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In This Issue

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3 CHC Plans Selected; Five Plans Not Picked Pursuing Protests

At the end of August, the Department of Human Services (DHS) announced the selection of three insurance plans for its Community HealthChoices (CHC) program: AmeriHealth Caritas, a majority-owned subsidiary of Independence Blue Cross; Pennsylvania Health and Wellness, a unit of publicly traded Centene Corp.; and UPMC for You, a subsidiary of the University of Pittsburgh Medical Center. DHS selected these three plans to operate statewide once CHC is fully implemented in 2019.

Community HealthChoices is a major change for how the state pays for long term services and supports in nursing homes and in the community for older adults and for those with physical disabilities. It also changes how Medicaid coverage is provided to those who are dual eligible (on Medicare and Medicaid) The affected population totals about 420,000, almost two-thirds of whom are over the age of 60.

When fully implemented, CHC will include:

- ✓ Most dual eligibles (those with Medicare who also receive full Medicaid benefits) *and*

- ✓ Individuals over 21 who are receiving Medicaid long term care coverage and services in a nursing home or in their own home through one of the home and community-based waivers administered by the Office of Long Term Living (Aging, Attendant Care, COMMCare, Independence and OBRA*). *Note: OBRA will continue to exist to serve individuals 18-21 years old

as well as individuals who are not nursing facility clinically eligible .

Fourteen companies submitted bids to become Community HealthChoices managed care plans. After DHS announced the three plans selected, five of the insurance companies not chosen decided to pursue a bid protest. Until those protests are resolved, DHS officials have halted their readiness review process and contract negotiations with the three chosen plans. DHS officials noted that, at the present time, they still plan to follow their implementation timeframe to start Community HealthChoices on July 1, 2017 in Southwestern PA.

More information about Community HealthChoices can be found here and in previous PHLP newsletters. We will continue to keep readers updated about developments related to this new program.

Open Enrollment for Medicare and Part D Drug Plans Starts October 15th

Medicare's Annual Open Enrollment Period starts October 15th and runs until December 7th. During this period all Medicare beneficiaries can change their health or their drug plan coverage. Any changes made during the period go into effect on January 1, 2017. 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 2017. 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 to stay with their current plan or join a new plan for next year.

If a Medicare plan will not continue in 2017, enrollees should receive notice in early October that their plan is ending December 31st. Beginning October 1, 2016 insurance companies are allowed to market their 2017 plans and Medicare's website, www.medicare.gov shows 2017 plan information.
Pennsylvanians on Medicare have many plans to choose from for their health and drug coverage in 2017:

Stand-Alone Prescription Drug Plans: There are 24 stand-alone drug plans available across the state for enrollment in 2017. Premiums for the prescription drug plans range from $14.60 to $170.60 per month. All of the nine current zero-premium plans will continue to be "zero-premium" for individuals who qualify for the Full Extra Help with their Part D costs next year (click here for the 2017 list). However, only eight of the nine are available for new enrollments. Please note that one plan, Cigna-HealthSpring Rx Secure, remains under federal sanctions and cannot accept new enrollments at this time.
Medicare Advantage Plans: Residents in every county in Pennsylvania continue to have a choice of Medicare Advantage Plans. Bradford County has the fewest Medicare Advantage Plans (9) and Lehigh County has the most (39). Most, but not all, of the Medicare Advantage Plans available include drug coverage. Anyone currently in a Cigna-HealthSpring Medicare Plan can remain in that plan but Cigna is still

under sanction with the federal government and cannot accept new enrollments into any of their Medicare Advantage Plans.

Special Needs Plans for Dual Eligibles (D-SNPs): These plans only enroll individuals with both Medicare and Medicaid (dual eligibles). Except for Bradford and Franklin counties, all other counties in Pennsylvania will have at least one D-SNP available. All current D-SNPs will continue to operate in 2017; however, as we noted above, Cigna is still under federal sanctions and cannot accept new enrollments into its Cigna-HealthSpring TotalCare D-SNP. United Healthcare only offered one D-SNP in 2016 (UnitedHealthcare Dual Complete). The company is now offering a second D-SNP in 2017: UnitedHealthcare Dual Complete ONE. Humana is also offering a new D-SNP plan in 2017 called Humana Gold Plus SNP-DE.

