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In This Issue

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Health Care Marketplace Updates

The Open Enrollment Period for individuals to join a Marketplace plan, and get premium tax credits as well as cost-sharing subsidies for 2014, ended March 31st. Those who did not enroll by this deadline will likely have to wait until the end of this year before they can sign up for Marketplace coverage that will not start until 2015. These individuals may also have to pay a penalty if they did not have Minimum Essential Coverage in 2014. Please note that individuals can apply for Medicaid* and the Children's Health Insurance Program (CHIP) at any time during the year as there is no deadline to apply for these programs.

Recently, the federal government announced that individuals who started a Marketplace application by March 31st but were unable to complete it for some reason will have extra time to enroll. Individuals in this situation should contact the Marketplace at 1-800-318-2596 or find local help here as soon as possible.

* In Pennsylvania, our Medicaid program is called Medical Assistance (MA). Throughout the newsletter, we use the general term Medicaid. When referring specifically to Pennsylvania, Medicaid will mean Medical Assistance.

How to Enroll After March 31st

Some people may qualify for a Special Enrollment Period allowing them to apply for tax credits and cost-sharing subsidies and to enroll in qualified health plans through the Marketplace after March 31st. Special Enrollment Periods are triggered by specific life events as outlined on the next page. Generally, individuals have 60 days from the triggering event to enroll in a plan (or change plans) and apply for tax credits and cost-sharing subsidies through Healthcare.gov.

Eligibility for a Special Enrollment Period

Experiencing one of the following events will give an individual a Marketplace Special Enrollment Period**:**

- **Life Changes**: marriage, divorce, birth or adoption, change in immigration status, or a permanent move to new area that offers different health plan options.
- **Loss of Minimum Essential Coverage**: includes losing employer coverage, having COBRA coverage expire, or no longer qualifying for Medicaid or CHIP. This would also include situations when an employer-sponsored plan is no longer affordable or adequate. Please note that voluntary termination of coverage, or loss of coverage due to non-payment of premiums, is **not** considered loss of Minimum Essential Coverage and would **not** qualify someone for a Special Enrollment Period.
- **Other situations**: exceptional circumstances (such as an increase in someone's income that would result in someone now being penalized for not having Minimum Essential Coverage when they had been previously exempt from the penalty), error or inaction by the Marketplace or the federal government, or misconduct by a non-exchange entity such as a navigator, an application assistor, or an insurance broker.

Penalties

The Affordable Care Act requires all individuals to have Minimum Essential Coverage (MEC) starting in 2014. Individuals who do not have this level of coverage may be subject to a penalty. Generally, to avoid the penalty, individuals cannot be without MEC for longer than 3 months of the year. Please note that any individual who enrolled through Healthcare.gov by March 31st will not be liable for the months that they were uninsured prior to signing up, even if they were uninsured for more than 3 months. Individuals who earn less than 100 percent of the Federal Poverty Level in 2014 ($11,670 for a household of one), and are found not eligible for Medicaid, qualify for an exemption and will not be liable for a penalty. This exemption applies to people in Pennsylvania because we are not expanding Medicaid at this time.

2015 Open Enrollment Extended

The federal government recently announced that the open enrollment period to enroll in health coverage through the Marketplace for 2015 will be from November 15, 2014 through February 15, 2015. During that time, individuals and families will be able to sign up for qualified health plans, advanced premium tax credits, and cost-sharing subsidies for 2015 coverage.

Healthy PA Update: Changes to Work Requirement and Comment Deadline Extension

In early March, Governor Corbett submitted a modification to the Healthy PA Waiver application that was previously submitted for federal approval on February 19th (readers can see information about the application in our February newsletter). The modification made the work requirement voluntary rather than mandatory. Governor Corbett made this change based on indications from the US Department of Health and Human Services that work requirements were not likely to be approved. Many legal advocates, including PHLP, believe that the work search requirement is impermissible under federal law. Currently, no other state ties Medicaid benefits to a work requirement. The federal government will consider both the initial application and the modification for approval.

