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In This Issue

CHC Notices and Enrollment Info Coming Soon to Those Impacted

Over the upcoming weeks, people in Southwestern PA who will be moving to Community HealthChoices on January 1st should be on the lookout for letters informing them about this new program followed by enrollment packets. These mailings are described in more detail below. In addition, between October 11th and November 3rd, the state is holding 39 meetings across the Southwest region where participants and their family members can go to learn more about Community HealthChoices (CHC). All those moving to CHC have been sent information about these meetings. The full schedule of these community meetings is available here. Registration is required because each location has limited space. Please share this information with any consumers and/or their family members who may want to attend!

Upcoming Mailings

Starting September 25th, "pre-transition" letters are being mailed to those moving to CHC. These letters will be tailored to the different groups of people who will go into CHC:

1) Dual eligibles, age 21 and older, who have both Medicare and Medicaid (also called Medical Assistance in Pennsylvania) and who do **not** get long term care services through Medicaid.

2) Adults age 21 and older in the Aging, Attendant Care, CommCare, and Independence Waivers. Adults in the OBRA Waiver who were recently assessed and determined "nursing facility clinically eligible" will also move to CHC.

3) Adults in nursing homes where Medicaid is paying for their care.

The pre-transition letter will be followed by an enrollment packet that will be sent by the state's Independent Enrollment Broker. The packet will include enrollment instructions and information about the three CHC plans consumers have to choose from: AmeriHealth Caritas, PA Health & Wellness, and UPMC CommunityChoices. People have until **November 13, 2017** to enroll in a CHC plan for coverage starting January 1, 2018. Those who do not make a choice by that date will be auto -enrolled into a plan by the state. It is important to remember that whether consumers choose their plan or are auto-enrolled by the state**, they can change their CHC plan at any time.**

Copies of the pre-transition letters and other mailings can be viewed at www.healthchoicespa.com. From that website, select "Information on Services" and then "Community HealthChoices" to see the link to the communications being sent to CHC participants.

Other CHC Updates

Since our last newsletter, the federal government has approved Pennsylvania's Waiver applications to create and implement Community HealthChoices. One Waiver (1915b) allows the state to operate CHC as a managed care program. The other Waiver (1915c) allows the state to offer home and community-based services to older adults and people with physical disabilities through Community HealthChoices.

The state is working with the three CHC plans to determine if they are ready to start providing coverage as of January 1, 2018. The plans continue to develop their medical provider network as well as their network of long term services and supports providers that include home care companies, medical equipment and supply companies, and nursing homes. Although the official deadline for determining whether or not the plans are ready to move forward with providing coverage was set for September 30, 2017, the state has unofficially determined the plans are ready.

More information about Community HealthChoices can be found at www.healthchoicespa.com.

Get Ready for the Open Enrollment Period for Medicare Advantage and Part D Drug Plans

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, 2018. 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 2018. 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.

If a Medicare plan will **not** continue in 2018, enrollees should receive notice in early October that their plan is ending December 31st. Beginning October 1, 2017 insurance companies are allowed to start marketing their 2018 plans and Medicare's website, www.medicare.gov will show 2018 plan

information. Click here to see a Medicare publication about what activities are and are not allowed by agents or brokers who enroll people into Medicare plans. Medicare's complete marketing guidelines can be found here.

Because the 2018 Medicare Advantage and Part D plans have not yet been announced at the time this newsletter was published, we will report on the plans Pennsylvanians will have to choose from in our October Newsletter. We can, however, report on the 2018 Medicare Part D Prescription Drug costs.

Medicare Part D Costs for 2018

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 2018:

- The plan's monthly premium (the national average premium for a basic drug plan will be $33.50);
- An annual deductible of **$405;**
- During the initial coverage period, a **25%** co-pay for each covered prescription until the person's total drug costs reach **$3750**;
- During the coverage gap (often referred to as the "doughnut hole"), a person will pay **35%** of the cost of brand-name drugs and **44%** of the cost of generics (plus a small dispensing fee) until the consumer's total out-of-pocket expenses reach **$5,000**; and
- During the catastrophic coverage period, a co-pay of **$3.35** for generics and **$8.35** for brand name drugs, or a 5% co-pay, **whichever is greater**, for the rest of the year.

