

In This Issue

Governor's Proposed Medicaid Budget for FY 2019-2020	2
Community HealthChoices Update	4
PHLP Offers FREE Help with CHC	7
2019 Federal Poverty Level Guidelines Published	7
Medicare Part D Plans Now Monitoring For Prescription Drug	8

Medicare Part D Copay Problems for Certain Dual Eligibles

In January, PHLP identified a problem impacting some dual eligibles (those enrolled in both Medicare and Medicaid) that resulted in people being charged Medicare Part D copays when they should not have been. After fielding calls from several affected participants, some of whom were unable to get their medications because they couldn't afford the incorrect copays, PHLP quickly brought the problem to the attention of officials at the Pennsylvania Department of Human Services. The problem impacts dual eligible participants living in Southwest Pennsylvania who get Home and Community Based Services (HCBS) in Community HealthChoices (CHC) as well as dual eligibles across the state receiving services through the Community Living Waiver for people with intellectual disabilities and autism.

Dual eligibles are people who have coverage from both Medicare and Medicaid. As a reminder, Medicaid is called Medical Assistance in Pennsylvania.

According to Medicare rules, dual eligibles who get long-term care services through Medicaid either at home or in a nursing home automatically get Medicare Part D Extra Help with a \$0 copay. Other dual eligibles automatically get Extra Help, too, but they have differently levels of copays and are charged either \$1.25 or \$3.40 for generic drugs and \$3.80 or \$8.50 for brand name drugs. A data glitch in the state's files that are sent to Medicare on a regular basis to identify individuals who should have a \$0 copay with their Part D Extra Help caused the problem.

According to state officials, approximately 45,000 people are impacted by this problem. For most dual eligibles living in Southwest

Subscribe...

Online at phlp.org/emaillist or by emailing staff@phlp.org

PA and getting HCBS in CHC, this problem began January 2019. For the dual eligibles in the Community Living Waiver, the problem likely began in April 2018. The state is still working on completely fixing this problem.

As of February 19th, this problem is fixed moving forward so impacted dual eligibles should no longer be charged for prescription copays at the pharmacy. The state is still working on the retroactive fix and hopes to have that completed in upcoming weeks. Once the problems are completely fixed, affected participants will receive a generic letter from their Part D plans and separately receive a refund for copays they paid when the copay should have been \$0. This refund should happen automatically, and consumers should not have to take any action to get the refund.

Participants with questions or who continue to have problems with Part D copays are encouraged to call PHLP's Helpline at 1-800-274-3258. We will provide an update on this issue in the next newsletter.

Governor's Proposed Medicaid Budget for FY 2019-2020

Earlier this month, Governor Wolf released a proposed budget for Fiscal Year 2019-20 that maintains existing Medicaid services and eligibility levels. The Governor proposes a general fund budget of \$34.15 billion - a 2.79 percent increase over the current fiscal year budget. It contains no new broad-based tax increases and instead relies on growth in existing tax revenues as well as a new severance tax on natural gas. Unlike last year, no consolidation of departments—i.e., Health, Human Services—is proposed. Those two Departments had been proposed to be merged last year budget but are now proposed to remain free standing departments.

The Governor proposes a total appropriation for Medical Assistance (MA) of \$18.66 billion, which includes both federal and state funds. This is a decrease over the current fiscal year of \$20.57 billion. The MA appropriation is comprised of \$4.07 billion in state general funds, \$11.55 billion in federal funds, and \$2.72 billion in provider assessments and other fees. Of that overall MA budget, \$14.39 billion (77 percent) is allocated for capitation payments to the physical health and behavioral health managed care organizations.

The budget assumes Medicaid enrollment will grow 1.26 percent over the next fiscal year, and assumes the Federal Medical Assistance Percentage (FMAP) rate will remain at 52.25 percent, effective October 1, 2019. The newly eligible FMAP will reduce from 93 percent to 90 percent effective January 1, 2020.

