Health Law PA News

Newsletter of the Pennsylvania Health Law Project

Harrisburg Philadelphia Pittsburgh

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Budget Deal Brings Major Change to Pennsylvania Medical Assistance

Caps on Services. The Rendell Administration and the Pennsylvania General Assembly reached agreement July 6th on a budget for fiscal year 2005-06 that is bittersweet for Medical Assistance (MA) recipients. Some of the harshest cuts that were proposed in February were eliminated. There will be no annual cap on payments for durable medical equipment. There is no annual limit on ambulance trips. Persons in the SSI and TANF-related categories of MA (primarily the elderly, persons with disabilities and families) escaped annual caps on inpatient hospitalization and monthly caps on prescription drugs. However, adults in the General Assistance category (primarily adults without dependants) will be limited to one inpatient hospitalization per year. And all MA recipients over age 21 will be subject to a limit of 18 annual outpatient visits for physical health treatment, and one inpatient rehab hospitalization per year. Payments to private mental hospitals are limited to 30 days per fiscal year for persons age 21 and older. Adults who are not in the mandatory managed care program (HealthChoices) will be limited to 5 hours or ten one-half hour sessions of psychiatric outpatient sessions per 30 day period, and psychiatric partial hospitalization of 540 hours per fiscal year. Those in HealthChoices might also be limited, subject to plan-by-plan contract negotiations.

Exceptions Process. The legislature provided for an exceptions process for the various caps, to be available when DPW determines that an exception is required by federal law, or is cost effective or that the recipient has a serious chronic systemic illness and denial of the exception will jeopardize the life of or result in the rapid, serious deterioration of the health of the recipient. DPW will establish rules for implementing the exceptions process.

New and Higher Co-Payments. Medical Assistance recipients over the age of 18 in the fee-for-service program face higher co-payments, although details around co-payment levels were

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left to the Department of Public Welfare (DPW). DPW officials, in a briefing to the Consumer Subcommittee of the Medical Assistance Advisory Committee (MAAC), said that the co-payments were expected to be no more expansive or higher than what was proposed by the Governor in February (See the March edition of the Health Law PA News for details of the proposed budget.). They speculated that some proposed co-payments might be reduced or avoided altogether if money could be found in the DPW budget to make up the cost. Specifically mentioned was the fact that if the new contract being negotiated for medical assistance transportation program (MATP) services in Philadelphia brought cost savings, the co-payments on MATP services might be eliminated.

Managed care organizations participating in Medical Assistance may choose to impose any or all of the co-payments charged under the fee-for-service program. Whether they impose the co-payments on consumers or not, the state will reduce its payments to the plans as if the plans were charging all of the co-payments.

Premiums and Co-payments for Loophole Families. Families whose income is over 200% of the poverty level will be subject to co-payments and premiums on a sliding scale basis for their disabled children in the "loophole" category of eligibility. The law does not set these levels, but lets DPW establish them. The final budget reduced the impact of this cut in the Governor's original proposal by half, so we expect that the levels set by DPW will be different than earlier proposals.

New Eligibility Limits Imposed. Persons who use the "spend-down" program to qualify for MA will be limited in what medical bills they can deduct from their income to qualify. Only bills incurred during the 3 months prior to the month of application for MA will qualify. The law also contains a number of new limits on estate planning options for long-term care, including a provision subjecting eligibility for home and community-based waiver services to the same medical and financial eligibility requirements as for nursing home eligibility. The practical effect of this provision will be to count the income and resources of a waiver applicant's spouse toward MA eligibility.

Some Surprises: Managed Care Lock-In and Six-Month Redeterminations. The budget deal contained some surprises to consumers and advocates. In a concession to the HealthChoices HMOs, the welfare code was amended to lock consumers into their HealthChoices HMO for a year at a time. Consumers have long opposed such a rule, arguing that it would disrupt treatment in situations where doctors or other health care providers drop out of a health plan, or where a plan imposes new prior authorization requirements that impede access to medicine or services. They contend that no financial savings would be gained from such a rule. This rule would not apply in voluntary (non-HealthChoices) HMO counties.