Everyone on Medicare should review their current coverage to see if it will continue to meet their needs in 2017. Those needing help during the Open Enrollment Period can contact APPRISE at 1-800-783-7067. Stay tuned to future newsletters for additional news about Medicare in 2017.

Marketplace Sends Notices to Those with Medicare Receiving Premium Tax Credits

Starting this Fall, the Centers for Medicare & Medicaid Services (CMS) will begin to do "periodic data matching" to identity Marketplace enrollees age 65 and older who are receiving premium tax credits and who also have Medicare. These individuals will be sent a notice from the Marketplace advising them of their options and the steps to take to get the health insurance most appropriate for their situation. This periodic data matching is a result of the efforts of dozens of advocacy organizations who have been encouraging CMS to take affirmative action to help ensure people are in the correct coverage for their circumstances.

Financial assistance (i.e. premium tax credits) through the Marketplace is only available to those who meet income guidelines and who do not have "minimum essential coverage" through some other insurance. Medicare beneficiaries enrolled in Part A or a Medicare Advantage plan have minimum essential coverage and are therefore not eligible for premium tax credits through the Marketplace. Those with Medicare Part B or Part D alone are not considered to have minimum essential coverage and therefore **could** qualify for tax credits.

It is important for consumers who receive the notice to take the appropriate action, as detailed in the letter, based on their individual circumstances. Those receiving premium tax credits through the Marketplace who are not eligible for this help are subject to paying back some or all of the financial assistance they receive. Individuals enrolled in Medicare Part A but who delay enrolling in Part B may find

themselves unable to get Part B at the time they need it due to Medicare's enrollment rules. Unless they are eligible for a Special Election Period, Medicare beneficiaries with just Part A can typically only enroll in Part B during the General Enrollment Period (January 1 through March 31) with coverage that does not begin until July 1st of that year. Late enrollment in Medicare Part B may also result in an ongoing premium penalty.

Those with questions about the notices or how Medicare and Marketplace coverage impacts each other can call PHLP's Helpline at 1-800-274-3258. Individuals can also contact APPRISE at 1-800-783-7067 for help understanding their Medicare coverage and enrollment options.

Medicare Part D Costs Announced for 2017

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 2017:

- ✓ The plan's monthly premium (the national average premium for a basic drug plan will be $35.63);
- ✓ An annual deductible of **$400;**
- ✓ During the initial coverage period, a **25%** co-pay for each covered prescription until the person's total drug costs reach **$3,700**;
- ✓ During the coverage gap (often referred to as the "doughnut hole"), a percentage of the costs of their drugs (**40%** of the cost of brand-name drugs and **51%** of the cost of generics plus a small dispensing fee) until the consumer's total out-of-pocket expenses reach **$4,950**; and
- ✓ During the catastrophic coverage period, a co-pay of **$3.30** for generics and **$8.25** for brand name drugs, or a 5% co-pay, **whichever is greater**, for the rest of the year.

Part D Cost for Those Receiving Extra Help from Medicare

Anyone who qualifies for the F**ull Extra Help** from Medicare (this includes all dual eligibles who have Medicare and who receive **any** benefit from Medicaid) will have the following costs in 2017:

- ✓ $0 premium (as long as he is enrolled in one of the nine stand-alone drug plans available in 2017 that provide standard benefits and charge a premium below the Extra Help Benchmark amount of $39.45)
- ✓ Small co-pays for their prescription medications:
  - $1.20/generics and $3.70/ brand names (if income is less than 100% FPL) **or**
  - $3.30/generics and $8.25/ brand names (if income 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 2017 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 **$82;**
- ✓ 15% co-pays on all of their medications until they reach total out-of-pocket expenses of **$4,950;**
- ✓ During the catastrophic coverage period, co-pays of **$3.30**/generics and **$8.25** /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!

All Medicare beneficiaries are encouraged to review their Part D plan options for 2017. APPRISE counselors are available to help-1-800-783-7067.

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Financial assistance (i.e. premium tax credits) through the Marketplace is only available to those who meet income guidelines and who do not have "minimum essential coverage" through some other insurance. Medicare beneficiaries enrolled in Part A or a Medicare Advantage plan have minimum essential coverage and are therefore not eligible for premium tax credits through the Marketplace. Those with Medicare Part B or Part D alone are not considered to have minimum essential coverage and therefore **could** qualify for tax credits.

