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Updates on Community HealthChoices

LTSS Continuity of Care Period Ends June 30th in Southeast PA

The 180-day continuity of care period in the Southeast for those getting long term services and supports (LTSS) at home ends on June 30, 2018. After that date, Community HealthChoices (CHC) plans can make changes to their LTSS provider network and they can terminate, reduce, or change the type and amount of LTSS their member has been receiving at home or in the community.

Lessons Learned from Southwest

Regular readers will recall that [serious problems](#) emerged at the end of the continuity of care period last summer in the Southwest. These problems included CHC plans reducing services without appropriate person-centered service planning and sending inadequate service denial notices to participants. PHLP shared these concerns with the Office of Long-Term Living (OLTL), which reacted swiftly by putting the plans under corrective action plans.

As a reminder, the person-centered service plan (PCSP) must be completed before a CHC plan can make any changes to home and community-based services. This plan is developed as part of a holistic process in which the CHC participant, working with the service coordinator and anyone else the participant wants involved, identifies her needs, preferences, and goals. The plan outlines the type and amount of services to be provided, such as Personal Assistance Services, and also includes information about any informal supports (such as unpaid family caregivers) available to help the participant. Once the PCSP is developed, the participant is supposed to sign the plan and receive a copy.

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As another reminder, 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. 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. CHC participants should appeal decisions when they do not agree. Appealing quickly will ensure people continue to receive services at the previously approved level while they go through the appeal process.

The experience in the Southwest is a reminder for the Southeast that vigilance from CHC participants, their advocates, and their providers is needed to ensure participants’ needs are met.

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 if they experience issues with the person-centered planning process or receive a notice that doesn’t give adequate detail.

Network Changes Expected

Two of the three CHC plans have announced significant changes in their LTSS provider networks effective July 1. Keystone First CHC has notified 67 service coordination entities (SCEs) that it will not be renewing their contracts past June 30. UPMC is cutting ties with 72 SCEs and home care providers. These contract terminations are expected to impact some 5,844 Keystone First participants and 4,337 UPMC participants currently receiving services from the terminated providers.

Impacted participants should already have received 45-day advance notice explaining that they can no longer use the provider after a certain date. The CHC plans are also responsible for helping participants find a different provider to ensure that services are not disrupted. As a reminder, consumers should generally have a choice of LTSS providers and should be offered a choice of who provides their service coordination.

Consumers cannot appeal a change to the CHC plan’s provider network. However, consumers can change their CHC plan and enroll into a plan that does have a contract with the provider. Consumers who wish to change their CHC plans should call the Independent Enrollment Broker at 1-844-824-3655. The Broker will tell the participant when the new plan will start. If someone needs the new plan to start sooner, she can request to have her plan enrollment expedited and provide reasons why an earlier start date is needed. The Broker will send these requests to the state for approval.

Consumers Can Appeal Terminations, Reductions or Changes in LTSS Services

If, after June 30th, the CHC plan acts to reduce, change, or end the participant’s in-home LTSS, it must send the member a written notice about the changes at least 10 days before the change takes place. Individuals who receive such a notice can appeal the CHC plans decision by requesting a grievance. The plan’s written notice will tell the member how to do this. **In order to keep LTSS in place during the appeal process, the member must request a grievance within 10 days of the mail**

date on the CHC plan’s written notice.

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.

PHAN Plans Community Listening Sessions for Southeast

The Pennsylvania Health Access Network (PHAN) is hosting a series of community listening sessions across Southeast PA to hear about participants’ experiences with CHC. Here are the upcoming events:

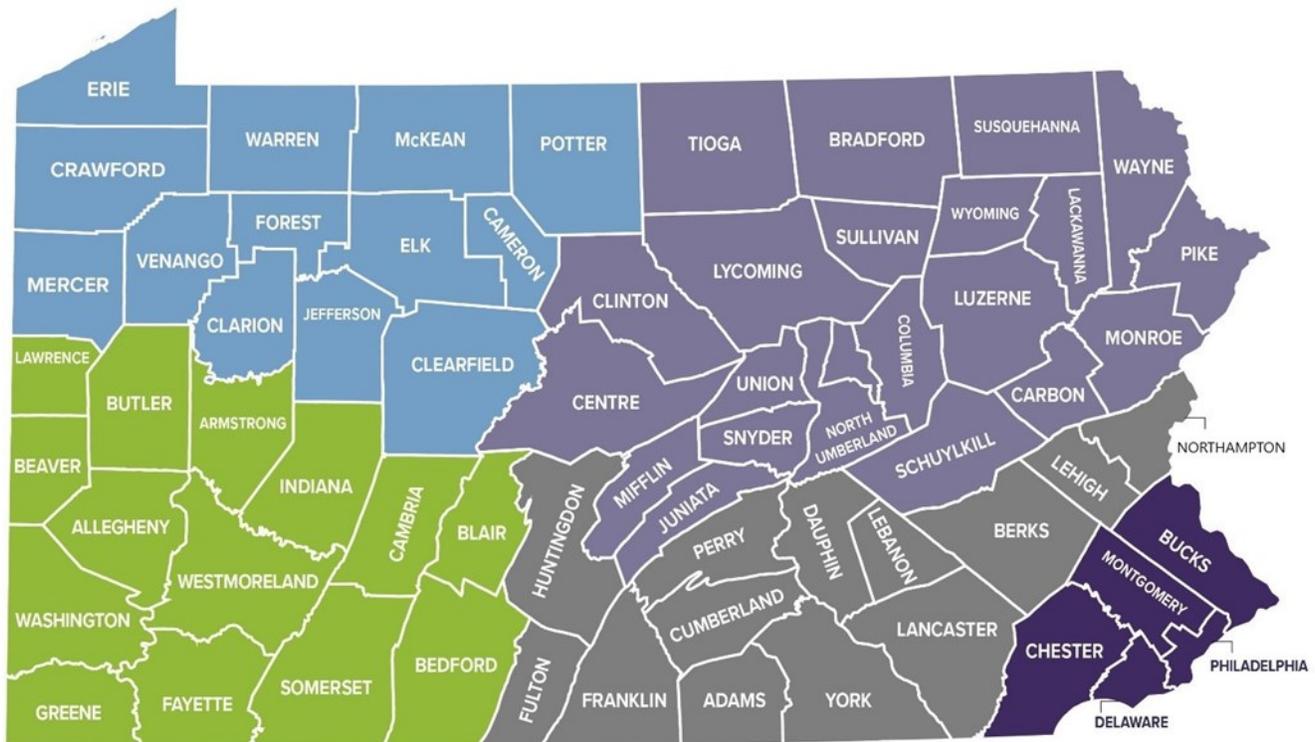
Woodlyn, PA – Tuesday, June 25, 10:00am Delaware County Housing Authority Kinder Park Community Room 1825 Constitution Ave, Woodlyn, PA	Coatesville – Thursday, June 27, 10:15am Brandywine Center 744 Lincoln Highway East, Coatesville, PA
Norristown, PA – Wednesday, June 26, 10:00am Aclamo Family Centers 512 West Marshall St, Norristown, PA	Philadelphia – Friday, June 28 <u>Congreso</u> – 10:15am Congreso Education & Training Center 2800 N American St, Philadelphia, PA <u>South Philadelphia</u> – 2:45pm South Philadelphia Library 1700 S Broad St, Philadelphia, PA

Interested participants should contact Jessy Foster at PHAN at 844-474-2643 or jessica@pahealthaccess.org with any RSVPs or questions.

Ramping-up for the Implementation of CHC in Phase 3

In preparation for the January 1, 2020 launch of CHC in the Northwest, Northeast, and Lehigh/Capital Zones, the Office of Long Term Living (OLTL) held nine provider workshops and three transportation summits across the affected counties. OLTL is planning additional provider workshops during the fall.

As a reminder, Phase 3 encompasses the remaining 48 counties that were not already part of the CHC rollout in the Southwest or Southeast. Approximately 143,000 dual eligibles and adults receiving long-term services and supports either at home or in a nursing facility will move to CHC in Phase 3, including approximately 66,000 in the Lehigh/Capital Zone, 49,200 in the Northeast Zone, and 27,700 in the Northwest Zone. See the map below.



