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In This Issue

Pennsylvania Moving Ahead with MLTSS, Releases Draft RFP

Pennsylvania's initiative to develop a managed long term services and supports system (MLTSS), now being called "Community Health Choices", continues to move swiftly. The Wolf Administration seeks to change how Medicaid and long term care services are delivered to dual eligibles (those on Medicare and Medicaid) as well as those enrolled in Home and Community Based Services (HCBS) Waiver programs or receiving nursing home care paid for by Medicaid.

The Department of Human Services (DHS) will require these consumers to enroll into a managed care plan and will pay the plan to deliver Medicaid and long term care services to their members. Currently, Medicaid coverage for dual eligibles and individuals in nursing homes is provided through the fee-for-service system (ACCESS card). HCBS Services are covered and paid for through a separate system. DHS plans to start Community Health Choices (CHC) in Southwestern Pennsylvania in January 2017 and expand it across the state over three years.

At the November 2nd meeting of the MLTSS Subcommittee of the Medical Assistance Advisory Committee, DHS officials reported receiving over 1,200 comments to its Concept Paper issued in September. DHS noted that the comments received were considered as it continues to develop the Community Health Choices program. PHLP submitted comments on behalf of our clients, the Consumer Subcommittee of the Medical Assistance Advisory Committee. In addition, PHLP submitted separate comments about designing a strong MLTSS appeals system.

On November 16th, a draft Request for Proposal (RFP) and draft Program Requirements were released that detail hundreds of requirements and financial standards all managed care organizations cho-

sen to operate as Community HealthChoices-MCOs (CHC-MCOs) must meet. The draft documents combined total over 280 pages, and PHLP is just beginning to analyze the information.

DHS will accept comments about the draft Program Requirements and the draft RFP until **Friday, December 11th**. Comments can be submitted by either:

- Email to: RA-MLTSS@pa.gov. Put "Community Health Choices" in subject line, or
- Mail to: April Leonhard, Office of Long Term Living, Bureau of Policy & Regulatory Management, PO Box 8025, Harrisburg, PA 17105-8025.

Please check PHLP's website closer to the comment deadline date to view the comments we will submit.

The Department is planning to issue the final RFP in January 2016 seeking bids from health plans wanting to contract to deliver Community HealthChoices services across the state's 67 counties. The health plan bids will be due 60 days following the final RFP's release. Successful bidders for each CHC zone will be chosen in Spring 2016. PHLP and other advocates are urging the Department to allow consumers along with members of several Medical Assistance Advisory Committee Sub-committees to review and score the bids from prospective CHC-MCOs. DHS has not yet responded to this request as of the publication of this newsletter.

Medicare Open Enrollment Ends December 7th

Everyone who has Medicare should review their current plan, as well as the plan options available in 2016, to decide whether their best choice is to stay with the plan they have or to switch to a different plan. During the Medicare Open Enrollment Period, people on Medicare can add drug coverage and change their Medicare Advantage plan or their Medicare prescription drug plan for the following year. Each year, plans can change the costs of their coverage, the drugs that they cover, and their provider network. National research shows that Medicare Advantage and Medicare Prescription Drug Plans are changing their benefits in 2016 to put more cost-sharing burden on consumers, so shopping around is very important; however, the research also shows that few people change their plans during the Medicare Open Enrollment period even though they may get better savings or better coverage if they do change. **Individuals who wish to change their Medicare plan for 2016 must take action by December 7th**!

Medicare beneficiaries in Pennsylvania continue to have many Medicare plan options available to them. As discussed in our October newsletter, next year there are 26 stand-alone prescription drug plans available across the state (9 of these plans are zero-premium for people with the full Extra Help). In addition, depending on their county, individuals have between 9 and 35 Medicare Advantage plans to choose from. Every county except for Bradford and Franklin have at least one Special Needs Plan for dual eligibles (those that have both Medicare and Medicaid) available in 2016.

People should consider the following when comparing Medicare plan options:

- **Cost**: What does the plan charge for a premium? Is there a deductible? What are the co-pays for medications, for other services? How much will my drugs cost in the doughnut hole or coverage gap?
- **Coverage**: Are the drugs I take covered on the plan's formulary? Does the plan have any special rules for coverage of my drugs such as requiring prior authorization, step therapy, or having quantity limits?

- **Pharmacy network:** Can I continue to go to my local pharmacy to get my medications? What are the plan's mail order options? Does the plan have "preferred" pharmacies? If so, how much will I pay at a preferred versus a non-preferred pharmacy?
- **Provider Network** (if considering a Medicare Advantage Plan): Are all the health care providers I use in the plan's network? Does the plan have any rules for how I access care such as needing a referral to see a specialist?

