

In This Issue

Behavioral Health Rehabilitation Services Transitioning to Intensive Behavioral Health Services (IBHS)	4
Medicare Part B Covers Opioid Use Disorder Services Starting January 2020	8
Medicare Announces 2020 Part A and Part B Costs	9
PA Asks Centers for Medicare and Medicaid Services (CMS) for Good Faith Effort Exemption to Delay Implementation of Electronic Visit Verification	10
CMS Extends Eligibility For Equitable Relief For Medicare Part B Enrollment Delays And Penalties	11
Public Charge Updates	12
PHLP Launches VOCA Program	12

Community HealthChoices (CHC) Updates

Southeast Participants Speak Out at Listening Session

In late October, senior state officials from the Department of Human Services heard from CHC participants and their caregivers at a listening session at the Philadelphia Corporation on Aging (PCA) in Philadelphia. The listening session, which was hosted by the Consumer Subcommittee of the Medical Assistance Advisory Committee, was an opportunity for participants in the Southeast to share their experiences with CHC.

During the three-hour listening session, participants, and caregivers voiced concerns about a range of issues, including service coordination caseloads, difficulty communicating with CHC Plans, and delays in home modifications. Participants also raised questions about how CHC can better serve participants with visual impairments and more effectively utilize the consumer-directed services model. There was also discussion about whether CHC is adequately serving participants with intellectual disabilities.

Deputy Secretary of the Office of Long Term Living, Kevin Hancock, attended the listening session. Representatives from all three CHC Plans also attended.

More Service Coordination Entities Terminated in Southeast

More than 20,000 CHC participants in Southeastern Pennsylvania will experience a change in service coordinator after two of the three CHC plans announced they are not renewing contracts with

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most external service coordination agencies effective January 1, 2020. Keystone First CHC is terminating contracts with 20 of its 23 external service coordination agencies and UPMC CHC is terminating the contract of one of its two remaining external service coordination agencies.

Affected participants already should have received a letter from their CHC plan explaining next steps. Participants may choose a new service coordinator who works directly for their CHC plan or choose one from the external service coordination agencies still contracted with their CHC plan. The remaining external agencies for Keystone First CHC are Liberty Community Connections, Participant Care Coordination, and United Disability Services; and for UPMC CHC it is All Abilities.

Participants who wish to keep their current service coordination agency can switch to PA Health & Wellness (PHW) if the agency has a contract with PHW; all but three of the service coordination agencies whose contracts with the other plans are ending do have a contract with PHW. Participants who want to switch must do so by December 13 for the plan change to begin on January 1, although they may also switch after that date for a later new plan start date. Participants considering switching plans should make sure their preferred service providers, such as their home health agency, participates with PHW! People on Medicaid only should also make sure their preferred medical providers are part of PHW or risk losing access to them. To change CHC plans, participants should call the Independent Enrollment Broker at 1-844-824-3655.

Individuals affected by the service coordination agency contract changes who do not switch plans or choose a service coordinator will be assigned to one by their CHC Plan.

Participants are supposed to have a choice of service coordinators and may switch service coordinators if they are not satisfied with the one they have. The CHC plans are also responsible for helping participants find a different service coordinator to ensure that services are not disrupted.

Community HealthChoices Will Be Statewide January 1st as Phase Three Launches

Community HealthChoices (CHC), Pennsylvania's Managed Long-Term Services & Supports Program, will complete its two-year, three-phase roll out on January 1, 2020 when the program begins in the Northwest, Northeast, and Lehigh/Capital Regions (Phase Three). On that day, CHC will be statewide for the first time.

CHC affects older adults and persons with disabilities who are: dual eligible (on Medicare and Medicaid), getting long term care services at home through an Office of Long Term Living waiver, or in a nursing home paid for by Medicaid. Specifically, CHC changes how these individuals get their Medicaid coverage. For those getting long term care services, it also changes that coverage.

