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In This Issue

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Community HealthChoices Delayed as Protesting Health Plans Appeal

On December 15th, PA's Department of Human Services (DHS) announced the state is postponing the start of Community HealthChoices for another six months-until January, 2018. This delay is the result of appeals to Commonwealth Court by three of the four insurance companies who were not selected by DHS to be Community HealthChoices managed care plans.

We noted in previous Newsletters that DHS was reviewing the bid protests filed by four insurance companies who applied to be Community HealthChoices managed care plans but who were not ultimately chosen. The state recently announced that the outcome of these protests was favorable to DHS and that the insurance companies had 15 days to appeal the decision on their bid protest to Commonwealth Court. Three plans decided to go forward—Gateway, Molina and United Healthcare have now each filed an appeal in Commonwealth Court and are asking the Court to "stay", or enjoin, Community HealthChoices while their appeals are proceeding.

Community HealthChoices was slated to start in the 14 county Southwest Region on July 1st, 2017. The recent announcement from DHS says the Southwest (Zone 1) implementation will be postponed until January 1, 2018 and that implementation in the Southeast (Zone 2) is delayed until July 1, 2018. The implementation date for Zone 3 (the rest of the state) remains unchanged and will be January 1, 2019. DHS' announcement can be found here.

Medicare Announces 2017 Part A and Part B Costs

In November, the federal government announced the premiums, deductibles, and coinsurance costs for Medicare Part A and Part B in 2017. These costs will take effect January 1, 2017.

Medicare Part A

Part A is the hospital benefit of Medicare that covers inpatient hospital care, care in a skilled nursing facility (up to 100 days), some home health care, and hospice services. Most people get Part A for free (because they, or their spouse, have paid Medicare taxes while working). However, some people have to pay for Part A. For those that have to buy Part A, the monthly premium in 2017 can be as much as $413.

In 2017, the Part A hospital deductible will be $1,316 per spell of illness. If someone is in the hospital longer than 60 days, their cost-sharing will be: $329/day for days 61-90 and $658/day for days 91-150. Beneficiaries in a skilled nursing facility that accepts Medicare pay no cost for Medicare-covered care for the first 20 days. Medicare can cover up to 100 days of skilled nursing facility care but the beneficiary has a $164.50 per day co-pay for days 21 through 100.

Medicare Part B

Part B is the medical benefit of Medicare that covers outpatient care such as doctor visits, outpatient hospital services, diagnostic tests, ambulance services, durable medical equipment and mental health services. Everyone on Medicare is subject to a monthly Part B premium. Most people have their Part B premium deducted from their monthly Social Security check. People with limited incomes and resources can qualify for Medicaid to pay their Part B premium.

Part B Premium in 2017

The amount someone has to pay for Part B in 2017 will depend on their situation. People currently on Medicare who have their premium automatically deducted from their Social Security check are either paying $104.90 or $121.80. These monthly premiums will increase slightly because of the very small cost-of-living adjustment to Social Security benefits in 2017. However, people will see no increase in the amount of Social Security deposited into their accounts next year because that cost of living adjustment will instead be applied to their 2017 Medicare premium.

For people whose Medicare **starts** in 2017, their monthly premium amount will be $134. In addition to new beneficiaries, the following people will pay a Part B premium of $134/month in 2017:

- Individuals, such as those not collecting Social Security benefits, who pay their Part B premium directly to Medicare rather than have it automatically deducted from their Social Security check.
- Individuals with limited income and resources who qualify for the Medicare Savings Program where Medicaid pays their Part B premium. These people will have to pay the $134 premium amount if Medicaid stops paying their premium at some point during the year.
- As in previous years, beneficiaries with annual income above $85,000/single or $170,000/married pay higher Part B premiums. Using the $134 premium amount as a base, these individuals are charged an increased premium on a sliding scale based on the amount of their taxable income.

Other Part B Costs in 2017

In addition to their monthly premium, those with Medicare Part B must meet an annual deductible before their coverage starts. In 2017, the annual deductible for all beneficiaries will be $183. Once this deductible is met, Part B covers outpatient physical and mental health services at 80%.

