Pennsylvania Health Law Project:
An Introduction

PENNSYLVANIA
Health Law
PROJECT

Presented for:
Pediatric Cabinet Meeting
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Marissa LaWall, esq.

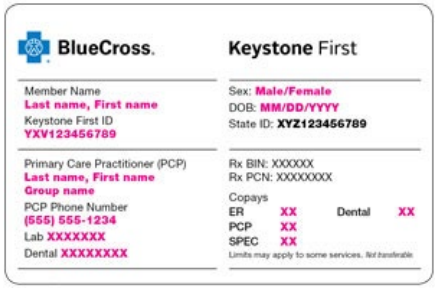
Helping People in Need Get the Healthcare They Deserve

About PHLP

- Statewide non-profit organization dedicated to increasing access to publicly-funded health care coverage and services
- A bit of what we do:
  - **Helpline** for client & advocates
  - Free legal advice and representation
  - Community education and self-help materials
    - See our Resource Library
  - Monthly Newsletter (sign up)
  - Policy advocacy to increase access to quality healthcare coverage & services

What are the Publicly Funded Health Insurance Programs?

- Medicaid (“Medical Assistance” in PA)
- Home and Community-Based Waiver Programs (CHC Waiver)
- Children’s Health Insurance Program (CHIP)
- Medicare



Who do we help?

- Kids with disabilities
- Low-income adults
- Older adults
- Social workers, advocates, providers (technical assistance)
- And many more!

There is NO INCOME LIMIT to qualify for PHLP services!

+ All of our services are free, regardless of income.

Client Spotlight: Kendrick and Kennedi

Watch on PHLP's YouTube Channel: https://www.youtube.com/watch?v=YrSpv5j2FPk

Types of Cases we Handle

- Insurance counseling (Do I qualify? How to apply?)
- Medicaid eligibility denials (application denied or coverage terminated by local county assistance office)
- Medicaid or Waiver Service denials
  - Home health services (SN or HHA)
  - Durable Medical Equipment (DME) like power wheelchairs, beds, etc.
  - Behavioral Health services (BHRS/Wraparound)
  - Prescription Drugs
  - Dental/Orthodontia
- Accessing care under Medicaid or Waiver
- Coordinating Medicaid coverage with other types of insurance (commercial insurance, Medicare, etc.)

We do NOT help with:

- Medicare appeals
- Education or IEP issues
- Malpractice claims
- SSI/SSD denials
- Criminal law matters
- Involuntary mental health commitments

We can provide referral to legal aid office, private bar, other appropriate organizations.

Technical Assistance to Providers

- Guidance and support to BAYADA staff on various issues that come up with prior authorization requests or appeals
  - LOMN review and drafting
  - Other medical necessity documentation
  - Problems filing appeal, maintaining Continuity of Care auths, etc.
- Contact us about individual client situations or policies or practices that impact multiple clients
- Trainings (both in-person and virtual)

Hot Topics in Pediatric Homecare

EPSDT & Medical Necessity

- Federal law requires Medicaid to cover medically necessary services for kids < 21
  - Including SN & HHA shift care!

- Medical necessity determination made based on info provided by child's doctors, home health agency, other providers or agencies that have evaluated the child

Definition of Medical Necessity

A service or level of care that is necessary for the proper treatment or management of an illness injury or disability is one that:

1) Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability*;*
2) Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability; **OR**
3) Will assist the recipient to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and those functional capacities that are appropriate of recipients of the same age

55 Pa Code § 1101.21a

Prior Authorization of Services

- "In the case of a denial of a previously authorized service, a reduction in benefits, the denial notice **must** contain specific information about the change in the Member's condition, or the error made when the PH-MCO previously authorized the service, that justifies the denial or reduction."

HealthChoices Agreement (January 1, 2024)

Prior Authorization Time Frames

- Prior auth decision required within 48 hours following MCO's receipt of required documentation
- If the plan requires additional information, they can request it. The member has 14 days to submit the documentation. However, once submitted the 48 hour window starts again.

