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In This Issue

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PA Medicaid Removes Restrictions on Hepatitis C Medications

Pennsylvania's Medicaid program now covers Hepatitis C medications without regard to liver damage. Hepatitis C is an infectious disease caused by a virus that primarily affects the liver. As of January 1st, Medicaid consumers with the Hepatitis C virus should be able to access these life-changing medications. Chronic infection can be cured about 95% of the time with these antiviral medications. Removing disease severity restrictions from the Medicaid coverage guidelines for Hepatitis C medications was the last step in a phased-in policy change announced last spring by the Pennsylvania Department of Human Services (DHS). Previously, Medicaid would only cover these direct-acting antiviral medications if the consumer had liver damage ("fibrosis") scores of F1 or higher. Opening access to these curative medications follows the clinical recommendations of DHS' Pharmacy & Therapeutics Committee as well as current medical guidelines. The Hepatitis C virus can grow undetected for decades before causing chronic and sometimes life-threatening liver problems. An estimated 3 million Americans are living with chronic Hepatitis C, about half of them undiagnosed. At least 20,000 people in the United States die each year due to liver disease caused by the Hepatitis C virus, making it the deadliest communicable disease in the country.

Readers may remember that PHLP, along with attorneys from the Center for Health Law & Policy Innovation of Harvard Law School, Community Legal Services, and Kairys, Rudovsky, Messing & Feinberg, was considering legal action if DHS did not remove its disease severity restrictions. PHLP, on behalf of our clients, is pleased that the changes are now fully in effect for those covered by Medicaid.

The updated prior authorization guidelines for Hepatitis C medications for consumers in Fee-for-Service Medicaid can be found here. Any prior authorization guidelines used by Medicaid managed care plans cannot be more restrictive than the state's guidelines.

We encourage any individuals who are denied coverage of these medications by their Medicaid managed care plan or by Medicaid fee-for-service to call PHLP's Helpline at 1-800- 274-3258.

CHIP Extended for Six More Years

Congress has finally acted to extend the Children's Health Insurance Program (CHIP)! The CHIP program was re-authorized on January 22nd for six more years as part of the Continuing Resolution passed by Congress to avoid a government shutdown. While Congress will have to re-visit the budget issues involved in the Continuing Resolution, CHIP is now fully funded until September 30, 2023.

This is very good news for Pennsylvania. Secretary Theresa Miller stated that the Department of Human Services was days away from sending out closing notices to families with children enrolled in CHIP. Having the CHIP program continue is a huge relief to those families whose children are covered by CHIP as they can get health care services without worrying about the program ending. CHIP will also continue to be available for families who have children without health insurance who want to apply for coverage.

The reauthorization also extends states' ability to use information from other programs such as SNAP, TANF and child care subsidies to enroll children into, and to renew, Medicaid and CHIP coverage. Pennsylvania uses this option known as Express Lane Eligibility. The federal funding also includes resources to enable Pennsylvania to conduct outreach and enrollment activities, have demonstration projects to address childhood obesity, and fund pediatric quality measures.

For more details about the CHIP reauthorization legislation (KIDS Act), please click here.

Community HealthChoices Rolls Out in Southwest PA

Starting January 1st, more than 85,000 older adults and people with disabilities in Southwest PA started receiving their Medicaid coverage for physical health services and their long term services and supports from one of three Community HealthChoices (CHC) managed care plans. Slightly more than half of CHC participants are enrolled in UPMC Community HealthChoices, almost a third are enrolled in PA Health & Wellness, and the rest are enrolled in AmeriHealth Caritas.

Everyone in CHC should now have their CHC plan identification cards; those who did not get a card should call their plan. Each CHC plan has a Member Handbook that can be viewed on the plan's website and will be mailed to members upon request.

Transition Issues

Participants in each of the CHC plans have experienced various challenges with the transition. Most of the individuals who contacted PHLP about CHC problems are dual eligibles with both Medicare and Medicaid coverage. Many of the problems were resolved quickly. Here's a highlight of some of the issues PHLP clients experienced:

- ***Confusion and Misunderstanding of CHC***:

  Participants are confused about their Medicare coverage and how their CHC plan works with their Medicare. Some fear that CHC caused them to lose the Medicare coverage they had prior to CHC. Over 90 percent of people moved to CHC have Medicare as their primary insurance. **CHC does not change Medicare and the move to CHC should not have disrupted anyone's Medicare coverage**. Medicare remains the primary insurance and pays first for most health care services before the CHC managed care plan is billed as secondary insurance.

  Dual eligible consumers are also confused about their medication coverage and co-pays. CHC participants with Medicare continue to get most, if not all, of their prescriptions covered solely through Medicare Part D and they continue to be responsible for paying their small Medicare Part D co-pays ranging from $1.25 to $8.35 when they get their medications. Only individuals receiving long term services and supports from their CHC plan will have $0 copay for Part D covered medications.

- ***Problems Accessing Health Care under CHC:***

  Some CHC participants have had problems scheduling medical appointments, had providers cancel their appointments, or had problems getting medical equipment. These problems have largely been because the medical providers are unaware of the new CHC program or confused about treating patients and getting paid by their CHC plan.

  Providers can contact the CHC plan directly for information and to learn how to bill the plan. Participants can also contact their CHC plan and ask them to reach out to their medical provider. Readers should remember that when CHC participants have both Medicare and Medicaid, most of their health care services get covered by Medicare. The provider will bill Medicare first, then the CHC plan. The Medicare provider must be enrolled in Medicaid but need not be in the CHC plan network to be paid by the plan.