Making Changes After Open Enrollment Ends

After December 7th, individuals may still be able to make changes to their Medicare health or drug plan under certain circumstances such as if they move or lose their current coverage. Typically, individuals can change plans at other times during the year only if they qualify for a Special Enrollment Period. Anyone who qualifies for both Medicare and Medicaid, as well as those who receive any level of Extra Help, have an ongoing Special Enrollment Period and can change their Medicare plan at any time during the year. Other circumstances that can qualify someone for a Special Enrollment Period can be found here.

Medicare also created a Tip Sheet that further discusses Medicare Advantage and Medicare Prescription Drug Plan Enrollment Periods.

Anyone who needs help comparing plans or learning about their plan options for next year can call Medicare (1-800-633-4227), APPRISE (1-800-783-7067), or PHLP (if dual eligible) at 1-800-274-3258. Plan options can also be researched on www.medicare.gov.

Medicare Announces Part A and Part B Costs for 2016

On November 10th, the Centers for Medicare & Medicaid Services announced what the premiums, deductibles and co-insurance costs for Medicare Part A and Part B will be for 2016.

Medicare Part A

Part A is the hospital benefit of Medicare that covers inpatient hospital care, care in a skilled nursing facility (up to 100 days), some home health care, and hospice services. In 2016, the Part A hospital deductible will be $1,288 per spell of illness. If someone is in the hospital longer than 60 days, their cost-sharing will be:

- $322/day for days 61-90
- $644/day for days 91-150

Beneficiaries in a skilled nursing facility that accepts Medicare pay no cost for Medicare-covered care for the first 20 days. Those staying longer will pay $157.50 per day for days 21 through 100. Medicare does not cover beyond the first 100 days of skilled nursing facility care.

Medicare Part B

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. Congress, through the federal budget legislation, did act to limit the increase in the Part B

premium and deductible in 2016, which were previously expected to be much higher than the amounts that were just announced.

Part B Premium

The monthly premium for Part B will go up next year for **some** beneficiaries but not others. The amount a beneficiary will pay depends on their circumstances:

$104.90 is the premium amount most Medicare beneficiaries will pay next year. Those who are already receiving Medicare Part B and who have this premium currently deducted from their Social Security check will continue to pay the same premium in 2016 that they pay this year. These individuals are not subject to any increased premium amounts because their Social Security benefits will not increase in 2016 and thus they are "held harmless" from any Medicare Part B premium increases.

$121.80 is the premium amount for those who enroll into Medicare Part B for the first time in 2016 as well as those who pay their Part B premium directly rather than have it deducted from their Social Security check (this includes individuals who are not collecting Social Security benefits). In addition, individuals with limited incomes and resources who qualify for a Medicare Savings Program where Medicaid pays their Part B premium will be subject to the higher premium in 2016. This means that Pennsylvania Medicaid will pay the $121.80 for individuals who qualify for this help; however, if an individual loses this help in 2016, she will have to pay $121.80 for Part B once Medicaid stops paying the premium. For more information about qualifying for a Medicare Savings Program, click here.

As in previous years, beneficiaries with annual income above $85,000/single or $170,000/married will pay higher Part B premiums. The premium amounts charged to these individuals are on a sliding scale based on the amount of their taxable income.

Other Part B Costs

In addition to their monthly premium, those with Medicare Part B must meet an annual deductible before their coverage starts. In 2016, the annual deductible for **all** beneficiaries will be **$166.** Once this deductible is met, Part B covers outpatient physical and mental health services at 80%.

More information about Medicare Part A and B costs in 2016 can be found here.

New CHIP Benefits Start December 1st

To meet the "minimum essential coverage" requirements of the Affordable Care Act, Pennsylvania's Children's Health Insurance Program (CHIP) will cover enhanced benefits starting December 1st. The changes were made to protect families whose children have full cost CHIP from having to pay a penalty for having insurance that does not meet minimum coverage standards or from having to get new coverage that did meet the standards. As a result, **all** kids enrolled in CHIP, regardless of whether they have free, low-cost, or full cost CHIP, will get the enhanced benefits. CHIP currently covers over 150,000 children under age 19 across Pennsylvania.

Starting December 1st, the improved coverage under CHIP will include preventive services such as oral hygiene education, plaque control programs, dietary instruction, and prescribed iron supplementation at no cost. In addition, CHIP plans will remove limits on certain essential health benefits such as pediatric vision and dental services including orthodontic services, durable medical equipment, and hearing aids. Currently, CHIP covers these services up to an annual dollar limit depending on the service. Finally, CHIP plans will be required to provide equal coverage for mental health and substance abuse services as they provide for medical and surgical benefits.

