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 6 November 2008

State Agencies Cut Budgets, More Cuts Predicted

As the economy goes into recession, people buy less and business revenues decline. Since a significant portion of the State's revenue comes from sales taxes and taxes on business revenues, when consumers buy less, sales tax revenues decline as do revenues from business taxes. The current Pennsylvania 2008-09 budget is based upon estimates of anticipated tax revenues made last Spring for a 12 month period. State tax revenues are now nearly $565 million below those estimates with little sign of improvement during the remainder of this fiscal year. In response to the tremendous shortfall in tax revenue, the Governor ordered spending cuts totaling $311 million; $72 million of those cuts coming from the Department of Public Welfare (DPW). DPW Secretary Estelle Richman has stated that existing services will not be cut nor will there be cuts in eligibility at this time. Savings in DPW will be realized by: slowing the expansion of existing programs such as the mental retardation waivers (waiting list initiative); slowing the implementation of new programs like the autism waiver and the adult community autism program (ACAP); and by instituting a hiring freeze. The Department of Health will see cuts amounting to $10.5 million.

Although the current delays in expanding existing programs and implementing new programs are serious, even deeper cuts are likely if the State's current economic problems continue as expected. Although the Governor has shielded Medical Assistance from significant cuts in the past, there is likely to be growing pressure from the State Legislature to make cuts in that program given the fact that Medical Assistance accounts for 19% of the entire state budget (2nd only to education in terms of budget expenditures). In addition, an estimated 34,500 more people will qualify for MA during this fiscal year, due to the rise in unemployment. The Governor's Budget Office will announce further cuts on December 9th.

Since a dramatic economic upturn is not expected in the next few months, many health advocates are calling on the federal government to shore up the Medical Assistance programs across the country by increasing the amount of money the federal government gives to the states for Medical Assistance (the federal Medicaid match or "fmap") as part of the next fiscal stimulus package. So far, the Bush Administration has opposed any increase in the federal Medicaid match.

(Continued on Page 2)

INSIDE THIS EDITION

(Continued from Page 1)

However, Janet Napolitano, the current Governor of Arizona who has been named by President-elect Obama as his choice for Secretary of the Office of Homeland Security, has testified in support of a $25 billion increase in federal Medicaid match over 2 years. The National Governors Association has gone on record supporting a $20 billion increase in federal funds to state Medicaid programs over 2 years. Avoiding cuts to Pennsylvania Medical Assistance in the near future is likely to depend on whether an increase in the federal Medicaid match is included in any future federal economic stimulus package.

Stay tuned to future newsletters for more information on the State budget's impact on Medical Assistance programs.

Expedited Processing of MA Applications for Individuals Requiring Emergency Medical Treatment

The Department of Public Welfare (DPW) has formalized a procedure to speed up the processing of a Medical Assistance (MA) application when an individual has a medical emergency and needs immediate coverage. Under this new procedure, effective 11/19/08, County Assistance Office (CAO) staff must make every effort to process an application for an individual who has indicated a medical emergency (either on the application or by contacting the CAO) within **five business days** of receiving the request. The medical emergency must be properly verified by a physician or a medical professional under a physician's supervision (e.g., physician assistant or certified registered nurse practitioner).

Verification of a medical emergency (i.e., an immediate need for surgery, medication or other medical procedures or devices) can be accomplished through any of the following:

- a statement from the medical provider on their letterhead or prescription pad;
- information submitted by a provider on completed Department forms (such as the Employability Assessment Form); or
- verbal telephone contact between the CAO and the medical provider.

Individuals in need of immediate MA because of a medical emergency should do the following:

- Complete and submit an MA application.
- Notify the CAO about this need (either by putting this information on the application or by contacting the CAO in person or by phone).
- Be ready with copies of all required verification information including proof of income, resources, residence, citizenship, identity, etc if this information was not submitted along with the application. If the individual has written documentation from a medical provider about the medical emergency, it needs to be submitted as well. The CAO should contact the individual by phone or by letter (if unable to reach by phone) telling her about other information necessary to process the application. **NOTE**: MA will <u>not</u> be approved until the CAO has all the documentation needed; however, CAO staff should assist the individual in getting the necessary information or verification if needed.

