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Significant Changes Proposed to Children’s Behavioral Health Services

On August 4th, Pennsylvania’s Department of Human Services issued [proposed regulations](#) revising behavioral health rehabilitation services (BHRS), commonly known as “wraparound”. These services will be replaced by new services to be called Intensive Behavioral Health Services (IBHS).

The biggest change with the creation of IBHS is the recognition of Applied Behavioral Analysis (ABA) as a **separate service** with its own requirements and provider qualifications, including four categories of staff:

- Clinical Director;
- Behavior Specialist Analyst;
- Assistant Behavior Specialist Analyst (to provide opportunity to obtain experience required to be licensed as Behavior Specialist Analyst); and
- Behavioral Health Technician-ABA.

Each staff category has specific requirements for training and experience in ABA, but only the Clinical Director is required to be a Board Certified Behavior Analyst (BCBA). Even then, the state will allow a three-year grace period during which a person with a graduate degree in ABA and one year experience can serve as Clinical Director without being board certified.

In addition, the proposed regulations:

- acknowledge that ABA can be used for “skill development” but, unlike an earlier Bulletin on ABA, do not specifically

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mention assisting with impairments in communication or skills needed to perform activities of daily living.

- include provisions regarding Evidence-Based Therapy (such as High-Fidelity Wraparound) which are usually interventions developed by organizations that provide training and certification, at a fee, for providers who wish to use that intervention.
- require any provider seeking Medical Assistance reimbursement for an Evidence-Based Therapy be certified by the organization that developed that intervention.

Public comments can be made **until September 4th** and should Reference Regulation No. 14-546. Written comments can be emailed to RA-PWIBHS@pa.gov or mailed to: Tara Pride, Bureau of Policy, Planning and Program Development, Commonwealth Towers, 11th Floor, P.O. Box 2675, 303 Walnut Street, Harrisburg, PA 17105.

Individuals with a disability who require an auxiliary aid or service may submit comments by using the Pennsylvania AT&T Relay Service at 1-800-654-5984 (TDD users) or 1-800-654-5988 (voice users).

PHLP will be posting a more detailed summary of the proposed regulations to [our website](#) soon.

Community HealthChoices Southeast Roll-Out Updates

In July, people in Southeastern PA who will move into Community HealthChoices (CHC) in January 2019 were mailed an [informational flyer](#) introducing them to the new program. As a reminder, the five counties that make up the CHC Southeast Region are Bucks, Chester, Delaware, Montgomery, and Philadelphia.

See below for additional information about upcoming activities related to the start of CHC in Southeast Pennsylvania.

Consumer-Focused CHC Events

The state will hold 72 consumer-focused CHC education events across the Southeast region from late August through October 2018. Each two-hour event is aimed at helping people who will be moved to CHC understand the new program and the changes it will bring. The announcement and schedule of the events will be mailed to consumers in August and is available for preview [here](#). Event location and registration information is included with the announcement. A handful of the events will include translation services in Cantonese, Mandarin, Russian and Spanish.

These events are aimed at consumers and their family members. CHC events for providers were held earlier this summer. Providers wishing to learn more about CHC should review the materials available on the state's [CHC website](#).

Upcoming Mailings to Future CHC Participants

- **Flyer about LIFE as an alternative to CHC:** In early August, a mailing will be sent to people who will be moved to CHC in January but who could possibly qualify for LIFE because they are age 55 and older and have been found “nursing facility clinically eligible”.
- **Pre-transition notice:** These are being sent in phases starting in late August. Dual eligibles (people with Medicaid and Medicare) who are **not** in a nursing home or getting Home and Community-Based Waiver services will be sent the letters first. Notices to people in nursing homes and in Waiver programs will be mailed in late September. Information will be targeted to these populations to describe the new program and how the person will be affected. It will also include a Question & Answers document to help people better understand CHC.

All notices will include information about appealing the move to CHC. Readers should note that an appeal will generally only be valid if the person does not fit into any of the three target groups who are required to move to CHC – 1) Dual eligibles, 2) people in nursing homes paid for by Medicaid, and 3) people served in the Aging, Attendant Care, Independence and OBRA Waivers who are “nursing facility clinically eligible”.

The pre-transition letters will be sent in seven languages: English, Arabic, Cambodian, Chinese, Russian, Spanish and Vietnamese. To ensure notices are mailed in the appropriate language, consumers are encouraged to contact the Department of Human Services Customer Service Center at 1-877-395-8930 to confirm their preferred language is noted in the system.

- **Enrollment Packets:** These will be sent soon after the pre-transition notices to the various groups of people moving to CHC. This packet will come from the state's Independent Enrollment Broker and contains more information about CHC and the plan options. It will also include instructions for the various ways people can enroll (paper form, online, and phone) as well as the deadline for choosing a plan. Representatives from the Independent Enrollment Broker have stated they will provide in-person enrollment help at someone's home, if needed.

