

In This Issue

Upcoming Webinar: Preparing for Your Community HealthChoices Appeal	3
Moving Towards Implementation of CHC in the Southeast Zone	3
FED Start Date Pushed Back to September 1st	4
Changes to Medicaid Transportation & the Human Services Code included in 2018-19 Budget	4
Medicaid Consumers Must Report Changes to Income or Household	5
MAWD P.O. Box Closure Causes Premium Payment Problems	6
Judge Blocks Kentucky's Medicaid Work Requirements	7
An Update on CHIP Rescission	8

Problems Emerge at the End of the SW CHC Continuity of Care Period

PHLP has been hearing from Community HealthChoices participants regarding actions taken to reduce services when the continuity of care period ended on June 30th. After talking with these participants and reviewing CHC plan notices and service plans, it appeared the CHC plans were violating the rights of consumers and not following the terms of their agreement with the state.

The problems CHC participants are experiencing include a lack of appropriate person-centered service planning and deficient notices reducing services the consumer have been receiving. Most of the problematic service reduction notices involve Personal Assistance Services that participants need to help them with activities of daily living such as bathing, dressing, and meal preparation.

PHLP has shared its concerns, further discussed below, with the Office of Long Term Living (OLTL) and will continue to do so as new examples of problems surface. OLTL reacted swiftly to the information and specific examples PHLP provided about deficiencies in the person centered service planning process and in the service denial notices people had been getting.

At the Consumer Subcommittee of the Medical Assistance Advisory Committee on June 27th, OLTL announced that all three CHC plans have been put under corrective action. As a result, the plans are retraining service coordinators on person-centered planning and submitting **all** notices issued to members when services are denied or reduced to OLTL for review. OLTL has assigned staff to review every service denial notice until it is satisfied that each CHC plan is complying with the agreement. Moreover, OLTL and staff from its Office of General Counsel are meeting in July with senior leadership

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from each CHC plan to review the minimum content required for a service denial notice when plans deny or reduce a CHC participant's services.

Lack of Person Centered Planning: Person-centered service planning is at the core of CHC. It is supposed to be a process in which the CHC participant, working with the service coordinator and anyone else the participant wants involved, identifies her needs, preferences, and goals. This informs the development of a service plan (sometimes called a care plan). The plan outlines the type and amount of services to be provided, such as Personal Assistance Services, to meet the individual's needs and help her achieve her goals. The service plan also includes information about any informal supports (such as unpaid family caregivers) available to help the participant.

Once the service plan is developed, the participant is supposed to sign the plan and receive a copy. The person centered service plan process is so central to the CHC program that home and community-based services received under continuity of care cannot be changed until the process is complete. Yet, PHLP has been hearing from participants who are being denied services when they have not gone through the service planning process. Others have gone through the process but have not been given a copy of the service plan that was developed. Still others have had incomplete service plans, such as unsigned plans or not having any goals listed at all.

LTSS Denial or Reduction Notices Sent to Participants Lack Detail: In addition to these service plan problems, CHC plans are sending denial notices to participants that do not include any explanation or reasons for why services are being reduced or why requests for new or increased services are not approved. CHC plans are required to send their members written notice of reductions and denials of services. These notices must detail the reasons for the change or denial. Justifications like "you have been assessed as not needing these services" or "the services are not medically necessary" without any further explanation are insufficient. The CHC participants who have contacted PHLP are receiving notices that do not explain why the CHC plan decided they do not need the services, what has changed to warrant a service reduction, or how requested services are not medically necessary.

In addition to the corrective actions described earlier in this article, vigilance from CHC participants, their advocates, and their providers in the Southwest is clearly needed to ensure the CHC program moves into its next phase in the region in a way that does not harm participants but assures their needs are met. CHC participants, their family members or other supports, are encouraged to read notices denying or changing services carefully. These notices include information about how to file an appeal. People should appeal decisions if they do not agree with them. Appealing quickly will ensure people continue to receive services at the previously approved level while they go through the appeal process.

We strongly encourage CHC participants or their advocates to call PHLP's Helpline at 1-800-274-3258 or email us at staff@phlp.org for advice or help with their appeal. Information about appealing a CHC decision can also be found on [PHLP's website](#).

Upcoming Webinar: Preparing for Your Community HealthChoices Appeal

PHLP attorneys, David Gates and Amy Lowenstein, will conduct a free webinar that will explain person-centered planning. It will also review appeal rights under Community HealthChoices (CHC) and explain what participants and advocates can do to present their best case after appealing. The webinar will be delivered in two parts.

- ◇ **Part One: Person Centered Planning** will be delivered **Tuesday, July 10th at 1 pm**. Register [here](#).
- ◇ **Part Two: Presenting Your Best Case on Appeal** will be delivered **Tuesday, July 17th at 1 pm**. Register [here](#).

