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

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Budget Debate Continues; Alternatives to Cuts Exist

Just over one month remains before the General Assembly and the Governor must agree on a budget and the cuts to Medical Assistance remain the central budget issue. The budget must be passed by the General Assembly and signed into law by the Governor before July 1, 2005. Until then the debate over the Medical Assistance cuts will rage on.

The Governor introduced his proposed budget in early February 2005. That budget proposes caps, co-pays and premiums for those on Medical Assistance. The caps would admittedly prevent over 100,000 current medical assistance recipients from accessing medically necessary care. The co-pays and premiums would make the care that individuals do receive more expensive (see March

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INSIDE THIS EDITION

Update on Medicare Prescription Drug Benefit

The Medicare Prescription Drug Benefit will start January 1, 2006. This is a voluntary benefit. All persons who have Medicare Part A and/or Part B can choose to enroll in a Medicare Prescription Drug Plan for coverage. Medicare will approve private prescription drug insurance plans and Medicare Advantage (most commonly Medicare HMOs) to offer the Medicare Prescription Drug Benefit. Each Medicare Prescription Drug plan will differ in terms of costs, drugs covered, and pharmacy network. Once the approved plans are announced in the Fall of 2005, consumers will have to thoroughly compare plans to determine which plan best meets their needs.

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Consumers can begin to enroll into a Medicare Prescription Drug Plan (PDP) beginning November 15, 2005 for coverage beginning on January 1, 2006. Eligible consumers who do not enroll in a Medicare PDP between November 15, 2006 and May 15, 2006 may face increased premiums when they later join a Medicare PDP, as a penalty for not enrolling during this initial period. Only those who have other prescription drug coverage that is as good as or better than the Medicare Prescription Drug Benefit coverage will not be subject to this penalty.

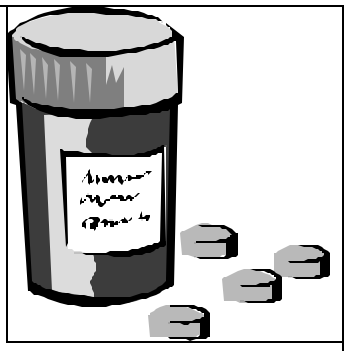
Impact on Dual Eligibles

"Dual eligibles" is a term that refers to Medicare beneficiaries who also have Medical Assistance (MA). Dual eligibles will fall into one of two groups:

Full Dual Eligibles

"Full dual eligibles"—these consumers qualify for prescription drug coverage through MA. Full dull eligibles will lose their prescription drug coverage under MA on December 31, 2005. They will continue to be eligible for MA coverage for all of their other health care services. Full dual eligibles will have to enroll into a Medicare PDP for prescription drug coverage starting January 1, 2006.

In the Fall of 2005, "full dual eligibles" will get a notice in the mail that they have been assigned to a Medicare PDP. These persons will be automatically enrolled into that PDP for coverage beginning January 1, 2006 unless they choose to enroll in a different Medicare PDP before the end of 2005. If at all possible, these consumers should compare the Medicare PDPs available in their area and make their own choice about which Plan would best meet their needs. This is especially important for consumers with chronic conditions and persons with disabilities who rely on medication for the treatment of their condition because automatic enrollment into a plan is random and does not take into account whether the plan will cover all of the consumer's prescription drugs.



Other Dual Eligibles

"Other dual eligibles" are consumers who get some help from MA, but who do not qualify for prescription drug coverage. This group includes persons in one of the Medicare Savings Programs who only get help from MA with their Medicare Part B premium and Medicare deductibles and co-pays.

Any "other dual eligible" that has not enrolled in a Medicare PDP by Spring 2006 will get a notice in the mail telling them that they have been assigned to a Medicare PDP. The person will be automatically enrolled into that Plan with coverage starting June 1, 2006 unless they choose to enroll in a different plan before mid-May 2006.

Help with the costs of the Medicare Prescription Drug Benefit

The cost of prescription drug coverage under a Medicare PDP will depend on which plan you choose and how many drugs you take. Medicare PDPs will charge a monthly premium (estimated to be about $37 in 2006). In addition, you will need to meet an annual deductible. In 2006, the standard deductible will be $250. Once you meet the deductible, you will have to pay for part or all of your drug costs until your total out of pocket expenses reach $3600. After that, you will have only small co-pays for your prescriptions for the rest of the year.