Please see CHIP's website or call 1-800-986-KIDS (1-800-986-5437) for more information.

Legislation has been introduced in the Pennsylvania House of Representatives that would move CHIP from its current home in the Pennsylvania Insurance Department to the Pennsylvania Department of Human Services (DHS). DHS currently operates the Medicaid program in Pennsylvania. In every other state, CHIP programs are administered by the state agency that administers its Medicaid program. The Legislation, HB 1633, is currently in the House Insurance Committee. This legislation would not change any current eligibility, benefits or provider networks that provide services to the children through the CHIP program. All changes would take place on the administrative end. If undertaken in the next two years, the federal government would reimburse 90 percent of the transition costs. The existing CHIP staff would continue to staff the program at DHS. Insurance Commission Teresa Miller and Human Services Secretary Ted Dallas noted that this change would allow better coordination of services, especially for families whose incomes fluctuate causing children to transition between CHIP and Medicaid.

PA Appellate Courts Require Insurers to Pay for Autism Services in School

In a long awaited ruling, *Burke v. Independence Blue Cross*, the Pennsylvania Superior Court recently held insurers like Independence Blue Cross (IBC) must cover "in school" services for children with autism.

When IBC refused to pay for seven-year-old Anthony's therapy in school, John and Suzanne Burke called PHLP. They knew how important it was for their son to receive Applied Behavioral Analysis therapy, which medical professionals say is vital to social acclimation and development.

At issue was a Pennsylvania law called Act 62, the Autism Insurance Law, which requires some private health insurers to pay for diagnoses and treatment of autism for children and adolescents. IBC argued that since the therapist worked at school, the law didn't apply to them because their policy had an exclusion clause that stated services could not be covered if the care was provided at certain locations including schools. In 2011, a state trial court disagreed and decided Independence Blue Cross, like all private insurers subject to Act 62, was legally required to pay for needed services and treatment for autism, including those provided in school regardless of any exclusion clause. But the state's largest private insurer refused to pay and fought the order at ***every*** opportunity.

This month, five years later, and after several appellate court decisions, PHLP's arguments prevailed. The Superior Court held the case raised an issue of "great public importance": the prevalence of autism-spectrum disorder diagnoses and the pithy amount of time parents have to successfully challenge insurers' denial of coverage. "Anthony Burke's right under Act 62 to receive autism services in school ... affects potentially tens of thousands of Pennsylvania schoolchildren."

Senior PHLP Attorney David Gates was very pleased with the Superior Court's decision. "Independence Blue Cross doggedly fought the Burkes all the way to the Pennsylvania Supreme Court and back down to Superior Court again. Now they and other families have an appellate court decision that requires insurers subject to Act 62 to cover autism treatment in school."

PHLP appreciates the assistance of the PA Insurance Department, a bipartisan group of members of the PA House of Representatives, former Speaker of the House Dennis O'Brien (the law's author) and Autism Speaks, all of whom filed amicus briefs in support of the Burke's appeal.

PHLP has met with the PA Insurance Commissioner and the Secretary of Human Services who have pledged their support in the implementation of this decision. Children eligible for both private-commercial health insurance and Medicaid should receive a greater amount of coverage for services from their private-commercial carriers than those same insurers currently pay. The Superior Court's decision removed a barrier that kept that from happening.

DHS Looking for Suggestions on How to Improve the Medical Assistance Transportation Program

The Pennsylvania Department of Human Services (DHS) recently released a Request for Information (RFI) seeking input and ideas on how to improve Pennsylvania's Medical Assistance Transportation Program (MATP). Comments and suggestions are due Friday, November 20th.

MATP provides non-emergency medical transportation as well as mileage reimbursement to Medicaid consumers who are registered with the program and who need help getting to and from their medical appointments. Right now, the MATP system is funded by the state; but, services are delivered, with a few exceptions, by the counties. One challenge DHS noted is that Medicaid consumers often go outside of their County, and often great distances, to access their Medicaid services and treatment. DHS is looking at whether a ***regional*** approach to delivering MATP services should be explored.

DHS is looking for input on ways the state can meet its stated objectives including increased consumer access to needed medical services particularly in rural and underserved areas, improving efficiency in delivering medical transportation, and maximizing cost-effective purchasing of transportation services.

To help people respond to this RFI, the state offers a list of topics and questions in the document (Part 4). Commenters can choose to respond to any or all of the topics and questions provided. All responses must be submitted electronically to RA-PWHCRFIResponses@pa.gov no later than the close of business on **Friday, November 20th**.

