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DHS Moving Ahead with Statewide MLTSS—RFP to Be Released Next Month

Pennsylvania’s initiative to develop a managed long term services and supports system (MLTSS) is now being called “Community Health Choices.” This initiative will transform the current Medicaid-funded long-term care system which includes Home and Community Based Services (HCBS) Waiver programs and nursing home care into a system administered by private managed care organizations (hereinafter “health plans”) where coverage of these long-term care services is combined with traditional medical services covered by Medicaid. The Pennsylvania Department of Human Services (DHS) continues to move swiftly by releasing a [Concept Paper](#) in mid-September that provides more details than the previously released [Discussion Document](#) did, but still leaves many unanswered questions and concerns about the new system as described below.

These are some of the major changes/clarifications included in the Community Health Choices Concept Paper:

- Enrollment in Community Health Choices will be mandatory for the target population of approximately 450,000 individuals. The target population includes: those age 21 and older who have Medicare and full Medicaid (dual eligibles) regardless of whether they need long-term care services; persons age 18 and older who receive services through one of the HCBS Waiver programs administered by the Office of Long Term Living (Aging, Attendant Care, CommCare, Independence and OBRA) ; and individuals age 21 or older getting Medicaid long-term care in a nursing home. Persons enrolled in the Act 150 program will not participate in Community Health Choices as originally planned. Affected individuals who wish to join a LIFE program (if applicable) instead of Community Health Choices can do so (more later).

- Behavioral health services will be “carved out”. Contrary to what was originally proposed, the existing Medicaid behavioral health managed care plans (Community Behavioral Health, Community Care Behavioral Health, Magellan, PerformCare and Value) will continue to provide for Medicaid-funded behavioral health services and other specialized services to their members. However, Community HealthChoices plans and the behavioral health plans will need to work closely together to coordinate services for those in Community Health Choices with behavioral health needs.
- Medicare coverage will be separate from Community Health Choices. Persons on both Medicare and Medical Assistance (dual eligibles) will continue to have the choice of how they receive their Medicare coverage. They can choose to get their coverage through: Original Medicare (using their red, white and blue card), a Dual Eligible Medicare Special Needs Plan (D-SNP) run by the same insurer that provides their Community Health Choices coverage; or any other available Medicare Advantage plan. Regardless of how they choose to get their Medicare, all dual eligibles must be enrolled in a Community Health Choices plan that will provide their Medicaid coverage as well as any Medicaid-funded long-term care services they need. The only exception will be those enrolled in the LIFE program as described in the next bullet.
- Individuals age 55 and older whose care needs meet the nursing facility level of care, can choose a LIFE program (if there is one serving their area) instead of Community Health Choices. These programs provide a wide range of medical services as well as home and community based services. Individuals enrolled in a [LIFE program](#) then get **all** of their care through this program. It is an alternative to regular Medicare and Medical Assistance.

Issues of Concern

After reviewing the Concept Paper and additional information provided by the Department, consumers who will be enrolled into Community Health Choices and their advocates have expressed the following concerns:

- Assessments to determine the type and amount of home and community based services will now be the responsibility of Community Health Choices plans who may have no experience in assessing for these types of services.
- Community Health Choices plans will be permitted to impose “medical necessity” requirements for non-medical home and community based services.
- After 180 days from the transition to Community Health Choices, a plan may cut up to 24% of a participant’s previously-approved home and community based services based only on the plan’s assessment and without any state review (though the consumer’s Medicaid appeal rights will apply). Such cuts are especially likely to occur given the proposed payment system which will pay the plans a flat per-person (capitated) reimbursement rate, regardless of the amount of services the plan authorizes.
- Participants may no longer have choice of their service coordination organization as the Community Health Choices plans can decide whether they will contract with outside organizations for service coordination.
- The continuity of care provisions only protect participants for the first six months following their transition to Community Health Choices. After that, participants may lose their existing home and community based service providers as the plans are not required to contract with all existing providers and existing

providers may not be willing to accept rates set by the plans.

- Will Community Health Choices plans impose medical qualifications on non-medical home and community based services providers?
- Will Community Health Choices plans have a sufficient number of home and community based service providers in their network to ensure that their members have a choice of providers?
- It is not clear whether youth age 18-21 with disabilities other than intellectual disabilities or autism, who are not already on OLTL waivers, will be able to obtain coverage of home and community based services beyond the scope of services covered under EPSDT (for example, home or vehicle modifications) through this new system.