Consumers with limited income and assets and those on Medical Assistance will qualify for a subsidy to help with the costs of their Medicare PDP coverage. All dual eligibles will automatically qualify for a subsidy and do not need to apply. These consumers will get a letter in the mail telling them that they have been approved for a full subsidy and that the subsidy will start as soon as they enroll in a Medicare PDP.

Dual eligibles will not have to pay a monthly premium (as long as they choose a basic plan) and they will not have to meet an annual deductible.

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Consumers and Advocates Express Concern and Confusion Over DPW's Implementation of ACCESS Plus

In our January Newsletter we described the new health care delivery system DPW is now implementing for Medical Assistance (MA) consumers who live in the 42 counties of the state that do not participate in HealthChoices (mandatory managed care). Deciding against expanding HealthChoices statewide, DPW has created a "managed Fee For Service" system it is calling ACCESS Plus. Under ACCESS Plus, consumers:

* must choose a Primary Care Provider (PCP) from whom they will get most of their physical health care
* need a referral from their PCP before they can see a specialist (with some exceptions)
* can access disease management services if they have certain chronic conditions like Asthma, Diabetes and Congestive Heart Failure.

On March 1, 2005, all the children in the 42 Fee For Service counties who had been participating in the Family Care Network were transitioned to ACCESS Plus. All those newly-eligible for MA (adults and children) after March 1st were immediately enrolled into ACCESS Plus. Finally, all other consumers (i.e. adults already on MA) eligible for ACCESS Plus were transitioned into the program effective May 1, 2005.

Over the last 3 months, PHLP has heard from consumers, advocates and providers in the ACCESS Plus counties who have questions about the program and who have expressed concern and confusion about how ACCESS Plus is being implemented.

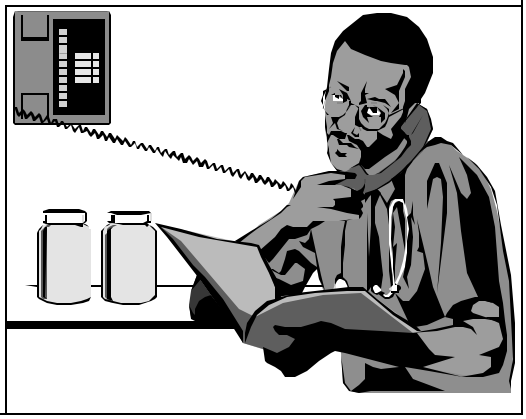
Lack of Outreach and Education

Prior to starting ACCESS Plus, DPW and McKesson Health Solutions (the ACCESS Plus contractor) contacted some hospitals and larger provider groups (like the PA Medical Society) to educate them about the new program and to elicit their support and participation. However, no efforts were made to outreach to consumers, advocates or community agencies to inform them of ACCESS Plus or educate them about how to access services under this new program.

PHLP has conducted trainings on ACCESS Plus for consumers, providers and advocates in several counties-including Cambria, Clarion and Warren. Attendees expressed confusion and concern about how this new program would affect them and/or the consumers with whom they work.

Lack of information for those newly enrolled in ACCESS Plus about how to get care

As noted above, the children previously participating in the Family Care Network were transitioned into the ACCESS Plus Program effective March 1st. Since then, all new MA recipients (adults and children) have been enrolled in ACCESS Plus. However, these consumers were not provided with any written information about how to use the program, about the services their PCP would provide, or about how to obtain referrals for specialty care. In addition, the ACCESS Plus website remained "under construction" and was not available as a source of reliable information.



During the week of April 25th, almost 2 months after ACCESS Plus started, the contractor began to mail out Identification cards, welcome packets and an Enrollee Handbook to consumers telling them how to obtain health care services under this

edition of the Health Law PA News, available at www.phlp.org, for more details on the Governor's proposal).

The budget is currently in the hands of the General Assembly. Since the Governor proposed his budget the General Assembly has had an opportunity to examine the proposal and hear from Medical Assistance stakeholders. Many legislators are now beginning to respond.