Medicaid's New Specialty Pharmacy Drug Program

Medicaid enrollees who get their prescription benefits through the Fee-for-Service system (ACCESS) must now obtain all their specialty drugs from one of two pharmacies chosen by the Pennsylvania Department of Human Services. This is a result of a new Specialty Pharmacy Drug Program that began in late September. Generally, specialty drugs include certain medications used to treat chronic and/or life-threatening diseases like hepatitis, lung disorders, or multiple sclerosis. A complete list of specialty drugs that must now be obtained through one of the two pharmacies shown below to be covered by Pennsylvania Medicaid is available here.

The two Specialty Pharmacies chosen by the state are:

Diplomat Specialty Pharmacy
Telephone: 1-844-891-3332
Fax: 1-877-231-8302

Walgreens Specialty Pharmacy
Telephone: 1-877-220-6194
Fax: 1-855-423-8303

Pennsylvania Medicaid sent notices about this new program to those individuals who had been getting specialty medications covered by the ACCESS card. The notices provided information about the changes and about the steps that people needed to take to make sure Medicaid continues to cover their specialty drugs.

Please note this change **only** impacts Medicaid enrollees who access their prescription drugs through the Fee-for-Service program (those who use their ACCESS card at the pharmacy). It does **not** apply to Medicaid consumers enrolled in a HealthChoices managed care plan or to anyone whose specialty drugs are covered by another source such as Medicare Part B or Part D, or coverage through an employer.

Those seeking more information on the Specialty Pharmacy Drug Program should call the Medicaid Call Center at 1-800-657-7925 (TTY 1-866-872-8970) or contact PHLP's Helpline at 1-800-274-3258. More information is also available on the DHS website and in a Medicaid Bulletin issued on the topic.

Pennsylvania Awarded One-Year Planning Grant for Certified Community Behavioral Health Clinics

Pennsylvania is one of 24 states awarded a planning grant from the federal government for Certified Community Behavioral Health Clinics (CCBHCs). Pennsylvania's Office of Mental Health and Substance Abuse Services and Office of Medical Assistance Programs, in conjunction with the Pennsylvania Department of Drug and Alcohol Programs, pursued the grant and received $886,200.

The point of the CCBHCs is to integrate behavioral health with physical health care, to increase the quality of care by certifying high quality and evidence-based practices, and to improve outcomes for individuals with serious mental illness, children with serious emotional disturbance, and those with long term and serious substance use disorders, as well as others with mental illness and substance use disorders. This is a significant opportunity for change regarding the delivery of behavioral health services, especially as it involves establishing a prospective payment system that is an important component of the CCBHC approach. Pennsylvania is focusing on Community Mental Health Centers and Federally Qualified Health Centers as possible CCBHCs although they will consider other entities as well. The state will issue Requests for Applications quickly as the planning grant begins immediately.

The development and funding of the planning grants was part of the Protecting Access to Medicare Act of 2014. The planning grants are the first of a two-phase process that allows states to certify Community Behavioral Health Clinics, establish a prospective payment system for Medicaid reimbursable services provided by the Certified Community Behavioral Health Clinics, and prepare an application to participate in a two-year demonstration program. Only eight states will be awarded two-year demonstration grants that will allow those states to provide behavioral health services through their CCBHCs and be paid using a prospective payment system beginning in January 2017.

The one-year planning grant relies heavily on stakeholder involvement, per federal requirements. The state will work with the Mental Health Planning Council, other consumers and family members, as well as providers and provider associations to develop the planning grant. Stay tuned to future newsletters for updates about Pennsylvania's progress in this area.

Marketplace Open Enrollment Underway

November 1st marked the start of the Marketplace Open Enrollment Period. Consumers have until January 31st to enroll in a 2016 Marketplace plan for the first time, renew their current plan, or pick a new plan. Individuals can also apply for financial help to help them pay for their Marketplace coverage.

Anyone who already has Marketplace coverage should compare 2016 plan costs and coverage to decide whether they want to keep their current coverage or join a new plan for next year. These individuals should also update their household size and income with the Marketplace to make sure they get the correct amount of financial help in 2016.

Although Open Enrollment does not end until January 31, 2016, **people need to act by December 15th if they want to make sure their new health insurance coverage starts on January 1, 2016**. Help with enrollment and comparing plan options is available through many organizations across Pennsylvania-see localhelp.healthcare.gov for resources. 2016 Plan Information is available at www.healthcare.gov or by calling 1-800-318-2596 (TTY: 1-855-889-4325).

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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