Medical Assistance Managed Care in Pennsylvania

A Guide to Pennsylvania's HealthChoices Program for Families

By: Danna Rodrigues, Staff Attorney

About PHLP

The Pennsylvania Health Law Project is a 501(c)3 nonprofit organization.

PHLP is a nationally recognized expert and consultant on access to health care for low-income consumers, the elderly, and persons with disabilities. PHLP engages in direct advocacy on behalf of individual consumers while working on the kinds of health policy changes that promise the most to the Pennsylvanians in greatest need.

About this Guide

This brochure explains the basics of Medical Assistance (MA) Physical Health coverage in Pennsylvania through the HealthChoices Program. Parents should be aware that Mental Health (MH) and Behavioral Health (BH) coverage is accessed separately under MA in Pennsylvania and this publication will not discuss that topic. Please refer to PHLP's website for publications that address MH/BH services under MA in Pennsylvania.

Pennsylvania Health Law Project
Helpline: 1-800-274-3258
www.phlp.org

Table of Contents

Medical Assistance Basics

What is Medical Assistance?

Medical Assistance (also known as Medicaid or MA) is Pennsylvania's health insurance safety net. Administered by the Department of Public Welfare (DPW), MA provides the broadest coverage of any insurance plan of physical and mental health services for children.

Will My Child Qualify for Medical Assistance?

To qualify for Medical Assistance, your family income must be below a certain limit **or** your child must have a serious disability. There is a common misconception that children with any health condition or all children with a particular diagnosis qualify for MA. That is not the case. . However, many children with serious disabilities **will** qualify for MA, regardless of their parent's income. Children in foster care and in federal and state adoption assistance programs automatically receive MA.

This manual does not discuss eligibility for MA, but rather assists families with accessing care and services once a child is already on MA. If you are wondering whether your child qualifies for MA, or you have applied and been denied MA, you can contact PHLP at (800) 274-3258.

Families should note that MA is not the same as CHIP (the Children's Health Insurance Program). CHIP is a program offered through the Pennsylvania Department of Insurance that provides free or low-cost health coverage to children who do not qualify for MA. This manual will not discuss CHIP. If you want to learn more about CHIP, visit CHIP on the web at www.chipcoverspakids.com or contact PHLP.

Is It Better for My Child to be on Medical Assistance Rather than CHIP?

MA has the broadest coverage of any insurance plan of physical and mental health services for children. It covers services often not covered by private or commercial insurance such as hearing aids, dental care and shift nursing services.

Your child can qualify for MA even if he or she is already covered by your commercial or private insurance plan. If approved, MA will be secondary to your child's commercial insurance and many families are pleased to find that MA will cover co-pays and deductibles

and also pays for services their private insurance does not cover. As a result, families are able to lower their health care costs by supplementing their child's existing coverage with MA. Later in this brochure, we will talk about how to use commercial insurance together with MA.

What Services Will Medical Assistance Cover for my Child?

Under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) federal mandate, children under 21 on MA are entitled to receive all medically necessary healthcare and services, including:

- Shift nursing and home health care
- Inpatient and outpatient hospital and clinical care, including care in the patient's home if medically needed
- Care by practitioners such as physicians, chiropractors, optometrists, podiatrists, and dentists
- Laboratory work and X-rays
- Some formulas and nutritional supplements
- Diapers for children ages three years and older who have a diagnosis of developmental delay
- Medical equipment and supplies
- Medications, including prescription and many over-the-counter medications (if prescribed)
- Prostheses
- Vision care and eyeglasses
- Hearing aids and other hearing devices
- Psychiatric care in clinic and hospital
- Medical services to treat conditions discovered in school examinations
- Dental care and orthodontia

Using Medical Assistance and Private Insurance Together

Having private or commercial health coverage insurance (such as coverage through your job) does not affect whether your child can get Medical Assistance. Many children have both commercial coverage and MA and their families find that MA is the best possible secondary coverage for picking up the costs not covered by their primary insurance.

