not since the company that formerly employed her husband changed hands and stopped offering health insurance to workers' dependents. When she first lost insurance, she called Blue Cross to try to buy it. "I just couldn't afford it," she said. They wanted at least $200-$300 per month. "And besides, I had pre-existing conditions. I've had depression, and fibromyalgia, and an underactive thyroid. Everybody told me they wouldn't cover those." Her disabled husband is insured through Medicare and also is a Vietnam veteran. However, because he worked for many years, his disability income, though small, puts the family income above the limits to qualify for public insurance programs.

Barbara pays $25 per month to be seen at a community mental health clinic. When samples are available, she gets free samples of a medication that otherwise would cost her $125/month, more than she can afford. Her other medications she gets for $4 under Wal-Mart's generic plan.

In the summer of 2007, she developed a rash on her arm, with pain "right down to the bone." She went to the emergency room where she was told she had a spider bite and an infection called cellulitis. She is recovered from the infection, but she hasn't been able to pay the hospital. She is being threatened with collection. She does have a doctor who she tries to see to follow-up on her thyroid blood tests and medications. In order to do that, she must have the $40 to see the doctor and additional money for the blood test. To add to these financial worries, Barbara lives in rural Armstrong county where travel distances are long and gas costs are increasing.

Barbara would like to be able to see a doctor when she doesn't feel well. She is ignoring a persistent cough and hoping that it will go away. She would like to be able to see a physical therapist for her fibromyalgia. She would like to be able to take care of herself properly with a primary care doctor and preventive care. She would like to buy health insurance that she could afford and that would cover her as she is without concern about pre-existing conditions. She knows that stress contributes to her medical conditions. She would like the stress of being uninsured to go away. She would like the opportunity to be healthy and stay healthy.

Ruth's Story

"We don't want people working here who have health problems," Ruth said she was told when applying for jobs. Ruth is 21-years old, and except for a few months here and there, hasn't had health insurance since she left her parents home at age 17.

It isn't for lack of working or lack of trying. In the past, she worked at Starbucks for a while and had insurance. She also worked at an advertising agency and at a major Philadelphia university. At both of those jobs, health insurance was available only after six months on the job. Her

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chronic headaches were not controlled and she ended up missing work from time to time. She lost each of those jobs just before she was eligible for health insurance.

At her last job, working in an after-school program, she had health insurance after three months on the job. She was able to see a physician for her chronic headaches and get a CAT scan. She was prescribed medication for migraines that helped control the headaches and greatly improved her functioning. Then, the after-school program closed. She was offered a continuation of the insurance under COBRA, but the cost was $400 per month. Ruth did not have $400 per month to spend on health insurance.

She called her former doctors and told them she had lost her insurance. She was told they could not continue to treat her.

Ruth's next job was as a nanny. Naturally, this job did not come with health insurance.

Ruth is now on unemployment, looking for her next job, and hoping it has benefits. Her migraines have been controlled with medication, but she is running out of her supply that she obtained when she had a doctor and prescription coverage. Without medication, and without a physician's help managing her headaches, Ruth is worried about her ability to find work. And without work, she has no money to pay for medications or doctors.

Ruth called the Pennsylvania Health Law Project for help. She applied for adultBasic Insurance in January 2008, aware that the coverage is limited and that there are thousands of people ahead of her on the waiting list.

Assisted Living Update

The Department of Public Welfare issued proposed regulations for Assisted Living Residences in August. Public comments were due September 15, 2008. The proposed regulations and comments submitted can be viewed at http://www.irrc.state.pa.us/Regulations/ (Regulation #14-514). PHLP, as lead agency for the PA Assisted Living Consumer Alliance, submitted extensive comments to the regulations. These can be found on the www.paassistedlivingconsumeralliance.org website (click on "regulations" in the left margin).

The General Assembly and the Independent Regulatory Review Commission have until October 15th to submit their comments to DPW. As part of its review of the regulations, the House Aging and Older Adult Services Committee held a hearing on September 18, 2008. PHLP and several other members of the PA Assisted Living Consumer Alliance (PALCA) testified at this hearing about their concerns.

Although the formal proposed regulations comment period is over, concerns can still be raised with the General Assembly or specifically with the House Aging and Older Adult Services Committee Members or with the Senate Health and Welfare Committee Members.

Beginning October 15, DPW will review all comments received and work to finalize the regulations. For additional information about the proposed regulations and other news about Assisted Living in PA, please see the PALCA website (www.paassistedlivingconsumeralliance.org) or contact Alissa Halperin at ahalperin@phlp.org.

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 hearing and/or visual impairments.

New Long Term Living Website Up and Running!

The Office of Long-Term Living (OLTL) has launched a new website with the goal of educating consumers, caregivers, family members, attendants, and providers about long-term living options in Pennsylvania. The new Website, www.LTLinPA.com replaces the old www.longtermcare.state.pa.us site. The new Website provides quick access to information about the many long-term living services and planning resources available throughout Pennsylvania. Web users can use the "site feedback" portion at the bottom of the Website to provide comments or suggestions for improvement. For more information about long-term living services available in PA, call th**e** Long Term Living Helpline (1-866-286-3636) from 8:00 am-8:00 pm Monday through Friday.

If you are having problems getting information about Home and Community Based Services Waiver programs, problems with the application and enrollment process, or problems accessing services once the Waiver has been approved, please call our HELPLINE at 1-800-274-3258 or 1-866-236-6310 (TTY).

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