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In This Issue

Community HealthChoices-SW Starts January 1st

Community HealthChoices (CHC), Pennsylvania's new Managed Long Term Services & Supports Program, will begin in the 14 county Southwest region on January 1st. The new program will affect over 80,000 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.**

Nearly half of the affected population chose a CHC plan for themselves by the initial enrollment deadline of November 13th. The rest were auto-assigned to one of the three CHC plans available: Amerihealth Caritas, PA Health & Wellness or UPMC Community HealthChoices. Confirmation/assignment letters have been sent to those moving to CHC. These consumers should also receive their CHC plan ID cards and Member Handbooks at the end of the month.

As a reminder, consumers in the Southwest region still have time to make a CHC plan choice. The Department of Human Services (DHS) has stated that as long as a CHC participant chooses a plan **by December 29th**, they will be enrolled into that plan starting January 1st.

Accessing Health Care Services or Treatment

Most people (over 90 percent) going into CHC are "dual eligibles" who have Medicare as well as Medicaid health insurance coverage. **Their Medicare coverage and benefits do not change under**

CHC and Medicare continues to be their primary insurance. When dual eligibles go get health care services they must show their Medicare card, their CHC plan card, **and** their ACCESS card.

Physical Health Services

For dual eligibles, most of the health care services they get are covered by Medicare. This includes doctor's visits, lab work, diagnostic tests, and durable medical equipment. The physical health provider will bill Medicare first and then the CHC plan. The Medicare provider must be enrolled in the Medicaid program but need not be in the CHC plan network to be paid by the plan.

If the dual eligible participant is trying to get a service that is **not** covered by their Medicare card (for example, dental care), their CHC plan will be their only coverage. For these services to be covered, consumers must go to providers within the CHC plan network and follow any other rules the plan has for accessing care in order for the plan to cover the service.

For people moving into CHC who are not on Medicare, the CHC plan will be their only health care coverage. These individuals must go to providers within the CHC plan network and follow the plan's rules for accessing care in order to have the service covered by the plan.

Behavioral Health Services

Behavioral health coverage is carved out from CHC, so everyone going into CHC will receive their Medicaid behavioral health coverage through their county's behavioral health plan. This will be new to people who have been in the Aging Waiver and to nursing home residents. The behavioral health plans will send these new members a Welcome letter and a Member Handbook early in January.

If the CHC participant accessing behavioral health services is a dual eligible, the provider will bill Medicare first and then the behavioral health plan. For services covered by Medicare, the Medicare provider must be enrolled in the Medicaid program, but need not also be in the behavioral health plan network to get paid. If the dual eligible participant is trying to access a service **not** covered by Medicare (for example, intensive outpatient drug & alcohol services or mobile mental health treatment), their behavioral health plan will be their only coverage and so they must go to providers within their plan's network and follow any other rules the plan has in order for their plan to cover the service.

For those CHC participants who are not on Medicare and who only have Medicaid, **the behavioral health plan will be their only coverage for behavioral health care**. These individuals must follow the plan's rules for accessing care, such as going to providers in the behavioral health plan's network, in order to have the service covered by the plan.

Accessing Home and Community-Based Services

All those in the Southwest region currently in the Aging, Attendant Care, and Independence Waiver programs are moving to CHC at the beginning of 2018. These Waiver programs will no longer exist in

Southwestern PA after December 31, 2017. At the same time, individuals determined to meet the nursing facility level of care who had been in the OBRA Waiver are also moving to CHC. Starting January 1st, the person's CHC plan will be responsible for covering and paying for all of their Waiver services.

In the transition to CHC, these individuals have the protection of a 180 day continuity of care period. That means their CHC plan must cover **all** of their existing Waiver services and allow them to use their current Waiver providers until June 30, 2018. After that period, the CHC plan can require their members use Waiver providers that are "in-network" with the plan. The plan could also revisit the person's service plan and decide to reduce, change or terminate a service. If this happens, the individual can appeal the plan's decision. Check PHLP's website in upcoming weeks to see a fact sheet about consumer's appeal rights under CHC!

