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DHS Changes Start Dates for HealthChoices Plans

Earlier this month, the Department of Human Services (DHS) announced new start dates for the physical health managed care plans chosen to operate under HealthChoices, Medicaid's managed care program. Initially, the plan changes were to go into effect in June 2017; but now, the start dates will be phased in across the state with Southwest and Northwest being the earliest regions with a start date of January 2018.

As we reported in our January newsletter, DHS recently completed a bidding process for HealthChoices physical health plans and chose to contract with six managed care companies. Two companies that currently have contracts with the state were not chosen to continue as HealthChoices plans. Some plans that were chosen will operate in fewer HealthChoices regions, while others were approved to operate in new regions. One company that was selected is completely new to Pennsylvania. HealthChoices physical health plans cover 2.2 million individuals with Medicaid across Pennsylvania. Approximately 700,000 people will have to choose new plans as a result of the changes.

DHS officials cited two reasons for changing the start date for the plan changes: 1) to allow time to resolve the bid protests filed by insurance companies who submitted bids but were not ultimately chosen and 2) to address consumer concerns about the number of people impacted by the plan changes and concerns about transitioning to new providers by phasing in the start dates for each region across the state.

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The new HealthChoices implementation schedule is as follows:

HealthChoices Region	Physical Health Plan Start Date
Southwest	January 2018
Northwest	January 2018
Northeast	March 2018
Southeast	July 2018
Lehigh/Capital	January 2019

Impact of Delaying the HealthChoices-Southwest Start Date

As a result of delaying the start date for HealthChoices plans, these changes will begin in the Southwest region at the same time Community HealthChoices (CHC), Pennsylvania's brand new managed long term services and supports program, is being implemented in the region (see the next article for more info about CHC). Although the population of people staying in HealthChoices is different from the population that will be going into Community HealthChoices, consumer advocates are concerned about these two major changes starting at the same time.

The potential for confusion and misunderstanding, especially among providers and other professionals that work with both populations, is extremely high. The program names are very similar, some insurance companies will offer plans under both programs and it is not yet clear how different and distinguishable the plan names and/or insurance cards will be under CHC versus HealthChoices, and consumers may have friends and family members getting notices that are different from the notices they get yet not realize the distinction.

The Consumer Subcommittee of the Medical Assistance Advisory Committee is urging the Department to be mindful of these problems and take action to minimize the confusion-such as by using different colored paper for the notices to distinguish between the programs and the information being presented. The numbers of people impacted by the new HealthChoices plan changes are significant. In the Southwest region alone, approximately 86,000 people will have to pick a new plan before January 1, 2018 or they will be auto-assigned to a plan. This is 18% of the total HealthChoices-Southwest population.

We'll continue to update readers about the HealthChoices plan changes as developments occur.

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Community HealthChoices Update

In April, the Office of Long Term Living (OLTL) begins its readiness review process with the three insurers selected to be Community HealthChoices (CHC) plans: AmeriHealth Caritas, Pennsylvania Health and Wellness, and UPMC. The insurers have been given the review criteria and benchmarks they must meet. OLTL is also creating a Q&A for the plans to address common questions raised. Throughout this process, OLTL will work closely with the Department of Health, the entity responsible for certifying that each plan has an adequate network of providers within each region.

Written Notices to Consumers

Notices and letters will be going out to different groups within the CHC population over the coming months with information about how CHC will affect them. Consumers in the Southwest region who will be going into CHC on January 1, 2018 will receive a general flyer on CHC in the mail this summer. Beginning in September, more detailed mailings will be sent out telling consumers about CHC, notifying them of their plan choices, and providing deadlines by which they must act or be auto-assigned to a plan.

OBRA Waiver Participants

Those currently in the OBRA Waiver will soon be receiving a notice telling them they are going to have their level of care reassessed. Those age 21 and older in OBRA who are determined to be "nursing facility clinically eligible" will eventually be transitioned to CHC while the rest remain in the OBRA waiver. The first notices will go out in May to 473 OBRA Waiver participants in the Southwest region. OBRA Waiver participants in other zones will be notified about the reassessments later this year.