Representative Mike Veon, House Minority Whip (D), while condemning the cuts in public comments, has sponsored legislation which would enable the Governor's proposed cuts to be implemented. Since the Governor's proposal includes such significant changes to the current program, this legislation – which would amend the welfare code – would have to be adopted before any changes to Medical Assistance benefits could be implemented. The bill that Representative Veon introduced is House Bill 1500 (HB1500). It can be viewed at http://www.legis.state.pa.us.

Representative Dwight Evans (D) has also been critical of the cuts and has offered proposals for alternative funding sources that could be utilized to avoid the harmful cuts. Representative Evans has suggested that a hospital bed assessment and/or a smokeless tobacco tax could be adopted to lighten the impact of the cuts on consumers, hospitals and other health care providers.

Some Republican legislators have also expressed concern over the impact these cuts will have on their constituents and they are working hard to come up with alternatives.

Some legislators fully support the cuts and have suggested implementing cuts that are even more severe.

The House of Representatives passed a version of the budget that included many amendments. The Senate must now also pass a budget bill. Once both chambers have passed budget bills the leadership from both chambers will engage in intense negotiations with the Governor's representatives to reach a final agreement.

At this point every legislator still has a say in what the final budget will look like. These legislators will be looking to constituents to contact them and let them know what they should do. Contact information for local legislators can be found at http://www.legis.state.pa.us.

Many consumers and advocates have suggested ways to save money and avoid the cuts. These possible alternatives include:

* Using a portion of the PACE savings that will be generated by the implementation of the Medicare Part D Drug Benefit to fund the services for seniors that are being cut from DPW's budget.
* A smokeless tobacco tax. Pennsylvania is the only state in the country that does not tax chewing tobacco.
* Aggressively seeking reimbursement from Medicare for services that Medicare covers but Medical Assistance ends up paying for.

Visit PHLP's website for more up to date information on the budget.

DPW Plans to Send Notices Regarding Cuts on June 1

Working under the assumption that the Governor's budget will pass as proposed—MA cuts included—the Department of Public Welfare has announced their intent to send notices to consumers by June 1 that notify them that their benefits will be reduced. DPW plans to issue these notices whether or not legislation adopting the cuts has been passed before June 1. DPW plans to issue a separate set of notices after the budget is approved which would notify consumers of any corrections to the earlier notice.

DPW has not announced whether it will be sending notices to providers as well.

Sending notices of a change in benefits before any changes have been approved by the legislature will cause mass confusion for Medical Assistance recipients.

HB1500 Evades Administrative Review, Contains more Restrictive Exceptions Process than Originally Promised by DPW

On May 3, 2005, Representative Mike Veon, House Minority Whip (D), introduced legislation that would amend the Welfare Code so that Governor Rendell's proposed cuts to Medical Assistance could be implemented. The legislation is HB1500 and can be found at http://www.legis.state.pa.us. Two particular provisions in the proposed legislation are extraordinary.

First, the legislation would exempt any changes to Medical Assistance benefits from the administrative or regulatory review processes. The legislation allows that the Secretary of the Department of Public Welfare to implement changes to benefits by simply issuing a notice in the Pennsylvania bulletin. Allowing changes to benefits to occur without going through the formal regulatory and administrative processes would prevent the public, consumers, providers and the legislature from having significant input on the Department's decisions.

Second, the legislation contains a standard for exceptions that requires recipients to prove that they meet all three criteria of the standard before receiving an exception. The Department had been promising that the standard would only require recipients to meet one of the three criteria. In other words the legislation proposes an "and" standard instead of an "or" standard.

According to the legislation an exception may only be granted when "the department determines that all of the following criteria are met:

* Recipient has a serious chronic systemic illness or other serious health condition, which alone or in combination with other illness, conditions, or major trauma, necessitates medical care and treatment beyond the limits specified in the recipient's benefits package.

* Denial of the exception will jeopardize the life of or result in the rapid, serious deterioration of the health of the recipient.

* Granting the exception is consistent with the efficient and economical administration of the medical assistance program."

