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State Launches New Tool & Process to Determine Clinical Eligibility for Medicaid LTSS

On April 1st Pennsylvania began a new method to determine clinical eligibility for Medical Assistance (MA) long-term services and supports (LTSS), which includes all nursing facility services as well as all home and community based services. To receive MA-funded LTSS an individual must meet both clinical and financial eligibility standards.

To be clinically eligible for LTSS, an individual must need the level of care provided in a nursing facility (referred to as “Nursing Facility Clinically Eligible” or “NFCE”).

An individual is NFCE if:

1. The individual has an illness, injury, disability or medical condition diagnosed by a physician; and
2. As a result of that illness, injury, disability or medical condition, the individual needs care and services that are above the level of room and board; and
3. A physician certifies that the individual is NFCE; and
4. The needed care and services are either:
 - a. skilled nursing or rehabilitation services as specified by the Medicare Program in 42 C.F.R. §§ 409.31(a), 409.31(b)(1) and (3), 409.32-409.35; or
 - b. health-related care and services that are not as complex as skilled nursing or rehabilitation services, but are needed and provided on a regular basis in the context of planned program of health care and management and were previously available only through institutional facilities.

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If the individual is not NFCE, then the individual is referred to as Nursing Facility Ineligible (NFI).

This month, the state began using the Functional Eligibility Determination (FED) Process to determine and redetermine whether an individual is NFCE. The FED Process involves several steps that start with an assessment tool (the FED Tool) which an assessor uses to record observations about the individual, as well as the individuals' answers to questions, in five categories: cognition, mood and behavior, functional status, continence, and treatment and procedures. The assessor enters the information and scores from the FED Tool into an automated program that translates the scores into a finding of NFCE or NFI.

Advocates have been concerned about the weight the automated program gives to the individual's answers. There has also been concern that the FED Process will be less forgiving than the previous process, which relied on a different tool called the Level of Care Determination (LCD), and disqualify more applicants from being clinically eligible.

The automated program for the FED Tool is not the sole determinant. There is some human element. The assessor applies the FED Tool in-person and can disagree with the FED score and process. Also a physician must certify all NFCE determinations, and instances where a certification submitted by the individual's physician or the assessor's opinion differs from the FED Process, a DHS physician will make the final determination.

DHS issued a bulletin about the new process which can be found on DHS' website and [here](#).

Individuals who are determined NFI have a right to an explanation and appeal rights. PHLP and other legal aid programs are available to help individuals challenge these clinical determinations.

Update on Medicare Part D Copay Problems for Certain Dual Eligibles

In case people missed PHLP's Medicare Special Alert, [sent to newsletter subscribers in mid-March](#), we wanted to make sure readers know that the Part D copay problem detailed in our [February newsletter](#) should be fully resolved. Last month, Pennsylvania Department of Human Services' officials reported that the final fix to correct this problem back to when it started had been completed.

As a reminder, the problem impacted about 45,000 dual eligible participants who receive home and community-based services through the following programs: Community HealthChoices (Southwestern Pennsylvania only) and the Community Living Waiver for people with intellectual disabilities and autism. These individuals were incorrectly charged small Medicare Part D copays when they should have had a \$0 copay.

All of these individuals should have been identified to Medicare as qualifying for no Medicare Part D copays as early as 2018 if that is when they first qualified for Home and Community-Based Services under CHC or the Community Living Waiver. Medicare then shared this information with the Part D plans. Over the last month or so, Part D plans have been sending impacted members a general letter to show that their Part D copays are zero and the date the zero copays began. In addition to sending this letter, Part D plan sponsors should have automatically refunded people who had this problem for the copays they paid in 2019 as well as 2018 (if applicable) before the problem was corrected. This refund should happen automatically, and participants should not have to take any action to get the refund.

Participants, or their advocates, who continue to have problems with Part D copays or who have not received a refund of improper Part D copays paid are encouraged to call PHLP's Helpline at 1-800-274-3258.