- Community HealthChoices Northwest
- Community HealthChoices Northeast
- Community HealthChoices Southwest
- Community HealthChoices Lehigh Capital
- Community HealthChoices Southeast

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

- Mid-July 2019:** Initial postcards will be sent to people identified as eligible for CHC briefly introducing them to the program
- Early August 2019:** Mailers will be sent out to CHC participants with details about dozens of Participant Information Sessions being held statewide and how to register for an event
- Late August 2019:** Pre-transition notices will be sent to those going into CHC. These will be sent out in several waves

September-October 2019:

Enrollment packets will be sent to CHC participants with information on choosing a CHC plan and primary care physician

Additional waves of pre-transition notices will be sent out to individuals who are newly eligible for CHC

Participant Information Sessions will be held across Phase 3 Zones

November 13, 2019: Last day for participants to select CHC Plan before auto-assignment

December 20, 2019: Last day for participants to make changes to CHC Plan effective January 1 (any changes after this date will not take effect until February 1)

January 1, 2020: CHC begins in Phase 3 Zones

June 30, 2020: Continuity of Care Period for CHC Participants receiving LTSS at home ends

Update on FED: DHS' New Process to Determine Eligibility for Long Term Services and Supports

Last month, we reported on DHS's implementation of a new tool—i.e., the functional eligibility determination (FED)—to determine clinical eligibility for long term services and supports (LTSS), including nursing home, Office of Long-Term Living (OLTL) home and community based services waivers, the LIFE (Living Independent for the Elderly) Program, the state-funded ACT 150 Program and others. The FED is used to determine whether someone needs the level of care provided in a nursing facility (referred to as “Nursing Facility Clinically Eligible” or “NFCE”). If someone is found to be NFCE they are clinically eligible for one of the programs above.

The state released initial data showing that, in the first two months (April 1-May 28, 2019) of the FED being utilized, 77 percent of people assessed were found to be NFCE and 23 percent were found to be nursing facility ineligible by the tool. OLTL plans to do a comparison with prior years for the same time period to determine whether the FED is yielding a lower or higher percentage of NFCE determinations than the former assessment process.

The percentages do not necessarily indicate how many people were ultimately determined to be NFCE or NFI (Nursing Facility Ineligible) and therefore clinically eligible or ineligible for the various programs that rely on the FED tool. In cases where the assessor or the assessed individual's doctor disagrees with the FED determination, a medical reviewer with OLTL makes the ultimate finding.

At the May 31st meeting of the Managed Long Term Services and Supports Subcommittee of the Medical Assistance Advisory Committee, several attendees expressed concern that the OLTL medical reviewers do not receive enough information from individuals' physicians to be able to determine whether the outcome of a FED is correct. The form physicians complete as part of the clinical eligibility determination process asks only for the level of care a person needs (*e.g.*, NFCE) and diagnoses. At

the meeting OLTL indicated it would accept additional documentation from physicians. However, there is currently no guidance informing physicians that they can provide more information and how to do so.

More than 20,000 people have been assessment for waiver, nursing home and other programs using the FED since April 1, 2019. However, as of June 17, 2019, no notices denying eligibility had been sent to those people who were found not to be clinically eligible for the waiver or other program into which they sought new or ongoing enrollment. Such individuals likely have no knowledge of their denial of eligibility since assessors are reportedly not permitted to share with individuals the outcomes of their assessments. PHLP expects denial notices will be sent out as of the publication of this newsletter, which means people will finally have the opportunity to appeal clinical ineligibility determinations made over the last few months.

PHLP continues to have outstanding questions about the clinical eligibility process generally, how and when people learn the results of their assessment, and whether the FED tool can effectively capture the extent of people's needs and translate that into an appropriate eligibility determination. As the process becomes clearer and we hear how it works in practice, PHLP will share that information with our readers.

