PENNSYLVANIA Health Law PROJECT

Health Law PA News

A Publication of the Pennsylvania Health Law Project

Volume 17, Number 11
December 2014

Statewide Helpline: 800-274-3258
Website: www.phlp.org

In This Issue

Most Harmful Medicaid Changes Delayed

Most of Pennsylvania's 1.1 million adult Medicaid recipients will **not** be adversely affected by the Healthy PA benefit changes that started on January 1, 2015. The Department of Human Services (DHS), formerly known as the Department of Public Welfare, indicated in a court filing related to litigation brought by Community Legal Services that it is implementing only the benefit package reforms approved by the federal government, which are the "Healthy Plus" and "Healthy PA (Private Coverage Option)" benefit packages.

The proposed "Healthy" benefit package, which contains significant benefit limits such as a $350 annual limit on lab work, is still under review by the federal government and is **not** being implemented effective January 1, 2015 as planned. Federal approval of the "Healthy" package is not anticipated before the January 20th inauguration of Governor-Elect Tom Wolf, who has publicly opposed the Healthy PA initiative.

For a summary of the services covered by the "Healthy Plus" and "Healthy PA (PCO)" benefit packages, see our November Health Law News. Adult consumers who were assigned to the "Healthy" package – mainly very low-income parents – will instead remain in their current benefit package.

DHS officials have made clear that if a HealthChoices managed care plan intends to adopt the coverage limits contained in the "Healthy Plus" or "Healthy" (if later approved) benefit packages, it is required to give its members written notice at least thirty days before the changes begin. To date, no managed care plans have mailed such a notice. Adult recipients in a HealthChoices managed care plan who

are assigned the "Healthy Plus" package should therefore not encounter its $2,500 annual limit on medical supplies unless and until their managed care plan adopts that limit and informs them in advance.

Roughly 40,000 adult Medicaid recipients previously in a General Assistance-related category were moved to the new Private Coverage Option in January and now receive the "Healthy PA (PCO)" benefit package. This package does not have dental or non-emergency medical transportation coverage. Individuals who need these services can take a medical frailty screen by calling DHS' Consumer Service Center (1-866-550-4355). If found to be medically frail, then the individual would be transferred to the HealthChoices delivery system and assigned the more robust "Healthy Plus" benefit package.

New Year, New Opportunities for Medicaid Coverage

As of January 1, 2015, adults (age 19-64) with incomes below 138 percent of the federal poverty level ($16,105/year for a single person and $21,707/year for a married couple) can qualify for Medicaid as long as they are not receiving Medicare coverage. 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. These rules are also used for determining eligibility for pregnant women, families, and low-income parents.

Individuals are encouraged to apply for Medicaid under this new category, even if they were denied in the past. Based on the new MAGI income rules, an adult who was denied Medicaid last year might be eligible now. People 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.

Individuals who wish to find out more about the MAGI rules and qualifying for Medicaid under this new category are encouraged to review PHLP's recently updated Medicaid Eligibility Manual now available on www.phlp.org.

Several Thousand Immigrants to Keep Medicaid Coverage

Pennsylvania's General Assistance (GA) Medicaid program scheduled to end in 2014 will continue to operate in 2015 for approximately 3,000 immigrants who are not eligible under the new adult category created by Healthy PA. All other individuals who had previously been enrolled in this program were moved to the Private Coverage Option for coverage starting January 1, 2015 unless determined medically frail, in which case they should remain in the HealthChoices managed care plan they had in 2014.

The GA program will continue for immigrants (those currently on the program as well as new applicants) who are unable to qualify under the new adult category because they have not been in the US in a qualified status for at least five years. However, as of January 1st, these individuals are no longer enrolled in a managed care plan but instead will get their coverage through the fee-for-service system (ACCESS card). The program's continuation for legal immigrants is the result of legal advocacy done by Community Legal Services.

Choosing a Healthy PA PCO Plan

The Private Coverage Option (PCO) is the new managed care delivery system that will provide coverage to most adults who qualify under the new adult Medicaid category that began on January 1, 2015.

