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Updates on Community HealthChoices

Consumer Subcommittee Listening Session A Success

The Consumer Subcommittee of the state's Medical Assistance Advisory Committee decided to hold its May meeting in Pittsburgh rather than at its normal meeting location in Harrisburg. The reason for the change in location was so the Subcommittee could also conduct a Listening Session on the implementation of CHC in the Southwest zone.

The meeting took place on Wednesday, May 23rd in downtown Pittsburgh. Community HealthChoices (CHC) was the only topic of the Listening Session and the Subcommittee meeting that followed. Approximately 70 people attended the Listening Session and meeting, and twelve CHC participants and advocates spoke as did several service providers. Kevin Hancock, the Deputy Secretary of the Office of Long Term Living (OLTL) was in attendance as was his Chief of Staff, Jill Vovakis. Staff from the Pennsylvania Department of Aging also attended.

Many issues and problems with the start-up of CHC were raised during the Listening Session and meeting including:

- Fears that CHC plans will immediately start to reduce the long term services and supports (LTSS) people receive at home, especially Personal Assistance Services, once the continuity of care period ends (see the next page);
- Concerns about the assessment process and tools the CHC plans are using to determine the type and amount of LTSS people get;
- Confusion and frustration over transportation to medical appointments as well as non-medical transportation and how

those services are delivered;

- Service coordination transition issues as service coordination entities learn new information and systems and try to help their clients navigate CHC to get their needs met.

OLTL staff committed to work with the CHC plans and providers in the Southwest to address many of the issues and problems CHC participants identified during the May 23rd event.

Other CHC Southwest Listening Sessions Scheduled

The Jewish Healthcare Foundation continues to host CHC listening sessions at various locations in Southwestern Pennsylvania. These are the upcoming sessions in June:

Consumer Sessions

- **June 7th**, **9:00 am**: CLASS, 1400 S. Braddock Ave., Pittsburgh, PA 15218
- **June 21st, 9:00 am**: Kane McKeesport, 100 Ninth St., McKeesport, PA 15132
- **June 25th**, **2:00 pm**: Transitional Paths to Independent Living, 69 East Beau St., Washington, PA 15301

Provider Session

- **June 13th, 9:00 am:** CLASS, 1400 S. Braddock Ave., Pittsburgh, PA 15218

LTSS Continuity of Care Period Coming to an End

The 180-day continuity of care period in the Southwest for those getting long term services and supports (LTSS) at home is ending on **June 30, 2018**. After that date, 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.

At this time, the Office of Long Term Living reports that none of the three CHC plans are terminating contracts with LTSS providers or Service Coordination Entities who are currently serving their members. In the future, if a CHC plan decides to no longer contract with a provider or Service Coordination Entity, it needs to give the provider 60 days written notice before the contract ends. The CHC plan must also provide a 45-day advance written notice to members currently receiving services from that provider telling them that they can no longer use the provider after a certain date. The CHC plan would be responsible for helping that member 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.

If, after June 30th, the CHC plan takes action 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.**

Ramping-up for the Implementation of CHC in the Southeast Zone

The Department of Human Services announced a schedule of all-day CHC educational conferences for providers in the Southeast region through its Community HealthChoices email list-serve. The sessions are scheduled from 8:30 am to 3:30 pm on the following dates:

- **June 4, 5, 6, 7 and 8th** at Temple University, Ritter Hall
- **June 18th** at West Chester University
- **June 19th** at Delaware County Community College
- **June 20th** at Montgomery County Community College
- **June 21st** at Bucks County Community College

To RSVP, visit **https://goo.gl/forms/4CjQEsFBScVNEpPB2**.

Updated CHC Questions and Answers Document Now Available

As CHC is implemented, the Department of Human Services (DHS) has been developing Frequently Asked Questions and Answers that have been posed by CHC participants and providers. DHS has now consolidated all the questions and answers into a single CHC Questions and Answers document. The document can be found here.

New Assessment Tool for Long-Term Care Eligibility Starts in July

Beginning July 2nd, Pennsylvania will start to use a new assessment tool called the Functional Eligibility Determination (FED) for determining whether older adults and people with physical disabilities meet the required level of care to qualify for Medicaid long-term services and supports at home or in a nursing home.

