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In This Issue

Alternative Medicaid Expansion Begins January 1st, Creates Enrollment Delays

State officials in the Department of Human Services (DHS) confirmed in late January that they changed the state's eligibility systems to implement Medicaid expansion effective January 1, 2015, but were unable to identify how many applicants for the expanded coverage had been actually enrolled. Individuals were able to submit applications beginning December 1, 2014 for coverage that was supposed to start on January 1, 2015. The Philadelphia Inquirer recently reported that, as of mid-January, DHS had enrolled 55,000 individuals into the expanded coverage, out of nearly 164,000 applicants.

Adults under age 65 with incomes below 138 percent of the federal poverty level ($16,243/year for a single person; $21,983/year for a married couple in 2015) can now qualify for Medicaid. This new adult category does not apply to individuals with Medicare. In determining whether someone qualifies under this new adult category, Medicaid will use the Modified Adjusted Gross Income (MAGI) rules for what counts as income, whose income counts, and for determining household size. Individuals can apply over the phone (1-866-550-4355), online (www.compass.state.pa.us) or by submitting a paper application to their local County Assistance Office.

Application Delays and Other Issues

Applications for Medicaid are generally supposed to be processed within thirty days under state law and within forty-five days under federal law. DHS officials responsible for eligibility and enrollment stated that they anticipate meeting these timeframes, but that the

significant volume of applications for expanded Medicaid and other programs, such as energy assistance and food stamp benefits, has created increased workloads and some delays at County Assistance Offices across the state.

As of January 15th, state officials reported 88,000 adults had been enrolled into the "Private Coverage Option," the managed care system for newly eligible adults, created by Governor Corbett's alternative Medicaid expansion called Healthy PA. Roughly half of the current PCO enrollment consists of individuals transferred from the General Assistance-related Medical Assistance program that ended December 31st for all adults except for legal immigrants who have been in the US for less than five years. PCO enrollment will increase to 119,000 as of February 1st when PCO plan selection becomes active for individuals recently approved for the new adult category. These enrollment figures do not reflect the total number of individuals enrolled under Medicaid expansion, as they do not include recipients found to be "medically frail." As a reminder, individuals with significant health needs who qualify under the new adult category should be enrolled into the existing HealthChoices managed care system instead of the new PCO managed care system.

In addition to delays in application processing, state officials acknowledged that some applicants were erroneously denied coverage for not verifying resources -- these denials were improper because the new expansion category has no resource test. DHS is working to identify and authorize coverage for affected applicants.

Individuals who have been denied coverage under the new adult category can contact PHLP's Helpline at 1-800-274-3258 for advice and assistance.

Update on Select Plan for Women

The Select Plan for Women program officially ended December 31, 2014; however, it is being extended until the end of June for women currently enrolled who have not yet been reviewed for coverage under Healthy PA. Women still in the Program should receive notice about their extended coverage.

Earlier this month, the Department of Human Services (DHS) issued a policy memo detailing the transition of those in the Select Plan for Women Program into other coverage. According to this memo, each County Assistance Office (CAO) is currently reviewing women who receive the Select Plan coverage to see if they qualify for coverage under the new adult category. This manual review must be done by February 24th. Women whose case records include enough information to determine ongoing eligibility will be enrolled in the new adult category and receive coverage through the Healthy PA Private Coverage Option if their income is below 138 percent FPL. Women whose income is above this limit will instead be referred to the Health Insurance Marketplace.

Women currently enrolled in Select Plan should do the following:

- **Those with income less than 138 percent FPL** ($16,243/year for a single person and $21,983/year for a married couple) should contact their caseworker or the Department's Customer Service Center at 1-877-395-8930 to see if they need to submit any additional information to have their eligibility for Medicaid reviewed.

- **Those whose income is above this limit** should enroll in a health insurance plan through the Marketplace **before February 15, 2015**. Failure to do this could result in their being without health coverage for all of 2015 since Select Plan for Women is **not** Minimum Essential Coverage nor is it Medicaid. As a result, when Select Plan ends in June it would not be a qualifying event that allows them to enroll in a Marketplace plan outside of Open Enrollment. See page 7 for more information.

