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Community HealthChoices Start Date Delayed Six Months

Earlier this month, the Department of Human Services (DHS) announced delaying the start date of Community HealthChoices (CHC) from January 1st until July 1st, 2017. As a reminder to readers, CHC will start in 14 counties in Southwestern PA in 2017, expand to Southeastern PA in 2018, and then to the remainder of the state in 2019.

This new program changes the way most dual eligibles (people with both Medicare and Medicaid) receive their Medicaid coverage and also changes the way people in the Aging, Attendant, COMMCARE, and Independence Waivers or in a nursing home receive their Medicaid-funded long term services and supports. When Community HealthChoices starts, managed care plans will be responsible for covering both Medicaid and long term services and supports for the target population (approximately 400,000 Pennsylvanians).

The Department is hopeful that by delaying the start date and allowing more time for outreach and education, people impacted by this new program will understand the significant changes and be in a better position to make their own plan choices rather than be auto-assigned into a plan. The delayed start date will also allow more time for the Department to ensure that every CHC plan selected has the staffing and training ready to accept enrollments, provide the necessary continuity of care, assess needs, coordinate care, and have a network of providers that meets the diverse needs of the Community HealthChoices population.

The Department is currently in the process of reviewing the bids submitted by 14 managed care plans who wish to participate in one or more Community HealthChoices Zones and intends to select plans later this summer. Individuals can visit the Department's Com-

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community HealthChoices [website](#) to learn more and to view information about the [monthly webinars](#) and on-going opportunities for public input, including providing comments by July 8th about the [Community HealthChoices Evaluation Plan](#). We'll continue to keep readers updated about developments in future newsletters.

Please note: Community HealthChoices affects individuals age 21 and older. Dual eligibles and others receiving services through the Adult Autism, Consolidated, and Person/Family Directed Supports (PFDS) Waivers or who are in the Adult Community Autism Program (ACAP) will **not** participate in Community HealthChoices. The way they get their Medicaid coverage will not change and they will continue to get their long term services and supports through the Office of Developmental Programs. In addition, the OBRA Waiver will continue to operate for certain individuals as discussed in a [previous newsletter](#). Finally, the LIFE program will continue to exist and anyone enrolled in the LIFE program will continue in that program and not be enrolled in Community HealthChoices.

DHS Sanctions MAXIMUS and Urges Quick Fixes to HCBS Enrollment Problems

Earlier this month, Department of Human Services' Secretary Dallas sent a letter to MAXIMUS notifying the company that the state is withholding payments until problems with its handling of applications and enrollments into Home and Community Based Services (HCBS) Waiver programs are addressed and resolved. Since 2010, MAXIMUS has been the Independent Enrollment Broker responsible for enrollments into the Attendant Care, COMMCARE, Independence and OBRA Waiver programs as well as the Act 150 program. Starting April 1st, MAXIMUS began to also handle enrollments for the Aging Waiver.

In the last month, the Department became aware of numerous barriers and delays faced by individuals trying to contact MAXIMUS. The letter highlighted problems with MAXIMUS' centralized call center—specifically, the failure to answer calls in a timely manner as required by its contract as well as unacceptable call abandonment rates. In addition, MAXIMUS had a large backlog of applications, raising concerns about its ability to meet the state's 60 day timeframe for application processing.

The letter gave MAXIMUS two weeks to resolve these problems. At a recent meeting of the Consumer Subcommittee of the Medical Assistance Advisory Committee, Department officials reported that MAXIMUS responded quickly to the letter by bringing on more staff and making other changes that are improving performance. The Department continues to monitor MAXIMUS to determine whether any further action, including additional financial sanctions, will be needed to ensure that vulnerable Pennsylvanians no longer experience unnecessary delays and other problems that prevent them from receiving the services they need to maintain their health and independence.

Individuals who have problems applying for a Waiver program can call PHLP's Helpline at 1-800-274-3258.

Easing the Transition from Marketplace to Medicare

The Centers for Medicare & Medicaid Services (CMS) recently launched a new effort to smooth the transition to Medicare for the growing number of soon-to-be-65-year-olds currently covered through the Health Insurance Marketplace (HealthCare.gov). Beginning this summer, Marketplace staff will be reaching out to enrollees approaching their 65th birthday to inform them about ending their Marketplace plan and enrolling in Medicare. This additional outreach is critical for consumers, because a botched transition to Medicare can have serious consequences.