The full procedure for this expedited processing will be included in the Medical Assistance Eligibility Handbook in a new section (303.211). Please call the PHLP Helpline (1-800-274-3258 or 1-866-236-6310/TTY) if you have any questions or if you need help getting your MA application processed under this new procedure.

DPW Required to Re-Bid Enrollment Assistance Program Contract

The PA Department of Welfare (DPW) recently announced that it would be breaking its Enrollment Assistance Program contract with ACS and putting a new Enrollment broker into place effective January 1, 2009. This action is the result of a directive from the Center for Medicare & Medicaid Services (CMS). CMS determined that ACS had a conflict of interest in that it's parent company provides various services to several of Pennsylvania's Medical Assistance (MA) managed care plans.

The Enrollment Assistance Program performs a number of functions:

- it helps consumers in HealthChoices counties choose a physical health plan;
- it helps consumers who live in ACCESS Plus counties choose between enrolling in ACCESS Plus or enrolling in a Voluntary Managed Care Plan (if available);
- it assists consumers enrolled in HealthChoices or Voluntary Managed Care Plans choose their initial PCP (later PCP changes are handled by the person's Health Plan); and
- it assists consumers in ACCESS Plus select an initial PCP and change their PCP.

The Consumer Subcommittee of the state's Medical Assistance Advisory Committee provided comments and recommendations to DPW regarding what should be in the State's contract with the new Enrollment Assistance Provider. In order for the Enrollment Assistance Program to provide meaningful help to consumers choosing among plans and providers, the Consumers' recommended the following:

- The new contractor must maintain accurate and up-to-date health plan provider lists so that consumers know which plans cover their current doctors and how each plan can address a given consumer's issues or priority needs (i.e. coverage of smoking cessation products).
- The new contractor must be able to quickly identify medical providers who can meet a consumer's identified needs- i.e., who are in close proximity to a consumer's home, who specialize in the treatment of a consumer's illness or condition, or whose office can accommodate the consumer's physical disability, language or other special need.
- The new contractor must be able to explain, in an impartial way, the key differences between the AccessPlus and Voluntary Managed Care delivery systems as well as provide written materials for consumers to consider when deciding between AccessPlus and a Voluntary plan.
- The Enrollment Assistance Call Center must be adequately staffed and trained to answer a wide range of questions. The Consumer Subcommittee should have an active role in the development of the scripts used by Call Center staff to ensure that consumers receive all the information they need to make good enrollment choices.

The new contractor must be able to provide any additional assistance or support needed by consumers with special needs such as those with physical or behavioral health disabilities, those with communication problems and those who need an interpreter or written materials in another language. These special needs should also be recorded and passed on to the PCPs and health plans selected by these consumers.

Given it's January 1st deadline, DPW is using an expedited bidding process in order to award a contract that must be up and running by the end of the year. The Enrollment Assistance Program RFP has already been released and bids have been submitted. DPW hopes to announce a contract with a new Enrollment Assistance broker soon.

Medicare Beneficiaries Should Evaluate 2009 Part D Plans

The Medicare Open Enrollment Period started November 15th and ends December 31st. During this six-week period, all Medicare beneficiaries can change their Medicare Prescription Drug (Part D) Plan whether they are in a stand-alone plan (PDP) or a Medicare Advantage Plan with prescription drug coverage (MA-PD). All beneficiaries should review their current plan and decide whether to remain enrolled in that plan or to switch plans for new coverage starting January 1, 2009. Beneficiaries should have already received information from their current plan about its 2009 benefits. Individuals should review that information and check the following:

- Costs-Review the plan's costs to see how they are changing in 2009 and decide if the plan is still affordable.
- Drug coverage-Make sure all of their drugs will continue to be covered in 2009 and see if there will be any special rules (like Prior Authorization or limits on how many pills someone can get during a month).
- Provider network-individuals who have a stand-alone prescription drug plan should make sure their pharmacy is still in the plan's network. Individuals in a Medicare Advantage (managed care) plan should make sure that all their providers (doctors, hospitals, medical equipment suppliers, etc) continue to be in the network.
- Plan benefits-if someone has a Medicare Advantage plan, they should check to see whether the plan is dropping coverage for any extra benefits in 2009 (like dental, vision, or hearing) or whether the plan is adding any new benefits next year.

