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Public Charge Updates

On August 12, 2019, the Trump Administration announced their final Public Charge rule, scheduled to take effect October 15, 2019. Public Charge is a test used by U.S. Immigration officials to decide whether a person can enter the country or get a green card (i.e., obtain lawful permanent resident status). Under this test, immigration officials review the totality of a person's circumstances to decide if they are likely to become a Public Charge, which can be a basis for denying their status. Factors reviewed include income, employment, health, education or skills, family situation, and whether a sponsor signed a contract promising to support the person. Officials can also look at whether the person used certain public benefits. Under the current rule, the only public benefits considered when determining who is likely to become a Public Charge are cash assistance and Medicaid-funded long-term care.

The new rule, however, expands the public benefits considered in the Public Charge review to include:

- Medicaid (also known as Medical Assistance), but NOT including Emergency Medical Assistance or Medical Assistance used by either children, pregnant women, or new mothers);
- Cash Assistance
- SNAP (also known as Food Stamps); and
- Federal Public Housing and Section 8 assistance.

It is important to note that use of public benefits is only ONE factor in the Public Charge test. Furthermore, the Public Charge test does NOT apply to all immigrants. Citizens and people who already have a green card are not subject to the test. Other exempt immi-

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grant groups include refugees; asylees; survivors of trafficking, domestic violence, or other serious crimes (T or U visa applicants/holders); VAWA petitioners; special immigrant juveniles; DACA and TPS; and certain people paroled into the U.S.

Everyone's situation is different. If you have questions regarding Public Charge and whether or how it impacts you, please contact an immigration attorney for individualized advice. For free or low cost options, visit https://www.immigrationadvocates.org/nonprofit/legaldirectory.

Immigrants with Medicaid coverage should seek health care treatment without fear of being reported. Healthcare providers should not ask for your immigration information or require you to show a photo ID to be treated. Additionally, you can receive health care without insurance by going to the emergency room, community health centers, and clinics. For further resources and information, please visit www.protectingimmigrantfamilies.org.

Many states have filed lawsuits to stop the Public Charge rule from taking effect. Those cases will be argued in early October and could very well delay the October 15th effective date. PHLP will provide further updates on the final Public Charge rule as we learn more.

DDAP Bulletin: Continuation of Services During an Authorization Appeal

In August, the Pennsylvania Department of Drug and Alcohol Programs (DDAP) released a Policy Bulletin updating the Treatment Manual for Single County Authorities (SCAs). There are 47 SCAs representing the 67 counties in Pennsylvania. SCAs receive federal and state funding through DDAP to plan, coordinate, manage and implement the delivery of drug and alcohol prevention, intervention and treatment services at the local level. SCAs also receive funding for treatment services from the Pennsylvania Department of Human Services (DHS), Office of Mental Health and Substance Abuse Services (OMHSAS).

Pennsylvanians receiving treatment services through SCAs are entitled to grieve denials or reduction of services. They can also grieve the level of treatment approved if they believe another level of service is more appropriate to meet their needs.

The DDAP Policy Bulletin (Number 19-02 issued on August 5, 2019) modified the state's Treatment Manual to require additional rights to challenge service denials. Effective immediately, Section 8.08 states, "*In the event an individual grieves a treatment funding decision related to a reduction or termination of services or length of stay in treatment, the SCA is required to continue funding treatment services at the current level of engagement until the appeal is resolved. This applies to all treatment services, including the provision of Medication Assisted Treatment (MAT).*"

There are four situations that individuals MUST be allowed to appeal:

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1. Denial or termination of services;
2. A level of care determination;
3. Length of stay in treatment; and
4. Violation of an individual's human or civil rights

The Policy Bulletin applies when the SCA has approved individuals in active treatment for a level or type of service. In these instances, if the SCA decides to terminate the service, or authorize a different level of treatment, the individual can grieve (challenge) that decision and continue receiving the previously authorized care. The two-stage appeal process, as outlined in DDAP's Treatment Manual remains the same.

