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In This Issue

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Governor Wolf Announces Plan for Traditional Medicaid Expansion

Earlier this month, Governor Tom Wolf announced an aggressive timeframe for ending former Governor Corbett's Healthy PA initiative and replacing it with traditional Medicaid expansion. Under the transition plan, the Wolf Administration will (1) undo the Medicaid benefit reforms in place since January 1st and instead enact a single benefit package for adult Medicaid recipients, and (2) wind down the "Private Coverage Option" (PCO) managed care system. The transition will be done in phases between now and the end of the year.

Phase One

According to Department of Human Services (DHS) officials, phase one will begin in April or May. Current PCO enrollees who received Medicaid managed care through the HealthChoices system in Dec. 2014 will be transitioned back to that system. This will affect about 108,000 individuals; specifically Pennsylvanians previously enrolled in General Assistance-related coverage or SelectPlan for Women in 2014 and who are now in a PCO plan. PCO enrollees affected by phase one will be mailed a notice explaining the change and the timing of the transition.

Also, as part of phase one, all adults in the Medicaid Fee-for-Service and the Medicaid HealthChoices managed care delivery systems will be assigned a new "adult" benefit package. Governor Wolf's approach collapses three existing benefit packages ("High Risk" known as Healthy Plus, "Low Risk" known as Healthy, and "Private Coverage Option") into one. DHS is finalizing the contents of the new benefit package. Once that is done, it will be posted in the

Pennsylvania bulletin for public comment and then submitted to the federal government for approval. Prior to the new benefit package starting, adult Medicaid enrollees will be mailed a letter explaining the change.

When the single adult benefit package begins, new enrollment in the Private Coverage Option will end. Instead, adults eligible for Medicaid under the new adult category will go into a HealthChoices plan. The health screening tool, also known as the "medical frailty" questionnaire, will no longer be part of the application process as the distinction between Healthy and Healthy Plus will go away with the move to a single adult benefit package.

Phase Two

In late summer or fall, DHS will move all recipients remaining in the Private Coverage Option to the HealthChoices managed care program. DHS is staggering the transition to ensure the HealthChoices plans have adequate provider networks to absorb the new enrollees and because there are geographic differences between the PCO regions and HealthChoices zones. DHS is considering allowing PCO plans to participate in a HealthChoices zone where they currently operate a PCO but not a HealthChoices plan, provided that they meet all of the HealthChoices requirements.

DHS officials stress that recipients will not experience any gaps in coverage during the transition to traditional Medicaid expansion. More information is available at www.healthchoicespa.com.

Governor Wolf To Give First Budget Address

On March 3rd, Governor Wolf will deliver his first budget address to a joint session of the Pennsylvania House and Senate. Throughout March, House and Senate Appropriations Committees will hold hearings with every state agency about the Governor's proposed budget for FY 2015-16.

House Appropriations Committee Budget Hearings

Department of Aging – March 9
Department of Health and Department of Drug and Alcohol Programs – March 17
Department of Insurance-March 23
Department of Human Services – March 25

Senate Appropriations Committee Budget Hearings

Department of Drug and Alcohol Programs – March 18
Department of Health – March 23
Department of Insurance – March 24
Department of Aging – March 24
Department of Human Services – March 26

PHLP's March newsletter will provide analyses of what the Governor's budget proposal means for health coverage for vulnerable Pennsylvanians.

Problem of Behavioral Health Consumers Being Wrongly Enrolled in PCO Has Been Fixed

Department of Human Services officials recently announced that 8,000 individuals receiving drug and alcohol or mental health services who were erroneously moved from the Medicaid HealthChoices system to the Private Coverage Option (PCO) at the beginning of the year have been moved back to their HealthChoices managed care plan. This fix is retroactive to January 1, 2015. As we discussed in previous newsletters, the move from HealthChoices to PCO coverage was problematic for these individuals because the PCO coverage did not include certain behavioral health services such as drug and alcohol non-hospital rehabilitation that are covered under HealthChoices. The Department says that the 8,000 individuals retroactively enrolled in HealthChoices include all the individuals identified as being impacted by this problem. Note: this fix only applies to individuals enrolled in a Medicaid HealthChoices plan in 2014 and then moved to a PCO plan in 2015. It does not apply to adults newly eligible for Medicaid.

Individuals who experienced this problem and whose case has not been fixed are urged to call PHLP's Helpline at 1-800-274-3258.