As a reminder, Medicare beneficiaries are responsible for paying the monthly Part A (if any) and Part B premiums regardless of how they get their Medicare (through Original Medicare or a Medicare Advantage plan). Individuals in Original Medicare (who use the red, white and blue card when getting care) with no additional insurance are subject to the Part A and B deductibles and coinsurance described above. Those in a Medicare Advantage plan can be charged the Part A and B deductibles, coinsurance, and copays set by their particular plan.

More information about Medicare Part A and B costs in 2017 can be found here.

Pennsylvania Long-Term Care Council Formed

Pennsylvania's Long-Term Care Council recently held its first meeting as it begins the work of reviewing regulations, financing, and service delivery in order to make recommendations and improve the existing long-term care system. The Council, formed by legislation passed in 2015, replaces the Intergovernmental Council on Long-Term Care. The Council includes 35 members appointed by the Wolf Administration and will be chaired by Secretary of Aging Teresa Osborne. More information can be found here.

Resource Limits to Qualify for Extra Help and Medicare Savings Programs in 2017 Announced

The resource limits to qualify for programs that help people with Medicare costs are increasing slightly next year. Starting January 1st, the resource limits for **Extra Help with Medicare Prescription Drug Costs** (also called the Low-Income Subsidy or "LIS") will be:

- Full Extra Help: $8,890 (single); $14, 090 (married)
- Partial Extra Help: $13, 820 (single); $27,600 (married)

NOTE: These figures include a $1,500 per person disregard given when applicants mark on the application that they expect to use their resources for funeral/burial expenses.

The Extra Help program helps people with their Medicare Part D costs. The amount of help someone gets depends on whether they qualify for full or partial help. More information about qualifying for Extra Help can be found here.

The resource limits for the **Medicare Savings Programs** are also increasing starting January 1st. These Programs help people pay their Medicare Part B premium and may also help pay the Medicare Part A and Part B deductibles and coinsurance if the person has very low income. The resource limit for the Medicare Savings Programs in 2017 will be $7,390 (if single) or $11,090 (if married). More information about qualifying for the Medicare Savings Programs can be found here.

Individuals who need help applying for Extra Help or the Medicare Savings Programs are encouraged to call APPRISE at 1-800-783-7067. Once the 2017 Federal Poverty Level figures are announced (usually in late January/early February), PHLP will update its publications about qualifying for Extra Help and the Medicare Savings Programs. Be sure to check the publications section of our website next year to see the updated fact sheets!

OLTL Waiver Application Help Now Available

As of early December, Person-Centered Counselors working through PA LINKs are available to help these individuals seeking a waiver administered by the Office of Long Term Living (OLTL) complete the PA 600L Medicaid application. The OLTL waivers include Aging, Attendant Care, COMMCare, Independence and OBRA Waivers.

Individuals interested in these Waiver programs begin the process by calling Maximus (1-877-550-4227) who sends them the Waiver application. Maximus should now be asking the person if they

need help with the application, and if the person responds affirmatively they should be given the PA LINK phone number.

We encourage anyone applying for a Waiver through Maximus who needs help completing the Medicaid application for an OLTL Waiver to tell Maximus about their need so they get connected with this important resource!

Help for People Who Mistakenly Missed the Transition from Marketplace to Medicare

The federal government recently announced a limited opportunity for people to request enrollment into Medicare Part B and/or request relief from a late enrollment penalty if they declined or delayed enrollment because of confusion or mistakes related to their having Marketplace coverage. This opportunity will **end March 31, 2017**.

The process is formally known as Equitable Relief and people need to request this relief in writing to the Social Security Administration. The person requesting relief will need to show that he delayed or declined enrolling into Medicare Part B because:

- he was confused about the need to enroll in Medicare or mistakes were made related to his Marketplace tax credits or cost-sharing subsidies, or
- he was given misinformation by someone acting on the government's behalf (such as a representative from Medicare or Social Security or a customer service representative from a Medicare Advantage Plan).

When requesting Equitable Relief, it is important to include as many details as possible about the confusion or mistakes made that resulted in the person delaying or declining enrollment into Medicare Part B or about the misinformation that was given and by whom. Also, the request should state what action the person is seeking: does the person want to enroll into Part B immediately or does she want it to go back two months (the person will have to pay back premiums if requesting retroactive coverage) and/or is the person seeking waiver of the late enrollment penalty? Please see a tip sheet created by the Medicare Rights Center for general information about requesting Equitable Relief. More information about this opportunity can be found here.