MA is always the "payer of last resort." This means that if your child has commercial coverage that coverage must be used first to pay for your child's care., MA will only pay for co-pays, deductibles, and items that are not covered by your child's commercial coverage.

You must follow these rules in order for MA to pay for the co-pays, deductibles, or other items that your commercial insurance plan does not cover.

- Your child's health care provider must accept your primary insurance and must also be in your child's MA-MCO network or registered as an MA provider with DPW if your child is in Fee-for-Service.
- Your child's health care providers must **first** bill the commercial insurance plan for services they provide to your child. Then, they can bill MA for any costs that the commercial insurance plan does not pay for.
- You must follow the *terms and conditions* of your commercial insurance carrier. For example, if the commercial insurer says that you must choose a provider from a certain list or get authorization for services, you must follow these rules, or else MA will not cover the expenses.

Health care providers who accept MA sign an agreement with DPW to accept MA payments that are less than their standard fees. Therefore, if your child's commercial insurance imposes a co-pay, MA will only pay it if the amount already paid to the health care provider was less than the MA stand fee. These **Health care providers must accept whatever payment they get from your primary insurance and MA and cannot balance bill you for any additional amount.**

It is your responsibility to check that your child's providers will accept both commercial insurance and MA. You should also make sure that you get all the authorizations and referrals that you need to. It is best to keep a log of these authorization numbers and referrals.

What Is the Difference Between Fee-for-Service and Managed Care?

There are two ways that children on MA can get their MA coverage:

- **through a HealthChoices Managed Care plan** (also known as an *MCO* or *health plan*)
- **through the MA Fee-for-Service** system (also known as *straight ACCESS*)

How your child receives MA (Fee-for-Service or Managed Care) controls how they will access health care services and providers. It also affects the options available if you are denied a service or treatment prescribed for your child.

HealthChoices (Managed Care) Plans

HealthChoices is what DPW calls mandatory managed care for MA consumers. People on MA must enroll in a managed care plan and get all their care through that plan unless they fall into an exempt group. Those who are exempt from managed care receive their MA through Fee-for-Service. We will discuss the exempt groups later in this brochure.

As of March 2013, HealthChoices exists in every county in Pennsylvania. The state has created 5 physical health HealthChoices "zones" or "regions": Southeast, Southwest, Lehigh/Capital, New West, and New East. Under HealthChoices, MA consumers must enroll into one of the physical health managed care plans available in their Zone and choose a Primary Care Practitioner (PCP). Once enrolled, the consumer must receive all of their physical health care services from providers within the plan unless the plan approves them to go "out-of- network".

Behavioral Health (BH) and Mental Health (MH) under Medical Assistance is separate from the physical health managed care system and will not be discussed in this publication. For more information on the BH/MH care system under Medical Assistance, please refer to PHLP's website.

Fee-for-Service System

If your child is in the MA Fee-for-Service system, you are not confined to a network and can obtain services from any health care provider and facility that is registered as an MA provider with the Pennsylvania Department of Public Welfare (DPW) who will accept the ACCESS card. Your child is not required to have a PCP and can get primary or specialty care

without referrals. DPW pays the provider (doctors, specialists, dentists, hospitals, etc.) a fee for every service provided to your child, which is why this system is called "Fee-for-Service".

Does HealthChoices Cover the Same Services as Fee-for-Service?

Yes. MA MCOs are required to cover the same services available under the MA Fee-for-Service program. Each MCO must have a network with enough providers to meet the needs of all members of the plan. The plan must also have a directory (available on the plan's website) to help you find a provider who is in the network, and a Special Needs Unit to help all members with special needs. MCOs must also follow the same standards used by MA Fee-for-Service when deciding whether a prescribed service is medically necessary.