Part D Costs for Those Receiving Extra Help from Medicare

Anyone who qualifies for the **full extra help** from Medicare (this includes all those who have Medicare and who receive **any** benefit from Medicaid), will have the following costs in 2018:

- $0 premium (as long as she enrolls in a Part D plan that provides standard benefits and charges a premium below the 2018 Extra Help Benchmark amount of $37.18)
- Small co-pays for their prescription medications:
    - $1.25/generics and $3.70/ brand names (if income is less than 100% FPL) **or**
    - $3.35/generics and $8.35/ 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 home **or** through a Home and Community-Based Services Waiver program.

Those beneficiaries who qualify for **partial extra help** in 2018 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 **$83;**
- 15% co-pays on all of their medications until they reach total out-of-pocket expenses of **$5,000;**
- During the catastrophic coverage period, co-pays of **$3.35**/generics and **$8.35** /name brands for the rest of the year.

Remember! A Medicare beneficiary who receives **any** amount of Extra Help from Medicare has no coverage gap (doughnut hole) no matter what Part D plan she joins!

Stay tuned to our next newsletter for more information about Medicare in 2018. Medicare beneficiaries who need help reviewing their plan options for next year are encouraged to call APPRISE at 1-800-783-7067.

Medicare Summary Notice Is Changing for Qualified Medicare Beneficiaries

Beginning in October, Medicare will add important information to the Medicare Summary Notices that are sent to consumers known as "Qualified Medicare Beneficiaries". Qualified Medicare Beneficiaries (hereinafter QMBs) are individuals on Medicare with low income and limited assets. These individuals qualify for Medicaid to pay their Medicare Part B monthly premium and to cover their Medicare Part A and Part B deductibles, co-insurance and co-pays. In Pennsylvania, the QMB program is also called "Healthy Horizons".

> Qualified Medicare Beneficiaries (QMBs) have income below 100% of the federal poverty level. The figures for 2017 are:
>
> - $12,060/year for a single person
> - $16,240/year for a married couple

Under longstanding Medicare law, Medicare providers and suppliers are prohibited from billing QMBs for any Medicare cost-sharing for services covered under Medicare Part A or Part B and face sanctions if they do. Despite these protections, QMBs continue to receive inappropriate bills for Medicare deductibles and coinsurance.

Those on Original Medicare (using their red, white and blue Medicare card) get a Medicare Summary Notice in the mail every 3 months that lists all the services billed to Medicare. It shows what Medicare paid to the service provider and what the consumer ***may*** owe the provider after Medicare pays. Starting on October 2, 2017, the Medicare Summary Notice will include new information for QMBs about their billing protections and showing their QMB status. The notice will also show Medicare cost-sharing owed is $0 for the service provided. Consumer advocates are hopeful that this new information will remind QMBs that they are **not** responsible for Medicare cost-sharing and help stop Medicare providers from wrongly billing QMBs for these costs.

Medicaid "Ordering, Referring, or Prescribing" Rule starts January 1st for Managed Care

Under federal Medicaid law, not only does a provider of services need to be enrolled in Medicaid but the medical provider that orders, refers, or prescribes the services must also be enrolled in the Medicaid program for Medicaid to pay for that service. This rule has already been in effect for the state's Medicaid fee-for-service system (i.e., the ACCESS card) since September 25, 2016. Starting January 1, 2018, this rule will also apply to Medicaid managed care plans, including the Community HealthChoices plans that will begin operating next year.

What Does this Mean for People Covered by Medicaid Managed Care?

Medicaid consumers in physical health and behavioral health managed care plans should check with their providers who order, prescribe, or refer to services to ensure they are enrolled in the state's Medicaid program or will be by January 1, 2018. Managed care plans should also be mailing letters to members informing them if they have recently received a service that has been ordered, referred, or prescribed by a provider who is not enrolled in Medicaid.

After the rule takes effect, a Medicaid consumer in a managed care plan can be denied services **if** the services were ordered, referred or prescribed by a non-Medicaid enrolled provider. For example, if a Medicaid recipient is prescribed a medication by a non-Medicaid enrolled doctor, the plan will deny the claim when the pharmacy bills for the medication.