DPW still intends to shift persons who are "dual eligible" for MA and Medicare from managed care to fee-for-service on January 1, 2006, as proposed, to coincide with the beginning of the Medicare prescription drug benefit.

The law also requires DPW to re-determine MA eligibility for many MA recipients every six months in place of the current annual re-determination. Consumers and advocates had argued that these re-determinations had been proven by studies to be burdensome to recipients and to lose money. Individuals who are excluded from the six-month eligibility re-determination are: 1) those receiving long-term care services, 2) those receiving MA benefits in an elderly or disability category, 3) pregnant women, 4) children under the age of 1 year, 5)

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Update on Medicare Prescription Drug Benefit Developments

The Medicare Prescription Drug Benefit begins January 1, 2006. This is a voluntary benefit, and anyone who has Medicare Part A and/or Part B can choose to sign up for this coverage. Full dual eligibles (individuals who have Medicare and have Medical Assistance that includes coverage for prescription drugs) will lose their drug coverage through Medical Assistance on December 31, 2005 and will need to enroll in the Medicare Prescription Drug Benefit.

Consumers who want to join the Medicare Prescription Drug Benefit will enroll in a Medicare Prescription Drug Plan. Medicare Prescription Drug Plans can either be stand-alone plans that only provide prescription drug coverage or Medicare Managed Care Plans that include prescription drug coverage as part of the benefit package. Each Plan will differ in terms of costs, drugs covered, and pharmacy network.

Applying for Low-Income Subsidies Is Underway

Consumers with limited income and assets can qualify for a subsidy to help them with the costs of the Medicare Prescription Drug Benefit. The Social Security Administration (SSA) began mailing applications for the low-income subsidy at the end of May. The applications are being sent to consumers who appear to meet the income guidelines for the subsidy according to SSA income data. The SSA is sending the applications out in waves throughout the summer based on an individuals' social security number. This means that Medicare consumers living in the same household may not receive the mailed application at the same time.

In order to apply for the low-income subsidy programs, consumers must complete and submit the application to either the Social Security Administration or the Department of Public Welfare. PHLP is encouraging individuals to apply for the low-income subsidies through the Department of Public Welfare because the Department is legally required to screen for other benefits for which they may qualify. Both the Social Security Administration and the Department of Public Welfare started processing the low-income subsidy applications on July 1, 2005.

Consumers can also obtain applications at the local Social Security Administration offices, the local County Assistance Offices, the APPRISE Program, or by calling Social Security at 1-800-772-1213. In addition to submitting an application via mail, applications can be submitted online at www.socialsecurity.gov. A copy of the application can be viewed online at ***www.ssa.gov/organizations/medicareoutreach2/.***

Dual eligibles (those consumers who have both Medicare and Medical Assistance) will automatically qualify for the subsidy and do not need to apply for this help. Medicare started sending notices at the end of May to dual eligible consumers to let them know that they will automatically qualify for a full subsidy and they do not need to apply for this help. Copies of these notices can be found on the Centers for Medicare & Medicaid Services (CMS) Website at ***http://www.cms.hhs.gov/medicarereform/lir.asp***.

Medicare Prescription Drug Plans Are Required to Cover Drugs in Six Categories

Each Medicare Prescription Drug Plan will have a formulary (a list of drugs that the Plan will cover).

The Centers for Medicare & Medicaid Services (CMS) recently announced that they will require that Medicare Prescription Drug Plans cover "all or substantially all" of the drugs in the following six categories:

* Antidepressant
* Antipsychotic
* Anticonvulsant
* Anticancer
* Immunosuppressant
* HIV/AIDS

"Substantially all" means that all drugs in these

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children living with relatives other than a parent when the adult's income does not affect eligibility, 6) children in foster care or adoption assistance programs, and 7) individuals receiving extended medical coverage.