According to the proposed modification, Pennsylvania's Medicaid program would include a one-year, voluntary, pilot program to encourage people to work. Individuals' participation would be encouraged using premium and co-pay reduction incentives. The Waiver modification states that after the initial one year pilot program, Pennsylvania will share the data with the federal government. It does not indicate whether Pennsylvania would seek permission to make the program mandatory in future years.

During demonstration year one, all people over the age of 18, including those previously exempt from the work requirement under the initial proposal, would be eligible to participate in job training and employment opportunities. However, no one would be required to participate in these activities to keep Medicaid.

To encourage participation, a tiered discount system would be implemented. In year one, the discount would be applied to the individual's co-payments to health providers since premiums do not start under Healthy PA until year two (if approved). Individuals working 30 or more hours a week would receive a co-pay reduction of 40 percent while those working 20-29 hours per week would receive a co-pay reduction of 25 percent. Anyone working less than 20 hours per week would receive a co-pay reduction of 15 percent as long as they are registered with JobGateway and engaging in job training activities each month. Those participating will be re-assessed every six months to ensure they are receiving the correct discount amount.

Comment Deadline Extension

Because Pennsylvania modified its Waiver application, the federal government extended the comment period until **6:00 a.m. on April 11, 2014** for people to submit written comments about Healthy PA.

Comments can be submitted using an online questionnaire, by e-mail, or by regular mail. Individuals commenting via e-mail or US mail are encouraged to put "Healthy PA Comments" in the subject line. The e-mail address for comments is: 1115DemoRequests@cms.hhs.gov. The mailing address for comments is:

Megan Stacy, Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mailstop: S2-01-16
Baltimore, Maryland 21244

OMHSAS Proposed Budget Makes Minimal Changes

Department of Public Welfare Deputy Secretary Dennis Marion presented the proposed 2014-2015 budget for the Office of Mental Health & Substance Abuse Services (OMHSAS) at the OMHSAS Planning Council meeting on March 6th and again in Harrisburg on March 10th. During his presentations, he noted OMHSAS' priorities: continued stakeholder engagement, following the mission and guiding principles, and possible implementations of the System Innovation Model and Healthy PA. The priority groups OMHSAS will focus on in the next fiscal year are those with co-occurring disorders of mental health and substance use, those involved with the criminal justice system, individuals with dual diagnoses of mental health and intellectual disabilities, and veterans. These priorities are guiding the Administration's proposed budget for the next fiscal year.

Funds requested for OMHSAS by the Governor for FY 2014-15 total $4.143 billion. This breaks down to $3.05 billion for the Behavioral HealthChoices Program, over $1 billion for community mental health funds, $39.1 million for community drug and alcohol treatment funds and $51.5 million for behavioral health services under Medicaid Fee For Service. The proposed budget represents an increase of $157 million to the HealthChoices program (capitation payments), a $19 million increase to community mental health funds, flat funding for community drug and alcohol funds, and a $1.4 million increase to Medicaid Fee For Service.

As readers may recall, in 2012 Pennsylvania enacted the Human Services Block Grant Program which initially allowed 20 counties to combine the funding they get from the state for a number of different programs into a single block grant. The county is then given flexibility and discretion over how the combined funds are allocated. In FY 2013-14, 10 more counties were added to the Block Grant Program. The proposed 2014-15 budget provides for the remaining 37 counties to participate in the Human Service Block Grant. Advocates continue to raise concerns about the block grant program (which was initially described as a "pilot") and the lack of outcome data available to support the effectiveness of continuing, and expanding, the program.

The proposed OMHSAS budget also allocates an additional $4.7 million to the Community Hospital Integration Program Project (CHIPPs), which will allow 90 more individuals living in a state mental hospital to be discharged with the services and supports necessary for their successful integration into the community. This is consistent with the Olmstead Plan for Pennsylvania's State Mental Health System and its stated goal to reduce the state hospital civil bed capacity by at least 90 beds each fiscal year.