As of mid-November, most (61%) of the 140,000 plus people in the Northeast, Northwest and Lehigh/Capital regions who will move to CHC had not chosen a managed care plan. These individuals were auto assigned by the state to one of three CHC plans—i.e., AmeriHealth Caritas, PA Health and

Wellness, or UPMC. However, most participants who were enrolled in an OLTL waiver and receiving Medicaid-funded long-term services and supports at home did select a CHC plan and were not auto-assigned.

It is not too late for people to choose a different CHC plan for January 1st. Participants have until Friday, December 20, 2019 to choose so that plan selection prevails. This option to switch plans before January 1st applies to everyone, whether they were auto-assigned to a plan, or a person who already made an affirmative plan selection but has since had a change of mind.

To minimize the risk of disruptions in healthcare services, it is advisable that those auto-assigned to a CHC plan take time to choose a plan that includes their critical healthcare providers. This is particularly true of the nearly 3,000 who were auto-assigned to a CHC Plan whose only insurance is Medicaid.

People with Medicaid as their 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 (duals) may 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.

While there is a brief period—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. 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 plans specific providers are participating, individuals may call the CHC Enrollment Broker at 1-844-824-3655 or use its [provider search tool](#).

Once CHC begins, participants may 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.

Behavioral Health Rehabilitation Services Transitioning to Intensive Behavioral Health Services (IBHS) – Part Two of PHLP’s Summary of Changes

As highlighted in our October newsletter, the state made significant changes to rules governing the delivery mental health services to children and adolescents. The Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) has established new regulations for Intensive Behavioral Health Services (IBHS) to replace Behavioral Health Rehabilitation Services (BHRS) for the delivery of child and adolescent services in the home, school, and community. The new regulations (Title 55, Chapters 1155 and 5240) become effective on January 17, 2020.

IBHS support children, youth, and young adults with mental, emotional, and behavioral health needs. IBHS offers an array of services that can meet the needs of these individuals in their homes, schools, and communities. There are three categories of service: 1) Individual services which provide services to one child; 2) Applied Behavior Analysis (ABA) which is a specific behavioral approach to services; and 3) Group services which are most often provided to multiple children at a specific place. The changes include increased requirements for staff training, supervision, and credentialing. These new regulations were built from needs identified, during a years-long process, by community stakeholders (including school district principals, provider agencies, and consumers) during targeted focused groups for improved access and quality of care for children, youth, and young adults.

In our [October newsletter](#), we detailed the changes to Applied Behavioral Analysis with IBHS. In this article we describe the two other categories of IBHS services: 1) Individual Services for one child and 2) Group Services provided to multiple children at a specific place.

Individual Services

Individual Services are provided one-to-one to children, youth, and young adults (under age 21) (hereafter referred to as youth) with mental, emotional, and behavioral health needs. These services can be provided with Behavior Consultation (BC) Services, Mobile Therapy (MT) Services and/or Behavioral Health Technician (BHT) Services. BC services include an assessment of the youth’s behavioral needs, development of an Individual Treatment Plan (ITP) which includes interventions to be used and when and where they occur. The youth’s ITP should be developed with the youth (as appropriate), family members, and other providers and school personnel as indicated. BC services can be provided in the home, school, or other community settings based on the needs of the youth. BC services replace BSC (Behavior Specialist Consultant) that were a part of BHRS.

Mobile Therapy (MT) services can also include an assessment and development of the ITP, if not already done by a BC. MT can include individual therapy, family therapy, assistance with crisis stabilization, and assistance with other problems encountered by the youth and/or family. MT services are similar to the MT services that were a part of BHRS.

BHT services are used to implement the youth’s ITP. BHT services replace TSS (Therapeutic Staff Support) services that were a part of BHRS.

Group Services

Group services are intensive therapeutic interventions that are provided in a group format. They can be provided in school or community settings such as a daycare or afterschool program. Group services include group and family psychotherapy, design of psychoeducational group activities, clinical direction of group services, creation and revision of the ITP, and oversight of the ITP implementation and consultation with the treatment team. IBHS regulations do not include a staff to client ratio for group services but providers of group services must identify that ratio in their service description to OMH-SAS. Parent-Child Interaction Therapy (PCIT) can be provided as a group service. Examples of group services include Group Applied Behavior Analysis, School-Based Programs, After-School Programs, and Summer Therapeutic Activities Programs.