Initiatives in the proposed Human Services and Medicaid budgets include:

- **Community HealthChoices (CHC)** – Starting with the Fiscal Year 2017-2018 budget, DHS began the three-year implementation of a managed long-term care program for older Pennsylvanians and adults with physical disabilities – Community HealthChoices. This program will ensure that one entity is responsible for coordinating the physical health and long-term service and support needs of participants to improve care coordination and health outcomes while allowing more individuals to live in their community. Costs related to older Pennsylvanians and individuals with disabilities—e.g., Aging and OBRA Waivers—were transferred into CHC beginning with implementation in the Southwest region on January 1, 2018 and in the Southeast region in Fiscal Year 2018-2019. Beginning January 1, 2020, CHC will be available in the Northeast, Northwest and Lehigh-Capitol regions. Future PHLP newsletters will review the full state costs of CHC.
- **Expanding the LIFE Program** – An increase of \$10 million is allocated for the Living Independence for the Elderly (LIFE), a managed care program that provides a comprehensive, all-inclusive package of medical and supportive services. An alternative to CHC, the LIFE program would serve an additional 300 consumers dually-eligible for Medicaid and Medicare;
- **Expanding Intellectual Disability Services** – An increase of \$29 million in state funds is proposed to serve an additional 765 individuals with an Intellectual Disability (ID) who are currently on a waiting list to be served in the Community Living waiver and funding for an additional 100 individuals with ID who are on the waiting list to be served in the Consolidated waiver. No closure of a state center is proposed and funding for state centers is reduced by \$188,000. The census of individuals residing in the remaining four facilities continues to decline and is projected to be 716 at the end of June 30, 2019.

General Assistance

Governor Wolf’s proposed budget maintains funding, approximately \$50 million, for the General Assistance program; a cash assistance program that provides minimal income support for desperately poor individuals with serious disabilities, people fleeing domestic violence, and individuals in active drug treatment for limited periods of time. To qualify, a person cannot make more than \$205 a month, and cannot have more than \$250 in “countable resources,” excluding a house and car.

Readers may recall that General Assistance was eliminated in 2012, under then-Governor Tom Corbett, and was restored late last year after the Pennsylvania Supreme Court found the process PA General Assembly used to end the program was unconstitutional. At the time the program ended, it supported about 60,000 Pennsylvanians. At the end of January, it had just more than 5,500 enrolled. Many individuals use the program to cover basic needs while they apply for Social Security disability benefits, which is a lengthy process.

Since the program has returned, some Republican legislators have called for eliminating it. Changes to the program would require the approval of the Republican-controlled Legislature; spokespeople for both House and Senate Republican majorities have said they plan to examine proposals for the program during the budget process that will unfold in the Capitol for the next several months.

The Pennsylvania House and Senate Appropriations Committees will be holding budget hearings with the various Departments.

House Appropriations Committee Budget Hearings of note	Senate Appropriations Committee Budget Hearings of note
<ul style="list-style-type: none"> · Department of Health/Dept of Drug and Alcohol Programs – February 25th at 3 PM · Department of Human Services – February 28th at 10 AM 	<ul style="list-style-type: none"> · Department of Health – February 27th at 10 AM · Department of Human Services – February 27th at 1:30 PM · Department of Drug and Alcohol Programs – March 4th at 10 AM · Department of Aging – March 5th at 3 PM

We'll continue to update readers about any developments related to the Governor's proposed budget impacting health care programs for vulnerable Pennsylvanians.

Community HealthChoices Update

Community HealthChoices (CHC), the state's mandatory managed care program for 1) those who have both Medicare and Medicaid (dual eligibles) and 2) older adults and persons with disabilities needing long-term services and supports at home or in a nursing home is being implemented in three phases. Phase One, which covers 12 counties in Southwest PA, began on January 1, 2018 and enrolled approximately 100,000 participants. Phase Two, which covers the five counties in Southeast PA, began on January 1, 2019 and enrolled approximately 130,000 participants.