Children's Social Security Benefits and Calculating MAGI

Beginning in October 2013, the Department of Public Welfare (DPW) began using new income rules when determining Medicaid eligibility for pregnant women, parents, and children. These tax-based rules, known as Modified Adjusted Gross Income (MAGI), are also being used when determining eligibility for the Children's Health Insurance Program (CHIP) and for determining who qualifies for premium tax credits and reduced cost-sharing through the federal Marketplace (Healthcare.gov).

Household MAGI combines **each** household member's MAGI. When determining MAGI, certain types of income, such as worker's compensation and child support, are not counted. Under the MAGI rules, Social Security benefits received by parents or tax filers are counted, but Social Security benefits received by dependent children or other tax dependents are almost always excluded.

Minor children can receive a Social Security benefit if a parent is retired or disabled and collecting Social Security benefits, or if a parent has passed away. Under the MAGI rules, these Social Security benefits that a dependent child receives count toward household income **only if** the child is required to file a tax return. Typically, children receiving these benefits have no other income that would require them to file taxes and therefore, their Social Security income should not be counted when determining household MAGI. However, if an individual child does have other income, such as wages that would require them to file taxes, then the taxable portion of the Social Security benefits **would** count towards MAGI.

In summary, when determining eligibility for Medicaid, CHIP, or Marketplace tax credits and subsidies, a dependent child's Social Security income should **not** be counted **if** the child is **not** required to file taxes. DPW recently issued a policy clarification (PMA 17039-350) instructing caseworkers on how to treat children's Social Security benefits. Because the DPW computer system counts Retirement, Survivors, and Disability Insurance (RSDI) benefits in the MAGI analysis, caseworkers must manually enter an exclusion code in these cases. Families or advocates who think a child's social security benefit is being counted in error should contact PHLP's Helpline at 1-800-274-3258.

Keystone First Enrollment Suspension Lifted

Individuals receiving Medicaid coverage and living in the Southeast HealthChoices Zone (Bucks, Chester, Delaware, Montgomery and Philadelphia Counties) can again enroll in the Keystone First Health Plan. Keystone First is one of five Medicaid managed care plans operating in the Southeast Zone. Readers may remember that the Department of Public Welfare approved Keystone First's request to suspend new enrollments into its plan beginning in April 2013. DPW approved it to balance membership among the various Medicaid plans available in the Southeast Zone. The enrollment suspension was lifted as of January 1, 2014.

Lawfully Residing Pregnant Women and Children Can Qualify for Medicaid and CHIP

For more than a year, Medicaid and the Children's Health Insurance Program (CHIP) have allowed certain immigrant children and pregnant women "lawfully residing" in the United States to qualify for coverage through those programs. In the course of PHLP's Helpline work, we realize that many individuals are not aware of this policy change and wanted to make sure our readers understood the rules about when children and pregnant women who are non-citizens can qualify for Medicaid and CHIP.

The Five-Year-Rule & the Exception: Under federal Medicaid eligibility rules, individuals have to be US citizens **or** be in a qualified immigrant status to qualify for coverage. This is **in addition** to meeting other Medicaid requirements such as fitting into a covered group and then meeting income and resource guidelines. Immigrants who are not citizens but who are qualified immigrants can generally only receive ongoing Medicaid if they have been living in the US in that qualified status for at least five years. The Five-Year-Rule, however, does **not** apply to pregnant women or to children under the age of 21. As long as these individuals have a qualified immigrant status (which includes legal permanent residents, refugees and asylees) and meet all the other programmatic requirements, they are eligible for Medicaid and do not have to wait five years to qualify.

Now, under federal law, the rules for Medicaid eligibility for immigrant pregnant and children have expanded to include those who are "lawfully residing" in the US as long as they meet all other eligibility criteria. The term "lawfully residing" includes not only qualified immigrants but other non-citizens who are in the US legally and who are permitted to live and work here indefinitely.

