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In This Issue

Legislative Hearing Focuses On Waiver Enrollment Problems

On October 18th, the Pennsylvania Senate Aging and Youth Committee and the House Aging and Older Adult Services Committee held a joint hearing on problems faced by older adults applying for the Aging Waiver and specifically on the failures of the Department of Human Services (DHS) and its vendor, Maximus, to support individuals applying for Waivers and promptly process their applications.

As a reminder to readers, Maximus is the state's Independent Enrollment Broker (IEB) and is responsible for handling applications and enrollments for the Waiver programs administered by the Office of Long Term Living (OLTL). In December 2010, Pennsylvania began using Maximus for people under the age of 60 with physical disabilities who apply for the Attendant Care (including Act 150), COMMCARE, Independence, and OBRA Waivers. In April 2016, Maximus took on Aging Waiver enrollments from Area Agencies on Aging (AAAs) because the federal government penalized Pennsylvania for a conflict-of-interest over Aging Waiver enrollments being handled by AAAs who are also providers of Waiver services.

At the October hearing, Secretary of Human Services Ted Dallas, OLTL Deputy Secretary Jennifer Burnett, and Secretary of Aging Theresa Osborne testified before the Committees and provided information about the enrollment process, improvements noted in recent months, and work that still needs to be done.

Representatives from several Area Agencies on Aging and Centers for Independent Living as well as other advocates testified about their experiences with Maximus, ongoing problems experienced by individuals they are helping, and suggestions for addressing the problems.

Members of both the Senate and House Committees questioned the Administration's witnesses and expressed their concerns about the delays and other enrollment problems and stressed the importance of fixing these problems before Community HealthChoices is implemented.

Some interesting facts emerged from the hearing. They include:

- There will be a new contract for enrollment services. OLTL recently released the draft Request for Proposal—see below for more information.
- Maximus created a "Research and Support Unit" for "complex cases".
- DHS plans to rely on "Certified Options Counselors" who are connected to the PA LINKs (formerly known as Aging and Disability Resource Centers or ADRCs) to provide in-person assistance with Waiver applications, which the AAAs had previously been providing. There are currently 100 Certified Options Counselors in Pennsylvania and all have other responsibilities. Many of those 100 are volunteers. There is no additional funding being requested to cover the costs of the Certified Options Counselors providing assistance with Waiver applications.
- DHS is paying Maximus $4.5 million for fiscal year 2016-17. That comes out to about $240 per each application Maximus ***starts.*** However, Maximus gets paid regardless of whether the applicant completes the application process.
- Although DHS can ***delay*** payments to Maximus until Maximus meets contractual obligations (which they did in June 2016), there is nothing in the contract that allows DHS to actually withhold all or part of the state's payment to penalize Maximus for poor performance.

We'll keep readers updated about any further developments related to OLTL Waiver enrollments in future newsletters.

Community HealthChoices Updates

Draft RFP for Independent Enrollment Broker Released for Public Comment

On October 28th, the Department of Human Services released a draft Request for Proposal for an Independent Enrollment Broker to handle the enrollment processes for the Office of Long Term Living's programs and for Community HealthChoices. **The deadline for submitting comments is 5:00 pm on November 21, 2016.** Comments must be provided using a template form provided here and e-mailed to RA-waiverstandard@pa.gov.

Other CHC Updates

The Office of Long Term Living (OLTL) is still reviewing the bid protests filed by four insurance companies who applied to be Community HealthChoices managed care plans but who were not ultimately chosen by the state (see our September newsletter for additional information). As a result, negotiations with the three plans that were selected are on hold as the protests are being reviewed. OLTL asserts that it still intends to start Community HealthChoices in Southwestern Pennsylvania on July 1, 2017.

Also, OLTL will be submitting its CHC Waiver request to the federal government for approval. Per the latest information received, this is expected to be done in November. Check the CHC website to view the Waiver request once it has been submitted.

Individuals who are interested in receiving CHC updates from the Department via email can sign up here. Stay tuned to future newsletters for more CHC news!