PHLP Thanks The Philadelphia Foundation for it's Generous Support

PHLP is pleased to announce the recent receipt of a $17,500 grant from the Alice H. and Joseph W. Campbell Fund #1, Isabele Howell Gest Memorial Fund #2, William P. Gest Fund #1 and the Charlotte L. Hammell Fund of The Philadelphia Foundation in general operating support of our efforts to ensure equal access to quality health care for low-income families and the working poor in Southeastern Pennsylvania. As Southeastern Pennsylvania's primary provider of philanthropic services, The Philadelphia Foundation manages more than 600 charitable funds established by caring families who want to give something back to their community. Revenue generated from these funds provides grants and scholarships to 800 cultural, educational and humanitarian programs, exactly as the donors intended. The Philadelphia Foundation was one of PHLP's earliest supporters in the 1980s, and it is safe to say that without their support, PHLP would not be here. Thank you!

Methadone Treatment Program Planning to Stop Serving Medical Assistance Recipients

There are 150 MA recipients currently receiving methadone treatment services at Discovery House in Curwensville, Clearfield County. Those individuals have received written notification from Discovery House that effective June 1, 2005 the program will no longer serve people on Medical Assistance due to low reimbursement rates, and that they will need to receive services elsewhere. This presents a significant problem since the next closest outpatient methadone treatment facility is three counties away from Clearfield County in Allegheny County.

Individuals receiving methadone treatment must travel 2 to 6 times per week to their service provider, depending upon the level of treatment. If Discovery House in Clearfield County stops providing treatment to 150 MA recipients this could present a huge barrier to access for these individuals and greatly impede their recovery in several ways. To begin with, there are insufficient numbers of methadone treatment providers who accept individuals on Medical Assistance Fee-For-Service (MA-FFS) across the state. It is very common that these providers have waiting lists, as is the case currently for two of the three Allegheny County methadone providers who accept MA-FFS. Even if these 150 persons in recovery currently at Discovery House could access treatment in Allegheny County the roundtrip travel for each treatment could be as much as 150 to 250 miles a day! This lengthy travel involved in accessing treatment is impractical for many people and will pose a hardship that interferes with a person's recovery, ability to attain or keep a job, attend to personal and family responsibilities and participate in supportive services.

Access to methadone treatment is much less of a problem in counties with Medical Assistance managed care. That's because the behavioral

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new system! The handbook, which DPW developed with substantial input from the Consumer Subcommittee of the Medical Assistance Advisory Committee (MAAC) is very informative and easy to read. The ACCESS Plus website is also finally up and running at www.accessplus.org.

Adequacy of the PCP Provider Network

A persistent question for consumers and advocates has been whether there will be a sufficient number of medical providers in the ACCESS Plus region willing to participate in the new program as PCPs. That question is still not yet answered. Having a strong network of PCPs will prevent consumers from having to travel great distances to access primary care.

Currently, all Family Care Network providers are listed as available PCPs on the accessplus.org website. Yet, according to the ACCESS Plus contractor, less than half of the providers have signed the ACCESS Plus agreement. PCPs must sign a Provider Agreement indicating they agree to the terms and conditions of ACCESS Plus. If providers refuse to sign up, the situation could prove chaotic for consumers who have selected them as PCPs.

PHLP has heard from consumers and advocates that some providers have concerns and questions about the new program and are hesitant to sign the ACCESS Plus agreement. The ACCESS Plus contractor staff report that they are continuing to work to secure agreements from providers but there is currently no deadline for having a sufficient number of providers enrolled in ACCESS Plus.

In order to alleviate problems, DPW has not turned on the "hard edits" in ACCESS Plus. In other words, providers will still be paid, even in the absence of the necessary referrals.

Improper Marketing/Enrollment Activities by Voluntary MCOs

About half of the ACCESS Plus counties have one or more Voluntary Managed Care Organi-

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Medicare Part D Brings Specific Concerns for Mental Health Consumers

Prescription medications used to treat mental illness are often an important part of an individual's successful recovery plan. That's why there is very real concern in the mental health community about the implementation of Medicare Part D in January 2006. PHLP has experienced increased calls to our Helpline from consumers, providers and county administrators all trying to understand the impact of Medicare Part D on consumers' access to mental health prescription medications. Concerns primarily surround three groups of Medicare beneficiaries; 1) those who currently receive their mental health medications through Medical Assistance but who also have Medicare (also known as "dual eligibles"), 2) those who get medications through county-funded mental health programs, and 3) those who don't qualify for either program and who typically have limited or no access to the mental health medications they have been prescribed. There are concerns unique to each group as well as some common issues.

