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Website: www.phlp.org

In This Issue

Community HealthChoices-SEPA Starts January 1st

Community HealthChoices (CHC), Pennsylvania's Managed Long Term Services & Supports Program, will begin in the five county Southeast region on January 1st. The new program will affect over 130,000 older adults and persons with disabilities who are: dual eligible (on Medicare and Medicaid), getting long term care services at home through an Office of Long Term Living waiver, or in a nursing home paid for by Medicaid. **Specifically, CHC changes how these individuals get their Medicaid coverage. For those getting long term care services, it also changes that coverage.**

Nearly half of the affected population chose a CHC plan for themselves. The rest were auto-assigned to one of the three CHC plans available: Keystone First, PA Health & Wellness or UPMC Community HealthChoices. The distribution of all 130,000 participants amongst the three MCOs is 49 percent (64,000) to Keystone First, 25 percent (33,000) for Pennsylvania Health and Wellness, and 25 percent (33,000) for UPMC. Confirmation/assignment letters have been sent to those moving to CHC. These participants should also receive their CHC plan ID cards and Member Handbooks by the first week in January.

Accessing Health Care Services or Treatment

Most people (over 90 percent) going into CHC are "dual eligibles" who have Medicare as well as Medicaid health insurance coverage. **Their Medicare coverage and benefits do not change under CHC and Medicare continues to be their primary insurance.** When dual eligibles go to get health care services they should bring their Medicare card, their CHC plan card, and their ACCESS card.

However, even if participants do not yet have their CHC plan card, their coverage is active and will work. Again, CHC participants are eligible for medical services and can receive care even if they have not received the CHC plan card.

Many providers, especially doctors' offices, have access to the Eligibility Verification System (EVS) which providers can, and should, use to verify a patient's eligibility for Medicaid and enrollment in CHC. EVS will also display the participant's CHC-MCO plan. CHC participants whose Medicare providers bill or refuse to see them should contact PHLP.

Physical Health Services

For dual eligibles, most of the health care services they get are covered by Medicare. This includes doctor's visits, lab work, diagnostic tests, and durable medical equipment. The physical health provider will bill Medicare first and then the CHC plan. The Medicare provider must be enrolled in the Medicaid program but need not be in the CHC plan network to be paid by the plan.

If the dual eligible participant is trying to get a service that is not covered by their Medicare card (for example, dental care), their CHC plan will be their only coverage. For these services to be covered, participants must go to providers within the CHC plan network and follow any other rules the plan has for accessing care in order for the plan to cover the service.

For people moving into CHC who are not on Medicare and who only have Medicaid, the CHC plan will be their only health care coverage. These individuals must go to providers within the CHC plan network and follow the plan's rules for accessing care in order to have the service covered by the plan.

Behavioral Health Services

Behavioral health coverage is carved out from CHC, so everyone going into CHC will receive their Medicaid behavioral health coverage through their county's behavioral health plan. This will be new to people who have been in the Aging Waiver and to nursing home residents. The behavioral health plans will send these new members a welcome letter early in January.

If the CHC participant accessing behavioral health services is a dual eligible, the provider will bill Medicare first and then the behavioral health plan. For services covered by Medicare, the Medicare provider must be enrolled in the Medicaid program, but need not also be in the behavioral health plan network to get paid. If the dual eligible participant is trying to access a service not covered by Medicare (for example, intensive outpatient drug & alcohol services or mobile mental health treatment), their behavioral health plan will be their only coverage and so they must go to providers within their plan's network and follow any other rules the plan has in order for their plan to cover the service.

For those CHC participants who are not on Medicare and who only have Medicaid, the behav-

ioral health plan will be their only coverage for behavioral health care. These individuals must follow the plan's rules for accessing care, such as going to providers in the behavioral health plan's network, in order to have the service covered by the plan.

Accessing Home and Community-Based Services

All those in the Southeast region currently in the Aging, Attendant Care, and Independence Waiver programs are moving to CHC at the beginning of 2019. These Waiver programs will no longer exist in Southeast PA after December 31, 2018. At the same time, individuals determined to meet the nursing facility level of care who had been in the OBRA Waiver are also moving to CHC. Starting January 1st, the person's CHC plan will be responsible for covering and paying for all of their Waiver services.

In the transition to CHC, these individuals have the protection of a 180-day continuity of care period. That means their CHC plan must cover **all** of their existing Waiver services and allow them to use their current Waiver providers until June 30, 2019. After that period, the CHC plan can require their members use Waiver providers that are "in-network" with the plan. The plan could also revisit the person's service plan and decide to reduce, change or terminate a service. If this happens, the individual can appeal the plan's decision. Check PHLP's website to see a fact sheet about participant's appeal rights under CHC!

If CHC participants need new or additional long term care services and supports after January 1st, they will need to contact their service coordinator. The service coordinator will work with the CHC plan to assure the person is assessed and the service plan is updated to obtain coverage for the additional services needed.