The Pennsylvania Department of Human Services (DHS) considers the launch of the program mostly a success in both regions, but acknowledges areas where improvement is needed. 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 By Dual Eligible Participants About Using Medicare Providers](#)

Some participants remain 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 any one'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.

Finally, many dual eligible consumers mistakenly believe they need to change to a Medicare provider enrolled in their CHC plan. This is incorrect. If a participant is in Original Medicare or has a Medicare option through a different company than their CHC plan, the participant's CHC plan is still responsible for coordinating with the participant's Medicare plan and providers. That includes the CHC plan picking-up its share of cost-sharing. For example, if a dually eligible participant is enrolled in a CHC plan and the participant needs to see a podiatrist, that podiatrist does NOT need to be in their CHC plan. Dual eligible participants can see that Medicare-participating podiatrist even if the podiatrist is not in the participant's CHC-MCO provider network. In this example, the participant should show his or her Medicare, Access, and CHC-MCO identification cards. The podiatrist will bill the CHC plan for the participant's Medicare co-insurance and deductibles.

[Termination of Service Coordination Sub-Agreements](#)

Some CHC Participants in both the Southwest and Southeast regions have been informed by their CHC plans that their current service coordinators will no longer be providing service coordination services.

As a reminder, all CHC participants receiving In-Home LTSS have a Service Coordinator to help participants identify needed services, arrange services that supports both a participant's needs and preferences, and coordinate the participant's long-term services with all their other services including medical care. Prior to the launch of CHC, service coordination was a billable service paid to independent agencies by DHS through the fee-for-service system. Under CHC, service coordination is an administrative function of the CHC plan which is solely responsible for providing the service either by hiring appropriately qualified staff or continuing contracts with existing service coordination agencies.

In the Southwest all three CHC plans, to varying degrees, have terminated some of their subcontracts with external service coordination agencies. CHC plans that decide to end their contracts are required to give participants 45 days of advance notice prior to the dissolution. CHC plans also must notify outside Service Coordination agencies 60 days prior the contract terminate. Some CHC plans might automatically assign a participant a service coordinator, but the participant does not have to accept that assignment and has the right to request and choose a different coordinator.

Most CHC Participants in Southeast have not experienced a forced change of service coordinators because the six month continuity of care period, which lasts until June 30th, guarantees that participants can keep their same LTSS providers. However, in January 2019 approximately 1,800 participants enrolled in UPMC's CHC plan learned that the Philadelphia Corporation for Aging (PCA) would

no longer provide service coordination for UPMC CHC participants. This contract break between PCA and UPMC did not violate participants' rights to keep their provider under the continuity for care rule because it was PCA (not UPMC CHC) that was not willing to contract with UPMC when CHC began. This change, unexpected by many, did not impact any home and community-based services like personal assistance, meals or transportation.

Transportation

There continues to be confusion over what transportation is the responsibility of the CHC plans and what is not. To be clear, the Medical Assistance Transportation Program (MATP) continues to be responsible for non-emergency medical transportation for all Medicaid consumers in the CHC region who are not residing in a nursing home. The CHC plans should be assisting their members who need help connecting to and arranging rides through MATP. However, the CHC plans will also be responsible to provide transportation to their members in certain circumstances:

- ◇ Nursing Home Residents: The CHC plans are responsible for the transportation of their members in nursing homes including emergency and non-emergency ambulance as well as all non-emergency medical transportation.
- ◇ CHC Members Living in the Community: For their members living in the community, the CHC plans are responsible for emergency and non-emergency **ambulance** transportation. In addition, the plans must pay for "specialized" non-emergency medical transportation for those requiring a stretcher van or who need to be transported from one medical facility to another.

CHC plan members who are getting long term services and supports at home are also eligible for non-medical transportation from the plan as long as it is detailed in the person's approved service plan. This could include, among other things, transportation to religious activities, to grocery shop, to employment or volunteer activities, or to Adult Daily Living Centers.