Renewed Interest in Community First Choice Option

The Affordable Care Act provides state Medicaid programs with several options for expanding coverage of long-term services and supports to help people with disabilities and older adults remain at home or in their communities. Readers may remember that during Governor Corbett's administration, the state applied for and received federal Medicaid funds under the "State Balancing Incentive Program" (described in several newsletters last year). The funds were used to expand the number of individuals served under various Home and Community Based Service (HCBS) Waiver programs including Aging, Attendant Care, Autism, COMMCARE, Consolidated, Independence, OBRA, and Person/Family Directed Supports.

With a new Governor, there is renewed interest in another funding option under the Affordable Care Act: Community First Choice, which gives states additional federal matching funds for providing attendant care services to Medicaid recipients with severe physical or intellectual disabilities. The Long-Term Care Commission created by former Governor Corbett recommended state officials consider this option.

In addition to enhanced federal funding, other highlights of the Community First Choice option include:

- **No caps on the number of people eligible for attendant care**: DHS would have to offer attendant care services to all eligible persons on Medicaid without waiting lists! This differs from the current HCBS Waiver programs where the number of participants is capped, often resulting in waiting lists. Although the services provided under the Community First Choice Options are more limited than those provided under the existing HCBS Waiver programs, this option would at least provide basic support services for individuals with disabilities who currently have no services.

- **A requirement that the state cover certain services**: Under this option, states must cover personal assistance with activities of daily living (ADLs) such as bathing, dressing, toileting as well as instrumental activities of daily living (IADLs) such as housekeeping or meal preparation. Under Pennsylvania's existing HCBS Waiver programs, these services are known as attendant care. Community First Choice also requires that states cover assistance with the "acquisition, maintenance and enhancement of skills for the individual to accomplish ADLs, IADLs and health-related tasks" (which comes close to the "habilitation" service covered by certain existing waiver programs) along with "backup systems" which include personal emergency response systems and can also include staff. Even though Community First Choice does not allow caps on the number of people that can be served under this option, it does allow the state to impose across-the-board caps on services, so long as the caps are not based on age or disability.

  In addition to these mandatory services, the state would have the option of covering two additional services:

  1) Certain costs for transitioning from an institution to the community. Transition costs include first month's rent and security deposit, deposits on utilities and purchase of bedding and kitchen supplies.
  2) Services and equipment "that increases an individual's independence or substitutes for human assistance" in meeting a need specified in the individual's service plan. These may include home modifications and assistive technology.

- **Person-centered planning and opportunities for self-direction**: The type and amount of services someone can get would be determined through a person-centered planning process. A service plan would be developed that outlines the type of services someone will get and how often the services will be provided. Services are to be "self-directed" with the state having the option of allowing eligible individuals to hire, train, fire and determine pay rates for their attendants.

- **Eligibility for obtaining services depends on someone qualifying for Medicaid and meeting level of care requirements**: Because the services provided through the Community First option would be provided through the Medicaid program, individuals will need to financially qualify for Medicaid (generally, people with disabilities and older adults must have income below the federal poverty level, currently $11,770/year for a single person, and resources below $2,000). However, the state would have the option of deducting an individual's medical expenses from their countable income when determining financial eligibility similar to the process used for qualifying for Medicaid to cover nursing home care.

  Because the Community First Choice Option provides support services to people with physical and intellectual disabilities to allow them to remain as independent as possible in their homes and communities, individuals must demonstrate that they need a level of care typically provided in a hospital, nursing home, Intermediate Care Facility (ICF) or an inpatient psychiatric facility for persons under age 21 or for those age 65 and older. Unfortunately, this means that adults age 21 to 64 with mental illness but without a physical or intellectual disability would not qualify. In addition, the option would only provide attendant care services to those with mental illness who qualify and will not provide additional mental health services not already covered under the Medicaid program.

For more information regarding the Community First Choice option, contact David Gates at dgates@phlp.org.

Governor Wolf Creates Advisory Group on Participant-Directed Home Care

On February 27th, Governor Tom Wolf issued Executive Order 2015-05 (Participant-Directed Home Care Services) forming "the Governor's Advisory Group on Participant-Directed Home Care" to counsel the Governor's Office and other executive branch agencies and offices of the Commonwealth on ways to improve the quality of care delivered through home care services programs.

The Advisory Group shall be composed of seven members, who serve at the pleasure of the Governor. The seven members include the Secretary of the Department of Human Services, or a designee (who serves as chairperson of the Advisory Group), and the Deputy Secretary of the Office of Long Term Living. The remaining five members will include participants (or their surrogates) and advocates for seniors and people with disabilities.

Specific appointments have not been released but an announcement is expected soon. The first meeting must be held before June 30, 2015. The group shall meet at least quarterly thereafter.