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

With Medicare Open Enrollment now underway, Medicare beneficiaries are receiving mailings telling them what their current plan's benefits will be in 2017 and about their plan choices for 2017. **Remember, Medicare Open Enrollment ends December 7th**! Below is a list of common mailings people on Medicare may receive. For a full list of Medicare consumer mailings, including links to notices, click here.

- **Medicare & You 2017 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 Medicare Advantage and Part D plans available in 2017 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 2017.

- **Plan Low Income Subsidy (LIS) Rider**: Individuals with Medicare drug coverage who currently receive Extra Help (also called the Low Income Subsidy) should have received this document by the end of September from their plan detailing what their prescription drug costs will be in 2017.

- **Plan Non-Renewal Notice**: Anyone currently in a Medicare plan that will end in 2016 should have received this notice by October 2nd.

- **Extra Help Notices**: Those currently receiving Extra Help who will lose this help at the end of the year, **or** whose co-pay levels will change in 2017, should receive one of the following notices:

    ◊ **Loss of Deemed Status Notice (Grey Notice)** is sent in September to individuals who automatically received Extra Help in 2016 but who no longer automatically qualify in 2017 be cause they lost Medicaid coverage before July 2016. These individuals may still qualify for Extra Help; but, they 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 2016 and will still qualify for the help in 2017, but who will pay different prescription co-pay amounts in 2017.

- **Reassignment Notices (Blue Notices):** Anyone with Extra Help whose Medicare Advantage or Part D drug plan will no longer be available in 2017 will receive notices by early November telling them that they will be reassigned to a different plan starting January 1, 2017. Those who wish to enroll in a different plan than the one picked for them can do so, but they need to join the plan of their choice before the end of December.

Medicare beneficiaries who need help understanding a notice they received or who need help choosing a Medicare health or drug plan for 2017 are encouraged to call APPRISE at 1-800-783-7067.

PHLP Offers Medicare 2017 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 2017.

The webinar will be held **November 16th from 10am-11:30am**. It will cover the following topics:

- Medicare Part D plans and costs in 2017
- 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
- What's Ahead?

To register for the webinar, please click here. Space is limited, so register today! We ask individuals who are registering from the same organization to gather around one computer when possible. This will help to ensure that space is available for all those who are interested in participating in the webinar.

Please share this announcement with others who may be interested in the webinar!

Coverage of Diabetic Testing Supplies for Dual Eligibles

PHLP frequently hears from dual eligibles (people who have Medicare and Medicaid) who have problems getting their diabetic testing supplies at their local pharmacy or who end up being charged more than they should for these items. As a result, we want to review how coverage for these items works when someone has both insurances and gets their diabetic testing supplies at a local pharmacy.

Diabetic testing supplies include test strips and lancets which are used to test the blood sugar level in people who have Diabetes. Unlike insulin and needles that are covered solely by Medicare Part D, **testing supplies are covered by Medicare Part B**. When people get these items at a local pharmacy, the pharmacist should bill their Medicare coverage first (either Original Medicare or their Medicare Advantage plan). Then, the pharmacist should bill the ACCESS card second. After billing both insurances, a dual eligible should only be charged a very small Medicaid co-pay (no more than $3 for each item). In some cases, there may not be any co-pay. Pharmacists who are having problems getting Medicaid (ACCESS) to pay second for test strips and lancets should call the Medicaid Pharmacy Services Provider Call Center at 1-800-537-8862, select Option 1 and then Option 1 again.

Dual eligibles who experience problems getting their diabetic testing supplies at the pharmacy can call PHLP's Helpline at 1-800-274-3258 for assistance.

Governor Wolf Issues Guidance for Consumers and Health Plans on Parity in Mental Health and Substance Use Disorder Coverage

Governor Wolf and the Pennsylvania Insurance Department recently issued an official Notice to health plans and to the public detailing the requirements on access to treatment for mental health conditions and substance abuse disorders (commonly referred to as drug and alcohol treatment). The state also released a Consumer Guide to help Pennsylvanians know their rights in accessing these services when they have health care coverage through an employer or the Marketplace.