Medicare Part D Extra Help News

Extra Help works with the Medicare Prescription Drug Benefit (Medicare Part D) to lower medication costs for people with limited income and resources. Any Medicare beneficiary who also qualifies for Medicaid (even if it is just to help pay the Medicare Part B premium) automatically qualifies for Extra Help. Other Medicare beneficiaries with limited incomes and resources can apply for Extra Help at any time of the year!

Extra Help not only helps limit what people pay for their Part D coverage and medications, it also eliminates any late enrollment penalty someone has and allows people to change their Medicare health or drug plans during the year. We wanted to share the following Extra Help news with our readers.

[Delays In Updating Extra Help Eligibility Guidelines](#)

People who applied for Extra Help earlier this year and were denied may want to appeal or apply again. The Social Security Administration (SSA), responsible for processing Extra Help applications, did not update the 2019 eligibility criteria for the Extra Help benefit as quickly as they should have. Therefore, representatives reviewing applications may have used outdated criteria when determining whether applicants qualified or not. Individuals who received recent denial notices can file an appeal. Other individuals who were denied since the beginning of the year should reapply. The 2019 guidelines can be found [here](#).

APPRISE, Pennsylvania's State Health Insurance Program, can help people on Medicare or those who are going to be qualifying for Medicare soon, apply for the Extra Help. We encourage people who want to learn more about Extra Help or who need help applying to call APPRISE at 1-800-783-7067.

Senator Casey Proposes Legislation to Expand Eligibility for Extra Help

Last month, Pennsylvania's Senator Casey proposed legislation to help more people on Medicare afford their medications by qualifying for Extra Help. The [Medicare Extra Rx HELP Act \(S.691\)](#) proposes to eliminate the resource limit that people have to meet to qualify and expand the full Extra Help benefit. Specifically, the income limit for full Extra Help would increase to 200 percent of the Federal Poverty Level--this is approximately \$25,000/year for a single person and \$33,800 for a married couple. There would no longer be a partial Extra Help benefit. Currently, full Extra Help is for people with incomes under 135 percent of the Federal Poverty Level (approximately \$16,800 for single individuals and \$22,800 for married couples) and partial Extra Help is available for people with income between 135 and 150 percent of the Federal Poverty Level ((approximately \$18,700/year for a single person and \$25,000/year for a married couple).

Millions of people on Medicare struggle to afford their prescription drugs. Some of these individuals are slightly above the income and/or resource thresholds needed to qualify for Extra Help while others get partial Extra Help but find it is not enough help to make their prescriptions affordable. People can click [here](#) to see the difference between costs for people that get full Extra Help compared to partial Extra Help this year.

As prescription drug costs continue to rise, people with limited incomes and resources may have to choose between medications and other daily living expenses. In addition to helping more people qualify for this important program and better afford their medications, the proposed changes would reduce the administrative burden of needing to verify that people meet the resource limit before an application is approved. More information about the reasons Senator Casey introduced this legislation can be found [here](#).

We'll keep readers updated if this legislation advances in Congress. Readers who want to express an opinion about this proposed legislation can contact their US Senators or Representatives.

PA Opens Comment Period to Improve MA LTSS Application & Enrollment Process

The Pennsylvania Department of Human Services (DHS) issued a [Request for Information](#) (RFI) to gather input and information about the application and enrollment services for beneficiaries who receive long-term services and supports (LTSS) and other benefits through the Office of Long-Term Living (OLTL). Specifically, the RFI is looking for information to assist DHS in determining how to improve its LTSS application and enrollment process, including services provided by the OLTL Independent Enrollment Broker. To improve on the current process, the Department believes that the new procurement should include the following elements:

- Conflict-free enrollment and choice counseling
- A more streamlined process with a single application and enrollment services entity
- An emphasis on individualized case management through a regional presence and assignment of a personal enrollment case manager to each LTSS applicant
- Improved customer service and assistance to LTSS applicants, including an in-home visit at the outset of the process, and help in completing and providing documentation to support the LTSS application
- Decreased service fragmentation and more efficient, effective and consistent operations through consolidation of clinical eligibility functions
- Improved communications and better use of technology
- Better engagement and communication with other community partners
- Enhanced accountability and quality control

The Department is requesting that all responses to this RFI be submitted by April 22nd to the following email account with “OLTL Application and Enrollment Services RFI” in the email subject line: RAPWRFICOMMENTS@PA.GOV.