More information about these communications to people moving to CHC can be found [here](#). Consumers, their family members or advocates can call PHLP's Helpline at 1-800-274-3258 if they have questions about CHC, how they will be affected, or whether they have a valid reason to appeal the move to CHC.

Important Information about CHC Person-Centered Service Plans

The three CHC plans now providing coverage in the Southwest region are taking steps to improve their person-centered service planning process and retrain their service coordinators to address problems identified by the state. As we reported in our previous newsletter, PHLP contacted the Office of Long Term Living in June on behalf of our clients identifying problems with denial notices and shortcomings in the person-centered service planning process being used by the CHC plans. The state investigated and ended up putting the plans into corrective action status. This month, we want to highlight for our readers the importance of reviewing person-centered service plans and what to do if an individual does not agree with their plan.

Person-Centered Service Plans Are Essential to LTSS

For people receiving services at home or in the community, person-centered service planning is the process through which the CHC participant – working with their Service Coordinator and anyone else the participant wants involved – identifies their goals, preferences, and what supports they believe they need to meet those goals. From this information, services that support those goals, preferences, and needs are identified. All this information is supposed to be incorporated into a document called a Person-Centered Service Plan (PCSP) that guides the delivery of services and supports to the participant.

CHC participants have a right to review their Person-Centered Service Plan **and** receive a copy of the plan. CHC participants who do not have a copy of their plan should request one from their Service Coordinator. Participants should then carefully review the PCSP to make sure it includes all of their goals and preferences for community living, including where they want to live, social and recreational activities in which they wish to participate, goals for work or education, and more.

Because goals and preferences drive what services will be made available to that person, their presence in the PCSP is very important. If the goals and preferences are inaccurate or incomplete, participants should request that the PCSP be changed.

Participants, or their family members or other advocates, should look closely at their PCSP to make sure it includes all services or items the participant needs to support the goals in the PCSP and details how often the services will be provided. Participants should not be asked to sign the PCSP until they have a chance to review it. If someone needs more time to review the plan before signing it, they should tell this to their Service Coordinator.

Updating Person-Centered Service Plans

CHC participants whose needs change can request new services or request more of the services they are already receiving. A request for a service plan change can also happen if the current services in

place are not meeting the person's needs. Examples of situations that might warrant new or increased services include: an informal caregiver gets sick or needs to go back to work; a person starts to use a wheelchair and needs doorways in their home widened or other modifications such as having a ramp installed; or a person starts to fall more and needs to have more Personal Assistance hours to help with activities of daily living.

When new services or increased services are needed, participants should first contact their Service Coordinator. The Service Coordinator should work with the participant to update the PCSP. This may require that the Service Coordinator meet with the participant to do a new assessment. The PCSP should be updated to reflect any new needs, goals, or preferences and any changes to services provided including type or amount.

What To Do If Someone Disagrees with their Person-Centered Service Plan

If someone disagrees with any part of their PCSP, they should first explain to their Service Coordinator what parts of their person-centered service plan they disagree with and why. If the Service Coordinator is unwilling to change the person-centered service plan, the participant can refuse to sign it. Another option is to sign the plan but also include a note about not agreeing with it. It is not clear whether plans are treating a disagreement noted on the service plan as a request for an appeal. We encourage people to also file an appeal with their CHC plan by calling their plan or writing a letter to their plan.

Even when a service is requested through a PCSP, the CHC plan could deny the service entirely or deny part of the request. In these cases, the plan must send a written notice of denial that should include the reasons for why the service is denied and how to file an appeal.

Participants or their advocates are encouraged to call PHLP's Helpline for advice or help if they need new or more community-based LTSS but their request is not moving forward, if they have problems with their PCSP, or if they are denied a service by their CHC plan. Our Helpline can be reached on Mondays, Wednesdays, and Fridays at 1-800-274-3258 or staff@phlp.org.

For additional information, watch PHLP's Person-Centered Service Planning [webinar](#).

Victory for Pennsylvanians Living in Extreme Poverty

Congratulations to our colleagues at Community Legal Services (CLS) and Disability Rights of Pennsylvania who won an important victory before the PA Supreme Court for people who relied on cash benefits through Pennsylvania's General Assistance Program. The lawsuit, Washington, et al vs. the Department of Public Welfare, was filed on behalf of people with disabilities who relied on the General Assistance program for income and organizations that advocate for poor Pennsylvanians who rely on safety net programs.