Immigrants considered to be "lawfully-residing" in the United States include:

- Lawful Permanent Residents
- Refugees
- Asylees
- Those granted withholding of Deportation or Withholding of Removal
- Cuban and Haitian entrants
- Others paroled into the United
- Those with Temporary Protected Status
- Those under Deferred Enforced Departure
- Those under Deferred Action except for DACA*
- Domestic Violence Survivors and Victims of Trafficking
- U Visa Holders – Victims of serious crime
- Nonimmigrant visa holders (students, tourists, visitors on business, and those who are permitted to live and work in the US indefinitely)
- Citizens of Micronesia, the Marshall Islands and Palau
- Longtime residents – individuals who have been in the US for a long period of time and who are completing the process of securing lawful permanent status or who cannot be returned to their home country and are therefore likely to remain in the US

* Youth with Deferred Action for Childhood Arrivals (DACA) status are **not** eligible for Medicaid or CHIP.

When applying for Medicaid, individuals may be asked for written proof of their immigration status. Caseworkers can also verify an applicant's citizenship and immigration status electronically through the federal data hub and the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) Program.

Medicaid eligibility for immigrants who are **not** pregnant women or children has **not** changed. These individuals generally must still have a "qualified immigrant" status and have lived in the US for at least five years under that status before they can qualify for Medicaid coverage.

The same immigration eligibility rules that apply to Medicaid for children also apply to CHIP. Children under age 19 "lawfully residing" in the US now qualify for CHIP and do not need to wait five years, as long as the child meets all other CHIP requirements.

Immigrants "lawfully-residing" in the US who apply for Medicaid or CHIP and are denied based on their citizenship status are encouraged to call PHLP's Helpline at 1-800-274-3258.

All Medicaid Managed Care Plans Now Limiting Dental Benefits for Adults

Coventry Cares implemented dental limits for its adult members on April 1, 2014. Coventry Cares is the last Medicaid managed care plan to impose the dental limits that the Department of Public Welfare implemented for adults in the Medicaid Fee-for-Service system in September 2011. Medicaid managed care plans were given the discretion to decide whether to implement the limits for their adult members. Over time, all the plans except for Coventry Cares had imposed the limits. All members of Coventry Cares over the age of 21 who qualify for dental coverage under Medicaid should have received written notice from the plan telling them about the dental benefit limits that began on April 1st.

As a reminder, under the adult dental limits Medicaid only covers one set of dentures per lifetime. Root canals, crowns, and periodontal services are **only** covered if a benefit limit exception is requested by a dental provider and approved by Medicaid. A benefit limit exception can be granted if, without the requested service, the patient's life would be in danger, the patient's health would get much worse, or the patient would need more expensive services.

Application Transfers between the Marketplace and Medicaid/CHIP

When the Affordable Care Act (ACA) was written, one of its goals was "no wrong door" for applying and enrolling into health care coverage–meaning people could apply through the federal Health Insurance Marketplace (Healthcare.gov) or directly to their state's Medicaid or CHIP programs and they would seamlessly enroll in the coverage that was most appropriate for their income and household size. Unfortunately, the technology infrastructure developed to exchange information between the federal Marketplace and Pennsylvania's CHIP and Medicaid agencies failed to operate as envisioned. As a result, people who applied for Marketplace coverage but were determined eligible for Medicaid or CHIP, as well as those who applied for Medicaid

or CHIP but were determined eligible for Marketplace coverage, were left in limbo waiting for the transfer of their information from one program to another.

Previous newsletters included information about problems and delays in information being transferred between programs. In the last month, the Department of Public Welfare, which operates Medicaid, and the Insurance Department, which operates CHIP, finally began receiving data for applicants from the Marketplace. An estimated 43,000 applications were to be transferred to the state by the end of March. Of these, approximately 37,000 applications were transferred to Medicaid and 6,300 applications transferred to CHIP.

Even though files are now being transferred, several challenges remain. Each application file from the Marketplace must have enough information to meet the requirements of Medicaid's eligibility system. Regrettably, many of the files are missing information needed to approve the applicant for Medicaid. Also, it is likely that rather than wait for the transfer to occur, individuals went ahead and applied directly to Medicaid or CHIP as we had suggested in past newsletters, thereby creating a duplicate case that must reconciled in the state's systems.