PA Department of Human Services Budget Updates

At the March 28, 2019 meeting of the Medical Assistance Advisory Committee (MAAC), representatives from the Pennsylvania Department of Human Services (DHS) presented their budget requests for Fiscal Year (FY) 2019-2020. Highlights from each of DHS office are summarized below:

Office of Medical Assistance Programs (OMAP) Budget Presentation by Deputy Secretary Sally Kozak. Appropriations for \$18.2 billion in total funds for Medical Assistance are:

- \$14.4 billion for capitation
- \$2.3 billion for Fee-for-Service programs
- \$0.8 billion for Medicare Part D
- \$0.2 billion for Medical Assistance Transportation Program (MATP)
- \$0.5 billion for other expenses

The Medical Assistance Transportation appropriation maintains the same county-based program for FY 2019-20. The department will implement a regional broker model to administer the transportation program in FY 2020-21. No timeline for the HealthChoices RFP was provided.

Office of Long-Term Living (OLTL) Budget Presentation by Deputy Secretary Kevin Hancock.

The OLTL budget request expands the total number of individuals covered in the OLTL waivers and includes funds to establish a single entity responsible for financial eligibility determinations.

Total federal, state, and other funding for OLTL is about \$9.59 billion, an increase of \$755,260,000 in available funding:

- Community HealthChoices: approximately \$7.223 billion
- Long-term Care: \$1.297 billion
- Home and Community-Based Services: \$371,318,000
- Managed Long-Term Care: \$328,655,000
- Services to Persons with Disabilities: \$245,997,000
- Attendant Care: \$124,094,000

Office of Mental Health and Substance Abuse Services (OMHSAS) Budget Presentation by Acting Deputy Secretary Valerie Vicari. Total funding for OMHSAS is \$4,766,000,000, with HealthChoices Behavioral Health Managed Care taking up 74 percent of that budget. As of December 2018, 2,618,000 people were enrolled in HealthChoices Behavioral Health. OMHSAS also requested the following for FY 2019-2020:

- Community Health Services: \$670,453,000
- State-operated facilities: \$461,177,000
- DHS Administered BHSI/drug and Alcohol and Act 152: \$53,156,000
- Medicaid: \$3,581,000,000
- Special Pharmaceutical Benefits Program (SPBP): \$852,000

Office of Developmental Programs (ODP) Budget Presentation by Deputy Secretary Kristin Ahrens. The 2019-2020 budget provides \$2,117,000,000 in state funds for ODP, including:

- Community Services Waiver Program: \$1,672,826
- Autism Intervention and Services: \$29,683,000
- Community ID Services: \$148,725,000
- Private Intermediate Care Facilities for the Intellectually Disabled: \$148,148,000
- State Intellectual Disabilities Center: \$117,136,000

Affordable Care Act Updates

The Affordable Care Act (ACA), the law which aims to make healthcare more available to people has been in the news once again. First, in late March, a federal judge threw out Medicaid work requirements enacted in Kentucky and Arkansas, halting Republican efforts to significantly change a program that has produced free health insurance to the poorest Americans. Also in late March, in an unrelated case, the US Justice Department urged a federal appeals court to strike down the entire ACA not just pieces of it. Finally, President Trump and Senate Majority Leader Mitch McConnell announced that Republicans will not offer a replacement plan for the ACA until after the 2020 elections. Each of these items and their consequences for Pennsylvania is explained in more detail.