Individuals who wish to change their plans for 2009 should enroll in the new plan by December 31, 2008. If possible, individuals should enroll early in December to ensure that the application is processed and the plan's systems are updated by January 1, 2009 to avoid problems getting prescriptions filled in early January.

Reassignments of Certain Individuals with LIS

Medicare is re-assigning over 70,000 consumers in PA who have the full low-income subsidy (LIS) and who were auto-enrolled into plans that will no longer be offered in 2009 or that will no longer be "zero-premium" for them in 2009. One plan that will no longer be offered in 2009 is the AmeriHealth 65 Special Needs Plan for people in Central and Eastern PA who have Medicare and Medical Assistance. Many of the re-assignments are due to the fact that the number of "zero-premium" plans available in PA is going down. In 2008 there were 18 of these plans; in 2009, there will only be 9 zero-premium plans (see www.phlp.org for a listing of 2009 zero-premium plans).

Individuals who are being reassigned by Medicare should have already received a notice on **blue** paper telling them which Plan they will be enrolled in for coverage starting January 1, 2009 if they do not make a choice on their own. Remember, Medicare enrolls people in plans randomly! As a result, everyone who receives this notice should check to make sure that the plan that Medicare picked for them will cover their prescriptions and work with their pharmacy. If this new plan will not cover your medications or work with your pharmacy, you should enroll in a different zero-premium plan by December 31, 2008. Individuals who are not sure if Medicare is picking a different plan for them starting January 1, 2009 can call 1-800-MEDICARE (1-800-633-4227 or 1-877-486-2048/TTY).

Medicare beneficiaries who enrolled on their own into a zero-premium plan that will no longer be zero-premium in 2009 should have received a notice on **tan** paper. These notices tell folks that if they do nothing and remain in their current plan they will have to start paying a premium next year. If the person wants to avoid paying a premium, the notice tells them they should enroll by December 31st into a new plan that will be zero-premium in 2009. A list of the 2009 zero-premium plans is attached to the notice.

Call PHLP's HELPLINE at 1-800-274-3258 if you have questions about your Part D plan options for 2009 or if you have any questions about the reassignment process.

Input Sought on New Autism Insurance Law

The Pennsylvania law that will require large group health insurance policies to cover services for persons under 21 with autism spectrum disorders (Act 62) goes into effect July 1, 2009. There are many issues that will need to be addressed in implementing this law such as how private insurance coverage will coordinate with Medical Assistance, Early Intervention and school based services, and what qualifications will be required of behavior specialists. The State (Departments of Insurance & Public Welfare) is soliciting questions about how the new law will be implemented. Questions can be submitted by email to ra-in-autism@state.pa.us. The PA Health Law Project is also interested in your questions as well as the answers you receive. Please send a copy of your questions and the answers to us at dgates@phlp.org.

There is a web site for information regarding the new law- www.paautisminsurance.org. The Insurance Department will be doing presentations around the State on the new law although those presentations have not yet been scheduled. The Insurance Department is also willing to do presentations for interested groups. Groups can request a presentation through ra-in-autism@state.pa.us.

Chestnut Hill Hospital Closed OB Unit

Philadelphia's Chestnut Hill Hospital (CHH) closed its Maternity Unit on November 7, 2008. Before closing, Chestnut Hill had delivered 1,000 infants annually (about 2% of the 53,000 infants born in the region each year). Women who have been receiving care from a specialist in the Chestnut Hill Maternity Unit must now receive their care elsewhere.

About 40 women who are enrolled in the three Medical Assistance HMOs in Southeastern PA (Americhoice, Health Partners, and Keystone Mercy), and who were scheduled for delivery at CHH between October and March, have been impacted by the Unit's closure. The three health plans are doing outreach to affected women by letter and by phone and are working with these women to help them find obstetrical care elsewhere to ensure continuity of care. In certain cases, women may be able to follow their CHH obstetricians to wherever they decide to practice. All of the affected women have selected alternative delivery sites.

