

In This Issue

Medicaid Expansion: One Year Later 2

CMS Reinforces the Prohibition on Balance Billing of Dual Eligibles 3

New Medicaid Managed Care Rules Released by CMS 4

Correction to PHLP D&A Publication 5

Community HealthChoices Update: 14 Plans Submit Bids to Participate

Fourteen health plans responded to the Community HealthChoices RFP and submitted bids to participate as a Community HealthChoices Managed Care Organization (CHC-MCO) in one or more of the state's Community HealthChoices regions. The deadline to submit a bid was May 2nd.

These are the plans who submitted a bid:

- Gateway Health Plan*
- UPMC For You*
- Accenda Health of Harrisburg
- Aetna*
- AmerihealthCaritas*
- Cedar Woods Care Management
- United Healthcare*
- Cigna-Health
- Geisinger Health Plan*
- HealthPartners*
- Molina Healthcare
- PA Health & Wellness/Centene
- Trusted Health Plan
- WellCare

Only 7 of the plans (noted with an *) have previously done business as Medicaid plans in Pennsylvania.

Subscribe...

Online at phlp.org/emaillist or by emailing staff@phlp.org

The Department of Human Services is now in the process of reviewing all of the bids and will choose from 2 to 5 health plans within the next few months to operate as CHC-MCOs in each region. As a reminder, Community HealthChoices will be implemented across the state in 3 phases. It will start in the Southwest region on January 1, 2017. The Southeast region is next and slated to begin on January 1, 2018. Finally, the Lehigh/Capital, Northwest and Northeast regions will implement Community HealthChoices beginning in 2019.

Medicaid Expansion: One Year Later

Last month marked the one-year anniversary of traditional Medicaid expansion under the Affordable Care Act in Pennsylvania. During that year, more than 625,000 Pennsylvanians gained access to health insurance coverage through the state's Medicaid program. With expansion, Pennsylvania's Medicaid program now covers over 2.2 million children, individuals with disabilities, pregnant women, and low-income adults.

Prior to expansion, many low-income Pennsylvanians made too much to qualify for Medicaid coverage yet still could not afford to purchase insurance on the Marketplace, even with subsidies. These people fell into a coverage gap that left them without coverage and access to needed care and treatment. Thankfully, Medicaid expansion closed this "coverage gap" through extending coverage to more individuals than ever before by increasing the income limit to 138% of the Federal Poverty Level with no asset test. The results are significant. Of the 625,000 new enrollees in Medicaid post-expansion:

- 46% are younger than age 35;
- Almost half are employed;
- More than 109,000 are parents.

Residents of every county in Pennsylvania have enrolled in Medicaid over this past year. The Department of Human Services reports that not only has the state implemented policy changes that enable more people to become eligible for Medicaid; it has also increased efforts to improve access to care once an individual enrolls in Medicaid. DHS notes that the number of providers participating in Medicaid has increased from 92,000 to 108,000.

For more information about Medicaid expansion and to apply for Medicaid coverage, visit www.HealthChoicesPA.com.

CMS Reinforces the Prohibition on Balance Billing of Dual Eligibles

The Centers for Medicare & Medicaid Services (CMS) recently issued its 2017 Call Letter to Medicare Advantage Plans reminding all Plans of the long-standing rules prohibiting Medicare providers from billing patients who have Medicare and Medicaid (referred to as “dual eligibles”) for any Medicare cost-sharing.

Federal and state law bars Medicare providers from collecting Medicare Part A and/or Part B deductibles, coinsurance or co-pays from dual eligible patients. The Call Letter reminds all Medicare Advantage Plans that they are required to:

- educate their providers about the balance billing protections that apply to dual eligibles enrolled in the Plan;
- protect their dual eligible members from being billed for Medicare cost-sharing; and
- include the balance billing restrictions in their contracts with providers and specify that when treating a dual eligible patient the provider only has two choices: to either accept what the Medicare Advantage plan pays them as payment in full, or to bill the state Medicaid system for the Medicare cost-sharing.

CMS cited to a study it released in 2015 that found confusion regarding balance billing and inappropriate billing practices persist among Medicare providers. To that end, CMS goes on to encourage Medicare Advantage plans to take extra steps to address the problem with their provider networks including:

- explaining that the balance billing prohibitions apply to all providers in the network-not just those that accept Medicaid;
- clarifying that the balance billing prohibitions apply even if the state Medicaid program does not pay the full Medicare cost-sharing amount; and
- monitoring compliance by reviewing plan grievances and complaints and doing targeted outreach to providers who violate the rules and bill members inappropriately.

Dual eligibles who are experiencing problems with their providers billing them for Medicare cost-sharing can call the APPRISE Program at 1-800-783-7067 or PHLP’s Helpline at 1-800-274-3258.

New Medicaid Managed Care Rules Released by CMS

On April 25th, the Centers for Medicare & Medicaid Services (CMS) released a final rule that makes substantial changes to the regulations governing Medicaid managed care. With these changes, federal policymakers intend to support delivery system reform efforts, strengthen consumer protections, and better align key rules across insurance programs.

With implementation being phased in over three years, the wide-ranging managed care rule will impact nearly all aspects of Pennsylvania's Medicaid program. Almost 80% of Medicaid consumers in the Commonwealth are currently enrolled in managed care, through which private insurance companies receive monthly capitation payments to maintain provider networks, pay claims, and manage the care of their members. This figure will increase considerably as consumers receiving long term supports and services and those dually eligible for Medicaid and Medicare are also enrolled in managed care through the Community HealthChoices initiative. Risk-based managed care has become the dominant delivery system for Medicaid, displacing fee-for-service, both in Pennsylvania and nationally. Much of the impetus for the new rule was the need to update and modernize the federal managed care regulations, which have not been changed since 2002.

Federal policymakers categorize the 1400 page final rule around four broad goals:

1. Supporting Delivery System Reform & Improving the Quality of Care
2. Strengthening the Beneficiary Experience of Care & Key Beneficiary Protections
3. Strengthening Payment and Accountability Improvements
4. Alignment with Other Insurers

Among other things, the final rule acknowledges that states can require managed care plans to implement value-based purchasing strategies. "Value-based purchasing" means emphasizing value over volume and rewarding health care approaches that produce better health outcomes for plan members rather than approaches that simply pay for services as they are provided. Value-based purchasing is an initiative that is already underway in Pennsylvania and will be incorporated into the state's contract with HealthChoices Medicaid managed care plans beginning in 2017.

PHLP and other advocates are closely monitoring how the Medicaid program implements the provisions of the final rule regarding grievances and appeals and access to care, for all consumers, and the "beneficiary support system" for consumers receiving long term services and supports. The "beneficiary support system" is a new requirement that states offer an independent source of advice – for consumers getting long term care through a home and community based waiver program or in a nursing home – on choosing an MCO, benefits and supports, appeals and grievances, and navigating managed care in general.

CMS provides summaries of key aspects of the final regulations [here](#).

Correction to PHLP D&A Publication

Our April newsletter including an article about a newly released publication from PHLP titled, “Access to Drug & Alcohol Treatment Services in HealthChoices: Know Your Rights.” Page four of the publication includes a list of the behavioral health managed care plans by county. We accidentally omitted a few counties from the list and have since corrected this. The corrected version of the document can be found [here](#). Please contact Janice Meinert at PHLP at 412-434-5637 or jmeinert@phlp.org with any questions about this publication. We apologize for the omissions.

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

[DONATE TO PHLP](#)

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