1) The unique concerns for dual eligibles surround the change from accessing medications through the Medical Assistance system to the Medicare system and the increased costs to consumers. Currently, dual eligibles and their physicians must understand and navigate the prior authorization process of DPW or their managed care plans to access prescribed mental health medications. Under Medicare Part D, dual eligibles will have to enroll in one of the Medicare prescription drug plans. Each plan will have a drug formulary (a restricted list of available drugs), which will be different from one plan to the next. These formularies may be very different from the formularies used by their current MA health plans.

The requirements for how extensive the Medicare plans' formularies must be are very minimal. There are real concerns about whether consumers will be able to access the latest behavioral health medications through the Medicare prescription plans. Navigating the new Medicare Part D benefit with the uncertainty of whether or not they will be able to access specific medications is very disconcerting for mental health consumers, family members, advocates and physicians. Those who have experienced the devastation that can come with a relapse in recovery are expressing their fear, worry and confusion that they will not be able to access their medications. Choosing the plan that best fits their needs at the outset will be critical to increasing their chances of getting their prescribed drugs.

Dual eligibles are also expressing concern about increased costs under Medicare. Many dual eligibles currently have no co-pays for any medication covered by MA. With Medicare Part D, even though they qualify for a full subsidy, all consumers will be required to pay co-pays for each generic and brand name medication. Individuals on several mental health and physical health medications may find the combined co-pays each month to be unaffordable. County mental health programs and charitable organizations may be of assistance to those who can't afford these co-pays.

2)Medicare beneficiaries who currently get mental health medications through county-funded mental health programs have other questions. In addition to learning how to access their medications through the Medicare Prescription Drug Plans, these consumers are questioning whether, and if, the county-funded medication programs

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will "wrap-around" the Medicare coverage by paying the co-pays for those who can't afford them, or providing medications that are not on the Medicare Part D Plans' formularies. Decisions on these issues will be made on a county by county basis so consumers and providers can't assume that what is offered in one county will be available in another county. Consumers, advocates and other interested stakeholders can contact their county mental health program to see what system is in place to address these concerns.

3) Those individuals who currently have little or no access to mental health medications are expressing cautious optimism. Medicare Part D offers prescription drug coverage for the first time to any Medicare beneficiary in need of mental health medications but there will still be significant costs. Costs of the Part D Plans will vary from plan to plan. Low-income consumers may qualify for a subsidy that will help with some or most of the costs. Single persons with incomes up to 150% of the Federal Poverty Level ($ 1197/month for 2005) and less than $10,000 in resources will qualify for a partial or full subsidy that will pay most of their Medicare prescription costs. Consumers must apply for the subsidy and may look to providers or case managers for assistance with this process.

Many of consumers' questions, concerns and confusion can be eliminated or reduced through education, outreach and one-to-one assistance. Sources of information will be the Social Security Administration, the local APPRISE programs and PHLP, among others.

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The New Medicare Prescription Drug Benefit is Coming Soon: Get the Facts!

PHLP's Pittsburgh Office is conducting **FREE** trainings on Medicare Part D across Southwestern Pennsylvania. These trainings include an overview of the Part D program, information about who is eligible for a subsidy, how to apply for the subsidy and how it will work, and how to choose a Medicare Prescription Drug Plan.

Upcoming trainings that are already scheduled: **May 17**, Lupus Support Group, Butler County; **May 26**, Jewish Family & Children's Services, Pittsburgh; **June 2**, Cambria County MH/MR, Cambria County; **June 10**, Achieva, Pittsburgh.

If you are interested in attending one of these trainings or scheduling a training for your staff and/or the consumers you work with, please call PHLP at (412) 434-4728 (voice and TTY), 1-800-274-3258, or 1-800-236-6310 (TTY). Let us know if you require any special accommodations for hearing and/or visual impairments, and we would be happy to provide such accommodations.

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zations (MCOs) operating in them. In those counties, MA consumers can choose to enroll in an MCO instead of ACCESS Plus and receive their physical health services through a health plan. When ACCESS Plus started, DPW prohibited the MCOs from marketing at the County Assistance Offices (CAOs) and from approaching consumers at other locations. Over the last few months, however, PHLP has received complaints and reports from consumers and advocates about improper marketing activities by certain Voluntary MCOs such as approaching consumers at doctor's offices and in personal care homes. These complaints have been brought to DPW's attention. DPW has investigated the complaints and is now considering action to further restrict Voluntary MCO marketing activities.