Accessing Nursing Home Care

Beginning January 1st, the CHC plans are taking over payment for nursing home care that had previously been the responsibility of the state. For those already in a nursing home when CHC starts, their CHC plan must continue to pay the nursing home for their care as long as the resident wants to stay in that home and continues to need the nursing home level of care. This is true even if the nursing home is not in the CHC plan's network. CHC participants who are determined to need nursing home care **after January 1st** will need to go to a home within their CHC plan's network in order for the plan to cover their care.

Resources for Help with CHC

If people are having problems with their CHC plan, accessing providers, or getting their needs met under this new program, they can contact **OLTL's Participant Helpline at 1-800-757-5042**. In addition, participants can contact:

- **APPRISE** (1-800-783-7067) – for help with questions or concerns about Medicare coverage or

about how Medicare works with CHC.

- **PHLP's Helpline** (1-800-274-3258) – for help with problems getting care under CHC or understanding CHC coverage and participants' rights when accessing care or services under CHC.

Southwest PA Update

In December 2018, the state announced that two CHC managed care plans, UPMC Community HealthChoices and AmeriHealth Caritas, are permitted to issue notices denying or reducing long term services and supports to the older adults and individuals with disabilities who are members of their plans. State officials also announced they had withdrawn permission for PA Health and Wellness to send new denial notices. All PHW denial notices must be reviewed by the state and cannot be sent to participants. This is a recent development for PA Health and Wellness after the state learned some of PHW's notices were deficient. As reported in prior PHLP newsletters, all three plans remain under corrective action regarding their person-centered service plans.

Participants whose long-term services or supports are denied or reduced by any of the CHC plans should immediately contact PHLP's Helpline at 1-800-274-3258 or Staff@phlp.org.

PHLP Offers FREE Help with CHC

Did Your CHC Plan:

- ◊ Cut Your Personal Care Hours?
- ◊ Refuse Your Request to Make Your Bathroom Accessible?
- ◊ Tell You Must Get Home Delivered Meals Instead of Assistance with Meal Preparation?
- ◊ Deny, Change or Reduce Your Community Long Term Services and Supports in Any Way?

We want to help. Contact the PHLP Helpline at 1-800-274-3258 or Staff@phlp.org. Our legal services are free and confidential.

Medicare Announces 2019 Part A and Part B Costs

The Medicare program recently announced the 2019 costs for Medicare Part A and Part B. These costs take effect January 1, 2019.

Medicare Part A

Medicare Part A covers inpatient hospital care, care in a skilled nursing facility (up to 100 days), some home health care, and hospice services. The costs next year will be:

- **Premium**: Most people get Part A for free because they, or their spouse, have paid Medicare taxes while working. However, for those who have to buy Part A, the monthly premium in 2019 can be as much as $437.
- **Hospital Stay**: The inpatient deductible is $1,364 per benefit period. If someone is in the hospital longer than 60 days, their cost-sharing will be: $341/day for days 61-90 and $682/day for days 91-150.
- **Skilled Nursing Facility Stay**: Medicare can cover up to 100 days in a skilled nursing facility when someone meets the criteria for Medicare to pay for this care. There is no cost for care for the first 20 days. For days 21-100, the beneficiary will have a daily co-pay of $170.50.

Medicare Part B

Medicare 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. The costs next year will be:

- **Premium**: Everyone on Medicare is subject to a monthly Part B premium. In 2019, the standard premium will be $135.50/month. Most people will pay this premium amount next year. A small percentage of Medicare beneficiaries will pay a slightly lower amount because of Medicare's hold-harmless provision that protects people who have their Part B premium deducted from their monthly Social Security check when the Part B premium increase would cause their Social Security benefits to be less than it is in the current year after the premium is deducted. More information is available here.

  As a reminder, people with limited incomes and resources can qualify for Medicaid to pay their Part B premium through the Medicare Savings Programs or "Medicare Buy-In." People with higher incomes pay a higher premium.

- **Other Part B Costs in 2019**: The annual deductible will be increasing a couple dollars to $185. That is the amount Medicare beneficiaries must pay for services before their Part B coverage kicks in. After that, Original Medicare covers outpatient physical and mental health services at 80% and the beneficiary pays the remaining 20%.

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 – whether through Original Medicare or a Medicare Advantage plan. Individuals with Original Medicare (who use the red, white and blue card when getting care) and no additional insurance are subject to the Part A and B deductibles and co-insurance amounts described above. Those in a Medicare Advantage plan pay the deductibles, co-insurance and co-pays set by the plan. Dual eligibles with Medicare and Medicaid insurance use their Medicaid coverage to pay their Part A and B deductibles, co-insurance and co-pays.

More information about Medicare Part A and B costs in 2019 can be found here.