Although implementation of Community Health Choices is to be phased-in across Pennsylvania in three geographic zones between 2017 and 2019, DHS is still planning to issue a single Request for Proposal (RFP) for all three zones on November 16, 2015 with bids due January 15, 2016. Successful bidders for each of the zones will be chosen by March 2016. DHS officials assert that choosing all the successful bidders by March 2016 will enable the chosen MCOs time to develop their provider networks. However, some advocates are concerned that by binding the state upfront to the terms in a single RFP for all three regions, DHS will limit its ability to make significant changes later to Community Health Choices in the zones scheduled to start in 2018 and 2019 based on lessons learned from implementation in the first zone (Southwest PA) in 2017.

To accomplish a November RFP release, DHS is cutting off comments to its Concept Paper on October 16th. Comments can be submitted by that date in the following ways:

- Email to: ra-MLTSS@pa.gov. Put “Community Health Choices” in subject line.
- Mail to: April Leonhard, Office of Long Term Living, Bureau of Policy & Regulatory Management, PO Box 8025, Harrisburg, PA 17105-8025.
- ATT Relay: 800-654-5984 for TDD users; 800-654-5988 for voice users.

Participants and advocates are encouraged to submit comments, ask questions, and provide suggested solutions in areas that are not yet finalized. Please check PHLP’s website closer to the comment deadline date to view the comments we plan to submit. PHLP and many other interested parties have also requested that DHS release more details for comment prior to the November release of the RFP. DHS has not yet made a decision on this request as of the publication of this newsletter.

DHS created a new advisory committee to provide feedback on its plans for Community Health Choices called the [MLTSS Subcommittee of the Medical Assistance Advisory Committee](#). It is comprised of 25 members, a majority of whom are persons receiving home and community based services. The Subcommittee will have its third meeting on October 9th and will continue to meet monthly. In addition to the MLTSS Subcommittee, the Consumer Subcommittee, the Long Term Care Subcommittee and the Managed Care Subcommittee also provide input on Community Health Choices. DHS has also held several public forums and meetings with stakeholder groups and continues to hold monthly webinars. More information about Community Health Choices can be found [here](#).

Annual Open Enrollment for 2016 Medicare Health and Drug Plans Starts October 15th

The time of year when all Medicare beneficiaries can make changes to their drug or their health plan coverage starts October 15th. This period, known as Open Enrollment, runs until December 7th. Any changes made by a beneficiary during this period go into effect on January 1, 2016. Beneficiaries already enrolled in a Medicare Prescription Drug Plan or Medicare Advantage plan should have received information from their current plan about what the benefits will be in 2016. This information should detail any changes to the plan's coverage or costs for next year. Everyone is encouraged to review this information to decide whether they should stay with their current plan or find a new plan for next year.

If a Medicare plan will not continue in 2016, enrollees should receive notice in early October that their plan is ending on December 31st. As of October 1st, insurance companies are allowed to market their 2016 plans and Medicare's website (www.medicare.gov) shows 2016 plan information. Pennsylvanians continue to have many choices for their Medicare health and drug coverage in 2016:

Stand-Alone Prescription Drug Plans: Pennsylvanians will have 26 stand-alone drug plans available for enrollment in 2016 when Open Enrollment starts. Premiums for available prescription drug plans range from \$18.40 to \$149.60 per month. Nine of these plans will be "zero-premium" for individuals who qualify for the full Extra Help with their Part D costs ([click here](#) for the 2016 list). All of the current zero-premium plans will continue to be zero-premium next year and they are joined by a new plan called Symphonix Value Rx. The SmartD Rx Saver plan that was previously under Medicare sanctions will not be offered in 2016. Members of this plan will be moved to the Express Scripts Medicare Value plan for coverage starting in January unless they choose a different plan

Medicare Advantage Plans: Residents in every county in Pennsylvania have a choice of Medicare Advantage plans. Bradford County has the fewest Medicare Advantage plans (9) and Berks, Lehigh, and Northampton have the most (35). Most, but not all, of the Medicare Advantage plans available include drug coverage.