Industry Rewarded. Some segments of the health care provider industry, which lobbied hard against many provisions in the proposed budget, were rewarded. In addition to elimination of the annual inpatient hospitalization cap for some MA recipients, hospitals will get a 2% rate increase, which will not be capped for hospitals that are profitable as the administration had proposed in February. Nursing homes will get a 3% raise instead of the 2% proposed in February. And besides their victory in eliminating the proposed 6 prescription per month cap, the pharmaceutical industry won a gain when reimbursement for drugs was set at the wholesale acquisition cost (WAC) plus 7%, rather than 6% as proposed. Other proposed savings in the pharmacy benefit area remained in the budget, including the establishment of a preferred drug list (PDL) for both the fee-for-service and managed care systems. The budget bill does not reference the PDL, since this is an initiative that DPW contends it can implement without new statutory authority. Some advocates have complained that if the physician community had taken a stronger stand against the proposed caps, the limit on outpatient visits might have been avoided.

Funding Sources. The primary source of the funding for the reduced budget cuts and increased provider payments was increased state revenues, although $20 million that had been targeted to reduce the waiting list under the adultBasic program under the Blue Cross Agreement of last February was shifted to the Medical Assistance Program. There will be no increase in the cigarette tax or imposition of a tax on spit tobacco, as had been suggested by supported in a number of circles.

Implementation Schedule. The legislation gives DPW an exemption from the several laws governing the regulatory review process until December 31, 2005, in order to facilitate the rapid implementation of the cost-saving measures. DPW hopes to send out individual recipient notices of the service caps and co-payment changes by July 27, 2005 and are aiming to implement the caps and co-payments effective August 8, 2005. DPW also expects to publish final regulations governing these changes by that date.

Feel free to contact PHLP at 1-800-274-3258 with specific questions about the MA budget. Also refer to our website , www.phlp.org, for more information about the details of the changes.

Contractor Selected for MATP Services in Philadelphia

The Department of Welfare has selected Medical Transportation Management, Inc. (MTM) as the contractor for the Philadelphia Medical Assistance Transportation Program (MATP) services. A request for proposal was issued in February 2005 and bidding closed in March 2005.

MTM, based in Missouri, provides non-emergency medical transportation for Medicaid consumers in several other states. DPW has suspended negotiations with MTM, until a protest by a disappointed bidder can be resolved. Until a contract is signed, there is the possibility that another contractor will be selected.

At this time, Wheels, Inc. will continue to provide MATP services in Philadelphia until September 1, 2005. To ensure a proper transition, it is possible that Wheels will provide services beyond September 1st. Consumers should schedule their appointment through Wheels until further notice. Members of the MATP Advisory workgroup will work with the new MATP contractor to ensure that consumers have adequate notice about any changes. If you have any problems getting rides through Wheels, please call the Pennsylvania Health Law Project at 1-800-274-3258.

ACCESS Plus PCP Auto-Assignment Process Underway

ACCESS Plus is the new health care delivery system for MA consumers who live in the 42 counties of the state that do not participate in HealthChoices (mandatory managed care). In those counties, MA consumers can either choose to enroll in a Voluntary HMO (if HMOs are doing business in the county), or they will be enrolled in ACCESS Plus.* Under ACCESS Plus consumers must choose a PCP who will give them primary care services and referrals to obtain specialty care. Persons who do not choose will be auto-assigned to a Rpimary Care Practitioner (PCP).

As of May 1st , over 93,000 current MA consumers were converted by DPW from the MA- Fee for Service (FFS) system over to ACCESS Plus. However, many of those consumers, along with many new enrollees, have not contacted ACCESS Plus to choose their PCP. DPW delayed auto-assigning those people hoping they would eventually call and make a choice. After delaying for 2 months, DPW has now begun auto-assigning over 81,000 consumers to PCPs.