Select Plan enrollees who have questions about their situation or the steps they need to take to ensure they have health care coverage this year can contact PHLP's Helpline at 1-800-274-3258 or contact a health care navigator in their area.

A federal class action lawsuit was recently filed by Community Legal Services and the Women's Law Project on behalf of those enrolled in the Select Plan for Women program. The lawsuit urges DHS to automatically transfer women to Medicaid whose income falls below the limit needed to qualify rather than complete the manual review process described above. The lawsuit also alleges that failure to refer women to the Marketplace in time for them to get coverage violates federal law.

"Raise Your Hand" Process Available For Adults Seeking a Medicaid Benefit Package Change

As of January 1st, adults on Medicaid receive one of three benefit packages: Healthy Plus, Healthy, or Healthy PA Private Coverage Option (PCO). We have discussed these benefit packages in previous newsletters. Adults with serious health conditions who are not already receiving the Healthy Plus benefit package can have their situation reviewed by using a process called "Raise Your Hand". This process was created to ensure that individuals are in the benefit package that best meets their medical needs- especially given that circumstances can change and the benefit package someone was initially placed in may no longer fit their needs if they become sick or their health declines.

Individuals enrolled in the Healthy or Healthy PA PCO benefit package who wish to have their benefit package reviewed can contact the Statewide Customer Service Center at 1-877-395-8930 (Philadelphia residents call 215-560-7226) or their caseworker and request a review of their benefit plan. The person can then either complete a health screening over the phone or request a health screening form that they can complete and return. Those receiving Healthy Plus already have the most comprehensive benefit package available and thus cannot make a "Raise Your Hand" request.

Once the screening form is returned or completed by phone, the County Assistance Office (CAO) will enter the information into the system and have the case sent to a Clinical Validation Team for review. This review should be completed within 10 business days and the result sent to the CAO. The caseworker then has five business days to update the benefit package if the review indicates a change is warranted. Notice will then be sent to the individual telling them about their benefit package upgrade. If the review does not result in a change to an individual's benefit package, the caseworker will send out written notice to this effect and the person can appeal this decision.

Issues Remain with Behavioral Health Consumers Wrongly Placed in PCO

As reported in our December newsletter, thousands of Medicaid consumers who meet the definition of "medically frail" were wrongly placed in the Healthy PA Private Coverage Option (PCO) instead of remaining in HealthChoices under the Healthy Plus benefit package. It appears the majority of these individuals were receiving drug and alcohol or mental health services prior to being moved to the new PCO delivery system. This is problematic because some behavioral health services (e.g., drug and alcohol non-hospital rehab) covered by HealthChoices are not covered by PCO plans. DHS is working with providers and county mental health and drug and alcohol offices to correct this issue. The Department has assured providers that these particular consumers will be placed in HealthChoices retroactive to January 1st. Providers can assist in the process by contacting OMHSAS Deputy Secretary Dennis Marion at dmarion@pa.gov with the following information:

- Recipient name;
- MA Recipient ID number;
- Recipient's county of residence;
- Facility name;
- County the facility is located in;
- Level of care; and
- Admission date.

Consumers enrolled in PCO coverage who are being denied a level of care such as drug and alcohol non-hospital rehab or drug and alcohol halfway house programs because these services are not covered can contact PHLP's Helpline at 1-800-274-3258 for assistance in getting the level of care they need.

2015 Federal Poverty Level Announced

The 2015 Federal Poverty Level (FPL) guidelines were published January 22, 2014 and are slightly higher than last year's poverty level figures. Public benefit programs such as Medicaid and the Children's Health Insurance Program (CHIP) use these guidelines to determine who qualifies for coverage. PHLP is in the process of updating resources on its website to include the 2015 income amounts needed to qualify for various programs. Below is a table showing the new monthly income limits that apply to various Medicaid categories as well as free CHIP.

	Healthy Horizons	New Adult Category and Children ages 6-18	Children ages 1-5	Free CHIP	Pregnant Women and Infants	MAWD and BCCPT
Household Size	100 % FPL	138% FPL*	162% FPL*	213% FPL*	220% FPL*	250% FPL
1	$981	$1,354	$1,589	$2,089	$2,158	$2,453
2	$1,328	$1,832	$2,151	$2,828	$2,922	$3,319
3	$1,675	$2,310	$2,713	$3,566	$3,683	$4,186
4	$2,021	$2,789	$3,275	$4,304	$4,447	$5,052

* Includes 5% disregard that applies to these categories

The income limit to qualify for a Home and Community Based Service Waiver program in 2015 is $2,199. Only the individual applicant's income counts when determining whether or not someone qualifies for a waiver.