Adult Medicaid recipients enrolled in the Private Coverage Option will initially receive their health benefits through the fee-for-service system. Individuals who do not have an ACCESS card (e.g., people who do not receive Supplemental Nutrition Assistance Program (SNAP) benefits) will not be sent one; rather, these individuals must use their eligibility notice to prove their coverage. While they are temporarily enrolled in fee-for-service, they will receive information about their PCO plan options and be instructed to pick a plan. If consumers do not select a plan, then one will be automatically assigned. The PCO plans available are based on where someone lives. Pennsylvania's 67 counties are separated into nine regions and there are at least three plans to choose from in each region.

Where can individuals find out information about PCO Plans available?

The plans offered in each region can be found on the PA Enrollment Services website. All plans must provide coverage for services as detailed in the Healthy PA PCO benefit package. Plans also have the option to offer additional benefits. Individuals can view a plan comparison chart that includes co-pay amounts and additional benefits each plan in a specific region might offer by visiting the PA Enrollment Services website and selecting their specific county.

What to Consider When Choosing a PCO Plan

When choosing a PCO plan, consumers should select a plan based on the doctors, specialists and other medical providers they want to see. Individuals can learn what PCO plans a local hospital or their doctor(s) accept by visiting www.enrollnow.net. Consumers should make a list of their current health care providers and then:

- contact those providers to find out what PCO plans they accept or
- search for their providers on the PA Enrollment Services website or
- call PA Enrollment Services at 1-844-465-8137, M-F 8am-6pm, and ask a representative for help in finding what plan/s has their providers in the network.

Once individuals know what PCO plan they want to join, they can enroll online or over the phone through PA Enrollment Services (1-844-465-8137). The start date for the PCO plan will depend on when someone joins—individuals who join a plan before the 15th of the month will have coverage in the PCO plan starting the first of the next month; if individuals join a plan after the 15th of the month, the PCO coverage will start on the 15th of the next month.

Can individuals change their PCO Plan?

If an individual is assigned to a plan or enrolls in a plan that does not meet his/her needs, a plan change can be made. However, individuals can only make one change and this change must be done within the first 90 days of enrollment. Note that this is different from the HealthChoices delivery system where consumers can change plans any time during the year.

What else should individuals know about PCO coverage?

Some other important reminders about PCO coverage include:

- Consumers in the PCO delivery system do not have dental coverage. In addition, these individuals do not have access to the Medical Assistance Transportation Program (MATP) for 2015. MATP will be available beginning 2016.
- Consumers assigned to the PCO delivery system who think they are medically frail and should be in the HealthChoices delivery system can "raise their hand" by completing the Health Care Needs Questionnaire with the Department of Human Services (1-866-550-4355). If found medically frail, they will be moved to the HealthChoices system.
- Individuals currently in the middle of treatment for an illness or injury can continue to be treated by their doctor for up to 60 days, even if the doctor does not accept the individual's Healthy PA PCO Plan. The doctor must agree to work with the PCO plan and accept the PCO plan's payment rates for the continued treatment to be covered by the PCO plan.

Alert: Some Behavioral Health Consumers Wrongly Placed in PCO

Behavioral health providers have alerted the Department of Human Services (DHS) and the Department of Drug and Alcohol Programs (DDAP) about a significant number of Medicaid consumers who meet the definition of "medically frail" yet have been placed in the Healthy PA Private Coverage Option (PCO). As a reminder, individuals who might otherwise qualify for the PCO, but who are determined to be medically frail, remain in HealthChoices and receive the Healthy Plus benefit package. This enrollment in the PCO is problematic because the PCO plans do not cover the broad range of behavioral health services that HealthChoices plans do.

DHS and DDAP are working to correct this error. Affected individuals (or providers who work with them) are strongly encouraged to go on COMPASS or call 1-866-550-4355 to complete the Health Screening as this may help the Departments to resolve this issue in a more timely way.