The auto-assignment process is not random. The ACCESS Plus Contractor must follow certain rules when auto-assigning consumers to a PCP:

1. If the consumer received services from any participating ACCESS Plus PCP within the last 6 months, the consumer will be auto-assigned to that PCP;
2. If not, but if a family member of the consumer is already assigned to a PCP, the consumer will be auto-assigned to the same PCP;
3. If not, the consumer should be auto-assigned to a participating PCP who is closest to the consumer's residence.

Following these rules, over 73,000 consumers have been auto-assigned to PCPs currently participating in ACCESS Plus. The remaining 8,000+ consumers do not have an ACCESS Plus PCP close to them (less than 30 minutes travel time) who is available to take new patients. Those consumers are being contacted to encourage them to choose a participating PCP. In addition, DPW and the ACCESS Plus contractor are working to get participating PCPs to increase the number of patients they will take, as well as to increase the number of providers who are willing to participate as PCPs in ACCESS Plus.

Keep in mind that ACCESS Plus consumers can switch PCPs at any time. If a consumer chooses (or is auto-assigned to) a PCP with whom they are not satisfied, they can call ACCESS Plus Enrollment Services at **1-800-485-5998** and choose a new PCP. The change should take place no later than a week from the time the consumer requests a new PCP. If you or the consumers you work with have problems choosing a PCP or accessing health care under ACCESS Plus, please call PHLP's Helpline at 1-800-274-3258.

*There are some exceptions to this rule. For example, dual eligibles (those on MA and Medicare) and persons who participate in the Health Insurance Premium Payment Program (HIPP) are not enrolled in ACCESS Plus and remain in MA Fee For Service (FFS).

Insurance Department Study Reveals New Information about Pennsylvania's Uninsured

The Pennsylvania Department of Insurance has released the results of its *Pennsylvania Health Insurance Status Survey* – a state-wide survey on health insurance in Pennsylvania. The results provide valuable information about the uninsured in the Commonwealth. The study reveals that a full 8% of Pennsylvanians have no health insurance of any kind, including 4% of children under the age of 18.

Unsurprisingly, the survey shows that individuals with less income are much more likely to be uninsured than those with higher income. Of the 4% of children under the age of 18 who have no health insurance, approximately 110,000 are eligible for state-funded, income based programs. Approximately 55,000 are income eligible for Medical Assistance. The remaining 55,000 are income eligible for the Children's Health Insurance Program. Of the 11% of adults age 18-64 who are uninsured, approximately 300,000 qualify for the adultBasic health insurance program. The adultBasic program currently only receives enough funding to provide coverage to less than 40,000 individuals, and the waiting list for this low-cost program now exceeds 100,000 individuals.

Among the uninsured population, the survey indicates that 7 in 10 uninsured Pennsylvanians do not have insurance because they can not afford it. More than 2 in 10 have no insurance because of some problem related to employment; either their employer doesn't offer insurance, or they switched jobs, or they lost their job.

The survey shows that the vast majority of uninsured Pennsylvanian adults are working. The study shows that 2 in 3 uninsured adult Pennsylvanians are working, and a full 44% of the uninsured population is working a full time job. The study also shows that of those who are uninsured and working, the majority have no employer sponsored insurance available to them, and some others simply can not afford the health insurance offered by their employer.

Not surprisingly, the study also showed that the uninsured are much less likely to use medical services, and suffer from worse health.

Of those individuals who are covered, the majority get their insurance through private insurers, but almost 30% of all Pennsylvanians rely on public programs for their health coverage. In addition, the study shows that high income workers are much more likely to have private health insurance than low income workers. Furthermore, the study shows that most people with private insurance have seen their premiums go up.

Of those enrolled in Medicare, 17% get additional Medical Assistance benefits, and 60% purchase Medicare supplement plans to complete their coverage.

The survey confirms the importance of Pennsylvania's state funded health care programs: 14% of Pennsylvanians get their coverage through state health insurance programs, including 29% of children.