Medicaid caseworkers are working through the transferred applications trying to obtain missing information, determine eligibility and then authorize coverage through their system (if the person has not already been approved). CHIP contractors are working in a similar fashion. It will take time for both CHIP and Medicaid to work through the backlog of transferred applications.

Anyone who applied for Medicaid or CHIP through the Marketplace and still has received no answer on their eligibility can call the Change Center at 1-877-395-8930 (Philadelphia residents should call 215-560-7226) to see if their application is pending with the state. If no application is found, PHLP recommends that the person apply again through COMPASS, through their local County Assistance Office, or over the phone by calling 1-866-550-4355.

CHIP to Medicaid Transition Begins

The Affordable Care Act changed the eligibility rules for how children qualify for Medicaid and CHIP. As of January 1, 2014, the Medicaid income guidelines for children ages 6 through 18 increased from 100 percent to 133 percent of the federal poverty level. This means that some children currently covered by CHIP now qualify for Medicaid and must move to this program by December 31, 2014.

Recently, CHIP contractors sent letters to families in this situation describing their options:

- Move to Medicaid now;
- Move to Medicaid at the child's renewal date; or
- Move to Medicaid at the end of this year.

Both CHIP and Medicaid cover medical, dental, behavioral health, vision services and prescription medictions. However, Medicaid has broader coverage than CHIP because under federal law Medicaid must cover **all** medically necessary health care services and treatments. Services that Medicaid pays for that CHIP does not

cover include hearing aids and other hearing devices, family-based mental health services and medical transportation to and from doctor visits, pharmacies and other medical appointments.

When a child moves from CHIP to Medicaid, they will get a letter from the Department of Public Welfare telling them the start date for their new coverage. Initially, the child will get Medicaid through the Fee-for-Service system (using their ACCESS card). The child's parents will then be sent information telling them: they must pick a Medicaid managed care physical health plan for their child, the plan choices available, and how to enroll their child in a plan (and pick a PCP) through PA Enrollment Services (1-800-440-3989 or www.enrollnow.net). Children whose parents or caregivers do not choose a plan or PCP will be assigned to one. Once the plan enrollment goes into effect, the child will no longer use their ACCESS card but will use their health plan card to obtain health care coverage and services.

Many doctors accept both CHIP and Medicaid plans. Parents should check with their child's doctor or clinic to see what Medicaid plans they take. If the child currently sees a specialist, parents should check with that office as well. In addition, parents can use the PA Enrollment Services website, www.enrollnow.net, to see what doctors and hospitals participate in the health plans available to them.

Though parents can choose their child's Medicaid **physical** health plan, they cannot choose their child's **behavioral** health plan. Instead, the child is enrolled in a separate behavioral health plan chosen by the county they live in. The child must access all mental health and drug & alcohol services through their behavioral health plan's network.

Important things to keep in mind when a child moves from CHIP to Medicaid:

- Parents must choose a Medicaid physical health plan and a PCP or one will be chosen for the child.
- The child can change the Medicaid physical health plan and/or PCP at any time!
- Medicaid Fee-for-Service and the Medicaid plans must continue to cover prior authorized services for the child until the end of the authorization period.
- If the child is in the middle of treatment, Medicaid Fee-for-Service and the Medicaid plans should continue to cover an out-of-network provider for 60 days as long as that provider is a registered Medicaid provider.

Long Term Care Commission Seeks Public Comment

Public input is being solicited on how the long term care system operates in Pennsylvania and on how it can be improved. As reported in earlier newsletters, Governor Corbett has created a Long Term Care Commission to evaluate the state's provision of long term care services in the home and community, as well as in skilled nursing facilities, and to make recommendations for how the system can be improved. The Commission is also charged with identifying effective ways to provide a better coordinated approach to delivering services and supports and ensuring quality health care for older adults and persons with physical disabilities across the Commonwealth. The 25 members of the Commission include consumers, a family caregiver, medical providers, disability advocates, advocates for the aging community, long-term care providers, and members of the PA legislature. The co-chairs of the Commission are Secretary of Aging Brian Duke and Secretary of Public Welfare Beverly Mackereth.

