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## Traditional Medicaid Expansion Underway

As of April 27th, all adults with Pennsylvania Medicaid coverage are receiving the new "Adult" benefit package. The "Healthy" and "Healthy Plus" benefit packages have been discontinued. Adults who are found eligible for Medicaid after April 27th will no longer be enrolled into the Private Coverage Option (PCO); instead, they will be covered under either HealthChoices Medicaid managed care or Medicaid fee-for-service (ACCESS card), depending on their situation, and receive the Adult benefit package.

In addition to the benefit package change for adults, the move to a simpler, traditional Medicaid expansion is underway. The transition of individuals from PCO to HealthChoices also began April 27th and will be done in two phases as we have reported in [previous newsletters](#). Phase One is happening now and impacts approximately half of the individuals now enrolled in the Private Coverage Option. Adults in the Phase One transition are receiving written notices that explain the changes to their coverage, including a description of the Adult benefit package. The notice has a one page summary insert of the changes, written in both English and Spanish, and should be printed on green paper. A sample of this April Benefit notice and other information about the transition can be found on [www.healthchoicespa.com](http://www.healthchoicespa.com) under "Consumer Resources."

At the end of July, those remaining in the Private Coverage Option will begin the transition to HealthChoices. These individuals may move from PCO to HealthChoices sooner if their case is re-reviewed due to self-reported income changes before July, or if they make a "Raise Your Hand" request as described in a later article. The projected end of PCO coverage for all remaining individuals enrolled is September 1, 2015.

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# Recent Policy Clarifies When to Annualize Income Under MAGI Rules

The Affordable Care Act requires Medicaid programs to use Modified Adjusted Gross Income (MAGI) rules when determining eligibility for certain groups of people: children through age 18, parents, caretakers, pregnant women, and adults age 19-64 who do not have Medicare coverage. MAGI rules differ from the traditional Medicaid income-counting rules because MAGI is based on **taxable income**. Since taxable income is determined on a yearly basis, and Medicaid eligibility is based on current monthly income, there has been confusion over how to apply the MAGI rules when an applicant's monthly income is expected to change during the tax year—for example, due to seasonal work.

The Pennsylvania Department of Human Services (DHS) recently released a [Policy Clarification](#) explaining that income may be annualized when Medicaid eligibility is determined under the MAGI rules if the applicant's current monthly income is over the [income limit](#) to qualify but the applicant expects their income to decrease, or to end, during the tax year. This annualization of income is aimed at reducing churning (going on and off Medicaid) that would otherwise result when there are fluctuations in monthly income.

In cases where a Medicaid applicant (or recipient) fits into a MAGI category and reports their income is expected to change or end during the tax year, County Assistance Office (CAO) caseworkers must manually calculate annual income. Here is an example of how it should work:

*Mary is a 45-year-old, healthy, single woman who applies for Medicaid and reports that she is working part-time as a school bus driver. Her current monthly income of \$1,360 exceeds the Medicaid income limit for her to qualify (\$1,354). However, Mary notes on her application that she does not work at all and has no income during June, July, and August each year when school is out. The CAO caseworker must then calculate Mary's annual income ( $\$1,360 \times 9 \text{ months} = \$12,240$ ) and compare that to the appropriate annual Medicaid income limit, which in Mary's case is \$16,248. When Mary's income is annualized in this way, she qualifies for Medicaid.*

Applicants must remember to report any predictable changes in income on their application so that the CAO caseworker knows to perform this annualization of income when determining whether they qualify for Medicaid.

**Note:** MAGI income rules do **not** apply to the following Medicaid categories: Healthy Horizons, Medical Assistance for Workers with Disabilities (MAWD), Home and Community Based Services Waivers, and the Medicare Savings Programs/Buy-In Categories of QMB, SLMB and QI-1. Caseworkers will continue to look at current monthly income when determining whether someone qualifies for any of these Medicaid categories. For more information on the various Medicaid categories, see PHLP's [Eligibility Manual](#).

# “Raise Your Hand” to Change from PCO to HealthChoices

Though the transition from Healthy PA to a traditional Medicaid expansion is now underway, over 137,000 individuals will remain in the Private Coverage Option (PCO) until the second transition phase is completed in early September. PCO enrollees who want to move to traditional Medicaid before then can now “raise their hands” as described below **and** no longer need to establish medical frailty. Reasons why some PCO enrollees may want move to Medicaid sooner include: a need for certain services covered by Medicaid, but not by PCO plans, such as dental care, dialysis, mobile mental health treatment, peer support, targeted case management, medical supplies, and non-emergency transportation, or because of problems accessing health care providers.