The suit challenged the passage of a state law that ended the General Assistance program in August 2012 and made it more difficult for families to get help through the Temporary Assistance for Needy Families (TANF) program. General Assistance had provided minimal cash benefits for individuals with serious disabilities, those experiencing domestic violence, or persons in active drug treatment. The plaintiffs argued that the passage of Act 80 of 2012 violated the Pennsylvania constitution and the Pennsylvania Supreme Court agreed in an unanimous decision.

One development following the ruling involves the elimination of a pre-application job search for people seeking TANF benefits. Other implications of the ruling are currently unclear. Readers can find more information about the case and decision on CLS's website here. Interested readers should check the CLS website for any developments related to this decision.

2019 Medicare Part D Regional Benchmark Premium Announced

At the end of July, the federal government released information about 2019 Medicare Part D plan premiums. The announcement included next year's average basic Part D premium of \$32.50. This is slightly less than the 2018 amount of \$33.59. It also included the Regional Benchmark premiums for next year. The regional benchmarks are used to determine which Part D plans will be "zero-premium" for people receiving the full amount of Extra Help. Currently, the Regional Benchmark premium for Pennsylvania is \$37.18. In 2019, this will be \$37.03.

In upcoming months, Medicare will be releasing information about the 2019 Medicare Advantage and Medicare Prescription Drug Plans that will be available to people living in Pennsylvania. We'll report on that information after it is released.

Consumers Seeking Individual Coverage this Fall Should Expect Challenges

Recent funding cuts and policy changes by the Trump administration are likely to make choosing a health plan for 2019 more challenging for people seeking Marketplace insurance or other individual coverage. The federal government drastically reduced funding available for Navigators who have historically helped people understand Marketplace coverage options and apply for coverage, including applying for help paying for this coverage. In addition, the federal government has made it easier for people to buy insurance outside of the Marketplace from plans that are not required to cover the “Essential Health Benefits” mandated by the Affordable Care Act.

The 2019 Marketplace Open Enrollment period will run from November 1st until December 15th. Plan enrollments during this time will become effective on January 1, 2019.

Funding for Marketplace Navigators Drastically Reduced for 2018-2019

In a [funding announcement](#) released July 10th, the federal government is making \$10 million available for Navigator grants in 2018-2019. This is down from \$62.9 million awarded in 2016. The Affordable Care Act (ACA) created Navigator programs to provide outreach, education, and enrollment assistance to consumers eligible for Marketplace and Medicaid coverage. Since taking office, the Trump administration has dramatically reduced funding for Navigators and Marketplace outreach and advertising.

The federal government justified the reduction in funding stating that increased public awareness about the Marketplace and how to enroll has lessened the need for in-person help. It also argued that Navigators have played a limited role in helping with Marketplace enrollment, especially compared to brokers. Yet, consumer advocates know that health insurance is complicated and can be difficult for people to understand. Navigators provide valuable help to: people with limited incomes and low insurance literacy; those with complicated family situations or income situations; those with limited English proficiency; and people who do not have access to a computer. These are all situations that can make it hard for people to apply on their own for coverage or for premium tax credits and subsidies to help them pay for the coverage. In addition, people seeking help from Navigators might learn they are eligible for Medicaid or CHIP instead of the Marketplace, and Navigators can help people enroll in that coverage.

We'll keep readers updated about what resources will be available in Pennsylvania to help with Marketplace enrollments when that information becomes available.

Access to Short-Term Insurance Plans Expanded

In upcoming months, people enrolled in short-term health insurance plans can stay enrolled up to three years instead of just three months. The official name for these plans is “short-term, limited duration”, abbreviated to STLD. This [federal policy](#) change was finalized in early August in an effort by the Trump administration to expand access to less expensive health insurance coverage compared to what’s available under the Affordable Care Act (ACA).

These short-term plans will likely have substantially lower prices than Marketplace plans; however, the reason they are less expensive is that they typically do not cover the Essential Health Benefits required by the ACA—specifically prenatal and maternity care, mental health and drug treatment, and prescription drugs.

These short-term policies are subject to state regulation and states can restrict their sale or require coverage of certain benefits. It is unclear at this time what action, if any, Pennsylvania will take in this regard. In a recent news story about short-term health plans, Jessica Altman, the Insurance Commissioner of Pennsylvania, said she was “extremely concerned that some insurance agents or insurer websites may try to market short-term policies as comparable to ACA plans.” In the past two years, she said, she has revoked the licenses of eight agents and brokers “because of deceptive marketing of these plans.”

There is concern that the availability of these plans in the fall will cause confusion for consumers at the same time that there are fewer resources available to help them understand their choices. Consumer advocates worry that people will be attracted to these short-term policies because of their lower premiums without realizing the coverage limits and the high deductibles that can come with these plans.

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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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.