Special Needs Plans for Dual Eligibles (D-SNPs): These plans only enroll individuals that have both Medicare and Medicaid (dual eligibles). All counties except Bradford and Franklin will continue to have at least one D-SNP available. All current D-SNPs will continue to operate in 2016; however, Advantra Cares will be available in far fewer counties next year—9 in 2016 compared to 38 in 2015. Also, next year, 22 counties will only have one D-SNP option in 2016 (compared to 8 counties this year). Both Health Partners Medicare Special and Cigna-HealthSpring TotalCare are expanding to additional counties next year. UPMC's D-SNP will be called UPMC for Life Dual in 2016 (currently, it's UPMC for You Advantage). After a few years of being absent from the D-SNP market in Pennsylvania, United will again offer a D-SNP next year—the plan will be called United Healthcare Dual Complete. [Click here](#) to see the list of D-SNPs by county for 2016.

Everyone on Medicare should review their current coverage to see if it will continue to meet their needs in 2016. Those needing help during the Open Enrollment Period can contact APPRISE (Pennsylvania's State Health Insurance Program) at 1-800-783-7067. Stay tuned to future newsletters for additional information about Medicare in 2016.

Medicare Part D Costs Announced for 2016

A Medicare beneficiary who **does not** qualify for any level of Extra Help from Medicare will pay the following costs for a **standard** Part D Plan in 2016:

- The plan's monthly premium (the national average premium for a basic drug plan will be \$32.50);
- An annual deductible of **\$360**;
- During the initial coverage period, a **25%** co-pay for each covered prescription until the person's total drug costs reach **\$3,310**;
- During the coverage gap (often referred to as the "doughnut hole"), a percentage of the costs of their drugs (**45%** of the cost of brand-name drugs and **58%** of the cost of generics plus a small dispensing fee) until the consumer's total out-of-pocket expenses reach **\$4,850**; and
- During the catastrophic coverage period, a co-pay of **\$2.95** for generics and **\$7.40** for brand name drugs, or a 5% co-pay, **whichever is greater**, for the rest of the year.

Part D Cost for Those Receiving Extra Help from Medicare

Anyone who qualifies for **full Extra Help** from Medicare (this includes **all** dual eligibles who have Medicare and who receive any benefit from Medicaid), will have the following costs in 2016:

- \$0 premium (as long as he enrolls in one of the nine Part D plans that will provide standard benefits and charge a premium below the 2016 Extra Help Benchmark amount of \$35.30);
- Small co-pays for their prescription medications:
 - \$1.20/generics and \$3.60/ brand names (if income is less than 100% FPL); **or**
 - \$2.95/generics and \$7.40/ brand names (if income above 100% FPL); **or**
 - \$0 if someone is on Medicare **and receiving Medicaid long term care services** in a nursing home or through a Home and Community Based Services Waiver program.

Beneficiaries who qualify for partial Extra Help in 2016 will pay the following costs:

- A portion of their Part D plan monthly premium depending on the level of their extra help;
- A deductible no higher than **\$74**;
- 15% co-pays on all of their medications until they reach total out-of-pocket expenses of **\$4,850**; and
- During the catastrophic coverage period, co-pays of **\$2.95**/generics and **\$7.40**/name brands for the rest of the year.

Remember! A Medicare beneficiary who receives any amount of Extra Help from Medicare has no coverage gap (doughnut hole) no matter what Part D plan she joins! Please see www.medicare.gov for more details about Part D costs for plans available in 2016.

Medicare Extra Help Renewal Process Underway

“Extra Help” refers to the Medicare program that helps people with limited income and resources pay their Medicare Part D prescription drug plan costs. Some people automatically qualify for Extra Help. This includes all dual eligibles (people who have Medicare and also get some amount of help from Medicaid, even if it is only help with the Medicare Part B premium). Other people apply to Social Security and get approved for Extra Help if they meet the income and resource [guidelines](#) of the program. This article reviews the process Medicare goes through every year to redetermine eligibility for the Extra Help program.

Redetermining Extra Help Eligibility for Those Who Automatically Qualify

Every July, Medicare begins to review the lists they get monthly from each state of people enrolled in both Medicare and Medicaid (dual eligibles). Persons who automatically get Extra Help now, and who are on their state’s list in July or August 2015, should have already been determined automatically eligible again for full Extra Help for all of 2016. This full Extra Help will remain in place for 2016 **even if** the person loses their Medicaid benefit at some point after August 2015.