DHS Managed Care Operations Memorandum #05/2023-004

In this context, “other responsibilities” includes but is not limited to the following:

i. Completing essential household duties such as shopping, housekeeping, laundry, yard work, errands, and medical appointments;

ii. Coordination of health care and services for the member;

iii. Attending religious service; and

iv. Care of other children in the home, including attending their extracurricular activities.

Parents as Paid Caregivers

NOTE: If the parent or caregiver is employed as a nurse or home health aide and may be assigned to staff the member's case, the PH-MCO must consider the time that parent or caregiver is scheduled by his or her employing agency to provide nursing or home health services to be the parent or caregiver's work schedule, during which time the parent or caregiver is unavailable.

Sample Work Verification Letter

[redacted]

[redacted]

To Whom It May Concern:

[redacted] has been employed by [redacted] since July 2018 as a Home Health Aide. As a licensed Home Health Agency with the PA Department of Health, [redacted] ensured, at hire, that [redacted] possessed all of the necessary credentials and clearances to meet the requirements listed in the state regulations for a Home Health Aide. Since [redacted] meets all of the state requirements, she has the capability to work any paraprofessional cases that [redacted] has available.

[redacted] is a valued member of our staff and we look forward to working with her for many years to come. Please feel free to contact me should you have any questions or concerns.

Sincerely,

[redacted]

[redacted]

Documentation Checklist

- ✓ Letter of Medical Necessity
- ✓ Plan of care (485)
- ✓ Social history (letter from Clinical Manager)
- ✓ Nursing Notes
- ✓ Medication/PRN Charts
- ✓ Seizure logs
- ✓ Nursing assessment/monthly progress notes/reports
- ✓ Letter from school
- ✓ Parents' work/school/vocational letters
- ✓ Parents' health/medical letters, SSDI award letters
- ✓ Sibling info (health/special needs, extracurricular activities)

Appealing Service Denials

Notice & Appeal Rights

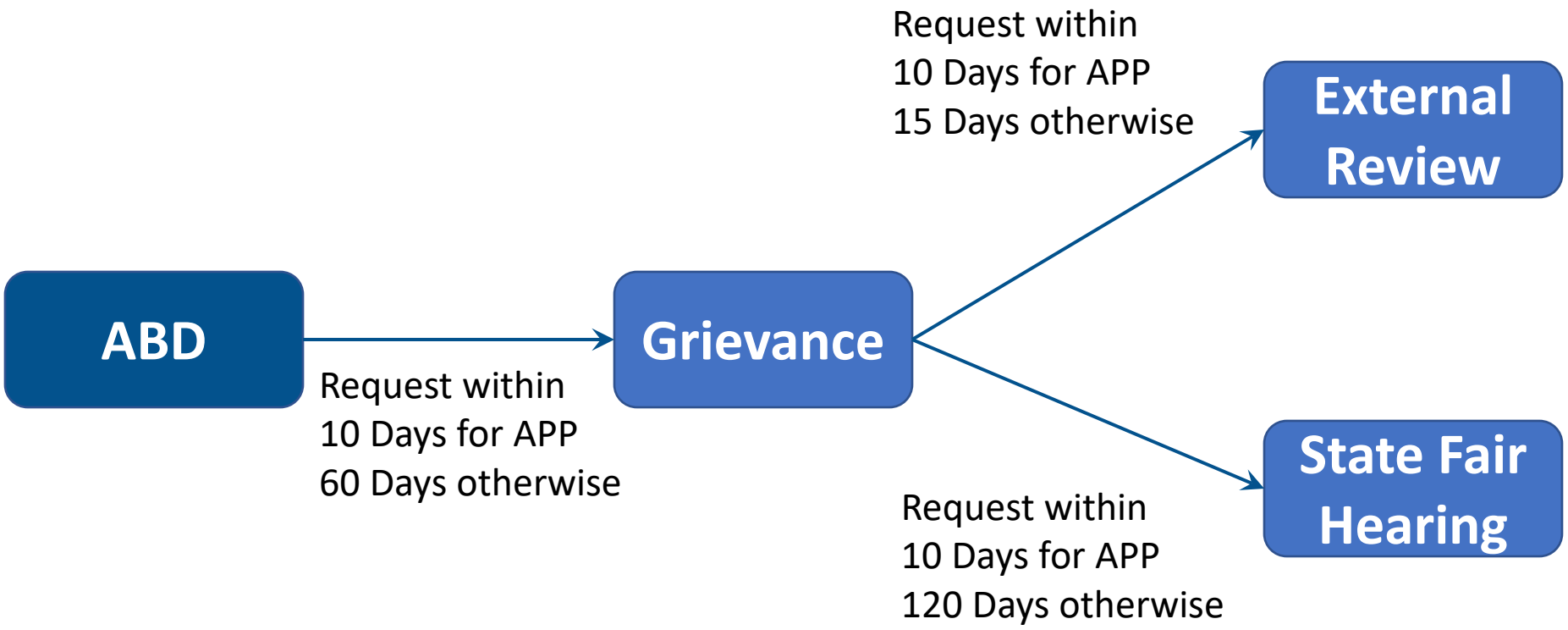
When Medicaid are denied, clients have a legal right to:

1. Receive written notice of the decision
   - Notice must have sufficient level of detail; not just cursory "not medically necessary"
   - Must be sent in advance of services ending (giving time to appeal)
2. Appeal the denial of services
   - "Denial" means ANY change in how the prescription is written or hours were requested, not just a complete denial
   - See language: "authorized other than as requested"

Appeal Rights Cont.

3. Participate in their appeal hearing(s), either in person, video Conference, or by telephone
4. Present evidence and witnesses supporting why the service is, in fact, medically necessary
5. Bring an attorney or other advocate to their appeal hearing
6. Continue receiving current services while an appeal is pending
    - Known as “continued benefits pending appeal”
    - So long as they filed the appeal within **10 days***

Appeal Framework: Medical Necessity



Must exhaust Grievance process prior to Fair Hearing or External Review

3 Levels of Appeal

Grievance →	External Review →	Fair Hearing
• Internal appeal with the MCO • The first appeal in the process • Ability to participate via phone, in-person, or video-conference	• Independent medical reviewer looks over Grievance file & decision; decides whether MCO's decision was appropriate • No meeting or hearing – entirely paper review	• Available to MCO enrollees after they exhaust Grievance • The only appeal option for clients in Fee for Service (ACCESS; No MCO)

Continued Benefits Pending Appeal

- If Medicaid denies a currently-authorized service, and client appeals within **15 days**, they get to keep services in place until appeal is decided
- Sometimes called Continuity of Care (COC)
- Appeals often take months to be decided
- Available at all levels of appeal, so long as file appeal **timely** after each decision

Keep an eye out for:

- Denials based on improper Medical Necessity criteria/definition (e.g. “Child has not been hospitalized in 90 days” or “child doesn’t have trach or vent”)
- Lack of sufficient detail in denial notices (e.g. cursory “not medically necessary”)
- Client doesn’t receive denial notice
- MCO fails to process client’s grievance request or won’t allow client to participate in grievance meeting (especially if child is 18)
- Prior auth decision taking longer than 48 hrs
- Pended auths w/ irrelevant information requested by MCO

What should I do if a denial occurs?

- DON'T TAKE NO FOR AN ANSWER!

- Refer client to **PHLP Helpline (1-800-274-3258)**
  - We can help with appeal – advice and possibly representation
  - Refer as early as possible! Ideally, as soon as denial occurs
  - We can help at ALL levels of appeal, including help w/ filing the appeal or deciding what kind of appeal to file
  - No need to review case for merit before referring.

Why refer clients to PHLP?

- Help maintain & maximize home health services when they are denied or when new auth is being requested.
- Clients often overwhelmed and/or confused by appeal process; may not know can appeal or where to turn for assistance with the process.
- *PHLP contact info is also printed on denial notices for where to go for appeal help*

How to refer clients to PHLP

- Have client call our Helpline at 1-800-274-3258 on Mon or Wed beginning at 8:00AM
- If want to discuss case ahead of time or after making the referral, Agency staff can call our Helpline any time or email staff@phlp.org

Questions?

Follow PHLP on Social Media!

Thank You

Helpline: 800-274-3258

Open for call-ins Mon & Wed
8:00 am to 8:00 pm

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