Moving Towards Implementation of CHC in the Southeast Zone

To pave the way for the January 1, 2019 launch of CHC in the Southeast Region, the Office of Long Term Living (OLTL) held nine CHC education sessions across the region for providers in June. As a reminder, the Southeast Region includes Bucks, Chester, Delaware, Montgomery and Philadelphia counties. Approximately 130,000 dual eligibles (persons on Medicare and Medicaid) and adults receiving long term services and supports at home or in a nursing home will move to CHC in Southeastern Pennsylvania.

Here is a timeline of what to expect in the months ahead:

- **July 2018:** CHC participants are sent a CHC Awareness Flyer briefly introducing them to the program.
- **August 2018:** Mailings will be sent to all CHC participants informing them of dozens of consumer-focused CHC events that will be held across the Southeast region and information on how to register for an event.
- **August 2018:** Those who will be going into CHC will be sent an enrollment packet with information on choosing a CHC managed care plan and primary care physician.
- **January 1, 2019:** CHC begins in the Southeast Region.

FED Start Date Pushed Back to September 1st

The new assessment tool for long-term care eligibility called the Functional Eligibility Determination (FED) will now start September 1st. Previously, it was scheduled to start July 2nd. This tool will be used to determine whether older adults and people with physical disabilities meet the level of care needed to qualify for long term care services at home or in a nursing home. At the July 6th meeting of the Managed Long Term Services and Supports Subcommittee, officials announced that start date was delayed to allow for more time to train the assessors who will be using the new tool.

More information about the tool and the concerns raised by consumer advocates can be found in our [May newsletter](#). We will keep readers updated about any developments related to the use of this new tool.

Changes to Medicaid Transportation & the Human Services Code included in 2018-19 Budget Agreement

Relatively minor changes to the Commonwealth's Medicaid program were included in the flurry of budget-related bills agreed to by the legislature and signed by Governor Wolf on June 22nd. Act 40 of 2018 ([House Bill 1677](#)) contains the following amendments to the Human Services Code:

- **Non-Emergency Medical Transportation** – The Department of Human Services (DHS) is directed to request federal approval to amend its Medicaid State Plan to provide non-emergency medical transportation – also known as the Medical Assistance Transportation Program (MATP) – through a statewide or regional full-risk brokerage model. Moving from a county-based MATP system to a regional broker model would allow DHS to claim federal match as a service rather than an administrative cost, generating an estimated \$15 million in annual savings.
- **Hospital Assessment** - The statewide “Quality Care Assessment” on acute-care hospitals was renewed for a period of five years and increased to 3.71 percent of net patient revenues. The assessment is expected to generate \$757 million overall and create General Fund savings of \$75 million in 2018-19. DHS uses the assessment, which generates federal matching funds, to fund inpatient and hospital supplemental appropriations.
- **Health Care Outcomes** – DHS is directed to create a new “Outcomes-Based Program” for both hospitals and its managed care organizations that focuses on data collection and data reporting regarding potentially avoidable medical events. As part of this effort, DHS must undertake a comprehensive analysis of existing state databases to increase efficiencies in the Medicaid program. DHS is required to provide a report and recommendations regarding these programs to the General Assembly no later than December 31, 2019. This amendment has no specific fiscal impact.

Medicaid Consumers Must Report Changes to Income or Household

Medicaid consumers and advocates report an increase in overpayment claims brought against consumers who the state asserts failed to report a change in circumstances that resulted in them receiving health coverage for which they no longer qualified. Overpayments can occur when a consumer does not report a change in their situation, such as income or their family size, that causes them to no longer meet the guidelines for Medicaid or other benefits they are receiving.

Under the terms of their application for health coverage, Medicaid consumers in Pennsylvania are required to report all changes to their situation; this includes changes to their address, income and who lives in their household. People may also be required to report changes to their resources if those are counted in determining their Medicaid eligibility. Changes experienced by **any** household member, even if that person is not receiving Medicaid, should be reported. Medicaid requires that people report changes by the tenth day of the month following the change.

Even small changes in income can cause an individual or entire household to no longer qualify for Medicaid. If someone continues to receive Medicaid when they are no longer eligible because they failed to report a change, local caseworkers are supposed to refer the overpayment to the state's Office of Inspector General who will investigate the situation and possibly pursue collection.

Some Medicaid consumers charged with overpayments erroneously believed they could not be held liable if they had not used their Medicaid coverage. This is inaccurate. Most consumers are enrolled in Medicaid managed care plans. The state pays each managed care plan a monthly capitation rate for each Medicaid enrollee. The money is paid to the plans as long as the individual remains enrolled in Medicaid, whether or not the individual uses the insurance. Consumers charged with overpayments can be held liable for the full amount of these monthly capitation payments.

Medicaid consumers can report changes by calling the Department of Human Services Customer Service Center at 1-877-395-8930 or by submitting the information in writing to their [local County Assistance Office](#). People who have COMPASS accounts can also report changes online.

Anyone charged with a Medicaid overpayment has the right to file an appeal. There may be circumstances when the Medicaid recipient is not at fault and therefore not liable for the overpayment. The [Supplemental Handbook](#) at Chapter 910 outlines the process for identifying and collecting overpayments for the various DHS benefit programs, and [policy guidance](#) from March 2015 outlines the process for Medicaid overpayments in particular.