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six categories that are available on January 1, 2006 (including generic and older brand-name drugs) must be included on a Medicare Prescription Drug Plan's formulary. Any new drug in one of these six categories that becomes available after January 1, 2006 will have to go through the Plan's Pharmacy and Therapeutic Committee review and approval process to determine whether it will be included on the plan's formulary.

There are certain exceptions to this requirement. For example, the plans are not required to include all dosages of drugs on their formulary. Furthermore, plans are not required to put these medications at the lowest cost-sharing tier, so consumers could still have significant co-pays for these medications.

CMS expects that Medicare Prescription Drug Plans will not use prior authorization or step therapy for consumers who are already stabilized on drugs in these categories. However, with the exception of HIV/AIDS drugs, plans can utilize these tools for consumers who begin treatment with drugs in these categories.

Please note that this requirement to cover "all or substantially all" drugs in the six categories listed above is only in effect for 2006. CMS will revisit this policy to decide if it will continue in future years.

Medicare Will Auto-Enroll Individuals Found Eligible for the Low-Income Subsidies

Medicare has announced that it will expand the population it is going to help enroll into Medicare Prescription Drug Plans to include individuals who are found eligible for low-income subsidies. Medicare plans to enroll dual eligibles (those who have Medicare and Medical Assistance) and those who are found eligible for the low-income subsidies as follows:

* **Full dual eligibles** (those who have Medicare and who currently get their prescription drug covered through Medical Assistance): These individuals will be auto-enrolled into a Plan for coverage effective January 1, 2006 unless they enroll into a Plan on their own by December 31, 2005.

* **Other dual eligibles** (those who have Medicare and Medical Assistance that does not include prescription drug coverage) **and those individuals who have applied and been found eligible for the Subsidy programs**: These individuals will be auto-enrolled into a Medicare Prescription Drug Plan effective June 1, 2006 if they have not enrolled into a Plan on their own by May 15, 2006.

Remember: The Initial Enrollment Period for the Medicare benefit begins 11/15/2005 and ends 5/15/2006. Consumers who do not sign up during this time period and who do not have creditable coverage (coverage that is as good as or better than the Medicare Prescription Drug Benefit) will have to pay a higher premium when they do join the Medicare Prescription Drug Benefit.

Call the PA Health Law Project's Helpline with questions or if you want additional information about the Medicare Prescription Drug Benefit at 1-800-274-3258.

WE'RE MOVING!!!!!

The Philadelphia office of the Pennsylvania Health Law Project is moving. As of **August 1, 2005** our new address will be:

The Lafayette Building, Suite 900
437 Chestnut St.
Philadelphia, PA 19106

All phone numbers and email will remain the same.

HealthChoices Counties Receive C/FST Reports from OMHSAS

Consumer/Family Satisfaction Teams (C/FSTs) are a critical tool for gathering input from behavioral health consumers about the mental health and drug and alcohol services they receive. C/FSTs are comprised of consumers, persons in recovery and family members who interview others about their satisfaction with services and their recommendations for improvements. As reported in the January 2005 edition of the Health Law PA News, C/FST Program Guidelines have been revised and can be found in Appendix L to the HealthChoices Behavioral Health RFP. The new Guidelines are now in effect and C/FST Programs must comply with them. Among other things, the new revisions include requirements for the Director of C/FST Programs to be a consumer, person in recovery or family member and require the primary contractor to establish a way to inform C/FSTs of HealthChoices members who wish to participate in the interview surveys.

Once the new Guidelines were finalized, the Office of Mental Health and Substance Abuse Services (OMHSAS) conducted site visits between January and March 2005 with the C/FSTs in all of the HealthChoices counties (to assess the needs of each Team in coming into compliance with the Appendix L Guidelines). OMHSAS then submitted a written report to each HealthChoices C/FST Program and gave the Programs three weeks to respond and make comments regarding the accuracy of the reports. The comment period has now ended and each C/FST Program is expected to develop action steps to come into compliance with the Guidelines in areas where they are not in compliance.