HealthChoices Special Needs Units

Every HealthChoices MCO must have a Special Needs Units for its members. The purpose of the Special Needs Unit is to make sure that members with special needs can get timely access to the primary care specialists, prescription drugs, and community services that they need. The Special Needs Unit is an important resource for many families because it helps families navigate the MCO and coordinate their child's care.

There is no set definition of what counts as a "special need." Anyone who thinks they have a special need can ask to talk to the Special Needs Unit.

The Special Needs Unit:

- Educates MCO staff and network providers about special needs populations
- Helps members get timely authorizations for needed items or services
- Recruits health care providers who have experience serving special needs patients, so that members have enough providers to choose from
- Helps with health-related issues such as lack of transportation
- Helps members choose a Primary Care Physician (PCP)
- Helps connect members to non-MA resources like community-based agencies, food pantries and other resources.
- Helps members when they age out of EPSDT services at age 21 and transition to receiving adult benefits under MA including Home and Community Based Services Waiver services

Is My Child Exempt from Managed Care?

The general rule is that everyone on MA must enroll in a HealthChoices MCO unless they are exempt. Reasons that your child might be in Fee-for-Service:

- Your child is the **HIPP program.**
- Your child is **newly eligible** for MA. In this case, your child will be in the MA-Fee-for-Service system temporarily, until he or she is enrolled into an MCO.

People in the Aging Waiver and the LIFE program are also exempt from HealthChoices, but since these programs are only for adults, we will not talk about them here.

Children in "HIPP" Are Exempt

The Health Insurance Premium Payment Program, better known as "HIPP", is a program where the state (DPW) pays the health insurance premium for people on MA who have access to cost-effective employer-based coverage. Once your child is approved for MA, DPW will explore whether your child has insurance available through a parent's employment. If they do, and if DPW determines that insurance to be cost-effective, the state then pays the premium for that employer-based coverage.

Children in HIPP are exempt from managed care and receive MA through the Fee-for-Service system (*straight ACCESS*). In this situation, the employer-based coverage is the primary insurance and must be billed first, followed by MA.

If your child is put on HIPP after being in MA managed care, they will be disenrolled from their HealthChoices plan and will need to obtain services from providers that accept their ACCESS card If the change substantially interferes with your child receiving the care and treatment they need, you can ask that your child be taken out of HIPP and put back into the MCO.

HealthChoices Regions and Plans

If your child is not exempt from managed care, the Physician Health Managed Care Organizations (health plans) that are available to your child depend on the region of Pennsylvania that your family lives in.

There are five Physical Health regions (or "zones") in Pennsylvania. See the map below to find which zone you live in. Your child may only enroll in an MCO that operates in the zone where he or she lives. The next few pages will discuss the different health plans available in each zone.

Lehigh Capital Zone

Counties: Adams, Berks, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Lancaster, Lebanon, Lehigh, Northampton, Perry, York

Plans available: Aetna Better Health, AmeriHealth Caritas (formerly AmeriHealth Mercy), Gateway Health Plan, United Healthcare Community Plan, UPMC For You

Plan Contact Information:

HealthChoices Physical Health Plan	Member Services Phone Number	Special Needs Unit Phone Number
Aetna Better Health	1-866-638-1232 TTY 711	1-866-638-1232 TTY 711
AmeriHealth Caritas	1-888-991-7200 TTY 1-888-987-5704	1-800-684-5503 TTY 1-888-987-5704
Gateway Health Plan	1-800-392-1147 TTY 711	1-800-642-3550 TTY 711
United Healthcare Community Plan	1-800-414-9025 TTY 711	1-800-414-8844 TTY 711
UPMC For You	1-866-353-4345 TTY 1-800-361-2629	1-866-463-1462 TTY 1-800-361-2629

New East Zone

Counties: Bradford, Carbon, Centre, Clinton, Columbia, Juniata, Lackawanna, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, Wyoming

Plans available: AmeriHealth Northeast, CoventryCares, Geisinger Health Plan

Plan Contact Information:

HealthChoices Physical Health Plan	Member Services Phone Number	Special Needs Unit Phone Number
AmeriHealth Northeast	1-888-991-7200 TTY 1-888-987-5704	1-888-498-0766 TTY 1-888-987-5704
CoventryCares	1-866-903-0748 TTY 1-800-613-3087	1-866-427-9721 TTY 1-800-613-3087
Geisinger Health Plan	1-855-227-1302 TTY 711	1-855-214-8100 or 570-214-7570

New West Zone

Counties: Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango, Warren

Plans available: AmeriHealth Caritas, CoventryCares, Gateway Health Plan, UPMC Health Plan, Inc./UPMC for You

Plan Contact Information:

HealthChoices Physical Health Plan	Member Services Phone Number	Special Needs Unit Phone Number
AmeriHealth Caritas	1-888-991-7200 TTY 1-888-987-5704	1-800-684-5503 TTY 1-888-987-5704
CoventryCares	1-866-903-0748 TTY 1-800-613-3087	1-866-427-9721 TTY 1-800-613-3087
Gateway Health Plan	1-800-392-1147 TTY 711	1-800-642-3550 TTY 711
UPMC for You	1-800-286-4242 TTY 1-800-361-2629	1-866-463-1462 TTY 1-800-361-2629

Southeast Zone

Counties: Bucks, Chester, Delaware, Montgomery, Philadelphia

Plans available: Aetna Better Health, CoventryCares, Health Partners of Philadelphia, Keystone First, United Healthcare Community Plan

Plan Contact Information:

HealthChoices Physical Health Plan	Member Services Phone Number	Special Needs Unit Phone Number
Aetna Better Health	1-866-638-1232 TTY 711	1-866-638-1232 TTY 711
CoventryCares	1-866-903-0748 TTY 1-800-613-3087	1-866-427-9721 TTY 1-800-613-3087
Health Partners	1-800-553-0784 TTY 877-454-8477	215-991-4370 TTY 215-849-1579
Keystone First	1-800-521-6860 TTY 1-800-684-5505	1-800-573-4100 TTY 1-800-684-5505
United Healthcare Community Plan	1-800-414-9025 TTY 711	1-877-844-8844 TTY 711

Southwest Zone

Counties: Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Fayette, Green, Indiana, Lawrence, Somerset, Washington, Westmoreland

Plans available: CoventryCares, Gateway Health Plan, United Healthcare Community Plan, UPMC for You

Plan Contact Information:

HealthChoices Physical Health Plan	Member Services Phone Number	Special Needs Unit Phone Number
CoventryCares	1-866-903-0748 TTY 1-800-613-3087	1-866-427-9721 TTY 1-800-613-3087
Gateway Health Plan	1-800-392-1147 TTY 711	1-800-642-3550 TTY 711
United Healthcare Community Plan	1-800-414-9025 TTY 711	1-877-844-8844 TTY 711
UPMC for You	1-800-286-4242 TTY 1-800-361-2629	1-800-463-1462 TTY 1-800-361-2629

Choosing a Physical Health Managed Care Plan that Meets your Child's Needs

It is important to choose your child's health plan carefully, so that your child can keep seeing his or her current doctors and other important health care providers. If you pick a plan at random, or if you let the state enroll your child in a plan automatically, you may end up with a plan that is not accepted by your child's existing doctors and other providers.

Below is a step-by-step guide to choosing a physical health plan (MCO) that best meets your child's health care needs. We will also talk about how to enroll in a plan once you find the plan that is best for your child.

Step 1: Make a list of all your child's health care providers

This includes your child's primary care doctor, any specialists your child sees, your child's hospital, your child's dentist, the pharmacies you use to get your child's prescriptions, and any medical suppliers that you use for items such as wheelchairs or oxygen.