These scenarios will likely occur when a Medicaid consumer also has primary insurance such as Medicare or a commercial insurance plan through an employer. For example, a child with autism might have primary insurance through a parent's employer and have Medicaid. If that child is evaluated by a psychologist who accepts the private insurance but is not a Medicaid enrolled provider, any mental health services recommended by the psychologist will **not** be paid for by Medicaid. This will cause a delay in that child receiving services as the family would have to begin again with a new evaluation from a Medicaid enrolled psychologist. Or, if the mental health service is provided, the provider will not be paid.

Another situation where this rule could cause problems for people accessing care they need involves individuals released from jails, prisons, substance use disorder treatment facilities, psychiatric facilities, nursing homes, rehabilitation programs and the like. If a non-Medicaid provider in any of these facilities writes a prescription, or otherwise refers someone with Medicaid for any treatment service, the individual's Medicaid plan will not pay for the needed medication or service.

What Does this Mean for Providers?

Providers in the Medicaid managed care system will be denied payment if they provide a Medicaid patient with a service that has been ordered, referred or prescribed by a non-Medicaid enrolled

provider. For example, if a non-Medicaid enrolled physician prescribes a wheelchair for her patient, the durable medical equipment supplier that provides that patient with the wheelchair will **not** be paid by the Medicaid managed care plan.

The provider who will be delivering the service, supplies, or equipment must include the ordering, referring or prescribing provider's National Provider Identifier (NPI) on the claim submitted to Medicaid. The Office of Medical Assistance Programs (OMAP) or the patient's Medicaid managed care plan will use the NPI to validate the provider's enrollment in the Medicaid program before paying the claim. Medical Assistance Bulletin 99-17-02 explains this process in more detail as well as how providers enroll into the state's Medicaid program.

Readers who are interested in more information about this rule can find the US Department of Health and Human Services regulation at 42CFR 455.410. Medical Assistance Bulletin 99-16-07 provides more information about implementation of the rule in the Medicaid fee-for-service system. Providers can find more information about enrolling in Medicaid here.

THIS RULE WILL ALSO APPLY TO PROVIDERS in the Childrens Health Insurance Program (CHIP): CHIP providers must be enrolled in the state's Medicaid program by January 1, 2018. This does not mean that CHIP providers must now accept Medicaid patients, but they do have to enroll with Medicaid to provide, refer, order, or prescribe services to CHIP patients and receive payment from a CHIP plan. A notice to all CHIP providers with details can be found on the CHIP website.

CHIP Faces Reauthorization Deadline of September 30th!

Pennsylvania's Children's Health Insurance Program (CHIP) needs to be reauthorized at both the federal and state levels in order to continue providing coverage to 176,000 children across the state. Federal CHIP authorization ends on September 30, 2017 while the state's authorization ends December 31, 2017.

Federal CHIP Reauthorization Efforts

On September 18th, Senators Orrin Hatch and Ron Wyden, co-chairs of the Senate Finance committee, introduced proposed legislation to extend the CHIP program for five years. Senator Hatch, along with Senator Ted Kennedy, crafted the initial bipartisan legislation that created the CHIP program

twenty years ago. The recent proposal continues federal funding for CHIP although the amount would be reduced in future years starting in 2021. The proposal prohibits states from restricting eligibility criteria next year, but would allow states to restrict eligibility and only cover families with income below 300% of the federal poverty level (currently $73,000/year for a family of 4) starting October 1, 2019. Pennsylvania allows families with income above this level to buy CHIP for their children, but they must pay the full cost of premiums for CHIP coverage. More information about the federal CHIP proposal can be found here.

Congress will **not** pass CHIP legislation before the September 30th deadline. At the time this newsletter is published, the House Energy and Commerce Committee is set to review the proposal during the first week of October. It is unclear at this time how long it will take for Congress to pass legislation needed to extend the CHIP program.

State CHIP Reauthorization Efforts

Pennsylvania's CHIP program is authorized through December 31, 2017. However, Act 84 of 2015 includes language that ends the program 90 days after the end of federal funding. Since federal legislation will not be passed by September 30, Pennsylvania's program could end December 29, 2017. Families with kids covered through CHIP would receive notice at least 30 days before the program ends. Pennsylvania's General Assembly is unlikely to act on reauthorization of CHIP without a guarantee of federal funds. Once Congress passes a CHIP reauthorization bill as it is expected to do eventually, the General Assembly would have to pass its own reauthorization legislation before December 31, 2017 to keep the program running smoothly.