Medicaid Work Requirements Struck Down In Arkansas & Kentucky

In two lengthy opinions, a federal judge found Medicaid work requirements proposed by Arkansas and Kentucky were unlawful. Both states wanted, and received permission from the Trump Administration, to impose stricter rules on Medicaid recipients. They wanted all able-bodied adults, ages 19 to 49, receiving Medicaid to complete 80 hours of employment each month or to complete other qualifying activities such as volunteer work. The recipient would be required to report these hours through an online portal and if they failed to report the work or did not meet the requirements, they would be terminated from Medicaid. Both states allowed exceptions for the medically fragile, pregnant woman, full-time students, and persons in treatment for substance use disorder. In Kentucky it was estimated 95,000 individuals would have their Medicaid terminated if the law was implemented. In Arkansas, which had begun enforcing the work requirements, 16,000 individuals lost Medicaid because of the work requirement.

The court struck down each state's work requirements because there were serious deficiencies in the way the law was written and it would cause disruption to the Medicaid program drastically impacting the recipients.

Both states sought and received permission from the Trump administration to require Medicaid recipients to work. The court's ruling is a significant setback for the administration which has insisted that Medicaid not be used as a vehicle to serve working age, able-bodied adults.

Currently 15 other states (including Pennsylvania) have discussed or proposed work requirements in their legislature. These rulings however may deter states seeking to implement similar laws.

Readers interested in the court's decision can read them here: [Arkansas Case](#) [Kentucky Case](#)

Justice Department Argues Appeals Court Should Reject All Components of the ACA

In late March the Trump administration broadened its attack on the Affordable Care Act, telling a federal appeals court that it now believed the entire law should be invalidated. The administration

had previously said the law's protections for people with pre-existing conditions should be struck down, but that the rest of the law, including the expansion of Medicaid, should survive. If the appeals court accepts the Trump administration's new argument, millions of people could lose health insurance.

The Justice Department disclosed its new position in a two sentence filing to the appeals court. The Department wants the appeals court to affirm the reasoning of the trial court, which found that the entire ACA was invalid because in 2017, when Congress eliminated the tax penalty for people who go without health insurance, the individual mandate became unconstitutional and all the provisions of the ACA are also invalid too.

The lawsuit challenging the ACA, *Texas v. Azar*, was filed last year by a group of Republican governors and state attorney generals. A decision from the appeals court is many months away, and it is widely anticipated that the appellate decision will be appealed to the U.S. Supreme Court for a final decision.

Republicans Decide To Move Any ACA Replacement Plan Until After 2020 Elections

While the Trump administration attacks the ACA in court, Republicans have no plans to replace it. President Trump has tweeted and Senate Majority Leader Mitch McConnell announced that any Republican plan to replace the Affordable Care Act would not occur until after the 2020 elections. President Trump said that he has Republican Senators working on a replacement plan, but they will not vote until after the election "when Republicans hold the Senate and win back the House."

Pennsylvania Releases Report on Residential Services for Residents with Intellectual Disabilities and Autism

Department of Human Services (DHS) Secretary Teresa Miller released the *Improving the Quality of Residential Services* report highlighting the improvements in residential services for Pennsylvanians with intellectual disabilities and autism. Pennsylvania has expanded services to 7,500 individuals since 2015, investing more than \$381 million. An additional \$15 million proposed in 2019-20 budget the department could serve 765 individuals on the Office of Developmental Programs (ODP) emergency wait list through the community living waiver, and 100 people who experience unanticipated emergencies through the consolidated waiver. Governor Wolf's 2019-20 budget proposal invests \$1.8 million to increase the frequency of licensing inspections and enables DHS to hire 30 additional licensing staff focusing on residential and day programs.

On the Adult Autism Waiver and Want to Direct Your Own Supports?

Individuals enrolled in the Adult Autism Waiver cannot direct their own services or supports. However, now that individuals on the autism spectrum may be eligible for the Consolidated, Community

Living or PFDS waivers which allow individuals enrolled in those waivers to self-direct their supports, the Office of Developmental Services (ODP) is allowing some individuals on the Adult Autism Waiver who wish to self-direct to get on a special list for those other waivers (called “Participant Direction Transfers”).