The Marketplace is not set up to serve Medicare-eligible seniors, and those who fail to enroll in Medicare when they first become eligible may face gaps in coverage, higher premiums, and serious tax penalties. CMS hopes its new initiative will prevent these problems by providing seniors with additional information and support during this critical transition period. Consumer advocates applaud CMS' proactive efforts to ensure that people in the Marketplace have information necessary to make a smooth transition to Medicare.

For more information about moving from Marketplace-based coverage to Medicare, see a [Frequently Asked Questions document](#) published by CMS. More information about the new initiative described above as well as other efforts CMS is taking to strengthen the Marketplace can be found [here](#).

Federal Funding for Medicare State Health Insurance Programs in Jeopardy

In recent weeks, the Appropriations Committee of the U.S. Senate approved a Fiscal Year 2017 bill that eliminates all federal funding (\$52.1 million) for Medicare State Health Insurance Programs (SHIPs). In Pennsylvania, our SHIP is called APPRISE. [APPRISE](#) currently has 52 local programs across Pennsylvania and is administered by the PA Department of Aging. Currently, APPRISE staff and volunteers help approximately 200,000 Medicare beneficiaries navigate the complexities of Medicare coverage by providing free, unbiased, and personalized help with Medicare plan choices and problems such as fraud and abuse, improper billing, and coverage denials. In addition, APPRISE helps low-income older adults and persons with disabilities apply for programs that help with Medicare costs such as the [Medicare Savings Programs](#) and [Extra Help with Medicare Prescription Drug costs](#).

The proposed elimination of federal funding for this important program is very concerning, especially as more people become eligible for Medicare each year and often need one-on-one help to understand and navigate the complicated program. In addition, APPRISE is expected to play an important role when Community HealthChoices begins next year in helping dual eligibles understand how this new program will interact with their Medicare coverage.

The U.S. House of Representatives is currently debating the appropriations bill and is expected to vote soon. Individuals who wish to take action regarding the proposed elimination of federal funding for the SHIP/APPRISE program are encouraged to contact their federal Representatives. National advocacy groups including [Justice on Aging](#) and [National Council on Aging](#) have more information about this important issue and action tools to help people make their voices heard.

Pennsylvania Parity Implementation Coalition Supports State Legislation

The [Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008](#) (MHPAEA) is a federal law that generally prohibits health insurers who provide group health plan coverage that includes mental health or substance use disorder benefits from covering these benefits in a more restrictive way than medical/surgical benefits. The [Patient Protection and Affordable Care Act of 2010](#) strengthened the Parity law by extending it to individual insurance policies as well. Collectively, the laws require affected health plans to prove that treatment limits applied to mental health and substance use disorder benefits apply equally to medical/surgical benefits. The enforcement of both laws as they pertain to parity falls largely to the states. As advocates and providers identified what appeared to be violations of the federal parity laws, the Pennsylvania Parity Implementation Coalition was formed to address these concerns.

Earlier this year, members of the Coalition were contacted by Representative Thomas Murt who was interested in initiating state parity legislation. The Coalition worked with Representative Murt on a bill that, among other things, would require insurance companies to submit an annual report to the PA Insurance Department detailing their compliance with the federal parity law. For example, insurance companies would need to report the frequency they required prior authorization for all prescribed mental health or drug and alcohol procedures, services or medications as well as for all medical/surgical services. The report would also be required to show the process by which the insurance plan determined the medical necessity criteria for mental health benefits and substance abuse benefits as well as medical/surgical benefits. Such information would assist plans in ensuring they were meeting the federal parity requirements and would help the Insurance Department to more easily identify issues with plan compliance.

Representative Murt's proposed legislation has been introduced and is now known as [House Bill 2173](#). Individuals and organizations who want to voice an opinion on the proposed legislation should contact their [state legislators](#).

The PA Parity Implementation Coalition is an open group that welcomes new members. Please contact Janice Meinert at jmeinert@phlp.org or 412-434-5637 to find out how to become involved with the Coalition.

Recent Lawsuit Settlement Should Increase Access to ABA Services

A Federal Court recently approved the settlement in a class action lawsuit, [Sonny O. v. Dallas](#), brought by Disability Rights PA on behalf of three families challenging Pennsylvania's Medicaid coverage of therapies using Applied Behavioral Analysis ("ABA") for children and youth on the autism spectrum. The settlement sets out changes and prospective actions that the Department of Human Services (DHS) has agreed to undertake with the goal of making high quality ABA-based therapies, provided by practitioners with training and experience in ABA, available to children and youth who have Medicaid and an autism diagnosis.