How to Obtain Individual and Group Services under Medical Assistance

Written Order (i.e., Prescription)

The process begins with a written order. Professionals qualified to do a written order include a physician, licensed psychologist, certified registered nurse practitioner, physician assistant, licensed social worker, licensed professional counselor, and licensed family therapist. The written order must be based on a face-to-face interaction with the youth. **PLEASE NOTE: In our October newsletter we stated a face to face interaction is not required for the written order – that is incorrect and we apologize for that error.** The order must be written within 12 months of initiation of services. The initiation of services is the first day an individual service or group service is provided.

The written order must include:

a behavioral health disorder diagnosis listed in the most recent edition of the DSM or ICD; or one or more orders for IBHS for the youth and includes the following:

- (a) The clinical information to support the medical necessity of the service ordered.
- (b) The maximum number of hours of each service per month.
- (c) The settings where services may be provided.
- (d) The measurable improvements in the identified therapeutic needs that indicate when services may be reduced, changed, or terminated.

The Assessment

Once the youth has a written order for services, an assessment must be completed, in the home or community-based setting. The qualifications of the professional administering the assessment depend on the service prescribed. An individual qualified to provide behavior consultation services or mobile therapy services must complete an assessment for individual services. A graduate-level professional must complete an assessment for group services.

The assessment must provide information on the youth and family's strengths, existing and needed

supports, and clinical information that includes the following:

- (i) Treatment history.
- (ii) Medical history.
- (iii) Developmental history.
- (iv) Family structure and history.
- (v) Educational history.
- (vi) Social history.
- (vii) Trauma history.
- (viii) Other relevant clinical information.

The assessment must also include the youth's level of developmental, cognitive, communicative, social, and behavioral functioning across the home, school, and other community settings. The cultural, language, or communication needs and preferences of the youth and the parent, legal guardian, or caregiver should also be included in the assessment.

The assessment provides specifics for what services are needed, in what setting, and in what amount. If the assessment indicates the youth needs more services than the maximum indicated in the written order, the assessor and the prescriber should discuss why. For the youth to receive more services than indicated in the written order, a new written order must be done.

Individual Treatment Plan (ITP)

An individual treatment plan must be developed from the information in the written order and assessment within 30 days of the initiation of individual services or group services. *(Please note from our October newsletter that the ITP timeframe for ABA services is 45 days).* An ITP for individual services is a detailed written plan of treatment services specifically tailored to address a youth's therapeutic needs that contains the type, amount, frequency, setting and duration of services to be provided and the specific goals, objectives and interventions for the service.

For Individual Services, the ITP must be developed in collaboration with the youth's parent, legal guardian, or caregiver as appropriate and include:

- (1) Service type and the number of hours of each service.
- (2) Whether and how parent, legal guardian, or caregiver participation is needed to achieve the identified goals and objectives.
- (3) Safety plan to prevent a crisis, a crisis intervention plan, and a transition plan.
- (4) Specific goals, objectives, and interventions to address the identified therapeutic needs with definable and measurable outcomes.
- (5) Time frames to complete each goal.
- (6) Settings where services may be provided.

- (7) Number of hours of service at each setting.

For Group Services: The ITP must be developed with the youth and parent, legal guardian, or caretaker as appropriate and include the following:

- (1) Specific goals and objectives to address the identified therapeutic needs with definable and measurable outcomes.
- (2) Whether and how parent, legal guardian, or caregiver participation is needed to achieve the identified goals and objectives.
- (3) Structured therapeutic activities, community integration activities, and individual interventions to address identified therapeutic needs for the child, youth, or young adult to function at home, school, or in the community.
- (4) Time frames to complete each goal.
- (5) Settings where group services may be provided.
- (6) Number of hours that group services will be provided to the child, youth, or young adult.