Resource Limits to Qualify for Extra Help and Medicare Savings Programs in 2019 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: $9,230 (single); $14,600 (married)
- Partial Extra Help: $14,390 (single); $28,720 (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 co-insurance if the person has very low income. The resource limit for the Medicare Savings Programs in 2019 will be $7,730 (if single) or $11,600 (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 2019 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!

Federal Judge Rules ACA is Unconstitutional , But No Immediate Impact

On December 14th a federal court in Texas struck down the Affordable Care Act (ACA), ruling that the law was rendered invalid after Congress eliminated the penalty, administered by the Internal Revenue Service, for not having health insurance. The ruling by U.S. District Judge Reed O'Connor is a victory for the 18 Republican state attorneys general and two Republican governors who filed the lawsuit.

Judge O'Connor's decision relies on the 2012 decision by the U.S. Supreme Court, which upheld the ACA. Readers may recall that in 2012 Chief Justice John Roberts joined the Court's conservatives in saying that in giving Congress power to regulate interstate commerce, the Commerce Clause of the Constitution did not give it the authority to require Americans to purchase health insurance. However, Justice Roberts joined with the Court's liberals to save the law, writing that the penalty imposed for not complying with the individual mandate was a legitimate exercise of authority because Congress "does have the power to impose a tax on those without health insurance."

After President Trump won the White House and Republicans took control of Congress, there was another effort to repeal the ACA. It fell short. Instead, as part of last year's tax bill, congressional Republicans repealed the individual mandate by setting the penalty for noncompliance at zero starting in January 2019. Twenty states then sued, claiming that because no tax revenue is to be collected as a result of the individual mandate, the remainder of the law is unconstitutional as well.

In his 55-page opinion, Judge O'Connor agreed. He wrote that the individual mandate is unconstitutional, saying that it "can no longer be fairly read as an exercise of Congress' tax power." The U.S. Justice Department, which in the past had defended the ACA, did not defend the ACA.

Judge O'Connor's ruling declared not only the individual mandate but the entire law unconstitutional; even parts of the law that have nothing to do with the mandate like generic biologic drugs, the Indian Health Service, and public health changes like calorie counts on menus.

The judge's ruling won't have any immediate impact. The ACA remains in effect while further appeals continue. But the decision does open the possibility that coverage for more than 1 million of Pennsylvanians could be at risk. "If this decision were to be upheld by the higher courts, it could jeopardize coverage for the over 1.1 million Pennsylvanians who have gained coverage only available to them because of the ACA," Gov. Tom Wolf said. "This would move our health care system backwards to a time when millions of Pennsylvania residents weren't protected from losing their insurance and Pennsylvania's uninsured rate was almost triple today's rate."

Almost 380,000 Pennsylvanians are enrolled in the ACA's Marketplace plans. created The open enrollment period to get coverage in 2019 closed Saturday, December 15th. Only six states have more people enrolled in Marketplace plans — Florida, California, Texas, North Carolina, Georgia and Virginia, according to the Kaiser Family Foundation.

In addition to the people who have purchased insurance through Marketplace plans, the ruling also could threaten Medicaid expansion, which Pennsylvania launched under terms spelled out in the Affordable Care Act. About 700,000 Pennsylvanians have health care coverage under the state's expansion of Medicaid.

Pennsylvania Launches Comprehensive Tool to Identify Resources for SUD Treatment and Support Services

On December 6, 2018, Pennsylvania released the Drug and Alcohol Referral Tool (DART), an online resource to help individuals seeking substance use disorder (SUD) treatment find treatment options and other related support services. The tool will act as a consolidated, centralized hub to assist people who are looking for services but are not sure where to begin.

The DART tool provides resources based on a person's age, county of residence, and veteran status. The DART tool also provides potential resources that consider issues of homelessness, transportation or legal concerns. While the tool provided information on available services, it does not assess eligibility.

Pennsylvania Seeks Comments About How to Design Individual and Family Needs Assessments

The Pennsylvania Department of Human Services (DHS) released on December 7, 2018, a Request for Information (RFI) to explore existing individual or family needs assessments, methods of connecting individuals and families to community resources, and models for providing whole-person or whole-family case management. DHS's wants "to make it easier for individuals to obtain meaningful information and access to the services they need to achieve overall well-being, positive health outcomes, and financial self-sufficiency." That includes building "a system that addresses each family's needs and amplifies the work of health care providers and community organizations." Organizations with experience or perspective are invited to respond by January 18, 2019 by visiting DHS e-marketplace.

Wishing You Health & Happiness This Holiday Season & In the New Year

As 2018 draws to a close, PHLP thanks everyone whose support has helped us provide assistance on health-related matters to more than 3,000 vulnerable Pennsylvanians. This year, we helped individuals gain or keep Medicaid coverage, restored skilled nursing services for children with disabilities after their Medicaid plan denied these services, and offered counsel and advice to help older adults and people with disabilities understand the new Community HealthChoices program.

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.

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