For more information, contact Ann Bacharach, abacharach@phlp.org or 215-625-3596.

PA ABLE Accounts Allow People with Disabilities to Save Money without Jeopardizing Their Public Benefits

In April 2017, Pennsylvania's Treasury Department launched the ABLE Savings Program which allows people with disabilities that started before age 26, and their families, to save money in a state-sponsored savings account without jeopardizing eligibility for many public benefits programs. As noted in our March newsletter, individuals may deposit up to $14,000 per year in an ABLE account. The entire balance of an ABLE account is **not counted** toward the resource limit to qualify for programs such as Medical Assistance (also called Medicaid), Home and Community Based Services Waivers, Temporary Assistance for Needy Families (TANF), and the Supplemental Nutrition Assistance Program (SNAP).

Additionally, withdrawals from ABLE accounts are also not counted as a resource or as income, so long as the withdrawn money is spent on Qualified Disability Expenses (QDE). Qualified expenses include any expenses related to the individual's disability which are made for the benefit of the individual- such as education, job training and support, assistive technology and personal support services, health care, legal fees, housing, and more.

These programs consider income as well as resources to determine who qualifies. Any increase in the value of an ABLE account due to interest or dividends is **not** treated as income when determining eligibility for these programs. In July 2017, DHS released Operations Memorandum #17-07-01 which provides guidance to county caseworkers on how to apply these income and resource rules when reviewing applications and renewals for these programs.

PHLP is pleased that Pennsylvania has taken this important step in protecting public benefits for the thousands of individuals with disabilities who have, up until now, been largely discouraged from saving money due to fear of losing their public benefits. Readers should also know that the Social Security Administration will not count up to $100,000 in an ABLE account as a resource when determining eligibility for Supplemental Security Income (SSI) benefits.

For more information about setting up an ABLE account, visit PAABLE.gov or call 1-855-529-ABLE (2253). Please contact PHLP's Helpline at 1-800-274-3258 for assistance if a County Assistance Office does not follow their policies about ABLE accounts or with further questions about how ABLE accounts impact eligibility for Medical Assistance and Waiver programs.

Latest Effort to Repeal the Affordable Care Act Fails Again!

On September 26th, Senate Republican leaders announced they would not hold a vote on the latest proposal to repeal the Affordable Care Act, the Graham-Cassidy bill, because they did not have enough support from Republican Senators for it to pass. This is the third failed attempt to repeal the Affordable Care Act through proposals that undermined protections for people with pre-existing conditions and drastically changed and cut federal funding for Medicaid. Senate Republicans were hoping to pass legislation by September 30th through a budgetary process that allows legislation to pass with a simple majority (51 votes) instead of 60 votes needed otherwise.

Numerous stakeholders publicly opposed the Graham-Cassidy bill. On September 21st, the National Association of Medicaid Directors issued a statement sharply criticizing the bill as unworkable and deeply destructive. On September 23rd, groups representing doctors, hospitals, and health insurance companies issued an open letter condemning the bill. Individuals with disabilities and other pre-existing conditions attended a hearing held by the Senate Finance Committee on September 25th to oppose the bill while other consumers and their advocates held rallies throughout Pennsylvania to

voice their opposition. Acting Secretary of the Department of Human Services Teresa Miller provided testimony at the hearing raising concerns about the bill's substantial cuts in federal funding and Pennsylvania's ability to respond and continue to cover the vulnerable populations that depend on programs like Medicaid.

Also on September 25th, the Congressional Budget Office (CBO) released a report with the preliminary analysis of the Graham-Cassidy bill. Following the release of this report and its finding that millions would lose coverage under the bill, enough Senators opposed the legislation to prevent the Senate from holding a vote on it.

Before the Graham-Cassidy bill was introduced, a bipartisan group lead by Republican Senator Lamar Alexander of Tennessee and Democratic Senator Patty Murray of Washington had been working on health care legislation to stabilize insurance markets and hold down premiums over the next couple of years. Both said they now hope to resume those efforts.

PHLP remains committed to closely monitoring any health care developments with a particular eye on those that impact our clients. As always, we will continue to report on proposed changes for our readers.

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.

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