Health Law PA News

Newsletter of the Pennsylvania Health Law Project

Harrisburg Philadelphia Pittsburgh

Statewide Help Line: 1-800-274-3258 On the Internet: www.phlp.org TTY: 1-866-236-6310

Volume 9, Number 1 March 2006

Governor's Budget Promises Universal Coverage for Kids in PA, Would Expand Home and Community Based Services, adultBasic and PACE

Governor Rendell's proposed budget for FY 06-07 represents a sharp contrast from the one he presented to the General Assembly last year. This year's budget proposal does not cut publicly financed health programs. Instead, the budget includes a bold proposal to offer health insurance to all of Pennsylvania's kids, at cost, regardless of parental income. The Governor also proposes modest expansion of other programs.

Universal Health Care for Kids

The "Cover All Kids" initiative would devote $14.6 million in state and federal funds to expanding the CHIP program to offer coverage to anyone in Pennsylvania who is willing to buy it. Lower-income families would continue to get the coverage for free, or for a very small monthly premium if they have slightly higher income. Families with even higher income would pay modest monthly premiums depending on their income. The program would be implemented over time, starting in January 2007, with all kids to be covered by 2011. There is rumored opposition by those in the legislature opposed to "entitlements."

adultBasic Expansion

Using money from the community health reinvestment fund and the tobacco settlement fund, the governor proposes to add 8,500 new low-income working adults to the adultBasic program. This would bring the average number of persons covered per month to 50,000. There are currently over 88,000 on the adultBasic waiting list.

(Continued on page 5)

INSIDE THIS EDITION

Medicaid Facing Long-term Reductions at the Federal Level

Medicaid is facing funding cuts on the federal level. The proposed federal budget includes $14 billion in Medicaid spending reductions over the next five years. Many of those reductions are included in the Deficit Reduction Act of 2005 (DRA), which was signed into law in February 2006. This law includes reductions in federal Medicaid spending of $11.5 billion over the next five years and $43.2 billion over the next ten years. Most of the reductions come from provisions for premiums and cost sharing, changes to benefits, and restrictions on asset transfers.

Cost Sharing and premium provisions under the DRA

Under the DRA, states will be allowed to charge unlimited premiums and co-payments up to 20% of cost of medical services to beneficiaries with family incomes over 150% of poverty. Beneficiaries with income between 100 and 150% of poverty could be charged co-payments up to 10 percent of the cost of service. Additionally, states would be able to charge a new co-payment for non-preferred prescription medications. Finally states could charge co-payments for the use of hospital emergency rooms for non-emergency care.

Currently, states can only impose nominal co-payments ($.50-$3) on medications and services and providers can't refuse services because someone cannot pay a co-payment. Certain groups, such as pregnant women and children that the state is required to cover, are excluded from cost-

(Continued on page 5)

Consumers Continue to Face Medicare Drug Mess

The Medicare Prescription drug benefit began on January 1, 2006. For many dual eligible consumers, this has meant confusion over which plan they are enrolled in, problems accessing medications, enormous, incorrect co-payments and long hold times on the telephone to get problems fixed. As we go to press, many people are still encountering big difficulties navigating the new system.

Enrollment problems

Many dual eligible consumers cannot find out what plan they are enrolled in, with some folks being enrolled in multiple plans and some in no plan.

If someone is not sure which plan she is in, she can call Medicare at 1-800-MEDICARE (1-800-633-4227) or she can log onto the Medicare website, www.medicare.gov, and follow the link "Compare Prescription Drug Plans" to "Find a Prescription Drug Plan" to find out. Both the website and the Medicare automated phone system will ask for information from the caller's red, white and blue Medicare card. If this does not resolve the situation (and it may not), call PHLP at 1-800-274-3258.

Beneficiaries should be able to find out whether their medications are covered by their plan or if they would get better coverage through a different plan by calling 1-800-MEDICARE or by using the Medicare website. If a dual eligible consumer wants to change plans, he can do that by calling Medicare and enrolling in a different prescription drug plan. Coverage in the new plan would begin the first of the following month. Retroactive disenrollment from a Medicare managed care plan into which one was "passively enrolled" is available, although some

(Continued on page 7)

State Centralizes PDA Waiver Approval Process, Citing Budget Concerns and Need for Uniformity

Consumers and advocates have recently expressed concern about changes in the process of approving consumers for the Aging Waiver (also known as the PDA Waiver). The changes have slowed down the process for getting into the Waiver.