Final Phase of CHC Enrollment Underway

The statewide implementation of Community HealthChoices (CHC) is entering its final phase as more than 143,000 people in the Northeast, Northwest and Lehigh-Capital Regions of Pennsylvania are being moved to the new program on January 1, 2020. This population includes people with Medicare and Medicaid (dual eligibles); people in the Aging, Attendant Care and Independence Waivers; most people in the OBRA Waiver; and people in nursing homes being paid for by Medicaid.

By now, all of those being moved to CHC should have received a notice telling them about the program, followed by an enrollment packet with information about how to enroll in a CHC managed care plan. The enrollment packets are being mailed through October 12. Anyone who does not receive an enrollment packet by October 19 or who would like the information sent again should contact the CHC Enrollment Broker at 1-844-824-3655.

As a reminder, the three CHC plans in the Northeast, Northwest and Lehigh-Capital Regions are: AmeriHealth Caritas Community HealthChoices, PA Health and Wellness, and UPMC Community HealthChoices. The enrollment packet sent to those moving to CHC includes brief comparison information about these three plans.

If individuals slated to move to CHC do not make a CHC plan choice by November 13th, the state will assign them to a plan. Later in November, letters will be sent to individuals moving to CHC either confirming their CHC plan choice or telling them about the plan they were assigned to by the state. However, individuals can still make a CHC plan choice or change after that date and, as long as they enroll in a plan by **December 20th**, their choice will prevail and will be effective January 1, 2020.

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To minimize the risk of disruptions in healthcare services, it is advisable that individuals take time to choose a plan that includes their critical healthcare providers. This is particularly true of the more than 4,000 waiver service recipients whose only insurance is Medicaid.

People with Medicaid-only insurance are most at risk of disruption in their healthcare services when CHC starts. This is because they must see providers who are in their CHC plan's network. In contrast, people who have both Medicare and Medicaid can continue to see their Medicare providers and the CHC plan must pay the Medicaid portion of their medical bills even if the provider is not in the CHC plan's network, if the provider is willing to bill the plan.

While there is a brief period—i.e., 60-days—during which CHC plans must pay out-of-network medical providers for ongoing treatment or prior authorized services, this "continuity of care" period does not apply in all situations and can be challenging to obtain even when required. Therefore, relying solely on continuity of care to be able to access medical providers is a risk that should be avoided. (The 60-day continuity of care period applies to regular physical health services and medication. A longer and more tightly monitored 180-day continuity of care period applies to waiver services such as personal assistance services.)

To determine in which CHC plans specific providers are participating, individuals may call the CHC Enrollment Broker at 1-844-824-3655 or use its provider search tool. Each plan is also supposed to be able to provide information about providers in their networks and each has its own, plan-specific provider search tool.

Unfortunately, CHC enrollment has begun even though the CHC plans are still working on contracting with providers so not all providers who ultimately will participate in a plan's network are listed as participating currently. Moreover, some medical providers are not aware that the CHC roll-out is affecting their patients. Therefore, individuals and their advocates may have to educate their providers about CHC and urge them to reach out to plans so they can become participating providers.

Once CHC begins, participants can switch plans at any time. There is no lock-in. However, depending on when a plan change is made, it could take from two weeks to a month and a half for the change to go through, so choosing the right CHC plan now will save time and potential problems accessing care.

Copies of each CHC enrollment notice and most of the information contained in the enrollment packet can also be found here.

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Changes to the Maximus HCBS Application Process

Starting this month, Maximus, the current Pennsylvania Independent Enrollment Broker (PA IEB), **will schedule an in-home visit as the first step** in the Home and Community-Based Services (HCBS) application process. Older adults and people with physical disabilities seeking support services at home, such as personal assistance services, respite, and home-delivered meals, contact Maximus at 1-877-550-4227 to start the application. People can also start the process by completing an online application using the COMPASS system and indicate that they are seeking home and community-based services. This process does ***not*** apply to people with Intellectual Disabilities or Autism who are seeking help at home.