At their first meeting in March, the Commission decided to solicit public comment and input on the current long term care system and how it can be improved. The Commission is planning to hold 4 public input meetings at various locations across the state to obtain regional input. **The first public input meeting is now scheduled for Friday, April 11th from 1:00-4:00 PM in Harrisburg** at:

The Honors Suite

333 Market Street

Harrisburg, PA 17101

The Notice of the first Public Comment Hearing will be published in the Pennsylvania Bulletin on April 5th and can be found here. According to the Notice, the Commission is especially interested in getting feedback on the following topics:

- **Prevention and Caregiver Support**
- **Accessibility**
- **Provision of Service**
- **Quality Outcomes and Measurement**

Anyone wishing to attend and provide public comment must register on or before April 10th by calling 717-425-5719 (TDD users can call 1-800-654-5984) or by registering online.

The Commission will also accept written comments and feedback through June 27, 2014. Written comments can be sent by email to ra-LTCCommission@pa.gov or by US mail to Attn: OLTL POLICY, P.O. Box 2675, Harrisburg, PA 17105.

Medicare Clarifies Coverage of Skilled Nursing and Therapy Services

Medicare recently clarified its criteria for payment of skilled nursing care and therapy services to emphasize that improvement is **not** required for Medicare coverage of these services. Certain individuals who had previously been denied Medicare coverage for these services on the basis of not improving can resubmit their claims to Medicare and have them re-reviewed. These actions are the result of a settlement agreement entered into in January 2013 regarding the lawsuit entitled *Jimmo v. Sebelius*. The class-action lawsuit was filed by the Center for Medicare Advocacy and Vermont Legal Aid on behalf of Medicare beneficiaries who were denied coverage of skilled nursing care and therapy services on the basis of not improving. The plaintiffs' sued the Centers for Medicare & Medicaid Services challenging this improvement standard and asserting that it was not supported by Medicare law.

In recent months, Medicare has fulfilled a number of requirements of the settlement including:

- Updating its policy manuals to clarify that improvement is **not** necessary for coverage of skilled nursing care and therapy services in inpatient rehabilitation facilities, skilled nursing facilities, home health care settings, and outpatient therapy settings. Instead, the policy clarifications explain that skilled nursing care and therapy may be covered when reasonable and necessary to improve a patient's current condition, maintain a patient's current condition, **or** prevent or slow further deterioration of a patient's condition.
- Conducting education about the clarified coverage criteria for skilled nursing and therapy services to ensure that various parties involved in the provision of services, as well as those who conduct the review of Medicare claims and issue payment decisions, understand the criteria and apply it correctly. The education is being provided in the form of written materials as well as conference calls with various stakeholder groups.
- Reviewing the claims of individuals who were previously denied Medicare coverage for skilled nursing care or therapy services on the basis of not improving. Individuals who wish to have their claims re-reviewed must request this re-review. More information about who can request a review of a previously denied claim and the timeframes for making this request can be found here.

Anyone wanting more information about this lawsuit and the Improvement Standard should visit the Center for Medicare Advocacy's website.

Federal PCIP Coverage Extended Through April

The federal government recently announced that the Pre-Existing Condition Insurance Plan (PCIP) coverage will be extended through April 2014 to allow current enrollees more time to find coverage through the Marketplace and transition to new coverage. Approximately 1,300 Pennsylvanians were still enrolled in PCIP coverage according to recent enrollment data. This is the third coverage extension for the program that was originally supposed to end December 31, 2013. As a reminder, Pennsylvanians were previously enrolled in PA Fair Care prior to being transferred to the federally-run PCIP program in July 2013. PCIP enrollees received notification about this extension through the mail and information is also available on the program's website.

In addition to having their coverage extended through April, PCIP enrollees have a Special Enrollment Period that allows them to enroll in Marketplace coverage and apply for tax credits and subsidies after March 31st. To ensure that they have no gap in coverage, PCIP enrollees are encouraged to enroll in a Marketplace plan by April 15th so that the new coverage will start May 1st.

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.

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