Previously, each county's Area Agency on Aging was given a certain number of PDA waiver "slots". Once the county evaluated a consumer and found him/her to be nursing facility clinically eligible, they submitted the request to the state for a *pro forma* approval that typically occurred within a day. When a consumer left the Waiver Program, the county then had another "slot" open that it could fill. Last year the state decided to no longer assign a certain number of "slots" to each county and instead take control of the PDA waiver approval process. This has resulted in a significant slowing down of the approval process, leaving elderly consumers who need home and community based services in limbo as the state requests more and more detailed information about the consumer's medical condition and needs.

When questioned about these changes, DPW officials indicated they arose out of waiver funding concerns. That is, when the state expanded access to the MA waiver programs (through Community Choice), they anticipated the expansion could be funded through the re-

(Continued on page 8)

PHLP and Consumer Health Coalition (CHC) Release White Paper on Smoking Cessation for Pregnant Women

The PA Health Law Project (PHLP) and the Consumer Health Coalition (CHC) recently released a white paper culminated from yearlong research on the problems of maternal smoking and interventions aimed at increasing smoking cessation and improving birth outcomes.

The recommendations to DPW to reduce smoking among pregnant women on MA included the following:

1. Identify outcome measures for all interventions used for smoking cessation and collect data accordingly.
2. Increase staff resources for oversight of DPW's Health Beginnings Plus (HBP) Program, a program designed by DPW in the 1990's to assist pregnant women eligible for MA to have a positive prenatal care experience.
3. Enforce the contract between DPW and the HBP providers and between DPW and the Physical Health HMOs regarding the requirement to use HBP providers or comparable resources.
4. Update DPW website to accurately reflect current HBP Providers in PA and recruit additional providers as needed.

Use collected data to determine efficacy of the HBP Program as tool for increasing smoking cessation for pregnant women, as this data does not currently exist.

The Healthy Beginnings Plus Program Standards and the Healthy Beginnings Plus Maternity Services Manual is a 175-page document, which outlines a thorough, detailed and impressive program of maternity

(Continued on page 9)

The Medicare Prescription Drug Benefit: Implementation Issues

The Pennsylvania Health Law Project Help-Line
1-800-274-3258; TTY : 1-866-236-6310

The Medicare Prescription Drug Benefit is underway. Many consumers, especially people with Medicare and Medical Assistance, are experiencing significant problems during the implementation period. The Pennsylvania Health Law Project will be conducting FREE trainings that focus on implementation issues, specifically enrollment and disenrollment, changing plans, and the exceptions and appeals processes. Join us at one of the following training locations:

FREE Trainings!

Please Call the Pennsylvania Health Law Project to RSVP so that we know how many people to expect:
1-800-274-3258
TTY: 1-866-236-6310

Visit us online at
www.phlp.org

Pittsburgh:
March 29, 10:15am-12:15pm
Monroeville Public Library
Program Room
4000 Gateway Campus Blvd.
Monroeville, PA 15146

Butler:
March 31, 10am - 12pm
Butler Area Public Library
Meeting Room 1
218 N. McKean St.
Butler, PA 16001

Washington:
April 4, 10am-12pm
Wilfred R. Cameron Wellness Center
Meeting Rooms A&B
240 Wellness Way
Washington, PA 15301

(Continued from page 1)

More Home and Community Based Services Waiver Slots

The budget proposes to add 1,500 slots for persons with physical disabilities who need long-term care services to be served in the community rather than in nursing homes. It would also add 2,800 slots to the aging waiver for persons over age 60 to be served in the community.

PACE Expansion

The governor intends to use PACE to "wrap around" the Medicare Part D program, allowing those who qualify for PACE to avoid the Part D premiums and donut hole. The governor would eliminate the PACENet monthly deductible, although those on PACENet would pay Part D premiums. Co-payments for PACE and PACENet would be no higher than they were prior to Part d, and those qualifying for the Part D low-income subsidy would pay premiums lower than under PACE. PACE and PACENet cardholders would have access to virtually any drug, since the state would cover drugs not on a recipient's Part D plan's formulary.