MAWD Premiums Can Now Be Paid Online

You can now pay your Medical Assistance for Workers with Disabilities (MAWD) premium online. Register [here](#) to access the payment website. Once registered, you will be able to see your balance and pay your monthly premium by check or credit card. This new service will hopefully eliminate delays and confusion caused by mailing payments.

MAWD is a program for workers with disabilities. It allows individuals to earn more income and continue to receive Medicaid benefits by paying a monthly premium.

To qualify for MAWD you must be 16-64 years old, disabled, and working. You must also have an income that is less than 250% of federal poverty income guidelines and \$10,000 or less in countable resources.

You can apply for MAWD [online](#), by phone 1-866-550-4355, by mail using an [application](#), or in person at your [County Assistance Office](#).

More questions about MAWD? View PHLP's eligibility [guide](#) and contact us at (800) 274-3258 or www.phlp.org.

DHS Public Benefits Notices Delays: An Update

Have you gotten a notice with a yellow cover sheet? Earlier this year, the Pennsylvania Department of Human Services (DHS) had problems with a back log at the mailing facility that sends out all their notices to participants. As a result, many notices were not sent out on time, and some people lost benefits, or did not get timely notice of a denied application. After PHLP, Community Legal Services of Philadelphia (CLS) and other advocates realized the problem, CLS and pro bono co-counsel from Morgan Lewis negotiated with DHS about how to fix this problem. As a result, at the end of May reprinted notices were mailed to many households across the state. The reprinted notices are the same notices that were sent earlier in the year. The reprinted notices are supposed to come with a new yellow cover sheet.

People who got notices with a yellow cover sheet need to act right away! DHS is giving them another chance to appeal a denial of benefits, or a termination or reduction of benefits, or to request reconsideration of a denial or termination of benefits. If their Medicaid was cut off, they must appeal by June 30th to have Medicaid continue. In the meantime, they can also ask the County Assistance Office (CAO) to pay any medical bills from the period when their Medicaid was off, and the County Assistance Office should reopen their Medicaid upon request through June 30th. **But to have Medicaid continue beyond June 30th, these individuals must appeal by June 30th.** They will also need to resolve whatever the issue was.

In addition to Medicaid, people may have gotten these notices about SNAP, Cash Assistance, and LI-HEAP. Many who had benefits cut off received one-time payment of benefits to cover the time period between the date that benefits were cut off and June 30. They will need to appeal by June 30 if they want those benefits to continue after June 30.

People whose SNAP benefits were terminated because a recertification was not completed can get SNAP turned back on all the way back to the date SNAP was closed if they complete the SNAP recertification by June 30.

PHLP, CLS, and local legal aid programs across the state can help individuals who got these notices.

Medicaid Covers Over-the-Counter Medications for Dual Eligibles!

People with Medicare and Medicaid (dual eligibles) get most of their prescription drugs through Medicare Part D. However, Medicaid covers some over-the-counter (OTC) medications. Unfortunately, PHLP often hears from dual eligibles who paid out of pocket for their OTC meds or went without these medications because they did not know to ask the pharmacy to bill Medicaid.

Over-the-counter medications are excluded from the Medicare Part D benefit. It is because of this exclusion that dual eligibles can use their Medicaid coverage for these medications. Although Medicaid does cover certain OTC medications, there is no exhaustive list of which OTC meds are covered by Medicaid. More information about the types of OTC meds that Medicaid covers can be found on DHS' website [here](#).

For Medicaid to cover an OTC med: it must be prescribed by a doctor, the manufacturer must participate in the Medicaid Drug Rebate Program, and it must fall into a "covered" category. Some examples of covered categories include analgesics such as aspirin or ibuprofen, antacids, laxatives and stool softeners, and certain vitamins and minerals. Please note that store brands of OTC medications are NOT covered by Medicaid.

Dual eligibles in Community HealthChoices who are taking an over-the-counter medication can contact their plan's member services to find out if the medication is covered. Those covered by the Medicaid fee-for-service system (i.e., the ACCESS card) can contact PA Medicaid Recipient Services at 1-800-537-8862. Pharmacies can also reach out to someone's CHC Plan or the Pharmacy Services department at the Department of Human Services if they have questions about coverage or how to bill for an OTC medication. Dual eligibles or their advocates who are having problems getting OTC medications can call PHLP's Helpline at 1-800-274-3258.