Anyone with Marketplace coverage who experienced ***any*** confusion or misunderstanding about their need to enroll in Medicare when first eligible is encouraged to apply for this Equitable Relief. Individuals who need further assistance can contact APPRISE at 1-800-783-7067.

New Outreach Effort to Enroll Eligible Children into Medicaid or CHIP

In November, the Department of Human Services (DHS) began a **one-time effort** to identify children who are receiving child care subsidies or SNAP benefits and enroll them into Medicaid or CHIP if they are eligible. This outreach effort targets children under 21 years of age in households that appear to meet the Medicaid income limits. Targeted households should have already received a mailing with information and instructions about what they need to do to have their children reviewed for Medicaid or CHIP eligiblity. These households will receive a second mailing in December.

- **Households with children eligible for child care subsidies but not receiving SNAP:** DHS has identified potentially eligible children by cross-matching the Medicaid database with the child care database, known as PELICAN (Pennsylvania Enterprise to Link Information for Children Across Networks). This process also identified eligible children currently on the waiting list to receive a subsidy.

  Households will be sent a mini-application that will be pre-populated with data obtained from PELICAN. Families should complete the application, correct any errors, sign it, and send it back in an envelope provided by DHS. The bar code on the application will make it easier to identify these one-time applications.

  Although this initiative is targeted at children under 21, adults 21 and older living in the household that receives the mini-application can request Medicaid on the same application. Caseworkers will try to verify necessary information through their existing systems, but they may need to request additional documentation from the family to determine whether household members qualify for Medicaid coverage.

  Children not eligible for Medicaid because household income is too high will be referred to the CHIP program if they are under 19 years old. Those 19 and older will be referred to the Healthcare Marketplace (www.HealthCare.gov).

- **Households with children enrolled in SNAP:** DHS will use its existing databases to identify children in households receiving SNAP benefits who seem to qualify for Medicaid but who are not yet enrolled. **If all children living in the household are part of the SNAP household**, the family will receive a consent form. In order for these children to be enrolled in Medicaid, families must return the consent form in the envelope provided or call DHS at 1-855-767-1630 to give verbal consent.

  If a household includes children who are not part of the SNAP household, they will be sent a mini-application instead of the consent form and must follow the process described above under the first bullet point.

All households targeted (whether because of child care subsidies or SNAP) have 60 days to respond to the mailings. However, mini-applications received after the 60 day period will still be processed. Please contact Ann Bacharach at abacharach@phlp.org or 215-625-3596 with questions or for more information.

Human Services Block Grants Now Available Statewide

The Human Services Block Grant program that was previously limited to 30 counties can now expand to all of Pennsylvania's 67 counties because of legislation signed by the Governor in early November after nearly unanimous passage by the legislature. The legislation, Senate Bill 613, was introduced by Senator Pat Vance. The program is voluntary and counties must submit a proposal to the Department of Human Services for approval in order to participate.

The Human Services Block Grant program started in 2012 under Governor Corbett's administration. Instead of funding certain county-based human services (i.e., mental health, drug and alcohol, intellectual disabilities, children and youth) under separate line items, the funding was combined and given to the county in one lump sum. The county still had to provide the following services: community-based mental health; drug and alcohol treatment and prevention; child welfare; homeless assistance; intellectual disability; and behavioral health. However, the goal of the Block Grant was to give the county the flexibility to spend monies across various human service programs to better meet the needs of their residents. Twenty counties initially participated in the program which then expanded to 30 counties in budget year 2013-2014. To learn if your county is already participating in the Human Services Block Grant program and to review your county's plan look here.

The program has been controversial from the beginning. County commissioners and some legislators praise the program and highlight the importance of funding flexibility while consumer advocates and other legislators continue to raise concerns about funding levels for human services and creating competition for funding among many vulnerable groups. For more historical information about the Human Services Block Grant program, see PHLP's past newsletters (June/July 2012, September 2012).