Reductions of Long Term Services and Supports (LTSS)

In the Southwest region, DHS has granted permission for all three CHC plans—i.e., UPMC Community HealthChoices, AmeriHealth Caritas, and PA Health and Wellness— 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. 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.

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.**

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.

2019 Federal Poverty Level Guidelines Published

The 2019 Federal Poverty Levels (FPLs) were published in the Federal Register on February 1, 2019. The new limits are slightly higher than last year's guidelines. The poverty guidelines are used to set income limits for public health programs such as Medicaid, CHIP, Medicare Part D Extra Help and Marketplace Premium Tax Credits.

PHLP updated its chart showing income and resource limits for Medicaid and other health programs to include the 2019 amounts. Click [here](#) to view this resource.

Medicare Part D Plans Now Monitoring For Prescription Drug Abuse

Starting January 1, 2019, Medicare Part D plan sponsors are using new systems to identify members who are at risk for abusing certain prescription drugs – specifically opioids and benzodiazepines. Part D plans can limit access to frequently abused drugs for those members identified as at risk for this abuse.

This new monitoring includes two components: safety reviews by Medicare drug plans and pharmacists and placing consumers into drug management programs within Part D plans. These new safety reviews and drug management programs should not be applied to consumers who have cancer, are in hospice, palliative or end-of-life care, or who live in a long-term care facility.

[Safety Reviews](#)

Medicare drug plans and pharmacies will now do safety reviews when consumers fill prescriptions for opioid pain medication at the pharmacy. The drug plan and pharmacist are reviewing for:

- Potentially unsafe opioid amounts
- Taking opioids with benzodiazepines (medications like Xanax or Klonopin that are commonly used for anxiety and sleep)
- New opioid use – consumers with **new** prescriptions for opioid medications may be limited to a 7-day supply or less.

If pharmacists cannot fill the prescription as written because of safety concerns, they will give the Medicare beneficiary a notice explaining how she or her doctor can contact the plan to ask for a coverage decision.

Part D plans will also be reviewing whether members are getting opioid prescriptions from multiple doctors and pharmacies. If so, the plan may talk with their doctors to make sure that the individual needs these medications and is using them safely.

[Drug Management Programs](#)

As of January 1, 2019, Medicare Part D plans can have drug management programs (DMPs). If a Medicare drug plan decides that a consumer's use of prescription opioids and benzodiazepines is not safe, the plan may limit access, coverage, and amounts of these drugs. For example, under its drug management program, the plan may limit a consumer to only getting these medications from certain doctors or pharmacies.

Before a drug plan can put a consumer in its drug management program, it must notify the consum-

er in writing that it believes the consumer's use of prescription opioids or benzodiazepines is potentially unsafe. The consumer and her doctor can then provide additional information to the drug plan. After the consumer has had a chance to respond to the first notice, the plan must send out a second notice within 60 days of the first notice. The second notice will confirm whether or not the consumer is being placed into a drug management program.

If the consumer is placed in a drug management program because the plan determines her to be at-risk for prescription drug abuse, she is then locked into an identified prescriber and pharmacy.

Important note: Dual eligible consumers and others eligible for Extra Help who would otherwise have a Special Enrollment Period to change their prescription drug coverage once during each of the first three quarters of the calendar year will not be allowed to change plans once they receive the first notice identifying them as potentially at-risk. If the consumer is ultimately not placed in a drug management program, they would again regain the ability to use this Special Enrollment Period to change plans. If the consumer is placed into the DMP, they are unable to use this Special Enrollment Period to change plans for a maximum of 24 months from the date they are determined to be at-risk.

[Appeal Rights](#)

Consumers should be aware that they can file an appeal if they disagree with the plan's decision to place them into the drug management program and limit their access to opioids or benzodiazepines. The second notice they receive will contain information about their appeal rights.

More information about these changes can be found [here](#). Individuals who receive these notices are encouraged to call APPRISE at 1-800-783-7067. dual eligibles and other individuals receiving Part D Extra Help can contact PHLP's Helpline at 1-800-274-3258.

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

[DONATE TO PHLP](#)

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.