Income and Resource Limits Increase for Programs that Help With Medicare Costs in 2015

With the announcement of the 2015 Federal Poverty Levels, the guidelines to qualify for the Medicare Savings Programs and the Medicare Extra Help Program change. Here are the income and resource limits someone must meet to qualify for help this year:

	Medicare Savings Programs				**Extra Help***			
	Monthly Income Limit			Resource Limit	Full Help		Partial Help	
	QMB (100% FPL)	SLMB (120% FPL)	QI-1 (135% FPL)		Monthly Income Limit	Resource Limit	Monthly Income Limit	Resource Limit
Single	$981	$1,177	$1,324	$7,280	$1,324	$8,780	$1,471	$13,640
Married	$1,328	$1,593	$1,792	$10,930	$1,794	$13,930	$1,991	$27,250

*Reminder: Any dual eligible automatically qualifies for the Full Extra Help even if his income and resources are over the limits listed above.

Individuals who wish to apply for the programs that help with Medicare costs and who need help are encouraged to call APPRISE at 1-800-783-7067.

Attention: Those with Marketplace Coverage and Incomes Less than 138% FPL Need to Take Action

Individuals with income below 138 percent of the federal poverty level (see page 4) and who receive premium tax credits to pay for Marketplace coverage need to take action to avoid having to pay back tax credits they receive in 2015. Pennsylvania expanded Medicaid beginning January 1st to adults with income below 138 percent FPL; therefore, these individuals are no longer eligible for their premium tax credits because they are now Medicaid eligible.

Anyone in this income bracket should move to Medicaid to avoid having to pay back any tax credits for 2015. The Department of Human Services (DHS) is sending out letters in early February to people identified by the Marketplace as being in this income bracket, encouraging them to take action and shift their coverage to Pennsylvania's Medicaid program. The letter will include step-by-step directions about what people should do, but here are some highlights:

1) Individuals should update their account with HealthCare.Gov. When they do this, they will be told if they seem likely to qualify for Medicaid. If so, HealthCare.Gov will send their information to DHS.

2) Those whose information is sent on to DHS for an official determination of whether they qualify for Medicaid then have two choices:

- **Choice 1 (Recommended):** Wait for a final decision from DHS about whether they qualify for Medicaid or not. If they do qualify, then they should cancel their tax credits and their Marketplace plan. Their HealthCare.gov coverage will continue until they cancel it. Pennsylvania Medicaid will send a written notice that tells someone whether she qualifies or not.

  Individuals will not have a gap in coverage if they wait until they receive this decision from Pennsylvania Medicaid before canceling their other coverage.

  If someone qualifies for Medicaid coverage, then she must go back to the Marketplace and cancel her health plan and tax credits. **Failure to cancel both may result in someone having to pay premiums owed to the plan and/or repay tax credits received.**

- **Choice 2:** End their tax credits and Marketplace plan now and wait for a final decision from Medicaid. If someone ends his HealthCare.gov plan now, he will not have to repay any tax credits. However, he may not have any coverage until he gets a final decision from DHS.

Anyone who cancels their plan and tax credits and then gets a final decision stating that they do not qualify for Medicaid will have to re-enroll for Marketplace coverage. These individuals will be able to re-enroll after February 15th because they were denied Medicaid—a qualifying event allowing them to enroll in a plan and qualify for premium tax credits outside of the Marketplace Open Enrollment Period.

Individuals with questions can go to HealthCare.gov or call the Marketplace at 1-800-318-2596 (TTY: 1-855-889-4325). In-person help is available, if needed, through navigators and other local application assisters. Those with questions about Pennsylvania Medicaid can call the Healthy PA Customer Service Center at 1-877-418-1187.

Long Term Care Commission Issues Report

The PA Long Term Care Commission has issued its Final Report including proposed recommendations to improve the state's current long-term services and supports system. The report was issued in December and accepted by then-Governor Tom Corbett.