Prior to September 2019, the Maximus in-home visit would happen **after** the local Area Agency on Aging completed its level of care assessment and after the doctor completed the Physician Certification. Now, once someone contacts Maximus or completes a COMPASS application for home and community-based services, an in-home visit will be scheduled within seven (7) days unless the applicant requests a visit outside of this timeframe.

During the in-home visit, a Maximus representative will explain the enrollment process, help the individual complete the application and collect needed supporting documents, and provide information to help the individual choose a Community HealthChoices plan or a Service Coordination entity (in areas where CHC has not yet started). Making the in-home visit by Maximus the first step in the process was done to minimize challenges faced by people applying for home and community-based services; however, people may still need additional help to complete the application. This might happen when someone needs to look up information or check information with a family member in order to answer all the questions on the application or when they need time to gather verification documents such as bank statements or life insurance policy information. Individuals who need more help beyond what Maximus can provide to complete the application are encouraged to call the PA LINK at 1-800-753-8827 and ask to speak to a Person-Centered Counselor.

After the in-home visit by Maximus, the application process will still include level of care assessment by the Area Agency on Aging, completion of the Physician Certification form, and review of financial eligibility by the local County Assistance Office. Individuals who qualify for Medicaid Home and Community-Based Services will get a written approval notice from their County Assistance Office. Those who are denied because they are not clinically or financially eligible will still receive a written notice of denial that can be appealed.

Individuals who have problems applying for home and community based services or who receive a denial notice are encouraged to contact Pennsylvania Health Law Project's Helpline at 1-800-274-3258 or staff@phlp.org.

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Get Ready for the Medicare Open Enrollment Period

Medicare's Annual Open Enrollment Period starts **October 15th** and runs until **December 7th.** During this period, all Medicare beneficiaries can make changes to their health or their drug plan coverage. Changes made during this period start January 1, 2020.

Beneficiaries already enrolled in a Medicare Prescription Drug Plan or Medicare Advantage Plan should have received information from their current plan about what the benefits will be in 2020. This information should detail any changes to the plan's coverage or costs for next year. Everyone is encouraged to review this information to decide whether they should stay with their current plan or join a new plan for next year.

Beginning October 1, 2019 insurance companies are allowed to start marketing their 2019 plans and Medicare's website, www.medicare.gov, will show 2020 plan information-see below for important information about changes to the Medicare Plan Finder. Activities and materials by Medicare companies as well as agents or brokers who enroll people into Medicare plans are subject to communications and marketing guidelines which can be found here. If a Medicare plan will **not** continue in 2020, enrollees should receive notice in early October that their plan is ending December 31st.

At the time this newsletter is published, details about 2020 Medicare plan offerings is not available. We will include this information in our next newsletter. APPRISE staff and volunteers can help people across Pennsylvania review their 2020 Medicare coverage options. Medicare beneficiaries who need help reviewing their plan options for next year are encouraged to call APPRISE at 1-800-783-7067.

Changes to Medicare Plan Finder

CMS rolled out a redesigned Medicare Plan Finder on www.medicare.gov at the end of August 2019. **After September 30th, the old Plan Finder will no longer be available**. Although, the new Plan Finder allows users to perform an anonymous search, people will have to create a MyMedicare account to perform personalized searches and save drug lists. This is a major change for APPRISE staff and volunteers and other advocates who help people review their plan options. Another big change is that advocates helping Medicare beneficiaries will not be able look up current coverage or Extra Help status for someone on www.medicare.gov without using the consumer's login credentials. We will cover this and more during our Medicare 2020 webinar on October 30th. See page 8 for more information.