For Individual Services and Group Services, the ITP shall be reviewed and updated at least every 6 months or if one of the following occurs:

- (1) The child, youth, or young adult has made sufficient progress to require that the ITP be updated.
- (2) The child, youth, or young adult has not made significant progress towards the goals identified in the ITP within 90 days from the initiation of the services.
- (3) The youth or young adult requests an update.
- (4) A parent, legal guardian, or caregiver of the child or youth requests an update.
- (5) The child, youth, or young adult experiences a crisis event.
- (6) The ITP is no longer clinically appropriate for the child, youth or young adult.
- (7) A staff person, primary care physician, other treating clinician, case manager, or other professional involved in the child's, youth's, or young adult's services provides a reason an update is needed.
- (8) The child, youth, or young adult experiences a change in living situation that results in a change of the child's, youth's, or young adult's primary caregivers.

Evidenced Based Therapies (EBT) can be provided through Individual Services and Group Services. EBT are behavioral health interventions that use scientifically established methods. More of EBT can be found in the state's [Family Fact Sheet](#) and in the [IBHS regulations](#).

For youth currently receiving BHRS, providers will work with families as they transition to IBHS. OMHSAS is committed to no disruption in services for those youth now receiving BHRS. Families who experience BHRS service disruptions should contact their Medicaid Behavioral Health Managed Care plan or call PHLP's Helpline at 1-800-274-3258.

Medicare Part B Covers Opioid Use Disorder Services Starting January 2020

Starting January 1, 2020, Medicare Part B will cover services to treat Opioid Use Disorder, including Medication Assisted Treatment (such as Suboxone and Buprenorphine treatment). In order to be covered by Medicare, the services must be delivered by Opioid Treatment Programs (OTPs) and these programs must become enrolled in Medicare. The [federal government](#) has established requirements for provider enrollment and reimbursement. Medicare beneficiaries who receive these covered services should have zero Medicare cost-sharing in 2020!

As many of our readers know, the Opioid Epidemic affects tens of thousands of people throughout Pennsylvania. The [PA Department of Health](#) has classified the prescription opioid and heroin overdose epidemic as "the worst public health crisis in Pennsylvania". Older adults and people with disabilities on Medicare may be struggling with addiction themselves or have family members and friends who are addicted to opioids.

Dual eligibles in Pennsylvania, covered by both Medicare and Medicaid, who receive Medication Assisted Treatment have used their Medicaid coverage for these services. Now that Medicare will cover these services as of January, Medicare will become the primary payer for these services and Medicaid will become secondary. Providers of these services who enroll in Medicare will be paid a bundled rate by Medicare for treatment services including management of the condition, care coordination, individual and group psychotherapy, and substance use counseling.

As readers who work with dual eligibles know, it can be difficult for dual eligibles to find providers that take both their Medicare coverage and their Medicaid coverage. And, Medicaid is always the payer of last resort. To address concerns about continuity of care for dual eligibles who are getting treatment from a provider that is not yet enrolled in Medicare as of January 1, 2020, the federal government has issued the [guidance](#) to state Medicaid programs, like Pennsylvania. Please note that Pennsylvania's Medicaid program already covers services to treat Opioid Use Disorder, including Medication Assisted Treatment. The federal guidance says:

- Medicaid must pay for services to dual eligibles by OTPs who are enrolled in Medicaid but not yet enrolled in Medicare.
- Medicaid can recoup payments made to OTPs back to when the provider starts to bill Medicare and the OTP will in turn bill Medicare for those services.

The SUPPORT Act of 2018 included provisions that resulted in Medicare's coverage of these services. This law also mandated that all state Medicaid programs cover Opioid Treatment Programs as of October 2020. Again, Pennsylvania's Medicaid program already has been covering these services. More information about this law can be found [here](#).

We'll keep readers updated about developments related to the new Medicare coverage for these important services in the new year. Dual eligibles who are having trouble accessing services for Opioid Use Disorder services are encouraged to call PHLP's Helpline at 1-800-274-3258.