The Commission found that despite the dedicated efforts of those working to make the current system operate effectively and efficiently and the $5 billion in public funds being spent annually, the long term services and support delivery system has many challenges: lack of coordination; a lengthy and complicated eligibility process; inefficiencies in service delivery that result in unnecessary costs; inconsistent provider reimbursement rules; funding and service silos that can hinder maximizing existing resources; and a lack of technology that hampers efforts to assess and ensure quality services. This led to the development of four broad recommendations to address these challenges. For reach recommendation made, the Commission proposed multiple strategies to enhance the state's long term services and supports system. The Commission developed its findings and recommendations after spending 2014 gathering input from public hearings held across the Commonwealth, seeking information and advice from experts in the field, and drawing on the knowledge, expertise and experience of its members.

The four main recommendations of the Commission are:

✓ **Improve Care Coordination**

The strategies for accomplishing this include developing and implementing a coordinated, integrated demonstration program and conducting a gap analysis to identify gaps and barriers that prevent the system from operating in a person-centered, efficient and effective manner

✓ **Improve Service Delivery**

Strategies for this include streamlining and expediting the eligibility process, increasing affordable and accessible housing options for recipients of long term services and supports, including home modifications as a covered service in all waiver programs, increasing assistance and support to unpaid caregivers, and elevating the profession of direct care workers

✓ **Improve Quality and Outcomes**

Proposed strategies include adopting a uniform assessment for all levels of care and expanding electronic health record initiatives to long term care providers

✓ **Make the System More Fiscally Sustainable**

The strategies here include a review of rate setting and reimbursement systems for all long term care services and supports providers, giving DHS budget flexibility to maximize use of appropriated funds, and adopting policies to assure the greatest number of people are getting needed services in the safest, most appropriate and least restrictive settings possible.

It is unclear at this time what, if anything, Governor Wolf and his administration will do with the Report and its findings and recommendations.

Marketplace Open Enrollment Ends Feb. 15, 2015!

Individuals who wish to purchase health insurance through the Marketplace must do so before February 15th. This is the last day of the 2015 Open Enrollment Period. After this date, consumers will only be able to enroll in Marketplace plan under certain circumstances including, but not limited to:

- Losing health insurance including Medicaid, CHIP, or health coverage through an employer
- Having a baby or adopting a child
- Getting married
- Being denied Medicaid or CHIP
- Moving out of your plan's service area
- Leaving incarceration

Those who experience any of these life qualifying events must act quickly (generally within 60 days of the event) to enroll in a Marketplace Plan. Individuals can find out more about what circumstances allow someone to enroll in a Marketplace plan outside of Open Enrollment by going to HealthCare.gov or by contacting the Marketplace at 1-800-318-2596. Anyone who needs help joining a Marketplace plan or applying for premium tax credits and subsidies can find local help by visiting localhelp.healthcare.gov.

Hardship Exemptions Can Help Individuals Avoid 2014 Tax Penalty

The 2014 tax year was the first year that tax filers and their dependents were required to have health insurance. Those who were without insurance during the year must pay a penalty (also called the shared responsibility payment). For tax year 2014, the penalty is 1% of yearly household income above the tax filing threshold, or $95 per person ($47.50 per child under 18 years of age), whichever is greater. The tax filing threshold is approximately $10,000 for an individual.

There are several exemptions from this penalty, some of which can be claimed on a tax return, and some of which require an application through HealthCare.Gov:

Exemptions Claimed on Tax Return

Residence in a State that failed to expand Medicaid

Because Pennsylvania failed to expand Medicaid in 2014, any resident with household income under 138% of the Federal Poverty Level is eligible for an exemption from the penalty. The exemption can be claimed when filing taxes using IRS Form 8965. A Medicaid denial is not needed for this exemption; the only requirement is that 2014 household income was less than the limits listed below.

Short Coverage Gap

Any tax filer or dependent who had a gap in health insurance coverage for less than three months in 2014 is eligible for an exemption. That exemption, too, can be claimed when filing taxes using IRS Form 8965.

Household Size	138% of the Federal Poverty Level in 2014
1	$16,105
2	$21,707
3	$27,310
4	$32,913
5	$38,516

For 2014 only, individual tax filers can also get an exemption if they had a coverage gap of more than three months early in the year but who had continuous coverage from May 1, 2014 through the end of the year.