Medicare and Community HealthChoices: As a reminder, dual eligibles moving to Community HealthChoices (CHC) will continue to have Medicare as their primary coverage. Their move to CHC is only changing their secondary Medicaid coverage. Dual eligibles continue to have all the Medicare plan choices available to anyone on Medicare– Original Medicare or Medicare Advantage plans. Dual

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eligibles also can join a certain kind of Medicare Advantage plan whose enrollment is limited to people that have Medicare and Medicaid-these plans are called Dual Special Needs Plans (D-SNPs). For those in Northwestern PA, Northeastern PA, and the Lehigh/Capital area moving to Community HealthChoices on January 1, 2020, each insurance company offering a CHC plan will also offer a Medicare D-SNP. **Please note that consumers are not required to enroll in the Medicare D-SNP that is offered by the same insurance company as their CHC plan.** If a dual eligible is happy with her current Medicare coverage, she can keep the coverage she has, but she will still need to enroll in a CHC plan for her **Medicaid** coverage. See page 3 for more information about CHC.

Individuals moving into CHC who need more help understanding how CHC will work with their Medicare coverage next year are encouraged to contact PHLP's Helpline at 1-800-274-3258. Those that have specific questions related to their Medicare coverage can also call APPRISE at 1-800-783-7067.

Medicare Part D Costs for 2020

A Medicare beneficiary who **does not** qualify for any level of Extra Help from Medicare will pay the following costs for a standard Part D Plan in 2020:

- The plan's monthly premium (the national average premium for a basic drug plan will be $32.74);
- An annual deductible of **$435;**
- During the initial coverage period, a **25%** co-pay for each covered prescription until the person's total drug costs reach **$4,020**;
- After the initial coverage period, a person will continue to pay **25%** of the cost of both brand-name and generic drugs (plus a small dispensing fee) until the consumer's total out-of-pocket expenses reach **$6,350**; and
- During the catastrophic coverage period, a co-pay of **$3.60** for generics and **$8.95** for brand name drugs, or a 5% co-pay, **whichever is greater**, for the rest of the year.

Part D Cost for Those Receiving Extra Help from Medicare: Anyone who qualifies for the **full Extra Help** from Medicare will have the following costs in 2020. This includes all dual eligibles who have Medicare and who receive **any** benefit from Medicaid:

- $0 premium (as long as she enrolls in a Part D plan that provides standard benefits and charges a premium below the 2020 Extra Help Benchmark amount of $35.63)
- Small co-pays for their prescription medications:
  - $1.30/generics and $3.90/ brand names (if income is less than 100% FPL) **or**
  - $3.60/generics and $8.95/ brand names (if income is above 100% FPL) **or**
  - $0 if someone is on Medicare **and receiving Medicaid long term care services** in a nursing

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home **or** through a Home and Community-Based Services Waiver program

Those beneficiaries who qualify for **partial Extra Help** in 2020 will pay the following costs:

- A portion of their Part D plan monthly premium depending on the amount of their extra help;
- A deductible no higher than **$89;**
- 15% co-pays on all of their medications until they reach total out-of-pocket expenses of **$6,350;**

Individuals getting Extra Help in 2019 will get a written notice if there is going to be a change to their Extra Help status next year. Here's a link to these mailings and others that Medicare beneficiaries are receiving this fall.

- During the catastrophic coverage period, co-pays of **$3.60**/generics and **$8.95**/name brands for the rest of the year

PHLP Offers Medicare 2020 Webinar

PHLP is offering a free webinar to educate advocates, providers, and professionals who work with dual eligibles and other low-income Medicare beneficiaries about Medicare in 2020. Dual eligibles are people who get coverage through both Medicare and Medicaid.

The webinar will be held on **Wednesday, October 30th from 10 a.m. to noon**. It will cover the following topics:

- Medicare Part D plans and costs in 2020
- Medicare Plan Finder Changes
- Programs that help Medicare beneficiaries with their costs
- Community HealthChoices updates

To register for the webinar, please click here. Space is limited, so register today! Please share this announcement with others who may be interested in the webinar.

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, educa-

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For the Pittsburgh Region, go to unitedwaypittsburgh.org and select agency code number

PHLP: Helping People in Need Get the Health Care They Deserve

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