This new tool will be used by assessors from the Area Agencies on Aging who meet with individuals early in the long-term services and supports application process to determine whether someone is considered "nursing facility clinically eligible". It will replace the Level of Care Determination (LCD) assessment tool that has been in use up until now. The FED has been tested in certain areas of the state over the last year and assessors are being trained on this new tool.

In DHS' testing, assessors administered both the LCD and the FED to 160 applicants to see whether the outcome would be the same. The testing showed that 19 of the 160 applicants, or nearly 12%, were found eligible using the LCD but would not be eligible using the FED as the Department is currently proposing to score it. Consumer advocates are therefore concerned that implementation of the FED effectively changes the functional eligibility standard for long term services and supports.

Consumer advocates have also expressed concerns about the FED in that it does not go into as much depth as the current assessment tool and it uses an algorithm, rather than the assessor's judgement, to determine whether someone is nursing facility clinically eligible (NFCE) or not. As noted above, there is concern that people who were found to be NFCE in the past will no longer meet this level of care when they are assessed with the new tool based on the algorithm developed, or based on the data that is taken into account by the algorithm, to determine the individual's level of care.

Another concern relates to people determined on the borderline of being NFCE. Up until now, assessors could use their skills and clinical judgement to determine whether the person was NFCE. Under the FED, there is not room for this clinical judgement by the person conducting the assessment. Consumer advocates are also concerned whether notices will adequately explain why applicants were found ineligible, and how fair hearings will work where the decision was made by an algorithm and the criteria used to make that decision are unknown to the assessor, Administrative Law Judge, and the person filing the appeal.

Attorneys from Community Legal Services (CLS) are currently in discussions with staff at the Department of Human Services about these concerns. Consumers, family members, and advocates for individuals who are determined not to be NFCE after this new tool starts are encouraged to call PHLP's Helpline at 1-800-274-3258 or, for those living in Philadelphia, CLS at 215-227-4798 for advice and assistance. We will keep readers updated about any developments on this issue in future newsletters.

PA House Passes "Presumptive Eligibility" Bill to Improve Older Adults' Access to In-Home Care

Many older adults need in-home services like Personal Assistance Services and nursing to remain living in their homes instead of a more restrictive setting like a nursing home. Unfortunately, when these individuals apply for the Aging Waiver to pay for in-home services, it takes months for them to be approved. Once they are approved, there is no retroactive coverage for in-home services the person may have needed while their application was pending.

As a result, if there is a need for in-home services during the application process, most individuals are forced to either forego necessary in-home services or try to pay out of pocket for the care they need. Some people in this situation are left with no choice but to give up their preference to stay at home and go into a nursing home to get the needed care which is usually more expensive than in-home care. This is because Pennsylvania allows nursing homes to presume the individual's Medicaid eligibility and begin providing care right away while the Medicaid application is being reviewed by the County Assistance Office. Unfortunately, this option is not currently available for in-home services under the Aging Waiver or other Home and Community-Based Services Waiver programs.

House Bill 1829 seeks to change this by allowing for "presumptive eligibility" for people age 60 and older seeking in-home care. Under the proposed bill, older adults would have the choice to remain in their homes and immediately receive coverage of necessary care while their Aging Waiver application is being processed.

The Medicaid Waiver eligibility rules – both functional criteria and financial criteria – will **not** be changed by this bill. In addition, the bill does **not** change the process for determining whether someone meets these criteria, including the in-person assessment done by the Area Agency on Aging to determine the person's level of care. Instead, the bill simply gives home care agencies, home health providers, and older adult daily living centers the option to make presumptive financial eligibility decisions and immediately begin providing care to Medicaid applicants while they wait for a final decision about the person's eligibility for a Waiver program.

The goal is to enable home care and home health providers to begin services quickly, especially upon a person's discharge from a hospital, in order to avoid placement in a nursing facility. If someone is ultimately approved for a Waiver program, then Medicaid will reimburse the provider for the services that person received during the application process. If the application is denied, then no Medicaid payment will be issued to the provider.

HB1829 was passed by the House earlier this year and has now gone to the Senate where its potential costs are being considered by the Appropriations Committee. If passed by the Senate, it will then go to the Governor for approval or veto. PHLP will provide future updates on the progress of this bill.