Impact of Medicaid Expansion for Those With Marketplace Coverage

Pennsylvania's decision to expand Medicaid twelve months after the January 1, 2014 start date of the Health Insurance Marketplace has created an unusual situation for tens of thousands of insured adults with estimated annual incomes between 100 and 138 percent of poverty. In 2014, many of these Pennsylvanians received premium tax credits to purchase health insurance plans through the Marketplace (HealthCare.gov). However , now that Pennsylvania expanded Medicaid to most adults with income below 138 percent of poverty through its Healthy PA initiative, those tax credits for Marketplace coverage are not available to people who have access to Medicaid. We've prepared responses to frequently asked questions about transitioning from Marketplace plans for Pennsylvanians who are now Medicaid-eligible.

I got a letter from HealthCare.gov telling me to renew. Then Healthcare.gov told me I may qualify for Medicaid. Can I have Healthcare.gov tax credits and Medicaid?

No. You cannot get HealthCare.gov tax credits to help pay for coverage if you qualify for Medicaid. In 2014, some people correctly signed up for Marketplace coverage and received help paying their premiums and out-of-pocket costs. But Pennsylvania expanded Medicaid through Healthy PA in 2015, and Pennsylvanians whose income is between 100 and 138 percent of poverty can now qualify for Medicaid. Those who now qualify for Medicaid aren't permitted by law to receive help with the cost of a Marketplace plan.

What happens if I don't apply for Medicaid?

If your income is less than 138 percent of poverty for 2015 ($16,105 for a single person, $21,707 for a family of two) and you stay on your Marketplace plan and get tax credits, you may have to pay back some or all of the premium tax credits to the Internal Revenue Service (IRS).

When do I have to make this change?

Healthy PA started January 1, 2015. If you think you qualify for Medicaid, you should apply as soon as you can. See the "New Year, New Opportunities for Medicaid Coverage" article on page 3 of this newsletter about how to apply. If you qualify for Medicaid, but do not act to end your tax credits or health coverage, you may have to pay back some or all of the tax credits you receive and be liable for premiums owed to the plan for the months you had Marketplace coverage.

Is there a deadline?

No. You can apply for Medicaid any time. There is no open enrollment period. But if you are getting tax credits to help pay for your HealthCare.gov Marketplace plan, you should apply for Medicaid as soon as you can to avoid having to pay back money for tax credits you receive.

How can I change from HealthCare.gov to Medicaid?

The easiest way to change to Medicaid is to call the HealthCare.gov Customer Service Center at 1-800-318-2596. Someone there can look at your account and tell you what steps you need to take.

Will the Marketplace automatically send my information to Medicaid?

No. In order for you to get Medicaid coverage in 2015, you will either have to apply directly to Medicaid (see page 3) or contact the Marketplace (1-800-318-2596 or www.healthcare.gov) to renew your information.

If you choose to renew your information via HealthCare.gov, after you finish your application, you will see a screen that says some people in your household may qualify for Medicaid or the Children's Health Insurance Program (CHIP). This means that HealthCare.gov has sent your account file to Pennsylvania's Department of Human Services.

You will also get an eligibility letter in your "My Account" telling you that HealthCare.gov sent your account file to Pennsylvania for Medicaid or CHIP.

If you take no action to either apply for Medicaid or contact the Marketplace to renew your information, then you will likely be responsible for paying back some or all of the tax credits you receive in 2015.

When should I stop my HealthCare.gov coverage?

This is up to you. You can wait for a final decision from Medicaid before cancelling your tax credit and your plan or you can cancel your tax credits and coverage while you wait for a decision from Medicaid. If you are approved for Medicaid, your coverage will be effective as of the date your application was received; if you applied before January 1st, then your coverage will start January 1st.

Your HealthCare.gov coverage and tax credits will continue until you cancel them. You will not have a gap in coverage if you wait until you receive a final Medicaid decision before canceling your plan and the tax credits you receive; however, you will be responsible for the premiums owed to the plan for the month(s) you are covered and may have to pay back some or all of the tax credits your receive.

If you qualify for Medicaid, you must go back to HealthCare.gov and cancel both your Marketpace plan and tax credits. If you don't do this, you may have to repay your tax credits and you may be responsible for paying premiums owed to your plan for the time period you were covered.

Can I keep my current doctor?