According to the Department of Public Welfare, many providers that used the CHH Maternity Unit already have, or are working to get, admitting privileges with another hospital. However, it is not yet clear what will happen to those maternity providers that were employees of Chestnut Hill Hospital. Women who need help finding a new doctor should contact their health plan.

Pregnant women should not experience excessive wait times in scheduling appointments with their new providers. The access standards for pregnant women in MA managed care plans are as follows:

- Women in their first trimester should not wait more than 10 days for an appointment;
- Women in their second trimester should get an appointment within five days; and
- Women in their third trimester should wait no longer than four days for an appointment; and
- Those with high-risk pregnancies should get an appointment within 24 hours.

Women who are having problems finding an Obstetrician as a result of the CHH Maternity Unit Closure, getting an appointment scheduled in a timely manner or understanding their options should contact PHLP's HELPLINE at 1-800-274-3258.

Consumers Recommend Improvements to DPW's New EPSDT Requirements

The Department of Public Welfare's (DPW) recent increase in EPSDT fees and accompanying requirements for development screening are viewed as welcome improvements by the Consumer Subcommittee of the state's Medical Assistance (MA) Advisory Committee. However, the Subcommittee has gone on record urging DPW to take further steps to assure high quality care for PA's children by better defining the content of the screening and by educating physicians on how to implement the new requirements.

As a reminder, beginning September 1, 2008 primary care providers in the MA fee-for-service system who are conducting 9, 18 and 30-month Well-Child visits for children on MA must complete a screening for developmental delays using standardized screening tools. In addition, a separate screening for autism spectrum disorders (ASD) must be completed at the 18 and 24-month visits. Please see our September Newsletter for more detailed information about these changes.

After reviewing these recent changes to the EPSDT requirements, the Consumer Subcommittee submitted formal comments along with detailed recommendations to DPW on how the system could be further improved. Specifically, the Consumers are urging that DPW:

Provide additional clarification and recommendations for developmental screening tools. The Consumers recommend that DPW follow other states such as Iowa, Illinois, Utah and Minnesota and provide a list of approved or recommended screening tools. Many validated screening tools are available and health care providers should be encouraged to use the tools that are the most accurate.

Add specific requirements to the Health Choices managed care contracts. The new requirements only apply to children in the MA fee-for-service (FFS) system, yet seventy percent of MA enrollees under 21 are enrolled in MA managed care plans. The Consumers believe that the new requirements should also apply to primary care providers in MA managed care. Within HealthChoices, DPW should include the language for the fee-for-service EPSDT requirements in its contracts with the managed care plans. The FFS billing code, 96110, should be added to the managed care billing systems to both assess compliance with the developmental screening requirement and to track its utilization.

Support health care providers as they implement developmental screening. Implementation of the new EPSDT requirements has caused some initial confusion and resulted in claim denials for primary care providers in the FFS system. Even with fee increases attached, primary care providers need support in implementing these new health care components. DPW can support these primary care improvements through several mechanisms. First, the Consumers recommend that the state obtain a volume discount on the most widely used screening tools. Second, physicians need to be educated. This can be done through a partnership with the Pennsylvania Chapter of the American Academy of Pediatrics to implement a statewide EPIC (Educating Physicians in their Communities) training module on developmental screening. Other complimentary primary care provider training should be made available through teleconferencing, conferences and other continuing medical education modalities.

For more information on the new EPDST fees and requirements and the Consumer Subcommittee's recommendations, please contact Ann Bacharach, who is the Special Projects Director at PHLP. Ann can be reached at abacharach@phlp.org or by calling 215-625-3596.

VA Coverage for Emergency Care in Non-VA Facilities

The Department of Veterans Affairs (VA) has the authority to pay or to reimburse for the cost of emergency healthcare provided to veterans in non-VA facilities. This authority was granted to the VA in the Veterans' Millennium Health Care Act passed in 2001. The Millennium Act pertains only to emergency treatment for non-service-connected conditions; the VA already had authority and procedures in place to pay for treatment of service-connected conditions in non-VA facilities.