Medicare Part D Co-Pay Glitch Update

[In past months](#), PHLP reported about a problem that caused dual eligibles receiving Home & Community-Based Services in the Community Living Waiver and Community HealthChoices in Southwestern PA to pay small Medicare Part D co-pays for their medications when the co-pays should have been zero. This problem primarily impacted people in January and February of this year, although some individuals had this problem last year, too.

By March, impacted dual eligibles should have no longer been charged a Medicare Part D copay at the pharmacy. At this time, Part D plans should have already automatically issued refunds to those who were mistakenly charged co-pays in January and February 2019 as well as last year. PHLP is aware of

impacted dual eligibles who have not yet been reimbursed for the incorrect Medicare Part D copays they paid.

Dual eligibles, or their advocates, affected by this problem who have not received their reimbursement are encouraged to call PHLP's Helpline at 1-800-274-3258.

Social Security Error Puts Medicare Coverage at Risk

In the beginning of 2019, the Social Security Administration failed to withhold premiums and make payments to Medicare health and drug plans for thousands of Medicare beneficiaries who had requested to have their premiums automatically deducted from their Social Security checks. As a result, some Medicare beneficiaries are currently receiving bills from their Medicare Prescription Drug Plan or Medicare Advantage Plan for premiums owed for past months of coverage. According to the federal government, this problem likely impacts approximately 250,000 people.

This processing error affects Medicare beneficiaries who: 1) newly enrolled in a Medicare Advantage Plan or a Medicare Prescription Drug Plan for coverage starting January 1, 2019 **and** 2) chose to pay their plan premiums through an automatic withholding from their Social Security checks. The problem has been corrected. Social Security will withhold these plan premiums starting in June or July.

Consumer advocates are concerned that affected individuals are at risk for losing their coverage for failing to pay the premiums they owe because of confusion or concerns that bills are a scam. Affected individuals will receive a bill from their Medicare Part D or Medicare Advantage plan requesting payment for the unpaid premiums. Plans are required to provide impacted enrollees with a grace period for repayment at least as long as the length of the delay in billing. For example, if someone is being billed for four months of premiums, their Medicare plan must give them a minimum of four months to pay the outstanding premiums. See a [CMS factsheet](#) about this issue for additional information.

Medicare beneficiaries with questions or issues related to this billing error should call the Pennsylvania's APPRISE program for assistance at 1-800-783-7067. Consumers can also call their Part D or Medicare Advantage plan directly with any questions.

SSA Mailed Letters About Programs to Help with Medicare Costs

In May, the Social Security Administration (SSA) mailed [letters](#) to people on Medicare who are likely eligible for programs that help with Medicare costs but who are not yet enrolled in these programs. SSA determines likely eligibility based on the amount of someone's Social Security benefits; however,

someone may have additional income or resources that impact whether they can qualify for these programs. The letters tell people about the income and resource guidelines for the Medicare Savings Program and the Extra Help with Medicare Prescription Drug Costs as well as how someone can apply for these programs.

As a reminder to our readers, the [Medicare Savings Programs](#) cover the monthly Medicare Part B premium, currently \$135.50. For individuals with the lowest incomes, these programs also cover Medicare Parts A and B deductibles and cost-sharing. The [Extra Help](#) program, also called the Low-Income Subsidy or LIS, limits what people pay for their Medicare Prescription Drug (Part D) coverage and medications.

When this annual mailing occurs, SSA releases data detailing how many letters were sent to various zip codes across the country. This data helps inform outreach efforts by advocates who try to connect older adults and people with disabilities to these important programs. Here are the five counties in Pennsylvania where the highest numbers of letters were mailed:

PA County	Number of letters mailed
Allegheny	8436
Philadelphia	8425
Montgomery	4447
Lancaster	3687
Bucks	3547

Readers interested in more information can visit [here](#). Representatives from Pennsylvania's APPRISE program can help people apply for these programs - people can call 1-800-787-7063 for help!

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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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.