Raise Your Hand requests can be made by either:

- (1) Calling the Statewide Customer Service Center at (877) 395-8930, or the individual’s caseworker at the County Assistance Office (CAO), and requesting a change. Individuals should note a pending need for a service covered by Medicaid but not PCO, if applicable; or
- (2) Completing a [health screening](#) (a health screening with only the recipient’s name and date of birth is sufficient to be considered a Raise Your Hand request) and submitting it to the local CAO.

Once a consumer makes a request, their caseworker will rerun eligibility within two business days and, in some cases, more quickly. The consumer will be enrolled in Medicaid fee-for-service (ACCESS card) immediately. They will then have that coverage along with their PCO coverage until the end of the current month, or the end of the following month, depending on when their eligibility is updated. The consumer will move into HealthChoices Medicaid managed care plans for ongoing physical and behavioral health coverage once PCO coverage has ended.

As a reminder, under Healthy PA, adults who qualified for Medicaid were given a benefit package based on their category of eligibility and whether they were considered medically frail. However, since the end of April and the start of the single Adult benefit package, the health screening process to determine medical frailty is no longer part of the Medicaid application. The Raise Your Hand process will remain in effect, with the notable changes described above, until the end of July for individuals with PCO coverage.

Anyone who makes a Raise Your Hand request, but whose coverage does not change from PCO to HealthChoices, is encouraged to call PHLP’s Helpline at 1-800-274-3258.

## Information for PCO Enrollees Entering Non-Hospital Detox or a Halfway House (and Their Providers)

A recent [policy](#) issued by the Pennsylvania Department of Human Services outlines the process for current PCO enrollees who have entered non-hospital detox or a drug and alcohol halfway house to transition to Medicaid quickly. In these cases, the provider of the services or the individual consumer should contact the consumer’s County Assistance Office to tell them about the start of the treatment program. The caseworker will update the system and authorize Medicaid back to the first of the month. The case is then referred to

the Office of Mental Health and Substance Abuse Services for retroactive enrollment into the behavioral health managed care plan operating in the consumer's County based on the Medicaid start date.

Individuals who need other services besides non-hospital detox or a halfway house, and who remain in PCO coverage until the second transition phase, can move to Medicaid sooner using the Raise Your Hand process described above.

## **New RFP Issued for Home and Community Based Services Independent Enrollment Broker**

In early April, the Pennsylvania Department of Human Services issued a Request for Proposal (RFP) for a Home & Community Based Services (HCBS) Independent Enrollment Broker. Since 2010, Maximus has been the Independent Enrollment Broker (IEB) handling applications and enrollments for individuals seeking the following HCBS Waiver Programs: Attendant Care, AIDS, CommCare, Independence, OBRA. The Independent Enrollment Broker also handles enrollment into the Act 150 program which can provide services to individuals who need a nursing home level of care but who do not financially qualify for a Waiver program. Maximus' contract ends this year, and the Department is seeking proposals from entities by May 28, 2015.

The [RFP document](#) outlines the IEB's responsibilities and includes some important changes, notably:

- The Aging Waiver will now be included as one of the Waiver programs for IEB application and enrollment assistance;
- Eligibility determinations must be completed within 60 days (currently, the requirement is 90 days);
- The application process will only include two in-person evaluations instead of three (the IEB will only meet with the applicant once instead of twice, and that visit will occur after the local Area Agency on Aging conducts an in-person level of care determination);
- The IEB must be in contact with the Nursing Home Transition Teams and let applicants know about the Money Follows the Person initiative, if appropriate;
- Financial sanctions can be imposed for IEB non-compliance with requirements; and
- More detailed reporting is required from the IEB to the Department.

Consumer advocates have expressed concerns about some of the changes to the Department during meetings of the Long-Term Care Subcommittee of the Medical Assistance Advisory Committee. These include the Aging Waiver's inclusion in the IEB's responsibilities and about the practicality of reducing the timeframe for an eligibility decision from 90 days to 60 days but only minimally changing the application process to eliminate one step. We will continue to keep readers posted as developments occur about the Pennsylvania Independent Enrollment Broker.