If you or the consumers you work with have questions or concerns about ACCESS Plus, or have problems accessing care under this new system, call PHLP's Helpline at 1-800-274-3258.

PHLP Working To Get Greater Language Services in HealthChoices Plans

Medical Assistance HealthChoices plans are governed by contracts that the state has with each HealthChoices plan. Although these plans, like all federally funded entities, are required to provide language services (such as interpretation and translation) to Medical Assistance enrollees, the states contracts have never fully specified details as to what plans must do to help Medical Assistance enrollees who are Limited English Proficient ("LEP").

In November 2004, working on behalf of the Consumer Subcommittee of the Medical Assistance Advisory Committee, PHLP provided the Department of Public Welfare with suggestions for requirements to be included in new contracts which will take effect beginning July 2005. The requirements would instruct plans to track LEP clients, and provide them various types of notification about language services, among other things.

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They will have co-pays of $0-$5 per drug until they reach $3600 in "out-of-pocket" costs. After reaching this limit, they will not have to pay anything for their drugs for the remainder of the year.

Other Medicare consumers who meet the following income and asset guidelines will also qualify for a subsidy:

- Single persons with incomes no greater than $14,355/year**, and who have no more than $10,000* in assets;
- Married couples whose income is no greater than $19,245/year** (for a household of 2), and who have no more than $20,000* in assets.

**Certain income and assets will not be counted when deciding if you are eligible for a subsidy.

Medicare consumers who are not dual eligibles will need to submit an application to see if they qualify for the subsidy. The Social Security Administration (SSA) will start mailing applications to low-income consumers starting at the end of May 2005. If you do not receive an application in the mail, beginning July 1, 2006, you can apply through the local Social Security Office, your local County Assistance Office (CAO), and the internet (www.socialsecurity.gov/medicare). After you apply for a subsidy, you will be sent a written notice telling you if you qualify for a subsidy and how much help you will get.

Please see the PHLP website (www.phlp.org) or call the Helpline at 1-800-274-3258 for more information.

Q&A: How Microboards Help Families Plan and Care for Individuals with Disabilities

What Is a Microboard?

A Microboard is a small, nonprofit organizations that functions as a provider agency for an individual with a disability. Microboards are comprised of persons who know and care about the individual with the disability. In keeping with the philosophy of Self Determination for persons with disabilities, Microboards are also referred to as Self Directed Support Corporations (SDSC). A Microboard can directly contract with county government as a service provider, and can then, in turn, hire individuals to provide direct services to persons with disabilities. It provides an alternative to the institutional model of care.

Who runs the Microboard?

A Microboard is typically governed by a board of officers who may include the following: the person with a disability, their family and friends who can provide a reliable and effective support network around the person. It is very important for the Microboards officers to believe in and value the person with a disability and to understand and appreciate the needs, wants and dreams of the person.

Microboard officers come together with a firm commitment to the principles of self determination and to that end they employ their expertise, skills, and resources to enhance empowerment of the person with a disability. Some examples of the principles that guide Microboards are:

* The freedom to make life decisions,
* The authority to receive and spend public monies, to recruit and fire paid support staff,
* The right to receive support from individuals who are freely chosen by them.

Through the application of self determination principles and the philosophy of person-centered planning a Microboard provides an entity through which a person's wishes and needs can be addressed in a manner that is empowering, liberating and enriching.

What are the Benefits of a Microboard?

Below are just a few of the many benefits that Microboards provide to individuals with disabilities.

* They assist families and their loved ones in establishing a lasting entity that will have oversight over future planning and supports,
* They provide person-centered structures that are specific to the unique needs of each person 's needs, skills, wants and challenges,
* In some cases, they cut down on administrative and other costs,
* They assist people to plan, direct and monitor their own services and supports,
* They are focused on the person and directed by trusted persons close to them,
* They are instrumental in providing guidance to quality life outcomes i.e. empowering a person to contribute and receive from their community

How Do You Set Up A Microboard?