Payment for treatment of non-service-connected conditions in non-VA facilities may be made when **all** of the following conditions are met:

- The veteran was provided emergency treatment in a hospital emergency department or similar facility;
- A prudent layperson would have reasonably expected that any delay in seeking medical attention would have been hazardous to health or life;
- A VA facility was not feasibly available and an attempt to use a VA facility would not have been reasonable;
- The veteran was enrolled in the VA health care system and had been seen by a VA provider within the 24 month period before the emergency treatment;
- The veteran has no coverage under a health insurance plan for payment (in whole or in part) of the emergency treatment;
- The veteran is financially liable to the provider of the emergency treatment for the services received;
- the veteran has exhausted without success all claims or remedies reasonably available against a third party for payment (If the emergency condition was a result of an accident or work-related injury), and;
- The veteran **submits the claim** within **90 days of discharge** (or within 90 days after claims against a third party have been exhausted)**.**

As the veteran has to file his claim for payment or reimbursement within 90 days of discharge or within 90 days after exhausting claims against a third party, he should start the claim process as quickly as possible after discharge. This could require the veteran to contact the hospital billing department *even before* he has received a bill from the hospital.

To request payment from the VA, a veteran should submit the following to the Fee Basis Department of her local VA Medical Center:
(1) a "Claim for Payment of Costs of Unauthorized Medical Services" (VA form 10-583) which can be downloaded from http://www.va.gov/vaforms/form_detail.asp?FormNo=583: and
(2) any bills or invoices she has received.

A VA representative can then help her submit any additional required documents, such as a certification that she is financially liable for the costs of the emergency treatment and meets the other conditions listed above.

If treatment of the emergency condition requires that the veteran be admitted for inpatient care, the veteran or a family member must request VA authorization within 72 hours after admission to the non-VA facility. The VA will not pay or reimburse a claim for treatment provided after the veteran could have been safely discharged or transferred to a VA facility. An authorization request can be made by telephone to the local VA Medical Center or VA Outpatient Clinic. Individuals who do not know the number to the local VA Medical Center or Outpatient Clinic can contact 1-877-222-VETS (1-877-222-8387).

If the veteran's claim for payment or reimbursement is denied, she has the right to appeal this decision to the Board of Veterans Appeals. For free legal help with an appeal, the veteran can call the Pennsylvania Health Law Project at **215-625-3663** or **1-800-274-3258**.

Stories of the Uninsured

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

Brenda's Story

Brenda has been working in the dry cleaning business since she was 13 years old. You'll know her age when you learn that she has worked in the business for 45 years. Coming home from work one icy snowy night in Pittsburgh, she slipped in front of her house. A car coming around the corner didn't see her and ran over her leg.

After the accident, she was able to obtain Medicaid; but, like many other people who have worked all their lives, she was embarrassed to have Medicaid. "I've worked all my life; never been on the system [welfare]. I'm a taxpayer. Anybody working pays for welfare. [Then suddenly] when you need it, people act as if they are giving something out of their own pocket."

Brenda's Medicaid coverage then disappeared. Brenda had worked all her life, so when she became disabled, she was eligible for Social Security disability income. In June of 2007, she began to receive $1018 per month. That placed her above the Medicaid income limit. After paying for food, rent, utilities, and other living expenses, she did not have enough left to buy private health insurance (even if someone would sell it to her since she has a disability). She spoke to one insurance company, but she couldn't afford the $265 a month premium they quoted her for coverage.

Brenda can no longer stand all day in a dry cleaning establishment. She walks with the aid of a cane. She has pins and screws in her ankle. She has nerve damage in her bad leg and has constant muscle spasms. Her doctors have recommended nerve blocks, and physical therapy. She was hospitalized twice when she had no insurance, and she believes that stress was the cause. She has $3000-$4000 in hospital bills. "I try to pay what I can," she says.