You may be able to keep your doctor. Ask your doctor, nurse-practitioner or clinic if they take Medicaid or Healthy PA PCO patients. If they do, ask which plans they accept.

If you are receiving treatment for an illness or injury that your Marketplace insurance plan approved, you may be able to continue that treatment when you change to Medicaid. You can continue your treatment with your doctor for up to 60 days even if the doctor does not accept Medicaid. The doctor must agree to work with the Medicaid plan and accept Medicaid payment rates for the continued treatment.

State Seeking Public Input on Certain HCBS Waiver Documents

The Office of Long Term Living ("OLTL") is seeking comments to documents it plans to submit to the federal government for review and approval relating to several Waiver programs that operate in Pennsylvania. Specifically, it is seeking feedback about the following:

- Renewals of the CommCare and Independence Waivers
- Amendments to the existing Aging, Attendant Care, and OBRA Waivers
- Transition plans for the CommCare and OBRA Waivers that detail how these programs will comply with new federal regulations

Comments are due February 3, 2015. Readers can view the Waiver renewals, amendments and transition plans here. Written comments can be submitted to RA-waiverstandard@pa.gov or to:

The Department of Human Services, Office of Long-Term Living
Bureau of Policy and Regulatory Management
Attention: Jennifer Hale
P.O. Box 8025
Harrisburg, PA 17105-8025

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).

Issues with Transition Plans

The transition plans available for public comment incorporate previous stakeholder feedback as well as comments from the federal government. Based on consumer and advocate feedback, timelines for many of the tasks required to transition to the new federal requirements were moved up. Many of the activities now have a target end date of December 2014; however, only one of those activities is listed as completed. If the others have not yet been completed, a more realistic target end date should be included in the plans. Other areas that PHLP has identified as problematic are:

- **Identification of "key stakeholders"** - The transition plans indicate that OLTL has identified key stakeholders as of December 2014. Aside from the appointed members of a specific advisory committee, it is unclear which consumers, consumer organizations and advocacy organizations have been "identified" as "key stakeholders". Given the importance of input from consumers and advocates during the entire transition process (see Section 4, #3 of the plans), OLTL should provide an opportunity for consumers and advocates to self-identify as stakeholders to ensure input from people with a variety of experiences and viewpoints. Furthermore, the opportunities for stakeholder input listed in the plan ("statewide bulletins, departmental websites, stakeholder meetings, webinars…") may not be sufficient to provide meaningful opportunities for consumers who don't have access to bulletins, a computer, or the ability to attend meetings. The plans have one brief statement regarding "Continued engagement with stakeholder community"; however, there is no mention about how that will be done. There should be additional forms of outreach and engagement with consumers, such as by selective mailings or phone calls or by email for those who have smartphones or computers.

- **Participant monitoring tool—**The creation of a tool for obtaining feedback from Waiver participants is a good idea, although the name "participant monitoring tool" makes it sound like a series of questions by which the participant is monitored, rather than the provider. Using that tool for participant input should not be limited to "face-to-face visits" by service coordinators and instead participants should be able to have their input recorded and made part of OLTL's provider monitoring efforts whenever the participant would like to share their input.

- **Transition from non-compliant programs**— If Waiver participants are in programs in settings no longer permissible under the new federal regulations, those individuals will need to transition to programs in settings that meet the new requirements. Careful planning will need to be done to ensure affected individuals continue to have their needs met in the new programs/settings with the least disruption possible. That planning is best done by a team that includes the participant, family members (if applicable), and others who have information or resources to provide, in addition to the service coordinator. Unfortunately, the plan leaves the critical planning tasks entirely up to often overworked service coordinators. OLTL should ensure that service coordinators use a person-centered planning process (as set out in the new federal regulations) and attempt to engage a team to determine the individual's needs and preferences and to find a new program that meets those needs and preferences. OLTL should also identify alternative sites/providers rather than leaving that task to service coordinators who may lack information about all potential providers.

Medicare Part D Prescription Coverage in 2015

Making Plan Changes During the Year

As a rule, beneficiaries are locked into their Medicare Advantage or Medicare drug plan choices for 2015 and can only change their coverage during the year if another enrollment period applies to them or if they qualify for a Special Enrollment Period.