IF CHC participants need new or additional long term care services and supports after January 1st, they will need to contact their service coordinator. The service coordinator will work with the CHC plan to assure the person is assessed and the service plan is updated to obtain coverage for the additional services needed.

Accessing Nursing Home Care

Beginning January 1st, the CHC plans are taking over payment for nursing home care that had previously been the responsibility of the state. For those already in a nursing home when CHC starts, their CHC plan must continue to pay the nursing home for their care as long as the resident wants to stay in that home and continues to need the nursing home level of care. This is true even if the nursing home is not in the CHC plan's network. CHC participants who are determined to need nursing home care **after January 1st** will need to go to a home within their CHC plan's network in order for the plan to cover their care.

Resources for Help with CHC

If people are having problems with their CHC plan, accessing providers, or getting their needs met under this new program, they can contact **OLTL's Participant Helpline at 1-800-757-5042.** In addition, consumers can contact:

- **APPRISE** (1-800-783-7067) – for help with questions or concerns about Medicare coverage or about how Medicare works with CHC.
- **PHLP's Helpline** (1-800-274-3258) – for help with problems getting care under CHC or understanding CHC coverage and consumers' rights when accessing care or services under CHC.

Start of Medicaid "Ordering, Referring, or Prescribing" Rule on January 1st Should Not Disrupt Care

State Medicaid officials announced at a mid-December public meeting that the "Ordering, Referring, or Prescribing" (ORP) enrollment rule that takes effect for Medicaid managed care plans on January 1st, 2018 should not result in disruptions to care or claims being denied. The ORP rule requires that for Medicaid to pay for a service, it must be ordered, referred, or prescribed by a Medicaid enrolled provider.

The state was instructed by the federal government to only apply the rule, in the context of managed care, to providers who are "in-network" with the Medicaid managed care plan. Because Pennsylvania already requires its physical and behavioral health managed care plans to use only Medicaid-enrolled providers in their networks, state officials anticipate little, if any, impact on consumers enrolled in Medicaid managed care.

The federal government's new interpretation of the ORP rule updates the information we provided in our September 2017 newsletter and alleviates the concerns raised in that article about the rule's impact on consumers who have other primary insurance in addition to Medicaid. If someone in Medicaid managed care sees a provider who takes their primary insurance but is not in their Medicaid plan's network, their Medicaid plan should continue to cover medications prescribed by this out-of-network provider because the ORP rule does not apply in this context.

At least one physical health HealthChoices managed care plan mailed notices to its members informing them that implementation of the ORP rule would require the plan to no longer cover a prescription or service the members were receiving. Under the change in policy described above, this message is no longer accurate; the managed care plan will reach out to its members who were sent this notice to issue a retraction.

State policymakers expect future guidance from their federal counterparts further clarifying how the ORP rule applies to Medicaid managed care. Providers who see patients with Medicaid are still strongly encouraged to enroll in the Medicaid program, both for reimbursement and program integrity purposes, and also to avoid any "downstream" barriers in care for their patients. Providers can find more information about enrolling in Medicaid here.

Consumers whose Medicaid managed care plan denies coverage of a medication or health care service because the provider who ordered, referred, or prescribed the service is not enrolled in Medicaid are encouraged to call PHLP's Helpline at 1-800-274-3258 for assistance.

Reminder about Social Security COLAs and Medicaid Eligibility

In 2018, people receiving monthly Social Security benefits will receive a cost-of-living adjustment (COLA) that will slightly increase the amount of their monthly benefit check. Sometimes, this small increase can cause people to go over the income limit for their Medicaid benefits.

We wanted to remind our readers that Medicaid caseworkers should **not** count the COLA increase as income **until the second month after the 2018 Federal Poverty Income Guidelines** are published for the Medicaid eligibility categories listed below:

- Healthy Horizons
- Medical Assistance for Workers with Disabilities (MAWD)
- Medicare Savings Program (Medicare "Buy-In")
- Home and Community-Based Services Waivers
- Nursing Home

The Federal Poverty Income Guidelines are usually updated and published in late January or February each year. This means that the earliest Medicaid should start counting someone's Social Security increase would be March if the guidelines are published in January. If the guidelines are not published until February, Medicaid should count the COLA starting in April. See Medical Assistance Eligibility Handbook Section 319.62 and Section 372.3 for more information on this policy.