Public Comment Opportunity-Consolidated and PFDS Waiver Renewals

In early December, the Office of Developmental Programs announced an opportunity for public review and comment on the state's proposed renewals to Appendices A through H of the Consolidated and Person Family Directed Support (PFDS) Waivers. **The comment period ends January 17, 2017.**

Individuals wishing to submit comments can do so in writing by the end of the day on January 17th or by participating in the following webinars (registration required):

- January 12, 2017 from 1pm-4pm
- January 13, 2017 from 9 am-12pm
- January 17, 2017 from 1pm-4pm

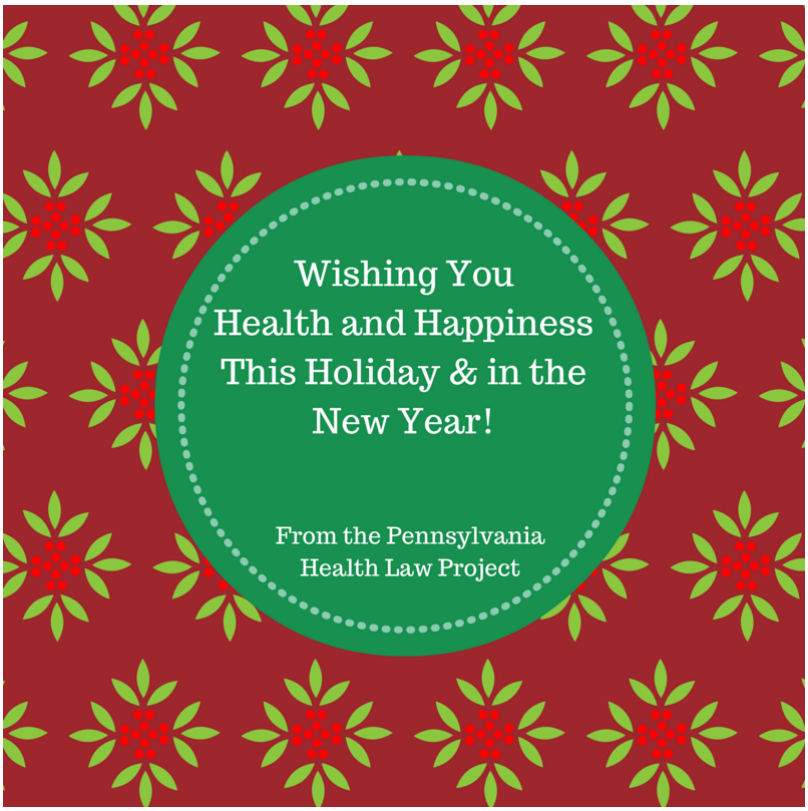
Please see a memo issued by the Office of Developmental Programs for highlights of proposed substantive changes, further details about submitting comments, and information about where people can get hard copies of the proposed renewal documents.

Comments on OLTL Waiver Amendments Due December 21st

The Office of Long Term Living has issued proposed amendments to the following Waivers: Aging, Attendant Care, OBRA, and Independence. **Comments are due in writing by close of business on December 21st.** The amendments can be viewed here. Primarily, the changes outline the transition plan for moving individuals from these Waivers into Community HealthChoices.

More information about submitting comments on any of the waivers being amended can be found at the links below:

- Aging Waiver: http://www.pabulletin.com/secure/data/vol46/46-47/2004.html
- Attendant Care: http://www.pabulletin.com/secure/data/vol46/46-47/2005.html
- OBRA Waiver: http://www.pabulletin.com/secure/data/vol46/46-47/2006.html
- Independence Waiver: http://www.pabulletin.com/secure/data/vol46/46-47/2007.html



As 2016 draws to a close, PHLP thanks everyone whose support helped us secure health care for almost 5,000 low-income persons and those who are otherwise vulnerable or disenfranchised. We've obtained health coverage for the uninsured, restored skilled nursing care for developmentally disabled children and adults, and advised low-income seniors confused about Medicare enrollment. The services we obtain for our clients are important to their well-being, and provide peace of mind: the kind of peace we wish for anyone who needs medical care. It is a privilege to do this work.

Please consider us when you are making any year-end contributions to charitable organizations and help us continue to advocate for the most vulnerable Pennsylvanians. Your support makes our work possible. Donations can be made by mail or by using our secure online form.

We wish you good health, and hope you will continue to stand for healthcare access in the New Year!

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