Brenda found it hard to believe that being determined disabled could cause you to *lose* health insurance. As someone who had worked in small businesses all her life, she sometimes had health insurance and sometimes did not. "I worked at one place for 10 or 15 years, but then they sold it. A new owner isn't interested in our health insurance." She fondly remembers one owner, who offered health insurance to his employees and for which she paid an affordable contribution. But when that job ended in 1998, her health insurance ended, too.

She thought of herself as a healthy person. Even though she had high blood pressure and needed thyroid medication, those were affordable for a working person; she could pay her family doctor. Now, the pain specialist wants $375 for a nerve block, and multiple visits are required for treatment. She has been prescribed physical therapy three times per week but hasn't gone. Her family doctor calls in her prescriptions for thyroid and blood pressure medication and asks her to make an appointment. She is embarrassed to go see him if she can't pay. Her damaged leg is getting smaller, from inability to use it or go to therapy. Without the nerve blocks, the leg goes into spasm. She filled out charity care forms at the local hospital and also applied for pharmaceutical assistance programs but she hasn't heard back. The medicine that costs $165 per month is beyond her reach.

Like many others who are uninsured, preventive care is completely out of the question. Her last mammogram was almost two years ago.

Finally, in May of 2008, Brenda was disabled long enough that she was eligible for Medicare on the basis of her disability. When we spoke, before that time, she was frustrated, resigned, and angry. "I don't think we have enough time to tell all the things I went through, and I know other people have gone through worse things. Other people have suffered. It shouldn't be like that. When you are injured, you can't get any health care. It shouldn't be like that."

Eric's Story

When Eric's mother found the Pennsylvania Health Law Project on the internet, she and her son were desperate. In March of 2007, Eric, then 39 years old, was diagnosed with congestive heart failure. As he told PHLP, "my echocardiogram showed my ejection fraction was 20%." Normal is between 55% and 75%. Doctors also call this "pump failure", because the heart's job is to pump blood throughout the body. Symptoms of congestive heart failure include fatigue, shortness of breath, and a limited ability to do strenuous or even moderate activities. Eric had all of these symptoms. Doctors told him that in order to stay alive, he would need a pacemaker and defibrillator. "I had to go for it," he said.

And then he lost his job. Eric has always done physical labor. "I did production work, landscaping, tree trimming." He worked for a trucking company but he could no longer do that work. He tried to find other jobs. "The one job I had, they were afraid I would die, and they would be blamed." Instead of seeing the pacemaker as a potential lifesaver, he started seeing it as a liability. His unemployment ran out and he had no money coming in. He was a 40-year-old man forced to move back in with his mother. "If it weren't for my mother, I wouldn't be alive," he said. "If anything happens to her, I'll be out on the street."

At first, Eric's mother was able to help him maintain health insurance by paying the monthly premiums under COBRA. COBRA is an abbreviation for a law, passed in 1986, that allows workers who have lost jobs to continue to purchase health insurance for a limited time through their former employer. This means individuals still have access to their group health insurance (which should mean lower rates than buying individual coverage), but when purchasing COBRA coverage, the unemployed worker must pay both the worker's share of the insurance and the employer's share of the insurance. For Eric, this came to $469/month – not affordable for a man with no income, or his mother who was supporting them both. Eric found himself disabled, with a serious medical condition, and about to be uninsured. In early June, his mother called the Pennsylvania Health Law Project.

Fast forward to October 2008. Fortunately, Eric's story does not have the dramatic but sad ending that evokes cries of outrage if it appears in the media. No miracle has occurred and Eric still has congestive heart failure. However, he does now have health insurance. Because he has remained unemployed and because his physician believed that Eric was unable to work, Eric was able to obtain Medicaid. He now has health insurance through Medicaid and is enrolled in HealthChoices, the state's Medicaid managed care program. But before the end of the story, the road was bumpy.

Eric applied for Medical Assistance, but the Bucks County office had moved from the address on the state website and his application was delayed. He went two months without any health insurance. He was unable to afford his medications; he became short of breath and had to go to an emergency room when fluid built up in his lungs. When he did get Medicaid insurance, he was unfamiliar with the fact that he needed to pick an HMO and a doctor, and so he ended up being assigned to an HMO that had no primary care doctors in his area. He did not have transportation money to get to his assigned doctors, who were more than an hour away. It took him several months to locate convenient physicians who would accept Medicaid, and then to change managed care plans in order to see those physicians.