Medicare Announces 2020 Part A and Part B Costs

The Medicare program recently announced the 2020 costs for Medicare Part A and Part B. These costs take effect January 1, 2020.

Medicare Part A

Medicare Part A covers inpatient hospital care, care in a skilled nursing facility (up to 100 days), some home health care, and hospice services. The costs next year will be:

- **Premium:** Most people get Part A for free because they, or their spouse, have paid Medicare taxes while working. However, for those who must buy Part A, the monthly premium in 2019 can be as much as \$458.
- **Hospital Stay:** The inpatient deductible is \$1,408 per benefit period. If someone is in the hospital longer than 60 days, their cost-sharing will be: \$352/day for days 61-90 and \$704/day for days 91-150.
- **Skilled Nursing Facility Stay:** Medicare can cover up to 100 days in a skilled nursing facility when someone meets the criteria for Medicare to pay for this care. There is no cost for care for the first 20 days. For days 21-100, the beneficiary will have a daily co-pay of \$176.

Medicare Part B

Medicare Part B is the medical benefit of Medicare that covers outpatient care such as doctor visits, outpatient hospital services, diagnostic tests, ambulance services, durable medical equipment and mental health services. The costs next year will be:

- **Premium:** Everyone on Medicare is subject to a monthly Part B premium. In 2020, the standard premium will be \$144.60/month. Most people will pay this premium amount next year.
 - ◇ A small percentage of Medicare beneficiaries will pay a slightly lower amount because of Medicare's hold-harmless provision. This rule protects people who have their Part B premium deducted from their monthly Social Security check from a Part B premium increase that would exceed their Social Security benefits increase, to avoid leaving these beneficiaries with a lower net Social Security benefit in 2020 than they received in 2019. More information is available [here](#). As a reminder, people with limited incomes and resources can qualify for Medicaid to pay their Part B premium through the [Medicare Savings Programs or "Medicare Buy-In"](#).
 - ◇ People with higher incomes pay a [higher premium](#).
- **Other Part B Costs in 2020:** The annual deductible will be \$198. That is the amount Medicare

beneficiaries must pay for services before their Part B coverage kicks in. After that, Original Medicare covers outpatient physical and mental health services at 80% and the beneficiary pays the remaining 20%.

As a reminder, Medicare beneficiaries are responsible for paying the monthly Part A (if any) and Part B premiums regardless of how they get their Medicare – whether through Original Medicare or a Medicare Advantage plan. Individuals with Original Medicare (who use the red, white, and blue card when getting care) and no additional insurance are subject to the Part A and B deductibles and co-insurance amounts described above. Those in a Medicare Advantage plan pay the deductibles, co-insurance and co-pays set by their plan. Dual eligibles with Medicare and Medicaid insurance use their Medicaid coverage to pay their Part A and B deductibles, co-insurance, and co-pays and should only be charged the small Medicaid co-pay that applies to the service they get

More information about Medicare Part A and B costs in 2020 can be found [here](#).

PA Asks Centers for Medicare and Medicaid Services (CMS) for Good Faith Effort Exemption to Delay Implementation of Electronic Visit Verification

On December 13, 2016 the 21st Century Cures Act (CURES) came into law. A section of that law (12006), requires an Electronic Visit Verification (EVV) system to be used for Personal Assistance Services and Home Health Aide in Medicaid. EVV allows the individual providing service to record electronically the exact date, real start and end time, and location of a visit. The law requires EVV to be in place by January 1, 2020 for Personal Assistance Services and 2023 for Home Health Services. Personal Assistance Services are provided through various PA Home and Community Based Waiver program. These services assist individuals with health conditions or disabilities with activities of daily living such as bathing, dressing, toileting and mobility.