It is important for consumers who receive the notice to take the appropriate action, as detailed in the letter, based on their individual circumstances. Those receiving premium tax credits through the Marketplace who are not eligible for this help are subject to paying back some or all of the financial assistance they receive. Individuals enrolled in Medicare Part A but who delay enrolling in Part B may find themselves unable to get Part B at the time they need it due to Medicare's enrollment rules. Unless they are eligible for a Special Election Period, Medicare beneficiaries with just Part A can typically only enroll in Part B during the General Enrollment Period (January 1 through March 31) with coverage that does not begin until July 1st of that year. Late enrollment in Medicare Part B may also result in an ongoing premium penalty.

Six Pennsylvania Organizations Continue Receiving Navigator Grants

In preparation for the start of the Marketplace's fourth Open Enrollment Period on November 1, 2016, the federal government recently announced this year's Navigator grant recipients. All six Pennsylvania Navigator entities awarded grants last year were selected again for the upcoming year. In order to continue receiving Navigator grant funds, the selected organizations had to have federal and state-specific trainings and certifications and were required to have strong past performance. A total of 98 organizations in 34 states were selected as recipients for the coming year. The Open Enrollment Period for 2017 Marketplace coverage ends January 31, 2017.

Navigators are a vital resource to consumers looking to enroll in the Health Insurance Marketplace as they provide in-person assistance for a variety of Marketplace-related matters. They conduct community education activities to promote awareness about the Marketplace, assist consumers in preparing applications, and provide unbiased information to help consumers choose the best plan for their needs. Navigators also help families apply for and enroll into Medicaid and Children's Health Insurance Program (CHIP) plans.

This is the second year of a three year grant cycle. The federal government chose the following Pennsylvania organizations to continue serving as Navigators for 2017:

- ✓ Consumer Health Coalition
- ✓ Penn Asian Senior Services
- ✓ Pennsylvania Association of Community Health Centers
- ✓ Pennsylvania Mental Health Consumers' Association
- ✓ Public Health Management Corporation
- ✓ Young Women's Christian Association of Pittsburgh

For more information, see the grantee summary provided by the Centers for Medicare and Medicaid Services. To find in-person assistance in applying for health coverage, visit https://localhelp.healthcare.gov.

Thousands of Providers Dis-enrolled from Medicaid

Over 136,000 consumers in Fee-for-Service Medicaid (using the ACCESS card to get care) could soon see a disruption in their care as the Department of Human Services dis-enrolls thousands of physicians and other providers who did not revalidate with the Medicaid program.

State Medicaid officials recently confirmed that more than 28,000 providers did not submit a revalida-

tion application prior to its July deadline. These providers will be dis-enrolled from the program on September 25, 2016, as required by federal rules intended to curb provider fraud. Of the providers identified, more than 10,000 had seen Medicaid patients within the past twelve months based on claims activity. The majority of active providers being dis-enrolled are physicians (6085), though other provider types include mental health therapists (751), dentists (383), and medical equipment suppliers (223), among others. According to state officials, affected providers who submitted a revalidation application after the July deadline but before September 25th may see a lag in processing but will ultimately be revalidated retroactive to the September 25th dis-enroll date.

At present, provider dis-enrollments based on the failure to revalidate will affect only recipients in Medicaid fee-for-service system. To stagger the impact on providers and consumers, DHS is not requiring the managed care plans to close out their in-network providers who did not revalidate in time. It is doing this by temporarily suspending the requirement in its managed care contracts that MCOs use only MA-enrolled providers. State Medicaid officials interpret the federal requirements to allow this additional flexibility in the managed care context.

Medicaid fee-for-service consumers who have a doctor or other provider being dis-enrolled were mailed a notice on September 8th. Those who received this letter should check with the providers listed to see if they have recently revalidated. If those doctors have not revalidated, consumers should try to find a new provider that **has** revalidated and who accepts the PA ACCESS card.

Actions Taken to Improve Access to Pediatric Shift Nursing and Home Health Aide Services for Children on Medicaid

This month, DHS took two important steps toward improving access to Pediatric Shift Nursing and Home Health Aide (HHA) services. First, it announced an increase in the state's hourly reimbursement rate for nursing services. Second, it released a detailed Operations Memorandum providing guidance to Medicaid managed care plans on how to appropriately determine medical necessity for these services.