Consumers, persons in recovery, family members and other stakeholders interested in their county's C/FST report can contact the County Mental Health Administrator for a copy of OMHSAS' report and the County's response. Stakeholders can also inquire about what steps, if any, the C/FST Program will be taking to come into compliance with the current Guidelines. For a copy of the revised Appendix L of the HealthChoices Behavioral Health RFP contact the OMHSAS Regional Office in your area or Janice Meinert at PHLP at 1-800-274-3258.

Upcoming Medicare Prescription Drug Benefit Trainings in the Southwest

PHLP's Pittsburgh Office is conducting 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.

These are some of the upcoming trainings already scheduled:
July 8— CAP Meeting at Achieva, Pittsburgh, 2 pm
July 12—Pittsburgh AIDS Task Force, Pittsburgh, 3 pm
July 15—Moorehead Towers, Allegheny County, 3 pm
July 18—Beaver County Assistance Office, Beaver County, 10 am

If you are interested in 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.

Personal Care Home Regulations to be Implemented

On February 24th, the Independent Regulatory Review Commission approved the Department of Public Welfare's (DPW) new regulations governing personal care home (PCH) licensure (The new regulations were published in the Pa Bulletin at 35 PaB. 2499). DPW is now in the process of preparing to implement the regulations. These regulations were released in their final form in November 2004. They were the result of years of stakeholder meetings and public discussions. There are many improvements in the regulations from the old set of regulations, which were fourteen years old, though there are also areas where advocates and consumers felt that the new regulations do not go far enough.

For example, the new provisions require 100 training hours for new PCH administrators prior to beginning employment. This is an improvement on the former regulations, which only required 40 hours of training for administrators. Staff also has improved training requirements, though the regulations do not specify how many hours of training direct staff must complete. However, direct staff must be trained in a number of areas prior to providing direct service. The old regulations did not include as many areas to be trained in. In addition, direct care staff must complete 12 hours of continuing education annually. There was no continuing education requirement in the old regulations. One thing to note is that staff and administrators hired prior to December 2004 will be grandfathered in and will not have to complete the increased training requirements.

Among the improvements to resident rights, under the new regulations, residents have more detailed contracts with the home that they reside in. This means that the contract must specify what services the home will provide for residents. Under the old regulations, the contract between the home and the resident was not required to include individualized services. As another example of an improvement in resident rights, the new regulations require that residents be allowed to receive visitors up to 12 hours a day, 7 days a week. The old regulations only required that residents be allowed to receive visitors up to 8 hours a day. There were many other resident rights added in the new regulations which were not mentioned in the old regulations. Some of the new rights are:

* The right to be informed of the rules of the home and be given 30 days notice before a new rule takes effect
* The right to communicate privately with the ombudsman
* The right to receive assistance in accessing health care services
* The right to receive services contracted for
* The right to appeal a decision by the home to discharge the resident.

While there are many improvements in the new regulations, there are also places where many think that the new regulations do not go far enough. For example, the new regulations have the same time frame for new admission medical evaluations from the old regulations, which means that a PCH can still wait 30 days after a person is admitted before doing a medical evaluation. And while the new regulations require that an assessment be made of the resident upon admission to the home, they only require that the assessment be done within 15 days of admission, meaning that a resident could go two weeks without receiving needed services.

Many of the requirements of the new regulations will not take effect until October 2005. Some requirements will not take effect until well after that date. DPW is developing training materials for its own staff as well as PCH staff and administrators. DPW is also developing a Licensing Measurement Tool which will its staff will use in its annual inspections of PCHs.

The Pennsylvania Health Law Project and other advocacy groups are looking closely at how these regulations are enforced. Please call the PHLP Helpline at 1-800-274-3258 if you have any questions or concerns about the new regulations or any complaints about a PCH. Consumer education materials on the new regulations are forthcoming. Watch our website (www.phlp.org) for more information.

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All phone numbers and email will remain the same.

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