The Executive Order directs the Advisory Group to:

1) Ensure the Commonwealth continues its efforts to reduce the numbers of Pennsylvania residents currently on waiting lists to receive home care services,

2) Evaluate the work of the Office of Long Term Living to ensure program standards of the Home Care Service Programs are being met as they apply to the provision of Participant-Directed Services (except for pending OLTL reviews and investigations that involve potential fraud or criminal conduct),

3) Ensure the Commonwealth continues its efforts to rebalance resources for long term care services from institutional care to home and community based services,

4) Ensure the Commonwealth adheres to the principles of participant-direction, independent living and consumer choice, and

5) Work on any other issues the Governor deems appropriate.

The Advisory Group is expected to study and discuss the experiences and best practices of other states that administer participant-directed home care services.

DHS Seeking Comments on Statewide Waiver Transition Plan

The Department of Human Services is seeking comments on its proposed statewide transition plan for all ten of the home and community-based service Waiver programs it currently operates. The transition plan describes how Pennsylvania will comply with new federal rules that require person-centered plans of care and that services be provided in settings integrated into the community. The proposed transition plan can be viewed here.

Pennsylvania's ten Waiver programs are: Aging, AIDS, Attendant Care, Autism, COMMCARE, Consolidated, Independence, Infant Toddler and Family, OBRA, and Person/Family Directed Supports.

Comments are **due March 22, 2015** and can be submitted two ways:

1) **Written comments**: Submit by e-mail to ra-pwhcbsfinalrulepl@pa.gov using the subject header "TP Final Rule" or by mail (using the same subject) to: David Alexander, Department of Human Services, Office of the Secretary, PO Box 2675, Harrisburg, PA 1710-2675

2) **Verbal Comments**: The Department will hold two public input webinars on March 5th from 11am to 1pm and March 9th from 1pm to 3pm. Individuals and organizations can comment on the transition plan during these webinars. Webinar participants (whether submitting comments or not) must register and can do so by phone (717-214-2283) or online.

Persons with a disability who require an auxiliary aid or service may submit comments using the Pennsylvania AT&T Relay Service at 1-800-654-5984 (TDD users) or 1-800-654-5988 (voice users).

More information on the Waiver Transition Plan can be found on the Department's website: http://www.dhs.state.pa.us/dhsorganization/officeoflongtermliving/hcbswaiver/index.htm. PHLP plans to post its comments on our website prior to the deadline for individuals who are interested.

New Special Enrollment Period for Marketplace

On February 20th, the Centers for Medicare and Medicaid Services (CMS) announced a new, time-limited Marketplace special enrollment period (SEP) connected to tax season. This new SEP is for those individuals or families who did not have health coverage in 2014 and are therefore subject to the penalty or "shared responsibility payment" when they file their 2014 taxes. Enrollments using this SEP are only allowed from March 15, 2015 until April 30, 2015. This SEP is in addition to the existing SEPs available when people experience certain qualifying life events that allow them to enroll in Marketplace coverage outside of the Open Enrollment Period which ended February 15, 2015.

CMS administrators have explained that this special enrollment period is designed to allow people who are just finding out that they will owe a fee to get covered for the remainder of the year and thus avoid additional fees for not having coverage in 2015. To qualify for this new SEP, people must live in a state that uses the Federal Marketplace (Pennsylvania does) **and** meet all of the following criteria:

- Not be currently enrolled in coverage for 2015,
- Attest that when they first filed their 2014 tax return, they paid the fee for not having health coverage in 2014, and
- Attest that they first became aware of, or understood the implications of, the penalty after the end of open enrollment (February 15, 2015) as they prepared their 2014 taxes.

If consumers wish to take advantage of this SEP, they can visit www.healthcare.gov/get-coverage or they can call the Marketplace Call Center at 1-800-318-2596. Alternatively, they can seek local help at https://localhelp.healthcare.gov.

Those who did not have Minimum Essential Coverage in 2014 may be able to get an exemption from the penalty. Please see our January newsletter for information about the hardship exemptions available to individuals who meet certain requirements. The federal government also recently announced the creation of a health coverage tax exemption tool on Healthcare.gov to help people without health care coverage in 2014 figure out if they qualify for an exemption from the penalty.

Federal Marketplace Incorrectly Counting Tax Dependents' Social Security Income

Recently, the federal government announced that the Federal Marketplace (Healthcare.gov) has incorrectly counted children's Social Security benefits in household income when determining eligibility for help to pay for qualified health plans as well as when identifying potential eligibility for Medicaid and CHIP. Tax rules state that children's income, including Social Security benefits, only counts if the child is required to file a tax return. Often, children receiving Social Security benefits do not have other income that requires them to file taxes; children must earn $6,200 or receive $1,000 in other unearned income before they are required to file taxes. Supplemental Security Income (SSI) never counts as taxable income.