Rate Increase

In a Bulletin released on September 3rd, DHS announced an increase in the reimbursement rate for Pediatric Shift Nursing services. This increase was made possible with the signing of the 2016-17 Fis-

cal Code which included language specifying funds in the state budget for a $5 per hour increase in the rate paid for Pediatric Shift Nursing services provided by Registered Nurses (RNs) and Licensed Practical Nurses (LPNs). This increase brings the hourly rate from $40 to $45 across the state and represents only the second rate increase for the service since 1993.

PHLP is hopeful that this rate increase will translate into Home Health Agencies being able to compete for and recruit quality nursing staff ultimately improving families' access to shift nursing care for their medically complex children. For years, PHLP has heard from parents whose children are authorized to receive shift nursing services but who have been unable to actually get the entire amount of authorized services because of a lack of available nurses.

For now, the $5 increase impacts only children enrolled in the Medicaid Fee-for-Service system (ACCESS). However, the fiscal code included language that specifically states there are funds available in the budget for Medicaid managed care plans to also increase the rate they pay for Pediatric Shift Nursing services effective January 1, 2017.

Guidance Issued to Plans

In a second step towards improving access to shift nursing and HHA services, DHS released a Managed Care Operations Memorandum reminding Medicaid managed care plans of the policies governing medical necessity determinations for these services. This guidance is a result of years of advocacy by PHLP on behalf of our clients who frequently encounter problematic denials and face procedural challenges when appealing their health plan's denials of shift nursing and HHA services as not medically necessary. According to the Ops Memo:

- ✓ A managed care plan cannot require that a minimum number of specified hours (e.g., 4 continuous hours) be medically necessary in order for it to authorize services;
- ✓ If a plan does not have sufficient information to determine medical necessity once a service request is submitted, the plan must make every effort to obtain the needed information before denying a request based on lack of information. The efforts include outreach to the child's family, the requesting physician, and other providers to collect additional information. They also include obtaining clinical information (e.g., doctor's letter, plan of care) and information about the family situation such as parent or caregiver work schedules and other responsibilities of the parent or caregiver in the home.
- ✓ Service denials must be provided to the family in writing and must include an explanation of the specific reasons why the service was determined not to be medically necessary.
- ✓ A request for HHA or shift nursing may not be denied for any of the following reasons:
    - Because a parent or caregiver is present in the home - unless the plan has adequate documentation that substantiates the parent or caregiver is actually able and available to provide the child's care during the time hours are requested;
    - Because the service will be provided in a location outside of the child's home (e.g. school);
    - Because the plan believes that the service should be covered as part of a child's Individualized Education Program (IEP) or Section 504 Plan.

PHLP continues to advocate on behalf of families to help improve their children's access to quality Shift Nursing and HHA services at home and in the community. If you are having problems accessing these services, or experiencing any of the problems described above, please contact PHLP's Helpline (1-800-274-3258) for assistance.

Re-designed CHIP Website Aims to Improve Access to Information

At the end of August, the Pennsylvania Children's Health Insurance Program (CHIP) launched its re-designed web site: www.chipcoverspakids.com. The content and navigation of the web site continues to have links to pages describing eligibility, how to apply and renew, and lists of available CHIP insurers in each county. Individuals and organizations can still order CHIP outreach materials through the web site.

The web site lists the CHIP Advisory Council meetings and provides minutes for recent meetings. A new link allows users to view CHIP YouTube videos that highlight the need for health insurance for typically active children and youth. In addition, the web site offers information on CHIP's transition from Pennsylvania's Insurance Department to the Department of Human Services and links to CHIP Facebook and Twitter pages. DHS' intent in re-designing the website was to make it easier for families to find the information they need to apply for benefits and ensure their children have affordable health care coverage.

PHLP Pittsburgh Office on the Move

Effective October 1, 2016, PHLP's Pittsburgh office is at a new location. The new address is **2325 East Carson Street, 1st Floor, Suite B, Pittsburgh, PA 15203**. Phone numbers and email addresses for the Pittsburgh staff will remain the same. During the transition, our Helpline will be closed the week of October 3rd. Since Columbus Day is a PHLP holiday, our Helpline will re-open on Wednesday, October 12th. We apologize for any inconvenience this may cause.

As a reminder, PHLP's Helpline operates on Mondays, Wednesdays and Fridays from 8am to 8pm. Thank you for your patience during our move.

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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For Southeast PA, go to uwsepa.org and select donor choice number 10277.

For the Capital Region, go to uwcr.org and pledge a donation to PHLP.

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