COMMCARE Waiver Participants

The state has decided to use the COMMCARE Waiver and amend it to become the "global CHC Waiver" to submit to the federal government in order to gain federal approval for CHC. As a result, the existing COMMCARE Waiver will end on December 31st. All COMMCARE Waiver participants in the Southwest region will be transitioned into CHC on January 1, 2018.

The 770 COMMCARE Waiver participants residing in other regions will receive a notice in October informing them they are being temporarily moved into the Independence Waiver until CHC is implemented in their region. The Independence Waiver is being amended to include COMMCARE Waiver services such as residential habilitation services and day habilitation services. As a result, this move should not cause any disruption in services for individuals transitioning from COMMCARE to the Independence Waiver while waiting for CHC to start in their area.

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Where to Get More Information About CHC

As a reminder, the implementation timeline for CHC is as follows:

- Phase 1 (Southwestern PA): January 1, 2018
- Phase 2 (Southeastern PA): July 1, 2018
- Phase 3 (remainder of the state): January 1, 2019

OLTL is continuing with Third Thursday Webinars on CHC. Registration for the webinars and additional information can be found here: www.dhs.pa.gov/citizens/communityhealthchoices. Individuals who are interested in receiving e-mail updates from the Department of Human Services about Community HealthChoices can sign up by visiting listserv.dpw.state.pa.us.

Related to Community HealthChoices, OLTL is planning on releasing the Request for Proposal for a new Independent Enrollment Broker in April. Once the proposal is issued, bidders will have 45 days to respond to the Request for Proposal. The state hopes to make their selection by early July.

The new Independent Enrollment Broker (IEB) will be responsible for enrolling individuals into CHC plans and determining whether CHC participants qualify for long term services and supports. The IEB will also continue to take applications for OLTL waivers and shepherd them through the process for those living in regions that have not yet implemented CHC.

Republican ACA "Repeal and Replace" Effort Abandoned For Now

Less than a month after introducing their bill to "repeal and replace" the Affordable Care Act and promising quick passage, House Republican leaders acknowledged they lacked sufficient votes among their own caucus for the American Health Care Act (AHCA) legislation to pass and pulled it on March 24th. This stunning turn of events means that ACA repeal and the drastic changes to Medicaid that had been included in the legislation are no longer under consideration at this time.

Beyond its impact on the Health Insurance Marketplace, the repeal legislation included a number of far-reaching changes to Medicaid, including:

- Capping federal funding through a "per-capita cap," or an annual fixed allotment per-person, based on 2016 expenditures plus an inflationary measure, instead of continuing its open-ended commitment to reimburse a portion of actual state expenses;

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- Ending the ACA's enhanced federal funding for Medicaid expansion for new enrollees after 2019 and for any "grandfathered" enrollees who have a break in coverage;
- Giving states the option of imposing work requirements on many non-disabled adult Medicaid enrollees;
- Giving states the option of a block grant funding structure, whereby states would have more flexibility in deciding which populations and services their Medicaid programs would cover in exchange for a fixed amount of federal funding.

Proponents of the ACA and the Medicaid program generally decried the "repeal and replace" legislation, arguing that it would have devastating effects on poor seniors, pregnant women and children, the working poor, and individuals struggling with addiction, among other beneficiary groups that depend on Medicaid. The nonpartisan Congressional Budget Office (CBO) estimated that the bill would reduce federal funding for Medicaid by $880 billion over ten years, and cause 24 million Americans to lose their health insurance coverage (including 14 million Medicaid enrollees). Pennsylvania state officials denounced the proposed legislation as amounting to a federal funding reduction that would leave them with no choice but to cut back Medicaid enrollment, benefits, and provider rates.

Congressional Democrats and Medicaid advocates alike declared victory after House Speaker Paul Ryan conceded on March 24th that the Affordable Care Act will remain "the law of the land" for the "foreseeable future." With Congress now turning its attention towards tax reform, the threat of new legislation undermining Medicaid in the near future appears to be past. However, the Trump Administration is likely to continue its effort to reform Medicaid through the administrative rule-making process and has already signaled that it will be flexible in interpreting existing Medicaid rules and willing to entertain state "Waiver" requests (such as for work requirements) that previous administrations denied.