The federal law allows states to have some discretion about the way EVV is implemented. PA Department of Human Services has held frequent public meetings this year to educate providers and consumers on how our state will implement EVV and the allowable options for providers/employers. In October, the state began a “soft launch” of the use of EVV for providers to gain familiarity with the process and allow the state and providers to work through kinks in the system so there was no disruption of payment for Personal Assistance Services in January. These services can be provided through a Home Health Care Agency or individuals can hire their own staff directly through a consumer driven model. In either case, the state wants to ensure timely payments to agencies and individuals without any delays.

Agencies had some discretion over what EVV system they used, and some were already using EVV. DHS contracted with Sandata and providers using alternate EVV systems must be able to interface with Sandata. Providers using alternate systems reported to DHS that the certification process with Sandata was taking longer than expected. As such, Pennsylvania has requested an extension from

CMS to allow additional time for these systems to go through the necessary testing with Sandata and become integrated to feed EVV data to the DHS aggregator.

If approved by CMS, the extension will allow DHS to extend the soft launch period and implement a tiered compliance structure before the denial of payments. Since the exemption has not yet been approved, providers are still required to begin using EVV by January 1, 2020. DHS expects a denial or approval from CMS by the end of this year.

DHS will update stakeholders on the Good Faith Effort Exemption request response from CMS once it is received. All questions about EVV should be directed to the state's resource account at RA-PWEVVNotice@pa.gov

CMS Extends Eligibility For Equitable Relief For Medicare Part B Enrollment Delays And Penalties

Although equitable relief for Marketplace enrollees who mistakenly delayed enrolling in Medicare Part B has been available for some time, the federal government recently announced it would allow people who become eligible for Medicare Part A through June 2020 to seek this relief. This process has been available to people who became eligible for Medicare Part A since July 2013. Equitable relief allows those who delayed enrolling in Medicare Part B when they became eligible because they were already enrolled in a Marketplace plan to enroll in Part B outside of normal enrollment periods and avoid or reduce a late enrollment penalty under certain circumstances. For more information about this change, see the CMS factsheet, [here](#).

In addition to this process, the federal government will increase outreach efforts to Marketplace enrollees. Starting in December 2019, mailings will be sent to all Marketplace enrollees who will turn 65 within the next month about the importance of enrolling in Medicare Part B. Medicare enrollment communications have also been updated with additional information about the risks of continuing Marketplace coverage and delaying Medicare Part B enrollment after becoming Medicare eligible.

As a reminder, equitable relief can be requested at any time through your local Social Security office. People who have questions or need help applying for equitable relief are encouraged to contact APPRISE at 1-800-783-7067.

Public Charge Updates

In our last article, we provided information on the new Public Charge rule, which was scheduled to take effective October 15, 2019. We are happy to report **the new rule did not take effect**. Various lawsuits were filed and on October 11, 2019 a New York court ruled that the public charge rule would not take effect while any court case was pending because of the potential harm it would cause the individuals receiving the public benefits. This case will continue to make its way through the court system, but for now, the rules applying to the public charge test within the United States have not changed.

Everyone should continue to utilize their Medicaid and other public benefits and to seek health care treatment without fear. Healthcare providers should not ask for your immigration information or require you to show a photo ID in order 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.

It is important to remember 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>.

PHLP Launches VOCA Program

This fall, PHLP launched its VOCA (Victims of Crime Act) program, thanks to a grant received from the Pennsylvania Commission on Crime and Delinquency. The VOCA initiative will focus on assisting victims of crime navigate the complex Medicaid system to secure health care and long-term services and supports (which includes home aide services, assistive technology, medical equipment, home adaptations, and job coaching). PHLP's VOCA program is especially focused on helping victims who acquired life-long disabilities as a result of their criminal encounter (e.g., victims of shootings or drunk driving). PHLP will accept individual referrals from victim service organizations and social services agencies throughout the commonwealth and educate individuals and organizations about how Medicaid can secure healthcare for victims and survivors of crimes.

For more information or for a presentation on the VOCA program, please contact Asha Ramachandran, Esq., VOCA Program Manager, at ARamachandran@phlp.org

Victims/Survivors of crimes may call PHLP's Helpline at **1-800-274-3258** or email us at staff@phlp.org to complete an intake.