Unfortunately, the state takes the position that lower income "dual eligibles" who are on both Medical Assistance and Medicare cannot qualify for PACE. This subjects the poorest persons in the state to restrictive Medicare drug formularies, while enabling those with more income to access virtually any drug through PACE.

Areas of Concern

The budget contains some areas of concern for recipients. The state intends to save money by increasing the number of recipients who are locked-in to a single provider. It is hard to understand the need for such a punitive measure in the face of HealthChoices and Access Plus, each of which already forces a recipient to go through a single "gatekeeper" who "manages" their care.

Also, the state intends to enter into selective contracts for the home health services, medical equipment, radiology and selective pharmacy items. This must be accomplished in a way that increases rather than decreases access to necessary items and services.

(Continued from page 2)

sharing. Under the DRA, cost sharing could become enforceable, meaning that providers could refuse to provide services if the beneficiary cannot pay the co-payment. Certain groups and certain kinds of services would still be excluded from cost sharing.

Benefit changes

The DRA allows states to change their Medicaid benefit packages to mirror the Federal Employees Health Benefits Program package, the State Employees Health Benefits Package or the benefits package of the HMO in the state with the largest non-Medicaid enrollment. Most groups of eligible beneficiaries would not be affected by this change (for example, pregnant women, dual eligibles, people with disabilities, consumers in LTC, and women in the breast or cervical cancer eligibility categories). Many children under 19 could be affected by this as it may limit the services that they would be entitled to. However, the state would still be required to provide EPSDT services, though those services could be offered as a wraparound to the benefit. Currently, states must generally offer the same menu of services to all beneficiaries. This provision would change that re-

(Continued on page 9)

OMHSAS Announces Expansion of HealthChoices (HC) Behavioral Health Managed Care

In January, OMHSAS announced its intend to expand behavioral health managed care to the remaining 42 counties in PA. The initial plan was to divide the 42 counties in 2 zones with the state contracting with chosen vendors. That plan changed after the OMHSAS received feedback from consumers, advocates and the affected counties. The feedback indicated that counties should be offered the right of first opportunity to carry the risk by holding the contract directly with the chosen behavioral health plan. OMHSAS agreed and sent letters to all counties outlining their options.

Option 1 - Counties can decide to not assume the financial risk for behavioral health managed care. If counties opt to not assume the risk, OMHSAS will competitively select a licensed MCO from those qualified MCOs that respond to the HC RFP that will be issued by OMHSAS. OMHSAS will contract directly with the MCO and will be responsible to monitor performance of the contract. The county will participate as a partner with OMHSAS in contract oversight and program development. DPW will create one or two zones depending on the number of counties for which they will assume the risk.

Option 2 – Counties can accept the right of first opportunity. Under this option, the county can choose from 3 different models. The 3 models include:

1. The county manages the program directly with its own employees. With this model the county would respond to the OMHSAS RFP detailing how it will meet the required fiscal and program standards for the HC program.
2. The county may subcontract for program management services. In this case the county is required to select its subcontractor through a competitive process and the selected subcontractor must meet the applicable licensing requirements of the PA Departments of Insurance and Health. The county is also required to submit a response to the OMHSAS RFP detailing how the county and subcontractor will meet the required fiscal and program requirements for the HC program.
3. The county may choose to align with other non-HC counties in order to collaboratively manage the program. Under this arrangement the multi-county entity would be required to sign a single contract. These multiple county groups can choose to manage the contract on their own or to select a subcontractor through a competitive process.

Counties have until February 22, 2006 to communicate their option to OMHSAS. DPW-OMHSAS will issue the RFP in July 2006. Proposals will be due back to DPW by September 2006. Implementation for behavioral health managed care is intended for July 1, 2007.

(Continued from page 2)
people at 1-800-MEDICRE are not aware of this.

Accessing medications

Consumers have encountered problems accessing their medications. The stand alone prescription drug plans are required to pay for a one-time fill of a month's worth of a medication that is not on the plan's formulary or which would normally require prior authorization (without requiring the consumer to get prior authorization). This is meant to give consumers time to request the medication through their plan or to change plans. See below for transition plan requirements for passive enrollees in Medicare HMOs.

Some dual eligibles have been charged high co-payments when the prescription drug plan did not have a record that the enrollee qualified for the low income subsidy. Dual eligibles should be charged no more than $5 for a co-payment. Pennsylvania is covering the extra co-payments for dual eligibles enrolled in a prescription drug plan while their information is being updated. Pharmacists can get instructions on how to bill the state for the excess co-payment by going to the DPW website.