  Another problem participants have experienced is their CHC plan not paying second for Medicare Part B covered medications and medical supplies. Although dual eligibles get most of their drugs covered solely through Medicare Part D, some medications are covered under Medicare Part B. Examples of Part B covered medications include anti-rejection medications for those who have received an organ transplant and medications that are taken with medical equipment such as a nebulizer. People can also get medical supplies such as diabetic testing strips and lancets at the pharmacy. These items are covered by Medicare Part B, and the CHC

plan is responsible for paying second to Medicare for these drugs or supplies.

Recently, dual eligible consumers needing Medicare Part B covered items at the pharmacy either did not get their needed medication or medical supplies or they paid the Medicare cost-sharing out of pocket. As a result of PHLP raising these issues to the Office of Long Term Living, the CHC plans are now working on updating their systems to allow pharmacy claims for Part B cost-sharing to go through and be paid by the CHC plan. The CHC plan should be able to issue an override to resolve any problems their members have until the systems are fixed. People experiencing problem getting Part B covered items at the pharmacy should ask their pharmacy to call their CHC plan to get an override if the claim is not going through. They can also request a five-day emergency supply of medication from the pharmacy to prevent them from missing doses until the problem is resolved by the CHC plan.

CHC Plan Welcome Calls/Needs Screening

CHC plans are making outbound welcome calls to each of their members. In addition, the plan is required to contact all members who are not receiving long term services or supports and do a needs screening within the first 90 days of enrollment. These contacts are an opportunity for participants to ask any questions they may have about CHC or raise any problems they have experienced since their coverage started. The plan should also be asking if the member has any unmet needs and helping to address them.

Where To Call For Help

CHC participants can contact their CHC plan with questions or to get help accessing care or resolving a problem. The CHC plan contact information can be found here.

CHC participants who have questions or problems that are not being addressed by their CHC plan can call the **Office of Long Term Living Participant Helpline at 1-800-757-5042.**

Individuals who wish to change their CHC plan can contact the **Independent Enrollment Broker at 1-844-824-3655.** If the plan change is made before the 15th of the month, the new plan should start on the first of the next month. If the plan change is made after the 15th of the month, the new plan will start the second month after the change.

APPRISE can help people who have questions about Medicare or need help with issues related to their Medicare coverage. **APPRISE's number is 1-800-783-7067.**

Contact PHLP if you have need further help with CHC-related questions or have problems that aren't being addressed by these other resources. **PHLP's Helpline number is 1-800-274-3258**.

Medicare Part B General Enrollment Period Now Underway

Now is the time of year when people on Medicare who do not yet have Medicare Part B can sign up for this coverage. Medicare Part B covers outpatient services such as doctor visits, diagnostic tests, mental health and drug & alcohol services, durable medical equipment, and ambulance transportation.

The Medicare Part B General Enrollment (GEP) period runs from January 1st through March 31st of each year. When people sign up for Part B during the GEP, their Part B coverage will not start until July 1, 2018. Those who wish to enroll into Part B must complete an Application for Enrollment in Medicare-Part B (Medical Insurance), CMS Form 40B. Enrollments are handled by the Social Security Administration. People can contact 1-800-772-1213 for more information, to request an enrollment application, or schedule an appointment at their local office.

The standard monthly premium for Part B in 2018 is $134. However, those who enroll during the GEP may have to pay an ongoing late enrollment penalty. This penalty increases their premium 10% for every 12 month period they were without Part B.

Individuals who have questions about Medicare Part B enrollment or who need help signing up for Medicare are encouraged to contact APPRISE at 1-800-783-7067.

New Medicare Cards Are Coming Soon!

Starting this Spring, Medicare will start mailing new cards to everyone on Medicare. These new cards will have a new Medicare Number that is not tied to someone's social security number.

The new cards will be mailed between April 2018 and April 2019. They will be sent to the address Social Security has on file for the person on Medicare. People should start using their new card once they receive it.

Other important information to keep in mind about these new Medicare cards:

- People on Medicare should make sure their address is up to date with Social Security. This can be done by calling Social Security at 1-800-772-1213 or visiting ssa.gov/myaccount.
- People may receive their new Medicare card at a different time than their friends, neighbors, or family members.
- Medicare will never ask someone for their personal information or payment in order to mail the new card. People should be aware of scams.

More information about the new cards can be found here.

Anyone with additional questions or concerns can contact APPRISE at 1-800-783-7067.

PA Budget Address Scheduled for February 6th

Governor Wolf is scheduled to address the PA General Assembly on February 6th to outline his proposed FY2018-2019 budget. In past years when a Pennsylvania team has played in the SuperBowl, the budget address was postponed for several days. Given that the Philadelphia Eagles are in the Super Bowl, readers should be aware this could happen this year.

Throughout February and March, the House and Senate Appropriations Committees will hold hearings with every state agency about the Governor's proposed budget.

House Appropriations Committee Budget Hearings of note:

- Department of Health/Dept of Drug and Alcohol Programs – March 1st at 10 AM
- Department of Human Services – March 6th at 10 AM

Senate Appropriations Committee Budget Hearings of note:

- Department of Aging – March 6th at 3 PM
- Department of Health –March 7th at 10 AM
- Department of Human Services – March 7th at 1 PM
- Department of Drug and Alcohol Programs – March 8th at 10 AM

More information about the budget hearings can be found at www.legis.state.pa.us.

Stay tuned to upcoming newsletters to learn more about what the Governor's proposed budget means for health care programs that cover vulnerable Pennsylvanians.

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