Persons automatically getting Extra Help now, but who **did not** appear on the state’s list in July or August, were sent a letter from Medicare in September on grey paper telling them they no longer automatically qualify for Extra Help in 2016. Enclosed with this letter is an Extra Help application which the beneficiary is encouraged to complete and mail in to Social Security to see if they can still get Extra Help in 2016 based on their income and resources.

Redetermining Eligibility for People Who Applied for Extra Help

Beneficiaries who are not dual eligibles but receive Extra Help qualified because they applied for the help and were approved by Social Security. Every fall, Social Security chooses a certain number of these beneficiaries to review and see if they still financially qualify for the Extra Help. Those selected for review were sent a form in September that they need to complete and send back to Social Security within 30 days. **Anyone who does not return the form loses their Extra Help at the end of the year.** Those who do return the form are reviewed and sent a letter from Social Security telling them whether or not their Extra Help will continue and/or whether the amount of their Extra Help will change in 2016.

Beneficiaries not selected for review by Social Security will have no change in their Extra Help status in 2016. Medicare beneficiaries with questions or concerns about their eligibility for Extra Help should contact the APPRISE program at 1-800-783-7067.

Marketing for Medicare 2016 Plans Started October 1st

Insurance companies offering Medicare stand-alone drug plans and Medicare Advantage (managed care) plans in 2016 have begun advertising and marketing their new plans as of October 1st. Each year, Medicare sets out rules that plans must follow when marketing their plans. The marketing guidance for the 2016 plan year includes some important updates. The full guidance can be viewed [here](#). Note that, in the full guidance document, changes from previous guidance appear in red. We wanted to highlight some important points for our readers:

Language Access for People with Hearing Impairments and People that do not speak English: Plans must provide free interpreter service to callers, and TTY service to all who need it, and this should happen within seven minutes of the initial call being placed to the plan.

Provider Directories: Plans are no longer required to send hard copies of provider or pharmacy directories. If plans do not send hard copies of these directories, they must include a notice telling people how they can find the directories online and how they can request hard copies. If someone requests a hard copy of a provider or pharmacy directory, plans must send one out within 3 days. Individuals also have the right to request plan materials in alternate formats, such as on CD or DVD, and can request plan materials be sent to them by e-mail.

Medicare plans are also required to have current provider directories posted to their websites that are updated monthly. The online directories must show which providers are not accepting new patients. The directories must also include the provider's address, phone numbers, and office hours.

As a reminder, people that sell Medicare plans are not allowed to solicit people door-to-door, cannot make outbound marketing calls, and cannot approach Medicare beneficiaries in public places such as in a parking lot, in a lobby, or on the sidewalk. See a [past PA Health Law newsletter](#) for more information about what is and is not allowed when marketing Medicare plans.

Mailings That People on Medicare Should Be on the Lookout For!

With Medicare Open Enrollment starting soon, Medicare beneficiaries are receiving mailings about their current plan's benefits in 2016 and about their plan choices for next year. Below is a list of common consumer mailings people on Medicare may receive. For a full list of Medicare consumer mailings, including links to notices, [click here](#).

- **Medicare & You 2016 Handbook:** Every Medicare beneficiary receives this book by the start of the Medicare Open Enrollment Period (October 15th). The book includes general information about Medicare benefits and consumer rights and protections. It also includes a listing of all 2016 Medicare plans available in the state where the beneficiary lives.
- **Plan Annual Notice of Change and Evidence of Coverage:** By the end of September, individuals currently enrolled in a Medicare Prescription Drug Plan or Medicare Advantage Plan should have received this information detailing their plan's benefits for 2016.
- **Plan Low Income Subsidy (LIS) Rider:** Individuals with Medicare drug coverage who currently receive Extra Help should have received this document by the end of September from their plan detailing their prescription drug costs in 2016.
- **Plan Non-Renewal Notice:** Individuals currently in a Medicare plan that will end in 2015 should have received this notice by October 2nd.
- **Extra Help Notices:** Individuals currently receiving Extra Help who will lose this help at the end of the year or whose co-pay levels will change in 2016 will receive the following notices:
 - ◇ **Loss of Deemed Status Notice (Grey Notice)** is sent in September to individuals who automatically received Extra Help in 2015 but who no longer automatically qualify in 2016 because they lost Medicaid coverage before July 2015. **These individuals may still qualify for Extra Help but will need to apply for it by filling out the application that is included with the notice.**
 - ◇ **Change in Extra Help Copayment (Orange Notice)** is sent in October to individuals who automatically qualified for Extra Help in 2015, and will still automatically qualify in 2016, but who will pay different co - pays for their prescriptions in 2016.
- **Reassignment Notices (Blue Notices):** Individuals with Extra Help whose Medicare health or drug plan will no longer be available in 2016 will receive notices by early November telling them that they will be reassigned to a different plan starting January 1, 2016. **Individuals who wish to enroll in a different plan than the one picked for them can do so but need to take action by joining the plan of their choice before the end of December.**