Each year, the **Medicare Advantage Disenrollment Period** runs from January 1st to February 14th. During this time, anyone who is enrolled in a Medicare Advantage Plan can drop that Plan and switch to Original Medicare. In addition, these individuals can join a stand-alone drug plan to ensure that they have Part D prescription coverage. These are the only changes that can be made during this period. Medicare beneficiaries cannot use this Disenrollment Period to switch to a different Medicare Advantage Plan, nor can they use it to simply switch from one drug plan to another.

Medicare has a number of **Special Enrollment Periods** targeted to certain populations and certain circumstances. If a person meets the requirements for a Special Enrollment Period (SEP), they can use the SEP to join, change, or disenroll from a Medicare health or drug plan outside of the normal enrollment periods. For those using a SEP to make a plan change, the new plan will start the first of the month following the change. These are some of the more common SEPs available:

- **Anyone receiving Extra Help from Medicare** has an ongoing SEP and can change plans at any time, or even multiple times, during the year.
- **Those who are dual eligibles** (have both Medicare and Medicaid) have an ongoing SEP and can change plans at any time, or even multiple times, during the year.
- **Anyone who has lost their Extra Help from Medicare for 2015** has a one-time SEP that lasts from January 1st to March 31st to switch their plan.
- **Those in plans that terminated at the end of 2014** have a one-time SEP that runs from December 8th to February 28th to join a new plan.
- **Anyone enrolled in a State Pharmaceutical Assistance Program** (namely PACE/NET, CRDP or SPDP) has a one-time SEP that allows them to join a Medicare Prescription Drug Plan or change their plan at any time during the year.
- **Those enrolled in a Medicare Advantage Plan who are affected by a significant change in the provider network during the year** may be given a one-time SEP to change their plan. **This is a new SEP in 2015.** Note: it is up to Medicare to determine whether a "significant change" has occurred and therefore whether enrollees are given this SEP.

Medicare consumers can contact Medicare (1-800-633-4227), APPRISE (1-800-783-7067), or PHLP (1-800-274-3258) to see if these or any other available SEP would apply and allow them to enroll in or change their Medicare drug plan during the year.

Reminder about Part D Plan Transition Requirements

Under Medicare rules, Part D plans must provide a one-time temporary supply of a medication within the first 90 days of coverage for enrollees who have been taking a drug that is either not in the Plan's formulary, or that requires prior authorization from the plan before it can be covered. This transition requirement applies to new plan enrollees as well as current plan enrollees who are affected by changes to their plan's formulary from one plan year to the next. The purpose of the one-time temporary supply (a 30 day refill) is to allow time for the prescriber to either switch their patient to another medication covered by the plan, or to seek authorization or a formulary exception from the plan.

Happy New Year from PHLP!

With 2015 upon us, we take a moment to express our appreciation for your support during an incredibly busy 2014 that featured the launch of the HealthCare.gov Marketplace coverage that enrolled over 300,000 Pennsylvanians and an agreement between federal and Pennsylvania officials to expand Medicaid coverage to 600,000 adults.

First, we would like to thank to our partners, funders, board members and supporters! Your commitment to our shared work and shared vision is invaluable. Second, we thank our clients. We could not have achieved so much without the continual input from individuals we serve every day. Your stories and your life experiences drive us to do better.

In 2015, PHLP remains committed to:

- Providing high quality legal assistance to as many individuals as possible to help them overcome barriers to accessing coverage and healthcare services
- Sharing information about policies and practices so that others can be informed to assist Pennsylvanians in need
- Influencing policies and practices that maximize health coverage and access to care, hold providers and insurers accountable, and achieve better health outcomes and reduce health disparities

We look forward to continued partnership and a productive and successful 2015. Happy New Year!

PHLP: Helping People in Need Get the Health Care They Deserve

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.

Support Our Work

Please support PHLP by making a donation on our website at phlp.org. You can also donate through the United Way.

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.

For the Pittsburgh Region, go to unitedwaypittsburgh.org and select agency code number 11089521.