Some of the key provisions of the agreement are:

Medical necessity criteria:

- DHS' Office of Mental Health & Substance Abuse Services (OMHSAS) acknowledged in a previously released [memo](#) that ABA can be covered under BHRS (“wraparound”) and that a child does not need to exhibit externalizing or negative behaviors to qualify for coverage.
- OMHSAS will issue new medical necessity guidelines specifically for ABA services- probably by the beginning of July. The state has already received input on the guidelines from a select group of clinicians.

Provider Qualifications:

- Providers who wish to bill for ABA will have to complete a form (“attestation”) stating that they have Behavior Specialist Consultants (BSCs) with training in and knowledge of specified components of ABA. However, there is no requirement that those BSCs be Board Certified Behavior Analysts.
- DHS will develop regulations that will define the training, experience and supervision required for staff who can bill as ABA providers. DHS has already held several conference calls for stakeholder input.
- DHS will increase the amount of ABA specific training that is part of the Bureau of Autism Services training for purposes of Behavior Specialist licensure and will require post-training testing for certification.

Access:

- Behavioral Health Managed Care Organizations (BH-MCOs) must track every request from a family for ABA. Additionally, they will have to make available to families an online directory of providers who state (on the ABA attestation form) they have BSCs with the requisite ABA training and experience.
- BH-MCOs will have to provide information to families, upon request, about the licensure, education and training of any BHRS practitioner who delivers ABA.
- If the Behavioral Health MCO does not have an agency in its network that has claimed expertise in ABA (the “attestation form”) and can “timely serve” (not defined) the child, the Behavioral Health MCO “will contract with an out-of-network provider to serve that [child] until the BH-MCO is able to make the services available in-network”.
- ABA provider agencies that do not have a mental health license will be allowed to enroll in MA. That procedure was set out in a [Bulletin](#) issued on June 6, 2016. This does not guarantee the provider a contract with a BH-MCO. However, if a BH-MCO must go out-of-network to provide the child with ABA, it will need to use MA enrolled providers. Furthermore, children on HIPP can be served by any ABA provider that has enrolled in MA.
- Families who are having problems accessing ABA and have been unable to resolve the problems with their Behavioral Health MCO and county can contact Jill Weaver at 717-409-3791 or ABA@pa.gov.

OMHSAS will soon be issuing a Bulletin that should include many of the provisions above. Many of the important details will need to be worked out through the process of drafting regulations which is currently underway. PHLP will alert readers to future opportunities for input into the draft regulations.

Bill Proposes Suspending Medicaid for Individuals Entering Corrections System

Pennsylvania Senator Pat Vance recently introduced legislation, [Senate Bill 1279](#), proposing that Medicaid benefits get suspended rather than terminated when a person enters the corrections system. Pennsylvania is one of 19 states in which Medicaid benefits end when a person enters the criminal justice system. When that individual is released, they must then reapply for Medicaid. Not only does this create an administrative burden for the state, it also makes it harder for individuals to get health care treatment until their eligibility is reviewed and they are re-enrolled in Medicaid.

This treatment gap can be especially difficult for individuals with mental illness and drug addiction. Lack of access to medications or treatment can lead to behaviors that result in further incarceration. Providing immediate access to coverage, and therefore treatment, would eliminate this treatment gap and provide another opportunity to continue to battle the state's opioid epidemic.

Senate Bill 1279 proposes temporarily suspending an individual's Medicaid for up to two years. If passed, Pennsylvania would then join 16 other states follow a time-limited suspension policy for people who are incarcerated.

Senator Vance and the Wolf administration both hope that the final 2016-17 budget will include this important change. Individuals and organizations that want to voice an opinion on the proposed legislation should contact their [state legislators](#).

Wolf Administration officials including Department of Human Services Secretary Dallas joined Senator Vance when she announced the proposed legislation. Secretary Dallas noted the importance of providing quick access to health care coverage upon leaving the corrections system and highlighted some activities that are presently underway to provide Medicaid coverage to eligible individuals released from the criminal justice system who had not been previously enrolled in Medicaid. This includes [expediting applications](#) for these individuals.

Our Mission

Founded in the mid-1980s and incorporated in 1993, PHLP protects and advances the health rights of low-income and underserved individuals. Our talented staff is passionate about eliminating barriers to health care that stand in the way of those most in need.

We seek policies and practices that maximize health coverage and access to care, hold insurers and providers accountable to consumers, and achieve better outcomes and reduce health disparities.

PHLP advances its mission through individual representation, systemic litigation, education, training, and collaboration.

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