PA ABLE Set To Launch April 3rd

Pennsylvania will officially launch its ABLE Savings Program (PA ABLE) on April 3, 2017! As of this date, children and adults with significant disabilities that started before age 26 (or their parent or guardian if the individual is a minor child or an adult without the legal capacity to enter into a contract) can establish state-sponsored investment accounts. These accounts will **not** be counted as a resource for public benefits such as Medicaid, SSI (unless over $100,000), housing choice vouchers, SNAP (food stamps), student aid or other means-tested federal programs. Also, money in the accounts will **not** be subject to federal or state tax and is protected from creditors. Up to $14,000 a year can be deposited in an ABLE account and anyone can make deposits. No lawyer is needed to set up an account- simply register with the PA Treasury Department at PAABLE.gov, and the person will

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be notified how to set up the account. Money can be withdrawn from the account for **any** purpose. However, funds withdrawn for a "qualified purpose" are not taxable. "Qualified purposes" include: education, housing, transportation, employment training and support, assistive technology, personal support services, health, prevention and wellness and funeral/burial expenses.

Since there is no trustee, money can be withdrawn by whoever set up the account, although it must be used for the individual with disabilities. ABLE accounts can be transferred to a sibling of the beneficiary **if** the sibling also has a disability. Money remaining in an ABLE account at the time of the beneficiary's death goes into the beneficiary's estate and is subject to estate recovery. That means the state Medicaid program can seek reimbursement from the estate for waiver-funded or nursing home services provided to persons age 55 and older.

Pennsylvania Treasurer Joe Torsella, U.S. Senator Robert Casey, and PA Senator Lisa Baker will celebrate the launch of PA ABLE at an event at the Capitol Rotunda in Harrisburg on April 3rd at 12:30 p.m. Those interested in attending can email info@PAABLE.gov.

More information about this program can be found at PAABLE.gov or by calling 1-855-529-ABLE (2253).

Medicaid for Former Foster Youth from Other States

Pennsylvania is pursuing a Section 1115 Demonstration Waiver from the federal government to continue to provide Medicaid to young adults who reside in PA but who aged out of foster care in a different state. The Affordable Care Act (ACA) requires states to provide Medicaid coverage to youth who were in foster care on their 18th birthday or later. These individuals qualify for Medicaid up to age 26 regardless of their income.

Initially, states were given the option of providing Medicaid coverage to their young adults who had previously been in foster care in a different state. Pennsylvania took up that option and began covering these individuals in January 2014.

However, the federal government issued a final rule last year that explained the ACA **does not** give states the option to cover those who were former foster youth in a different state. Instead, states have the option to submit a Demonstration Waiver to the federal government seeking permission to continue covering this population.

Pennsylvania will continue to cover young adults who live here now, but who were in foster care in a different state, under the Medicaid expansion category as long as the individual's income is below the limit for that category (138% FPL). The Pennsylvania Department of Human Services is also

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requesting a State Plan Amendment to allow eligibility for these young adults who have income above that limit and a Demonstration Waiver to limit the group affected by the State Plan Amendment to young adults in PA who were in foster care in another state. The stated goal of the Demonstration Waiver will be to test whether extending Medicaid coverage to this group "increases and strengthens overall coverage for former foster youth and improves health outcomes for these youth."

The state projects 30 people each year will fall into this category of young adults now living in Pennsylvania who aged out of foster care in a different state. Of these, 20 will qualify under the adult Medicaid expansion category and 10 will qualify under the demonstration program. There are currently 5 former foster youth enrolled in Pennsylvania Medicaid who aged out of foster care in another state. Pennsylvania can continue to cover these individuals while they are pursing the Demonstration Waiver.

Interested individuals can view the draft Section 1115 Demonstration Waiver here. Comments can be submitted **before April 4th** by emailing RA-OIMcomments@pa.gov. PHLP will submit comments supporting Pennsylvania's Waiver request.

Pennsylvania plans to submit the waiver request by the end of May and expects to hear back from the federal government within 90 days of submission.