ODP has set aside a combined 15 slots statewide in the Consolidated, Community Living and PFDS waivers (5 slots for each waiver) for individuals enrolled in the Adult Autism Waiver who wish to direct a majority of their own paid services and supports. Before deciding whether to request to be added to this special list, individuals should consider the following:

- There is no dollar cap on the amount of services that can be paid for under Adult Autism waiver. While the Consolidated waiver is also uncapped, there is no guarantee that an individual transferring from the Adult Autism Waiver will receive the similarly uncapped Consolidated waiver. They may be offered the Community Living Waiver (capped at \$70,000 a year) or the PFDS waiver (capped at \$33,000). That will be determined by their County MH/ID agency. However, if they are offered a capped waiver, they can turn it down and still remain in the Adult Autism Waiver.
- They will need to switch most of their services from the agencies currently serving them to people they recruit, hire and direct. Supports brokers can assist them with those tasks once they transfer.
- They may have to get a different supports coordinator
- These waiver transfer slots are not for individuals seeking residential placements.
- Once an individual transfers to one of the other waivers, they will lose their Adult Autism Waiver slot. So for example, if they accept one of the capped waivers and wish to return to the uncapped Adult Autism Waiver, they will go back on the interest list for the Adult Autism Waiver until a slot for that waiver opens up.

For individuals enrolled in the Adult Autism Waiver who wish to get on the waiting list for the other waivers in order to self-direct their services, the procedure is as follows:

- The individual contacts their supports coordinator to discuss getting on the special waiting list.
- The supports coordinator should discuss the differences between the Adult Autism Waiver and the other waivers that allow self-direction.
- If the individual decides to go forward with getting on the special waiting list, the supports coordinator sends information about the individual to a email to a special email box at ODP and the Bureau of Autism Services Regional Representative.
- If a slot is available, ODP will notify the County MH/ID agency who will contact the individual for further discussions about the waiver transfers and self-direction of services. The County MH/ID agency will enroll the individual in the other waiver if they still wish to transfer.
- If no slots are available, ODP will keep the individual’s information until a slot becomes available at which time they will contact the County MH/ID agency and the individual’s Adult Autism

Waiver supports coordinator. ODP expects to have 15 new “Participant Direction Transfer” slots each fiscal year. In the meantime, the individual will remain on the Adult Autism Waiver.

More information can be downloaded [here](#).

Participant Listening on Community HealthChoices in Johnstown, Cambria County: Wednesday May 22nd

The May meeting of the Consumer Subcommittee of the Medical Assistance Advisory Committee will be held in at the [Holiday Inn in downtown Johnstown](#) (rather than the usual Harrisburg meeting location). This meeting will take place on May 22nd, from 10 am to 3 pm and Community HealthChoices will be the focus of the entire meeting.

In the morning, there will be a [listening session for CHC participants](#), their family members and their caregivers who want to provide feedback about their experience with CHC. Leadership from the Office of Long Term Living will attend this session.

If you are interested in speaking at the listening session, please RSVP with your name and any accommodation requests to: jmeinert@phlp.org or 215-625-3663.

Pennsylvania Announces First Participants in New Rural Health Model

Governor Tom Wolf announced the first five hospitals and payers to participate in a new alternative payment model from the Centers for Medicare & Medicaid Services (CMS) Innovation Center that uses all-payer global budgets to support rural hospital transformation. The Pennsylvania Rural Health Model, announced by CMS in January 2017, is part of a program designed to improve rural community health and put struggling rural hospitals on stable financial footing. The program uses a global budget payment model in which hospitals receive fixed funding for a fixed period of time to improve rural community health, instead of paying hospitals for individual services or cases. CMS and the state intend to include a total of 30 hospitals over the course of the six-year demonstration project.

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

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