If someone's Medicaid is terminated based on their increased Social Security benefit before the timeline described above, she should call the Pennsylvania Health Law Project Helpline 1-800-274-3258. We can help determine if the decision was appropriate and discuss how to appeal the decision quickly to avoid a loss of benefits.

Medicare Announces 2018 Part A and Part B Costs

The Medicare program recently announced the 2018 costs for Medicare Part A and Part B. These costs take effect January 1, 2018.

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 that have to buy Part A, the monthly premium in 2018 can be as much as $422.

- **Hospital Stay**: The inpatient deductible is $1,340 per benefit period. If someone is in the hospital longer than 60 days, their cost-sharing will be: $335/day for days 61-90 and $670/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 $167.50.

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. Most people have their Part B premium deducted from their monthly Social Security check. 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".

  In 2018, the standard premium will be $134/month. This will apply to people who:

  * are new to Medicare in 2018;
  * get billed for the Part B premium instead of having it deducted from their Social Security check; or
  * lose their Medicare Savings Program (Buy-In) help in 2018.

  People who were on Medicare before 2017 ***and*** who have had their Part B premium automatically deducted from their monthly Social Security check will have premium increases based on the 2018 cost-of-living adjustment to their Social Security benefits. These people will likely see no increase in the amount of Social Security deposited into their account next year because that cost of living adjustment will instead be applied to their 2018 Medicare premium.

  Higher income Medicare beneficiaries will pay a monthly premium that is significantly higher than the standard premium amount. More information about this can be found here.

- ***Other Part B Costs in 2018:*** The annual deductible will be the same as it is currently- $183. 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 coinsurance amounts described on the previous page. Those in a Medicare Advantage plan pay the deductibles, coinsurance, and copays set by the plan. Dual eligibles with Medicare and Medicaid insurance use their Medicaid coverage to pay their Part A and B deductibles, coinsurance, and copays.

More information about Medicare Part A and B costs in 2018 can be found here.

Update about Medicare Summary Notices for QMBs

As we reported in our September newsletter, Medicare made system changes in early October to show providers could not bill Qualified Medicare Beneficiaries (QMBs) after billing Medicare. In addition, the Medicare Summary Notices sent to QMB consumers each quarter detailing what healthcare services were billed to Medicare were to be updated to show $0 cost-sharing owed for covered services.

The federal government recently announced that, as of December 8th, they were temporarily suspending these changes. The decision was made because the changes caused provider payment problems. Medicare hopes to reinstate the changes next year after the current problems are fixed.

One of the recent changes has **not** been suspended--providers can check a patient's QMB status through the systems they use to check other insurance coverage. For more information about QMB billing protections, see the Center for Medicare & Medicaid Services' QMB Program webpage.

Consumers who have both Medicare and Medicaid can contact the Pennsylvania Health Law Project Helpline at 1-800-274-3258 for help with billing problems.

Reminder About Part D Plan Transition Requirements

Medicare beneficiaries who have trouble getting an ongoing medication covered by their Medicare Part D plan early next year should be aware they have a right to a transition fill. Under Medicare rules, Part D plans must provide a one-time, 30 day supply of a medication within the first 90 days of the plan year to their members who have been taking a drug that is either not in the plan's formulary, or that requires prior authorization or other approval from the plan before it can be covered.

This transition requirement applies to new plan members as well as current plan members who are affected by changes to their plan's formulary from one plan year to the next. The purpose of the one-time supply of medication is to allow time for the prescribing doctor to either switch their patient to a medication that is covered by the plan, or to seek authorization or a formulary exception from the plan. Those who qualify for a Special Enrollment Period (including anyone who is a dual eligible or who receives Extra Help) also have the option of changing their Part D plan to one that does include their current medications on the formulary.