New Appeals Framework for Medicaid Managed Care

Medicaid consumers who are denied a benefit by their Medicaid managed care plan will have to navigate a new appeals process beginning July 1, 2018. State officials confirmed that the new appeals framework will apply to both the physical and behavioral HealthChoices plans. It is already in effect for the **Community HealthChoices** program, which began January 1, 2018 in the Southwest region.

The new appeals framework includes what Pennsylvania's Medicaid program calls complaints, grievances, and fair hearings. As defined by state law, a "grievance" is an internal plan appeal regarding the medical necessity or appropriateness of a requested service and a "complaint" is an internal appeal about any other enrollee dissatisfaction. A "fair hearing" is a proceeding before an Administrative Law Judge that is required by federal law to be available when a Medicaid consumer's request for a covered service or benefit is denied.

Changes to the Medicaid managed care appeal process were required by new federal rules intended to align the appeal rules for Medicaid, Medicare, and commercial payers. Consumers who have a benefit or service denied by their plan on the basis of medical necessity will now have only one level of internal appeal available. They must also go through, or "exhaust", this grievance process before they can request a fair hearing. An exception to the exhaustion rule applies where a managed care plan fails to issue notice of its adverse action or fails to decide a grievance within thirty days.

Previously, consumers were allowed two levels of grievances and were permitted to bypass the grievance process and instead go directly to a fair hearing. After July 1st, Consumers will have 60 days from the date of the benefit denial notice to ask for a grievance, and, if their grievance is unsuccessful, 120 days to ask for a fair hearing.

The new appeals framework does not change the "aid-paid-pending" rule, also known as "continued benefits pending appeal". Under Medicaid rules, consumers who have been getting a service that their managed care plan attempts to change, reduce, or stop can continue to receive the service at the previously approved level during the appeal process **as long as they appeal within 10 days of the mail date on the plan's written notice of adverse action or denial**. The new framework also preserves the ability of consumers to request an "external review" by a physician not employed by the Medicaid managed care plan following an unfavorable grievance decision.

PHLP encourages consumers, family members, or advocates for individuals who are denied services to contact our Helpline at 1-800-274-3258 for advice and assistance. Readers can also view this PHLP Factsheet for more information about appealing a Medicaid managed care plan denial. The federal Medicaid regulations on managed care appeals can be found at 42 CFR Part 438, Subpart F, and the state regulations governing appeals for both Medicaid and commercial payers can be found at 28 Pa. Code Chapter 9, Subchapter I.

Medicaid Coverage Streamlined for People Leaving Pennsylvania State Prisons

Most individuals being released from a Pennsylvania state prison should now have Medicaid coverage active immediately upon their release. The process of applying for Medicaid coverage for individuals returning to society was recently automated under an innovative new partnership between Pennsylvania's Department of Corrections (DOC) and Department of Human Services (DHS). The two agencies will share data to better secure Medicaid coverage for those being released and to lessen the need for correctional facility staff to manually complete Medicaid applications for those leaving state prisons. In Pennsylvania, we call our state prisons State Correctional Institutions. This new policy only applies to people leaving these facilities and does not apply to people leaving county jails or federal prisons.

A person who is incarcerated is not eligible for Medicaid while in jail or prison. Often people leaving incarceration need health care coverage quickly when they are released to be able to continue to get treatment and get medications when they are back in the community. The DOC and DHS have been collaborating to ensure that people have coverage quickly when they are released from state prison. These earlier collaborations included a shortened COMPASS application process for reentrants and suspending Medicaid when someone became incarcerated. This new automated application process now in effect developed out of these earlier collaborations.

State policymakers decided to automate applications for all those being released rather than limit the re-opening process to those who previously had their Medicaid suspended. As outlined in a recent DHS press release, state policymakers were especially concerned about continuity of care for individuals engaged in treatment for a substance use disorder in prison, for whom a temporary disruption in their treatment upon release could trigger relapse.

Anyone released from a state prison who is unsure of their Medicaid status can call the DHS Customer Service Center at 1-877-395-8930. People who think they were wrongly denied Medicaid coverage can call the PHLP Helpline at 1-800-274-3258.