People can call their [local Legal Aid Program](#) or the Pennsylvania Health Law Project at 1-800-274-3258 for advice or help with their appeal.

MAWD P.O. Box Closure Causes Premium Payment Problems

Over the last month, PHLP has heard from a number of people whose Medical Assistance for Workers with Disabilities (MAWD) premium checks were returned marked “address undeliverable” by the post office. After speaking with representatives from DHS, we learned that the MAWD P.O. mailbox that receives monthly premium payments from participants was inadvertently closed from May 15, 2018 to June 5, 2018.

On June 15th, DHS released [Policy Clarification PMW-18980-316](#) describing the situation in more detail. This closure caused many MAWD premium payments to be returned to sender. Consumers whose payments were not returned may notice delays with the processing of their MAWD premium payments for May.

Our advice to consumers is to continue paying monthly MAWD premiums on a timely basis. If a check was mailed back as undeliverable, simply mail it to the MAWD office again. A blank version of the MAWD premium statement and voucher can be downloaded [here](#).

MAWD premium checks should be mailed to the same address that consumers have always used:

*Commonwealth of Pennsylvania
Department of Human Services
Medical Assistance for Workers with Disabilities
P.O. Box 8052
Harrisburg, PA 17105-8052*

In addition to paying timely each month, consumers should also keep good records of the premiums they pay, including when the premium statement is received, when the payment is mailed, the amount of the payment, and the check or money order number for reference.

Consumers with questions regarding their MAWD premiums should contact the DHS Customer Service Center at 1-877-395-8930. Anyone receiving a notice of MAWD termination due to non-payment of premiums has a right to appeal and can contact PHLP’s Helpline for help.

Judge Blocks Kentucky's Medicaid Work Requirements

A federal judge recently blocked Kentucky's plan to require many Medicaid recipients to work, volunteer, or train for a job as a condition of coverage. [The decision](#), by Judge James E. Boasberg of Federal District Court for the District of Columbia, is a setback for the Trump administration, which has been [encouraging](#) states to impose work requirements and make other changes in their Medicaid programs.

The federal government [approved](#) Kentucky's plan to require people on Medicaid to work and to pay monthly premiums in January. The changes were set to start on July 1st. Earlier this year, the National Health Law Program, the Kentucky Equal Justice Center, and the Southern Poverty Law Center filed a lawsuit on behalf of 16 Medicaid beneficiaries in the state. Consumers and their advocates were concerned that Kentucky's new requirements would cause many people to lose their health benefits. This could happen if people were: deemed able to work or volunteer but did not; unable to provide the documentation every month to prove they had worked the required 80 hours; or, unable to keep up with premium payments.

The decision issued in this case is narrow. The court did not hold that as a matter of law demonstrations imposing work requirements on Medicaid beneficiaries can never be lawful. Nor did Judge Boasberg dispute the Secretary of the U.S. Department of Health and Human Services' assertions that work improves health or that improving health is a Medicaid objective. Instead, the court ruled that the Trump administration's approval of the plan had been "arbitrary and capricious" because it had not adequately considered whether the plan would "help the state furnish medical assistance to its citizens, a central objective of Medicaid." In other words, when the federal government issued its approval of Kentucky's plan, the Secretary failed to gauge its impact on Medicaid's central objective of covering people who are poor.

Because the decision concerns only Kentucky, it has no immediate or automatic effect on other states that have approved or pending work and community engagement demonstrations. [Arkansas](#), [Indiana](#) and [New Hampshire](#) have already received permission from the federal government to follow in Kentucky's footsteps, and seven other states are waiting for the Trump administration to decide whether they can, too. Should other approvals be challenged, they could experience Kentucky's fate.

"The Trump administration's attempt to transform the Medicaid program through executive action has been restrained," said Jane Perkins, the legal director for the National Health Law Program, which provides legal services for the poor. "The purpose of the Medicaid Act is to furnish medical

assistance, and this approval could not stand because it was doing just the opposite — restricting coverage.”

At the present time, Pennsylvania has not pursued work requirements for people on Medicaid. Readers may recall that last year, the legislature had passed a bill requiring Pennsylvania’s Medicaid program to seek federal approval to impose work requirements. This legislation was vetoed by Governor Wolf. Further attempts to pass similar legislation have not been successful.

An Update on CHIP Rescission

We reported in our last newsletter that President Trump sent a rescission package to Congress, asking that \$15 billion be removed (rescinded) from the federal budget for Federal Fiscal Year 2018. Cuts to the CHIP program, recently reauthorized until 2027, made up \$7 billion of the request.

Since then, the House passed the rescission request by a narrow vote of 210 to 206. The Senate, however, failed to move the CHIP rescission bill out of committee to the floor for a vote before the rescission package expired on June 22nd. As a result, any further rescissions requests will require a new proposal from the President.

PHLP will continue to monitor Congressional action and provide further updates as needed.

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.

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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.