Marketplace Special Enrollment Periods Can Help People Still Enroll in Coverage

Now that the 2018 Marketplace Open Enrollment Period has ended, readers should remember that consumers can still join a Marketplace plan during the year **if** they qualify for a Special Enrollment Period.

Individuals or families can qualify for a Special Enrollment Period (SEP) if they experience any of these life events:

- **Household changes within the past 60 days** – This applies if the applicant, or anyone in their household: got married; had a baby; adopted a child; placed a child in foster care; or got divorced or legally separated and lost health insurance. This SEP would also apply if the death of someone in their household caused the applicant to no longer qualify for their current health plan.
- **Changes in Residence** – Anyone who had qualifying health coverage at some point during the 60 days before a change in residence can use this SEP if she/he is: 1) moving to a new zip code or county; 2) moving to the U.S. from a foreign country or U.S. territory; 3) a student

moving to or from the place they attend school; 4) a seasonal worker moving to or from the place they live and work; or 5) moving to or from a shelter or other transitional housing.

- **Loss of qualifying health coverage** in the past 60 days or expecting to lose coverage in the next 60 days. These scenarios include: losing job-based coverage; losing individual coverage from a plan or policy purchased outside the Marketplace; losing eligibility for Medicaid, CHIP, or Medicare; or losing coverage through a family member.

- Other life circumstances may also qualify someone for a SEP :

  * Becoming newly eligible for Marketplace coverage because the person became a U.S. citizen;

  * Leaving incarceration;

  * AmeriCorps VISTA members starting or ending their service.

Individuals needing help determining if they are eligible for a Special Enrollment Period can contact a health care navigator. Additional information about SEPs can also be found on HealthCare.gov.

CHIP's Fate Still Uncertain

At the time this newsletter is published, the federal government has not yet reauthorized the Children's Health Insurance Program (CHIP). Over 180,000 children in Pennsylvania will lose coverage next year without action by Congress to fund the program.

At the state level, the General Assembly passed, and Governor Wolf signed, legislation reauthorizing the state CHIP program for another two years. Despite the good news at the state level, the CHIP program remains in jeopardy without reauthorization.

Letters were mailed to families by the CHIP plans in mid-December alerting them that Pennsylvania's program will end in the first quarter of 2018 unless Congress renews federal funding. A definitive closing date for the program has not been announced. This letter, including Frequently Asked Questions, can be viewed on the CHIP website.

Federal reauthorization appears less than certain before the end of the year. There has been some discussion of postponing reauthorization until January and including stop gap funding in a Continuing Resolution before Christmas. At the time of this writing, the amount of the stop gap funding that may be approved is unknown and might not be enough sustain the CHIP program in Pennsylvania beyond the end of January.

We'll continue to keep readers updated about the future of Pennsylvania's CHIP program.

Wishing You Health & Happiness This Holiday Season & In the New Year

As 2017 draws to a close, PHLP thanks everyone whose support has helped us provide assistance on health-related matters to 4,800 vulnerable Pennsylvanians. This year, we helped individuals gain or keep Medicaid coverage, restored skilled nursing services for children with disabilities after their Medicaid plan denied these services, and offered counsel and advice to help older adults and people with disabilities in Southwestern PA understand the new Community HealthChoices program.

The services we obtain for our clients are important to their well-being, and provide peace of mind: the kind of peace we wish for anyone who needs medical care. It is a privilege to do this work. Please consider us when you are making any year-end contributions to charitable organizations and help us continue to advocate for the most vulnerable Pennsylvanians. Your support makes our work possible. Donations can be made by mail or by using our secure online form. We wish you good health, and hope you will continue to stand for healthcare access in the New Year!

Our Mission

Founded in the mid-1980s and incorporated in 1993, PHLP protects and advances the health rights of low-income and underserved individuals. Our talented staff is passionate about eliminating barriers to health care that stand in the way of those most in need.

We seek policies and practices that maximize health coverage and access to care, hold insurers and providers accountable to consumers, and achieve better outcomes and reduce health disparities.

PHLP advances its mission through individual representation, systemic litigation, education, training, and collaboration.

You can help

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