State Decides to Adopt New Drug and Alcohol Assessment Tool to Ensure Access to Treatment

The Acting Secretary for the Department of Drug and Alcohol Programs (DDAP), Jennifer Smith, recently announced the state's intent to use a new assessment tool for individuals in need of substance use disorder treatment. Licensed treatment providers are currently required to use the PA Client Placement Criteria (PCPC) assessment tool for adults. DDAP plans to convert to using the nationally recognized American Society of Addiction Medicine (ASAM) tool. According to Acting Secretary Smith, this decision was made in consultation with the Governor's Policy Office and the Office of General Counsel.

One reason for the transition to a new assessment tool comes from the Medicaid Managed Care Final Rule that was issued last summer by the federal government. The final rule limits federal reimbursement for residential treatment of Medicaid recipients age 21 to 64 to 15 days in a calendar month. This rule will have a significant negative impact on Medicaid treatment for substance use disorders in the state as PA Medicaid Behavioral Health plans currently pay for various levels of residential services, often for many months, based on the clinical needs of the individual. This 15-day rule is known as the Medicaid Institutions for Mental Diseases (IMD) exclusion and prohibits the use of federal Medicaid financing for care provided beyond 15 days to most patients in mental health and sub-

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stance use disorder residential treatment facilities with more than 16 beds. The rule's intent was to ensure that states, and not the federal government, had primary responsibility for funding inpatient psychiatric treatment.

Because of the IMD exclusion in the Medicaid Managed Care Final Rule, DDAP intends to submit an 1115 Waiver request to CMS seeking permission for federal dollars to be used for residential treatment of substance use disorders. The 1115 Waiver application requires that states use the ASAM assessment tool. By converting to the ASAM tool, PA will be better-positioned to receive approval for its 1115 Waiver request.

Pennsylvania drug and alcohol treatment providers are already using the ASAM tool for adolescents. Additionally, many commercial insurance providers use the ASAM for both adults as well as adolescents, so converting to this tool will create consistency for providers and payers across the treatment system.

DDAP recognizes there will be challenges for providers and payers in this conversion from the PCPC to the ASAM tool, so they are already working on establishing a strategic plan and will include input from stakeholders to create a workable process. DDAP's goal is to fully implement the ASAM tool by July 2018.

Help for People Who Mistakenly Missed the Transition from Marketplace to Medicare Extended Until September 30th!

Individuals who had Marketplace coverage and delayed enrollment into Medicare now have until **September 30th** to ask the government for relief from Medicare late enrollment penalties **and/or** the Part B enrollment rules that would normally apply. The federal government created this opportunity after learning that many people in the Marketplace failed to enroll in Medicare when they first became eligible because they mistakenly believed that their Marketplace subsidies would continue. People who do not enroll into Medicare when they first become eligible have very limited enrollment opportunities and, as a result, if they fail to act they may experience a gap in coverage. They may also be subject to late enrollment penalties that result in them paying higher premiums when they do enroll.

Who Can Apply for Relief?

Anyone who qualified for premium-free Medicare Part A on or after March 1, 2013 but stayed in a Marketplace plan rather than enrolling in Medicare Part B can apply for relief.

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- Those who do not yet have Part B can request to both enroll in Part B and not be subject to late Part B enrollment penalties.
- Those who do have Part B but are paying late enrollment penalties can ask for relief from the penalties.
- Individuals can request relief even if they did not qualify for Marketplace premium tax credits or subsidies.

Again, **the deadline to apply for relief is September 30, 2017**! Medicare beneficiaries requesting relief will be notified by CMS of whether or not their request is granted.

Where to Get More Information?

The federal government is sending notices to people enrolled in the Marketplace who became eligible for Medicare because they turned 65. They also created a fact sheet about the help available and how to request it.

Even though notices are targeted to people eligible for Medicare based on age, younger people with disabilities who qualify for Medicare can also apply for this relief if they mistakenly stayed in the Marketplace rather than enrolling in Medicare Part B.

People who need help applying for relief are encouraged to call Pennsylvania's APPRISE Program at 1-800-783-7067.

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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