# Notable Announcements from April MAAC

At the April meeting of Pennsylvania’s Medical Assistance Advisory Committee, the Pennsylvania Department of Human Services announced it plans to release a request for applications in August or September for a re-procurement of physical managed care plans in all five HealthChoices zones. At the same meeting, the Office of Long Term Living discussed a document that will be published at the end of May to initiate the stakeholder input process for a plan to implement a type of Managed Long Term Supports and Services in Pennsylvania. We will update readers as more details become available.

## U.S. Supreme Court Decides Medicaid Payment Case

The U.S. Supreme Court recently heard and issued a decision in a case entitled Armstrong v. Exceptional Child Center. The issue before the court in Armstrong was whether doctors and hospitals can sue states in federal court if they feel the rates they get paid by the state Medicaid program are too low. The Supreme Court said no – the Supremacy Clause of the Constitution provides no independent right of action to allow providers to sue state Medicaid programs.

In Armstrong, a group of Idaho residential habilitation providers serving people with intellectual and developmental disabilities sued the Idaho state Medicaid agency. Idaho had been approved to increase Medicaid reimbursement rates by the federal Center for Medicare & Medicaid Services in 2009, but the state never implemented the new rates because of budget constraints. The providers believed the state’s failure to implement new reimbursement rates conflicted with federal law, and sought relief from a federal court. They expected a federal court would find Idaho Medicaid officials violated the Medicaid Act and order the state to increase provider reimbursement rates.

A closely divided U.S. Supreme Court decided federal courts had no authority to hear Medicaid providers’ challenge to a state’s reimbursement rates. The decision was a disappointment to Medicaid providers because federal courts have played a crucial role in interpreting the Medicaid Act. It leaves Medicaid providers (and potentially beneficiaries) without a judicial remedy when a state’s low Medicaid payments threaten beneficiaries’ access to care. As a result, parties wanting to challenge rates appear to be only left with the option of filing a complaint directly with the U.S. Health and Human Services Secretary. This avenue of redress was exactly what the Obama Administration touted in its amicus brief in support of the state of Idaho noting that a decision regarding equal access was “of the sort appropriate for expert judgment by the State and CMS and for resolution in the course of their ongoing bilateral relationship.” Further information about the decision can be viewed [here](#).

## Basics About Health Insurance Options for Immigrants

Determining when immigrants qualify for programs like Medicaid, CHIP or Marketplace Premium Tax Credits and cost-sharing subsidies can be confusing. This is because each program has different rules about what someone’s immigration status must be in order to qualify for coverage and the rules can be different

depending on the age of the immigrant. Some programs may require someone be “lawfully present” while others require that someone be a “qualified immigrant.” To further complicate this issue, many immigrant families have “mixed status,” with different members having different statuses. In addition, if one of the family members is undocumented, the family may be fearful of seeking health care coverage or providing information about their status.

When someone applies for coverage through Pennsylvania Medicaid, CHIP, or the Marketplace, these entities cannot require the applicant to provide information about the citizenship or immigration status of any family or household members who are not applying for coverage. Also, coverage cannot be denied to an applicant because a family or household member who is not applying has failed to disclose his or her citizenship or immigration status.

Below is a highlight of which immigrants can qualify for Medicaid, CHIP, or Marketplace tax credits or subsidies. More can be found in PHLP’s [Health Care for Immigrants Manual](#).

## Qualified Immigrants

“Qualified Immigrants” are generally eligible for Medicaid coverage as long as they meet all other eligibility criteria such as income and resource limits. Qualified Immigrants include Lawful Permanent Residents (green card holders), Asylees, Refugees, and Victims of Trafficking.

### *Five Year Waiting Period*

For most categories of Medicaid there is a five year waiting period for qualified immigrants. This means the individual must wait five years after receiving their “qualified” immigration status before they can get Medicaid. There are exceptions to this rule. Legal Permanent Residents who used to be Refugees or Asylees don’t have to wait five years. Also, the waiting period also does not apply to children under 21 or pregnant women.

In Pennsylvania, Qualified Immigrants who have not yet met the five year waiting period qualify for state-funded Medicaid **if** they have very low income and resources **and** need Health Sustaining Medications; have a temporary disability; **or** are over the age of 59. Beginning in January 2015, those who qualify for state-funded Medicaid in these circumstances must receive their coverage through the fee-for-service system (ACCESS card) and cannot be enrolled in a HealthChoices physical health or behavioral health plan.