PA House Passes Bill to Improve Access to Care in a Mental Health Emergency

House Bill 1997, introduced by Representative Aaron Bernstine, passed the Pennsylvania House by a unanimous vote on May 1st. If passed by the Senate and signed into law by the Governor, the bill allows designated mental health facilities to deem Medicaid eligibility for individuals who are in crisis with an immediate need for inpatient behavioral health services. The authorized facilities would be able to submit a Medicaid application on behalf of the individual needing behavioral health services who may be incapable of applying on their own. The bill also permits the individual to declare income and assets through self-attestation (that is, without having to provide verification) on the Medicaid application.

If the County Assistance Office determines the individual is Medicaid eligible, Medicaid payment would be authorized for any inpatient behavioral health services received during the period of presumed eligibility. If the qualifying behavioral health facility deems an individual Medicaid eligible, but the County Assistance Office determines that person is **not** eligible, the facility will **not** be reimbursed by Medicaid for services provided. The facility could only bill the patient if the individual provided false or fraudulent information that the facility used to deem them eligible for Medicaid.

According to the language in HB 1997, this process will be implemented to "Prevent harm to an individual with an immediate need for inpatient behavioral health services as a result of a health crisis or emergency based upon prior hospitalizations for a chronic behavioral health condition".

The bill was referred to the Senate Health & Human Services Committee on May 18th. We'll keep readers updated about whether this bill is ultimately passed and signed into law by Governor Wolf.

CHIP Rescission: What Does it Mean for Pennsylvania?

Earlier this month, President Trump sent a rescission package to Congress, asking that $15 billion be removed (rescinded) from the federal budget for Federal Fiscal Year 2018. Cuts to the Children's Health Insurance Program (CHIP), recently reauthorized until 2027, make up $7 billion of the request.

CHIP is funded through a block grant; it is not an entitlement program. This means that states receive a set amount of funds that must be spent over a defined period. Currently, unspent CHIP funds can be extended or redistributed to other states' CHIP programs. In the past, Congress would also redistribute unspent CHIP funds to other child-serving programs within the U.S. Department of Health and Human Services.

The proposed cuts to CHIP include $5 billion in the allotments states receive. Should this cut take effect, it would hamstring the flexibility that currently exists in the program and undermine the bipartisan agreement reached earlier this year to fund the program through 2027.

The remaining $2 billion would be cut from the CHIP Contingency Fund. This is concerning because the Fund was expressly designed to prepare for possible, but not predictable, events or circumstances. When CHIP reauthorization was delayed by Congress, it was the CHIP Contingency Fund that allowed states to continue coverage instead of closing their programs. The Congressional Budget Office projects that the rescission *"would not affect outlays, or the number of individuals with insurance coverage."* However, natural disasters like hurricanes, new health threats like the Zika virus, and new treatments like the expensive medications that treat Hepatitis C, could create higher demand for CHIP coverage or create unexpectedly higher expenses for state's programs. Reducing the Contingency Fund would impact states' ability to react to and provide the coverage needed when the unexpected happens.

Certain rules apply to rescission requests. Congress must act on the request within 45 days and pass it by a simple majority vote in the House and Senate. It is unclear at this time whether there are enough votes in favor of the rescission request for it to pass the Senate. PHLP will continue to monitor CHIP developments. For more information, contact Ann Bacharach, abacharach@phlp.org

Mailings to People Who May Qualify for Help with Medicare Costs

In May and June, the Social Security Administration, along with the Centers for Medicare & Medicaid Services, will mail letters to Medicare beneficiaries who may qualify for programs such as Medicare Part D Extra Help or the Medicare Savings Programs but who are not yet enrolled. The federal government is encouraging people to apply for these programs because it knows there are people who would qualify for help but who are unaware that the programs exist.

The letters are being sent to people whose monthly Social Security benefits are within the income guidelines for these programs. Keep in mind that people who receive these letters will still need to apply for the programs and have their applications reviewed to determine if they qualify for help. For example, some of the individuals may have other income and/or resources that Social Security would not be aware of that will make them ineligible.

Readers can find more information about the Extra Help Program and the Medicare Savings Program on PHLP's website. Both programs help with Medicare costs-the Extra Help program helps with the cost of Medicare Part D (drug) coverage and the Medicare Savings Programs generally pays the person's monthly Medicare Part B premium (currently $134).

Individuals who need help applying for these programs are encouraged to contact APPRISE at 1-800-783-7067.

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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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