Many consumers have been unable to access their medications because they have not yet received an identification card from their plan. However, those consumers should be able to use either the confirmation letter that they should have received from their plan, or they can call their plan and get their plan ID number to give to the pharmacist to access their medications.

Finally, some dual eligible consumers have had trouble accessing medications because they are not recorded as being enrolled in a plan. While dual eligibles were supposed to be automatically enrolled in a prescription drug plan, some dual eligibles fell through the cracks. Dual eligibles who were not enrolled in a plan should enroll in a plan by calling Medicare. They should be able to access medications in the meantime through a point of service enrollment into Wellpoint, a national prescription drug plan. The pharmacist can do the point of service enrollment.

If this system fails, anyone who is dual eligible should still not walk away from the pharmacy empty handed. The state will pay for a five day supply while the consumer tries to straighten things out.

Passive enrollment

Another group of problems that many dual eligibles have encountered is around passive enrollment. Many dual eligibles who were in Medical Assistance Managed care were passively enrolled into the Medicare HMO Special Needs Plan (SNP) associated with their Medical Assistance managed care plan. Many of these people have had problems accessing care as a result. The Pennsylvania Health Law Project and Community Legal Services filed a class action lawsuit on behalf of people who were passively enrolled in November 2005. That litigation, Erb v. McClellan, is on-going in the Eastern District of PA; however, in the meantime, there are several steps that passively enrolled people can take to receive services.

Until March 31, 2006, the Medicare Special Needs plans are required to pay for the services that the passive enrollees were receiving under Medical Assistance, even if the providers are not part of the Medicare HMO's network. This means that the Medicare HMOs cannot impose prior authorization requirements or limit consumers to providers in their networks. After March 31, 2006, the plans can begin requiring that consumers go through a primary care provider and use net-

(Continued on page 8)

(Continued from page 3)
sulting reduction in nursing home admissions and nursing facility days. However, when the waivers were expanded nursing facility days did not decrease, but in fact, slightly increased. This caused the Department of Aging (PDA) and the Office of Health Care Reform to scrutinize the counties' waiver determination processes. They found a wide variation on how consumers were evaluated and found waiver eligible. In response, the PDA established a centralized process to review all waiver eligibility determinations to assure the consumers are, in fact, nursing facility clinically eligible. State officials say this will improve consistency and assure they are achieving the goal of nursing home diversion. This centralized review process has added delay to the waiver approval process although the state is now working on a tool to speed up the process.

Consumers and advocates have also expressed concern about a recent directive that seniors who are receiving hospice services can no longer be found eligible for the PDA waiver. The state's reasoning is that the Medicare hospice rate should cover all the services a consumer needs and therefore PDA waiver services are not needed. Advocates for the elderly have countered that PDA waiver services may still be needed in these cases because the Medicare rate does not actually cover all needed services-especially the consumer's personal care and respite needs.

Persons working with elderly consumers who have been denied waiver services, who are experiencing unreasonable delays in being evaluated for the PDA waiver can refer them to PHLP's Helpine at 1-800-274-3258.

(Continued from page 7)
work providers. The plans are also required to cover any medications that the passive enrollees were receiving under Medical Assistance until March 31, 2006. Information about the transition requirements is contained in the "attestations" each of the Medicare HMOs signed, copies of which can be downloaded from our website at www.phlp.org.

Consumers who have been passively enrolled into a Medicare Special Needs Plan can disenroll from Medicare managed care and go into traditional Medicare, where they can see any Medicare provider.

Disenrollment from the Medicare Special Needs plans can be retroactive to January 1 or can be done effective the first day of the following month. To disenroll, the consumer should call 1-800-MEDICARE and say she was passively enrolled and would like to disenroll. The consumer will also have to tell Medicare if she wants to disenroll back to January 1st, February 1st or March 1st. The consumer should also have the name of a plan she wants to join or a list of her medications and choice of pharmacy available so the staff at 1-800-MEDICARE can help her choose a prescription drug plan that meets her needs. The consumer will get a confirmation number from Medicare regarding her enrollment into the new prescription drug plan. She should keep this information. She should also get a disenrollment confirmation letter. If consumers have any problems disenrolling from a Medicare HMO, please contact the Pennsylvania Health Law Project helpline at 1-800-274-3258.