Eric is still on a bumpy road. His cardiologist has told him he will not be able to return to the kind of physical labor that he did in previous jobs. The Social Security Administration has turned down his request for Social Security Disability. They told him he could sit at a desk, and work at a computer, although he has no training or skills for those jobs. He frankly acknowledges that he is not a "sit at a desk" kind of person. He didn't need to say that the likelihood of an untrained person being hired in the current economy is zero.

Eric talks about how he felt when he was uninsured – angry and fearful. "Here I am, an American and I paid my taxes and I can't get health insurance." Unfortunately, being an American, and paying taxes, has little to do with having health insurance, as 47 million Americans have found out.

Specialty Pharmacy Drug Program Starts January 2009

Starting January 12, 2009, certain Medical Assistance recipients will have to use a Specialty Pharmacy to get certain medications. Under the new Specialty Pharmacy Drug Program, the following MA recipients will have to use one of 2 approved preferred specialty pharmacy providers to get their specialty medications:

- individuals who live in the 42 counties currently participating in the ACCESS Plus program ; **and**
- who are in the MA fee-for-service (FFS) system for pharmacy coverage (use their ACCESS card to get services); **and**
- who take certain "specialty medications". Specialty medications are medications that may require special packaging, storage, or special training to use; medications that may need to be given by injection through a vein or under the skin; and medications given by injection either at the patient's home or in a doctor's office. The Specialty Pharmacy Drug Program includes medications for the following conditions (this list is NOT exhaustive): Cancer, Endocrine Disorders, Hemophilia, Immune Deficiency, Multiple Sclerosis, and Osteoarthritis.

The two specialty pharmacy drug program preferred providers chosen by the Department of Public Welfare (DPW) through a bidding process are **Accredo Health Group** and **Medmark, A Walgreens Specialty Pharmacy**. Once the new program starts, DPW will no longer pay other retail pharmacies or providers for dispensing the medications included in the Specialty Pharmacy Drug Program. However, DPW will continue to pay providers for the administration of the medications. MA recipients can continue to get any medications that are not included in the Specialty Pharmacy Drug Program at any pharmacy of their choice that participates with the MA program.

The Specialty Pharmacy Drug Program will not apply to MA recipients who:

- Are enrolled in a Voluntary MA Managed Care plan for their physical health services; or
- Have other coverage in addition to MA that covers pharmacy services (i.e., Medicare or private health insurance). However, if the other coverage does not cover the specialty medication at all (making MA the only payer), the recipient will be required to get that medication through a specialty pharmacy.

Medications included in the Specialty Pharmacy Drug Program continue to be subject to the state's Preferred Drug List and follow any prior authorization and quantity limit rules that apply. DPW will occasionally update the list of medications covered under the new program and will send advance notice of any changes to the list of covered drugs.

In addition to dispensing medications, the specialty pharmacy preferred providers will offer a clinical support system for MA recipients including: a toll-free call center available 24 hours/day, 7 days/week to respond to questions; personal medications counseling including identification of side effects and how to handle side effects as well as storing medications properly; directions for therapy administration and management; monitoring compliance; and care coordination.

MA recipients who are currently taking a medication that will be included in the specialty pharmacy drug program will receive a notice informing them of the change. DPW is also doing outreach to providers who prescribe specialty medications about the new program.

Individuals can find more information about this program and the list of drugs included in the program in an MA Bulletin (99-09-01) available online at http://www.dpw.state.pa.us/PubsFormsReports/NewslettersBulletins/003673169.aspx. MA recipients who cannot access the internet can call the MA call center at 1-800-657-7925 to get a complete list of medications in this program.

Please call the HELPLINE at 1-800-274-3258 if you are having any problems accessing medications under this new program or have any questions about this.