The structure and the composition of Microboards vary, however there are some basic steps that need to be taken.

Circle of Support. The first step is to identify close family and friends to be a part of your "circle of

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support." This "circle of support" can then begin developing what is popularly known as a "person-centered" plan of care for the individual with the disability.

Contact the County MH/MR. It is important to arrange a meeting with your county MH/MR to discuss your intent to establish a Microboard.

Mission Statement. This group will need to develop a mission statement for the Microboard which will outline the goals and purpose of the organization.

Bylaws. The mission statement will need to be accompanied by organizational bylaws that will provide direction for the governance of the corporation.

Incorporation. The organization must become incorporated through the Department of State. Incorporation is usually done with the help of an attorney. Incorporation makes a non-profit group legitimate so that it can act as a fiduciary entity on the behalf of the person with a disability at any given time.

Individual Service Plan (ISP). The members of the board need to develop an ISP. When developing an ISP, it is crucial to work with the person's Supports Coordinator to identify the needs and strengths of the individual. The Microboard should work hard to develop an ISP that is person-centered and reflects various supports (i.e. traditional and non-traditional)/service needs of a person.

Develop a Budget. Once the ISP is completed, it will be used to develop a budget for serving the individuals identified needs.

How do I get more information about Microboards?

For more information about how to set up a Microboard, you may contact the PA Health Law Project at 7171-236-2269 or 717-236-6310 or e-mail our office staff at gegun@phlp.org and dgates@phlp.org

The Microboard Project is made possible by the Pennsylvania Developmental Disabilities Council.

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health managed care plans generally pay providers a weekly "bundled rate" that covers the methadone treatment and individual and group counseling sessions. This bundled rate of reimbursement in managed care results in a higher daily rate for providers serving Medical Assistance managed care recipients than those providers serving Medical Assistance Fee-For-Service recipients. This payment inequity poses a barrier to access to treatment for MA recipients in the Fee-For-Service system.

In Allegheny County, for example, there are five providers who accept clients with MA- managed care but only three who accept those in Fee-For-Service. Two of the 3 providers who accept FFS now have waiting lists - resulting in only 1 provider available to MA-FFS recipients in Allegheny County! Additionally, of the 36 outpatient methadone treatment facilities across the state, 29 of them are located in managed care counties while a total of 7 facilities exist in the 42 Fee-For-Service counties. This appears to be in direct correlation to the fact that program costs for methadone treatment do not differ from one county to the next but the Medical Assistance reimbursement does differ in managed care vs. Fee-For-Service. DPW's Office of Mental Health and Substance Abuse Services (OMHSAS) has a two-year plan to convert the Fee-For-Service counties to a managed care system for behavioral health services. If this occurs, there should no longer be the inequity between the re-imbursement in these two service delivery systems. Those in favor of this conversion from managed care to Fee-For-Service for behavioral health services can encourage OMHSAS and the County administrators to make this transition occur sooner.

If you or someone you know is having difficulty accessing methadone treatment or is concerned about losing access to their methadone treatment services, please call the PA Health Law Project Helpline at 1-800-274-3258.

Non-Profit Organizations Appeal
Insurance Commissioner's Blue Cross Surplus Decision

In March a group of non-profit organizations from around that state filed an appeal of the Insurance Commissioner's decision that none of the four Blue Cross Plans harbor any excess surplus. The Commissioner's decision ended a year long proceeding in the Insurance Department regarding the surplus levels of the four Blue Cross plans. Despite the fact that an independent expert found a combined surplus of over $6 billion, the Commissioner held that none of the plans had excessive surplus.

PHLP and Community Legal Services had filed briefs before the Insurance Department proceedings on behalf of non-profit organizations from across Pennsylvania. These briefs argued that the surplus levels were excessive in relation to the Plans' failure to fulfill their charitable mission and that a portion of the excess surplus should be directed towards coverage for the uninsured.

These same organizations are the ones that have filed the appeal of Insurance Commissioner Koken's decision. The organizations filed the appeal jointly with private litigants who have also been challenging the appropriateness of the current surplus. The appeal was filed in the Commonwealth Court of Pennsylvania. The case is Ciamaichelo and Stevens, Inc. v. Pa Ins Department; 533 CD 2005.

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