PHLP Offers Medicare 2016 Webinar

PHLP is offering a free webinar to educate providers, advocates and other professionals who work with dual eligibles (people who have both Medicare and Medicaid) and other low-income Medicare beneficiaries about Medicare in 2016.

The webinar will be held **October 29th** from **10 am-noon** and will cover the following topics:

- Medicare Part D plans and costs in 2016
- Programs that help Medicare beneficiaries with their costs
- Helping Medicare beneficiaries in times of transition, including becoming a dual eligible or losing their dual eligible status

To register for the webinar, please [click here](#). Space is limited, so register today! Please share this announcement with others who may be interested in the webinar.

DHS Announces Value-Based Payment Thresholds

In September, the Department of Human Services (DHS) officially launched a competitive process that will result in the selection of insurance plans to manage the delivery of physical health care services and prescription drugs to two million Pennsylvanians enrolled in the state's mandatory Medicaid managed care program (known as Physical HealthChoices). For the first time, DHS will review proposals and select physical health plans in all five HealthChoices zones, which cover all 67 counties of the Commonwealth.

The selection of insurance plans will not significantly alter the arrangements familiar to Medicaid enrollees and health care providers. The Wolf administration is committed to maintaining the HealthChoices structure. However, DHS will require all the managed care plans it selects to increase focus on the Medicaid beneficiary as a whole and reward health care approaches that produce better health outcomes rather than approaches that pay for services as they are provided. State officials emphasize moving the Medicaid program away from volume and towards value will require the cooperation of managed care plans and physicians, hospitals, and other health providers. Future PHLP newsletters will report on some of these strategies—e.g., accountable care organizations (voluntary networks of hospitals, doctors, and other providers that work together to coordinate care to patients); integrated care plans for persons with persistent serious mental illness; and patient-centered medical homes.

DHS' solicitation is available [here](#). Proposals from interested insurance companies are due by November 17, 2015. The three-year contract period begins January 1, 2017.

Six Pennsylvania Organizations Receive Navigator Grants

With the 2016 Marketplace Open Enrollment Period set to begin on November 1, 2015, the federal government announced grants totaling \$67 million to support outreach and enrollment efforts to connect consumers with affordable health care coverage. The three-year grants were awarded to 100 organizations located in 34 states, including six organizations in Pennsylvania.

These grants support the efforts of Navigators who receive targeted training and certification and who play a key role in helping consumers enroll in Marketplace health plans (HealthCare.gov) and apply for financial assistance available to help lower the cost of their coverage. Navigators also help connect people to other affordable health care coverage as appropriate, including Medicaid and the Children's Health Insurance Program (CHIP). In addition, Navigators engage in vital outreach and education activities within vulnerable communities to raise awareness about coverage options available through Healthcare.gov as well as other government programs.

Consumers can begin enrolling in Marketplace coverage for 2016 through Healthcare.gov on November 1st. Applications for Medicaid and CHIP coverage can be made at any time during the year. Consumers should visit HealthCare.gov to find in-person Navigators in their community. Below is a list of the six Pennsylvania organizations receiving Navigator grants for 2016 through 2018. All but one, Public Health Management Corporation, is a current Navigator.

1. [Consumer Health Coalition](#)
2. [Penn Asian Senior Services](#)
3. [Pennsylvania Association of Community Health Centers](#)
4. [Pennsylvania Mental Health Consumers' Association](#)
5. [Public Health Management Corporation](#)
6. [YWCA of Greater Pittsburgh](#)

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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Support Our Work

Please support PHLP by making a donation on our website at phlp.org. You can also donate through the United Way.

For Southeast PA, go to uwsepa.org and select donor choice number 10277.

For the Capital Region, go to uwcr.org and pledge a donation to PHLP.

For the Pittsburgh Region, go to unitedwaypittsburgh.org and select agency code number 11089521.

PHLP: Helping People in Need Get the Health Care They Deserve