Do you currently get the Health Law PA News through the mail? Would like to get this newsletter by e-mail? If so, contact Jennifer Nix at jnix@phlp.org to change the way you get the Health Law PA News!

(Continued from page 5)
quirement.

Asset transfer changes

The DRA extends the look-back period for asset transfers to five years, from the current three years. This applies to applications to Medicaid for coverage of long-term care. Currently, Medicaid will look at the three years prior to a person's application for Medicaid coverage of long-term care. If the applicant made any transfers of assets at or below market value, then the person's eligibility for Medicaid would be delayed depending on the amount that the asset was worth. Under the DRA, the look-back period was increased to five years. This will take effect for any transfers made on or after February 8, 2006. Additionally, the DRA makes individuals with more than $500,000 in home equity ineligible for Medicaid and gives the states the option to increase the amount to $750,000.

In addition to DRA provisions that the federal government expects will result in Medicaid spending reductions, the Administration also expects to reduce Medicaid spending by an additional $14.1 billion over the next five years through regulatory and legislative changes. The additional regulatory and legislative changes include reassigning administrative costs between Medicaid and TANF, limiting pharmacy reimbursement for certain medications, eliminating "pay and chase" for pharmacy claims, and clarifying the reimbursement rules for rehabilitation services.

The federal budget proposal also includes a proposal to increase spending on transitional medical assistance and to increase outreach for Medicaid and SCHIP under a "Cover the Kids" campaign.

(Continued from page 3)
care services for pregnant women on Medical Assistance. Regulations for the Health Beginnings Plus Program are located in the PA Code at www.pacode.com/secure/data/055/chapter1140/chap1140toc.html. They define the Healthy Beginnings Plus Program as "an enhanced, comprehensive package of prenatal and postnatal services provided to eligible MA recipients by enrolled qualified providers." The mandate of the HBP Program is to provide low-income pregnant women on Medical Assistance with a full array of medical and non-medical services. The comprehensive package of services consists of care coordination, medical/obstetrical services, nutritional counseling, psychosocial services and health promotion for all pregnant women. These prenatal services include MA reimbursable smoking cessation counseling services. MA maternity care providers in PA must apply for and be certified as a Healthy Beginnings Plus Program provider.

PHLP and CHC were encouraged by our initial research, as it appeared that HBP was consistent with best practices for smoking cessation services for pregnant women. However, the Healthy Beginnings Plus Program was not fully implemented or monitored by DPW in either the MA Fee-For-Service system or in HealthChoices. All indications point to the need for the DPW to fully implement and monitor smoking cessation services as outlined in the Healthy Beginnings Plus Program Manual. Only after smoking cessation services are delivered in the context of the Healthy Beginnings Plus Program can data be collected to determine the program's effectiveness in decreasing rates of smoking for pregnant women on Medical Assistance and improving birth outcomes.

PHLP and CHC were drawn to this project because of Pittsburgh's unfortunate distinction of being the number one of fifty most populated cities in the country with the highest maternal smoking rate, according to a 2000 survey con-

(Continued on page 10)

DPW requesting Family Planning waiver

The Department of Public Welfare has requested a waiver from the Centers for Medicare and Medicaid Services (CMS) to expand eligibility of family planning services under Medical Assistance. The proposed waiver would provide family planning services to women ages 18-44 who are at 185% of poverty or below.

To be eligible, women must have no health insurance coverage for family planning services. Beneficiaries will get coverage of all FDA approved methods of contraception, pap smears for the early detection of cervical cancer, testing for sexually transmitted diseases, including HIV, family planning related physical exams and outpatient office visits, and testing for anemia. This waiver would not provide coverage for abortions. Beneficiaries receiving coverage would be able to receive services at MA providers, including doctor's officers, hospitals and family planning clinics. The state expects to save $15 – 21 million by implementing this program.

(Continued from page 9)
ducted by the Annie E. Casey Foundation. Additionally, there are many rural counties in PA with even higher rates of maternal smoking than Pittsburgh.

The white paper in its entirety can be accessed at www.phlp.org or by calling PHLP at 1-800-274-3258.

Pennsylvania Health Law Project
Lafayette Building, Suite 900
437 Chestnut St.
Philadelphia, PA 19106