## Lawfully Present

The term “Lawfully Present” refers to those who have various statuses including: Qualified Immigrants as described above; those with Humanitarian statuses or circumstances (including Temporary Protected Status, Special Juvenile Status, Asylum applicants, Convention Against Torture, Victims of Trafficking); or those with legal status conferred by other laws (e.g., temporary resident status, LIFE Act, Family Unity individuals). It also applies to those who are not immigrants but who are legally in the U.S. on a temporary basis such as those with work visas or student visas.

Children under 21 who are lawfully present can qualify for either Medicaid or CHIP under the normal program rules. Pregnant women who are lawfully present can qualify for Medicaid if they fall within the

Medicaid income limits. In addition, lawfully present adults can qualify for premium subsidies (even if their income is less than 100 percent of poverty) and for cost sharing help through the Marketplace.

## Other Immigrants

Immigrants who are not lawfully present or who are undocumented cannot qualify for CHIP or for Marketplace coverage. These individuals also cannot qualify for Medicaid unless they have an emergency medical condition. Emergency Medical Assistance (EMA) is a temporary enrollment in Medicaid to treat the specific emergency medical condition. Labor and delivery is considered an emergency condition, although routine prenatal care is not. Individuals must submit detailed medical documentation describing the emergency medical condition and treatment needed in order to be approved for EMA. In addition, the individual must meet all of the other Medicaid eligibility criteria such as the income and resource requirements.

Here’s a chart to summarize what immigration status is needed to qualify for various health care programs in Pennsylvania.

	Medicaid	CHIP	Marketplace Premium Tax Credits and Subsidies	Emergency Medical Assistance
<b>Adult</b>	Qualified Immigrant (five year waiting period) with some exceptions	N/A	Lawful Presence	No Status Required
<b>Pregnant Women</b>	Lawful Presence	N/A	Lawful Presence	No Status required
<b>Children</b>	Lawful Presence	Lawful Presence	Lawful Presence	No Status Required

## New Law Extends Important Medicare Program and CHIP

On April 16, 2015, President Obama signed the [Medicare Access and Children’s Health Insurance Program \(CHIP\) Reauthorization Act](#) into law. Although the law includes a number of provisions, we highlight those that are of particular importance to PHLP’s clients.

### The Qualified Individual Medicare Savings Program is Now Permanent

The **Qualified Individual** (QI) program pays the Medicare Part B premium for Medicare beneficiaries whose income is between 120 percent and 135 percent of poverty (\$1,177 to \$1,324 per month for a single person) and whose resources are limited (\$7,280 for a single person and \$10,930 for a married couple). It is a Medicaid program funded entirely by the federal government. The QI program began in 1997 and was initially authorized and funded for only five years. Since 2003, it has been extended and funded on an annual basis through various laws. Medicare beneficiaries and their advocates, worried about the temporary

reauthorizations and fearing each year that the program would end, urged Congress to make the program permanent. Those advocacy efforts have now paid off!

In addition to making this important program permanent, the law also includes increased, dedicated funding to help organizations expand their outreach efforts to identify individuals who qualify for help through this program and get them enrolled. Less than half of the people who should qualify for the QI program are actually enrolled and receiving this Part B premium help.

## CHIP Funding Increased and Extended

This law also extends funding for the Children's Health Insurance program for two years-through September 30, 2017. It also expands the federal matching rate for the program by 23%. This increases the federal match to Pennsylvania from 66% to 89%. Governor Wolf's budget proposal included this increased funding.

In addition to extending the program, the Act:

- Protects children from any cuts in services and any new enrollment or renewal barriers by extending the "maintenance of effort" requirements through 2019;
- Extends funding for outreach and enrollment efforts, CHIPRA quality improvement measures, and demonstration grants to address childhood obesity; and
- Includes funding for infant home visiting services and family-to-family information centers.

Even though advocates had hoped to see the funding extended through 2019, this legislation preserves the program, adds funds and avoids the damaging cuts to CHIP funding that had been initially proposed by Committees in the House and Senate.

## Our Mission

Founded in the mid-1980s and incorporated in 1993, PHLP protects and advances the health rights of low-income and underserved individuals. Our talented staff is passionate about eliminating barriers to health care that stand in the way of those most in need.

We seek policies and practices that maximize health coverage and access to care, hold insurers and providers accountable to consumers, and achieve better outcomes and reduce health disparities.

PHLP advances its mission through individual representation, systemic litigation, education, training, and collaboration.

## You can help

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For the Capital Region, go to [uwcr.org](http://uwcr.org) and pledge a donation to PHLP.

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