What does this mean?

Because Healthcare.gov is counting children's Social Security benefits in total household income, the premium tax credits and cost-sharing help a family receives are being calculated incorrectly. As a result, families eligible for premium tax credits may get a smaller tax credit than they should and some families will not get a tax credit at all even though they are eligible for premium help. In addition, families may not get help with cost-sharing such as co-payments and deductibles when they should, in fact, qualify for this help.

This problem also means that families potentially eligible for Medicaid or CHIP will not be correctly identified and will not be referred by Healthcare.gov to those programs.

The IRS will correct the error through tax reconciliation when families file their taxes for 2014. Families who

received an incorrect premium tax credit will receive a tax refund based on the correct income information. However, there will be no refunds for any cost-sharing payments made by families who should have received cost-sharing help had their income been calculated correctly.

Pennsylvania fixed this problem for Medicaid and CHIP

There is some good news. Pennsylvania fixed this problem with Medicaid and CHIP in 2014. As a result, families referred to Medicaid or CHIP from Healthcare.gov, or who apply to these programs directly, will have their income calculated correctly.

What should consumers do?

Anyone who received the wrong amount of financial help should appeal the eligibility decision through Healthcare.gov. Those who were not correctly referred to Medicaid or CHIP can apply directly to those programs through COMPASS, over the phone at 866-550-4355 or by using a paper application.

For more information see the Assister and Advocate Alert. Individuals seeking help with a Marketplace appeal or problem can find sources of help here. Individuals who need help with Medicaid or CHIP can contact PHLP's Helpline at 1-800-274-3258.

PACE and PACENET: Important Programs to Help Older Adults with Prescription Drug Costs

PACE and PACENET offer older Pennsylvanians who have limited income a safety net from high medication costs. The programs are funded by the Pennsylvania Lottery. Applying for the programs is quick and easy and people do not need to submit any verification documents with the application. Seniors can apply online or by phone at 1-800-225-7223. Usually, applicants get a decision about whether or not they qualify in less than a week after they apply. Individuals can have other prescription coverage and still qualify for PACE or PACENET. The only exception is people with full Medicaid coverage; these individuals cannot qualify for PACE or PACENET. For more information about the guidelines to qualify and how the programs help with prescription costs, see below.

	PACE	PACENET
Age	65 or older	65 or older
Residency	Must live in PA for at least 90 days prior to date of application	Must live in PA for at least 90 days prior to date of application
Income *	Previous year's income must be: $14, 500 or less – Single person $17,700 or less – Married couple	Previous year's income must be: $14,500 - $23,500—Single person $17,700 - $31,500—Married couple
Benefit **	Enrollee must pay $6 co-pay for each generic medication and $9 co-pay for each brand name medication	Enrollee must pay a monthly deductible ($33.91 in 2015). Once the deductible has been met, then generic medications have a co-pay of $8 and brand name medications have a co-pay of $15 for each medication.

* Part B premiums deducted from Social Security checks are **not** counted as income. PACE/PACENET will only count the Social Security benefit **after** the Part B premium has been deducted.

** PACE and PACENET work as secondary coverage to Medicare Part D. Individuals with Part D coverage in addition to their PACE or PACENET may have different costs than those listed above. For more information about how these programs work with Part D, see the program's Frequently Asked Questions.

More information about the programs can be found online. Individuals with questions are encouraged to contact the PACE/PACENET program directly at 1-800-225-7223 or contact APPRISE at 1-800-783-7067.

New PHLP Resource: 2015 Income and Resources Limits for Medicaid & Other Health Programs

PHLP created a chart to show the 2015 income and resource guidelines for Medicaid, CHIP, and Medicare Part D Extra Help programs. To view that chart, click here.

U.S. Supreme Court to Hear Oral Argument on Affordable Act Challenge

On March 4th, the U.S. Supreme Court will hold oral argument in King v. Burwell, the latest legal challenge to the Affordable Care Act. This is the second time in three years the Court has considered the five-year-old law. At issue is the legality of the subsidies in more than 30 states, including Pennsylvania.

The case, developed by conservative legal scholars, argues that only people using state-run marketplaces are entitled to subsidies. If the court agrees — a decision is expected in June — subsidies will disappear in states that do not have their own online marketplaces. More than 470,000 Pennsylvanians have insurance plans under the Affordable Care Act, and almost all of them receive subsidies.

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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