Marketplace-Granted Exemptions

Denial of Medicaid because of State's failure to Expand Medicaid

Individual tax filers who applied for and were denied Medical Assistance in Pennsylvania due to Pennsylvania's failure to expand Medicaid in 2014 are eligible for an exemption, but must apply for it through the Marketplace. This is different from the exemption noted above since this exemption does not require that someone's 2014 annual income fell below the limits shown in the table above as long as her monthly income was below these limits at the time she applied for and was denied Medicaid.

General Hardship

There are also several other general hardship exemptions available. Tax filers must apply for these exemptions on the Marketplace website, HealthCare.Gov. These exemptions relate to financial or domestic circumstances that presented an obstacle in obtaining coverage such as: homelessness; eviction; utility shut off; bankruptcy; domestic violence; death of a family member; debt from medical expenses; high expenses caring for an ill, disabled, or aging relative; or failure of another party to comply with a medical support order for a dependent child determined ineligible for MA or CHIP.

A tax filer can apply for one of these exemptions on behalf of themselves or a dependent up to 3 years after the month of the hardship. However, because documentation of the hardship is required, applying sooner rather than later is encouraged.

For more information about exemptions or the shared responsibility payment, consult a tax professional or visit HealthCare.Gov.

Attention Aetna and Coventry Medicare Part D Plan Members!

Aetna and Coventry Medicare Part D Plans (stand-alone prescription drug plans as well as Medicare Advantage plans) made changes to their pharmacy networks for the 2015 plan year. However, incorrect information about the pharmacy networks was shared with Medicare during the Open Enrollment Period. This resulted in Medicare's Plan Finder misidentifying pharmacies as in-network with these Medicare Part D plans in 2015. Aetna and Coventry were also using this wrong information to inform prospective members about whether their pharmacy was participating in the plan's network in 2015. Affected consumers were erroneously quoted in-network cost-sharing rates for their medication when they were exploring plan options and enrolling. However, they quickly discovered after January 1st that their pharmacy was actually out of network and the medications were being denied by the plan resulting in their having to pay the full price to obtain the medication, even if they qualified for Extra Help.

In Pennsylvania, Coventry's stand-alone Part D Plans operate under the name "First Health" and their Medicare Advantage Plans operate under the name "Advantra".

Medicare has been working with Aetna and Coventry to resolve this problem. At this time, these plans have temporarily expanded their pharmacy networks so that any pharmacy in the Aetna Premier Preferred network (it's broadest) is considered in-network for members of any Aetna or Coventry plan. Granting this temporary access to an expanded network began mid-January and was made retroactive to January 1st. It will continue until at least February 28th. Medications obtained from a pharmacy in the expanded network should be automatically covered at in-network rates during this period. Members who experience problems can have their pharmacy contact their plan or the member can contact their plan directly to get the problem resolved.

In addition to this temporary network expansion, members of these plans can also:

- Seek reimbursement for medications they purchased at out-of-network rates since January 1st. Aetna and Coventry are reaching out to their members who had a rejected claim at an out-of-network pharmacy. This outreach is being done by mail and by phone. The plan will provide information about how members can seek a refund of the amount they paid above the in-network cost-sharing rate for a particular medication. The plans are also helping members find a pharmacy that will be in their plan's network to use going forward. Those who have not been contacted by their plan about reimbursement can contact Member Services (number on the back of the member ID card) for information about how to seek a refund.

- Contact Medicare (1-800-633-4227) to ask for a Special Enrollment Period (SEP) to change plans and/or to file a complaint against the plan. Medicare is granting SEPs on a case by case basis for affected members. Individuals who do not wish to change their pharmacy and/or who have concerns about getting their medication under their current plan can contact Medicare for help finding a different plan and for approval to change plans. As a reminder, plan members with Extra Help have an ongoing SEP and can change their plan at any time during the year by contacting 1-800-633-4227, enrolling on www.medicare.gov, or enrolling directly with another Medicare drug plan.

More information about the temporary network expansion as well as other information related to the network pharmacy issue can be found on Aetna's website. Individuals who need help with this issue are encouraged to call their plan directly or the Pennsylvania 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.

You can help

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