> In his press release, Governor Wolf stated: "This guidance will help ensure that all parties – consumers and insurance companies – understand how the federal and state laws relating to mental health and substance use disorder treatments interact so they may be properly implemented. Ensuring that Pennsylvanians have access to the mental health and substance use care that they need is a priority for my administration, and I urge all insurance companies subject to these regulations to take implementation very seriously."

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Parity Act) is a federal law that generally prevents group health plans and health insurance issuers providing mental health or substance use disorder benefits from covering these benefits in a more restrictive way than they cover medical/surgical benefits. Additionally, the Affordable Care Act (ACA) requires most health plans to cover ten Essential Health Benefits that include mental health and substance use disorder services.

It is primarily the responsibility of states to enforce implementation of the Parity Act and the Affordable Care Act. The Parity Implementation Coalition of Pennsylvania (PHLP is a participant) has worked closely with the Pennsylvania Insurance Department to ensure enforcement of the Parity Act and the ACA. The Coalition commends Governor Wolf and the Insurance Department for issuing the Notice and the Consumer Guide to educate Pennsylvanians on these important laws and to guide health insurers on their responsibilities under the law.

Pennsylvanians with questions about the type of coverage they have, or about their rights to mental health and substance abuse treatments services, should contact the Insurance Department at 1-877-881-6388. Individuals can also call this number to report possible parity violations.

Marketplace Open Enrollment Starts November 1st!

The Annual Open Enrollment period for 2017 Marketplace coverage (HealthCare.gov) will soon begin. From **November 1st through January 31st**, consumers can enroll into a Marketplace plan, change their plan, and apply for financial assistance to make their Marketplace plan more affordable.

This year, the federal government increased its efforts to connect with uninsured consumers to urge them to get coverage. This includes sending over 10 million direct mailings- a dramatic increase to the 800,000 mailings sent last year. These mailings target those who are either recently uninsured, who recently sought coverage through HealthCare.gov or a State Medicaid program, or who lost their eligibility for Medicaid or CHIP. The government is also trying to connect to young adults through YouTube, Facebook, and for the first time, Instagram. The messaging highlights the affordability of Marketplace plans, stresses the Open

Enrollment deadline, and reminds consumers of the financial penalty that results from being uninsured.

While Marketplace Open Enrollment runs until January 31st, 2017, **those wanting to have coverage in place on January 1st should enroll by December 15th.** For help with enrollment and comparing plan options, consumers can find health care navigators in their area by going to the Marketplace website at localhelp.healthcare.gov . 2017 Plan Information is available at HealthCare.gov or by calling the Marketplace at 1-800-318-2596 (TTY: 1-855-889-4325).

REMINDER: "One Set Per Lifetime" Dentures Limit Reset Last Year

In April 2015, when Governor Wolf discontinued the Healthy PA initiative and simplified Medicaid expansion, he enacted a new Adult Benefit Package. Even though the new Adult Benefit Package includes the same dental benefit limits that went into effect in 2011, including the "one set per lifetime" limit on dentures, the dental benefits were effectively "reset" when the system updated in April 2015.

In practice, this means that Medicaid consumers who had dentures paid for **prior to April 2015** but who now have a need for new dentures can receive them under normal prior authorization guidelines. A consumer who had dentures paid for by Medicaid **after April 2015** will have to meet the more restrictive "Benefit Limit Exception" (BLE) criteria in order to get new dentures covered.

Guidance issued to Medicaid managed care plans last year clarified that this Adult Benefit Package change applies to Medicaid consumers in Fee-for-Service (ACCESS) as well as consumers in the HealthChoices system. However, individuals continue to contact PHLP's Helpline who are denied dentures by Medicaid managed care plans using the BLE criteria even though their last set of dentures were provided **before** April 2015. Our staff has been successful at getting the Medicaid managed care plans in these cases to re-review the recent request for dentures using the correct prior authorization criteria.

Other dental services covered by Medicaid for adults include exams, x-rays, cleanings, fillings, and extractions. Exams and cleanings are limited to twice a year. Root canals, crowns, and deep cleanings are only covered if a Benefit Limit Exception is approved. For a full listing of benefits and limits contained in the Adult Benefit Package, see the "Consumer Resources" section of www.healthchoicespa.com.

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

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.