Rethinking Care Program

Pennsylvania is one of 8 states chosen to participate in the Center for Health Care Strategies' Rethinking Care Program. This Program is designed to focus on Medicaid beneficiaries with multiple chronic conditions who are heavy users of the healthcare system. The target population for PA's program will be individuals with Serious Mental Illness (SMI) who also have other physical health conditions and will focus on physical health and behavioral health care coordination .

Nationally, five percent of Medicaid beneficiaries use up to 50 percent of total Medicaid spending. These individuals, however, often receive uncoordinated and fragmented care resulting in costly hospitalizations, institutionalizations, worsening health conditions and decreased quality of life. The Rethinking Care Program is an effort to improve coordination of care in order to improve health outcomes.

The Program was developed by the Center for Health Care Strategies to serve as a national Medicaid "learning laboratory" to design and test better approaches for caring for beneficiaries with complex medical needs. The Rethinking Care Program will be piloted in 8 regions across the country. Participation as one of 8 pilots will provide PA with intensive technical assistance, access to the national learning collaborative and comprehensive external evaluation.

In PA, there are over 500,000 adults with Serious Mental Illnesses such as schizophrenia and bi-polar disorder. Recent research revealed that those suffering with SMI have an average loss of 25 years off the normal life span. Individuals with SMI are far more likely to have, or be vulnerable to, multiple chronic illnesses.

The goal of PA's Program is to improve quality of care and reduce expenditures for MA consumers with complex medical and psychiatric needs who have the greatest potential to benefit from improved care management and integration. The state will pilot the program in 3 regions across PA. In Central PA, the Access Plus Program will be paired with a BH-MCO; in Southwest and Southeast PA, one of the PH-MCOs in each region will be paired with one of the BH-MCOs (to date, the state hasn't announced the plans who will participate).

Coordination of care for participating consumers will focus on issues such as pharmacy management, hospital discharge with appropriate follow-up, coordination of alcohol and substance abuse treatment and consumer engagement. Evaluation measures will capture hospital admission and re-admission rates, emergency room visit frequency, medication prescribing patterns and consumer satisfaction.

PA's Program is expected to be developed by the end of 2008. Implementation of this two year pilot is scheduled for January 2009 in the Southwest and Southeast and July 2009 in the Central region.

Stay tuned to future newsletters for updates about the Rethinking Care Program.

Attendant Care Waiver Renewed

The Centers for Medicare & Medicaid Services (CMS) approved PA's Attendant Care Waiver Program in September 2008. We reported in previous Newsletters that this waiver was up for renewal as of July 1, 2008. Prior to approval , CMS granted the state a 90 day extension of the previous Waiver. The newly-approved Attendant Care Waiver includes the following changes:

- **Financial Management Services (FMS) is now a separate and distinct service for participants using the "consumer employer" model of service**. FMS provides payroll and other financial functions, as well as orientation and skills training, for individuals who hire their own attendants rather than get attendants through the agency model of service. Previously, these services were bundled into the Personal Assistance Services and had no distinct service definition or provider standards.

(Continued on Page 12)

(Continued from Page 11)

- **Criminal History and Child Abuse clearances are required for <u>all</u> direct care workers**. Previously, these clearances were optional and done at the discretion of the consumer. Starting July 1, 2008, all individuals performing personal assistance services must get a criminal history background check. However, Attendant Care Waiver recipients who self-direct their services have the right to employ a worker regardless of the outcome of the background check.
- **The State is developing a comprehensive and integrated Quality Management Strategy**. This is being done across all waivers and the details are still being fleshed out. Some of the goals of this strategy include establishing a regular group of stakeholders to address quality management issues, establishing a consistent process to resolve Level of Care issues, developing consistent written materials that inform current and prospective waiver participants about the benefits and potential liabilities of self-direction, and establishing a comprehensive complaint reporting and management system.

Please contact PHLP (1-800-274-3258 or 1-866-236-6310/TTY) if you are having any problems related to the Attendant Care Waiver Program or if you have any questions about waiver programs in general.

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 <u>staff@phlp.org</u> to change the way you get the Health Law PA News!

Pennsylvania Health Law Project
The Corn Exchange
123 Chestnut St., Suite 400
Philadelphia, PA 19106