Once you have your list ready, you can:

- Contact your child's doctors and other providers to see which of the available plans they take; **or**
- Call PA Enrollment Services at 1-800-440-3989. A representative can check to see which plans work with your child's doctors and other providers; **or**
- Check the PA Enrollment Services website (www.enrollnow.net) to look up your doctors to see what plans they take.

Hopefully, there will be at least one plan that works with all of your child's different doctors and other providers your child uses to get health care.

Step 2: Make a list of all the medications your child takes

This includes the dosage and quantity, too. Make sure you list all your child's medications, even those your child takes for a mental health condition. Your child will get all of his or her outpatient prescription medications through the plan you choose. Once you make your list, contact the plan or plans that work with your child's doctors by phone or by going onto their website to check if your child's medications are covered under those plans.

There should never be a monthly limit on the number of prescription medications a child can get under his or her health plan. Most plans impose a six drug per month limit on adults, but this limit should never apply to children under 21. If a plan tells you that your child is subject to the six-drug limit, contact PHLP for assistance.

Step 3: Review any special programs/benefits offered by each plan

Check the Health Plan Comparison Chart. You can find this chart on the PA Enrollment Services website (www.enrollnow.net). There should also be a copy of this chart in the packet you get by mail which prompts you to choose a health plan. This chart shows the co-pays charged by the different plans (*note: only kids age 18 and older are subject to co-pays under MA*) and provides information about additional services provided by the plan that might be important to you, such as diapers or other supplies.

If you can't get on the Enrollment Services website, you can call PA Enrollment Services by phone at 1-800-440-3989 to ask about the co-pays and extra programs or benefits offered by the plans.

Step 4: Contact PA Enrollment Services to enroll in a plan

After you've decided what plan is best for your child, contact PA Enrollment Services at 1-800-440-3989 to enroll in a plan and to choose a Primary Care Provider (PCP).

If you're not ready to pick your child's PCP when you choose a plan, you have 14 more days after you join a plan to pick your child's PCP. If you don't pick a PCP within that time, the plan will pick one for you. You can change your child's PCP at any time by contacting the plan directly.

Your selection of your child's PCP is important because you must go through the PCP to get referrals to specialists and the PCP is responsible for requesting prior authorization for certain services like physical therapy and home health care. Some MCOs require that the Letter of Medical Necessity requesting prior authorization of services come from your child's PCP, even if the requested service will be provided by a specialist or other provider within the network..

What Happens After I Choose a Plan?

After you choose a plan for your child, that MCO will send you a card. The card may or may not list your child's PCP. The MCO will also send you a Member Handbook describing how to obtain services from the plan, co-pays, member rights, and appeal information.

Can I Change My Child's Plan?

Yes! Under HealthChoices a person can change their plan at any time. To change your child plan, simply contact PA Enrollment Services at 1-800-440-3989 Monday through Friday from 8 am to 6 pm. Or go onto the enrollment services website at www.enrollnow.net.

When will the plan change go into effect?

Most changes take place within 4-6 weeks. When making the change, you should ask for the specific date when the change will happen.

Usually, a change will happen on the first day of a month. For example, if a child is in Plan A and they make the switch to Plan B on 3/3, chances are Plan B will be in effect on 4/1 because the child made the switch early enough in the month. If that same child decides to leave Plan A and enroll in Plan B but doesn't make the switch until 3/20, the change won't occur until 5/1.

What if my child's doctor or hospital no longer takes my child's insurance?

Sometimes a PCP or hospital will stop participating in a Medical Assistance MCO's network. If this happens, your insurance plan (MCO) must send you a notice at least 30 days in advance. That notice will explain your options and give you telephone numbers for help.

You will have two options if this happens:

1. Stay with your child's doctor and change your child's MCO to another plan that your child's doctor does accept; **or**
2. Stay with your child's MCO and change to a new doctor that does accept your child's MCO.

If you don't do anything, your child will be auto-assigned to a new PCP that you may not like. Before you decide to change your child's MCO, make sure you pick a plan that works with all of your child's doctors and that will cover all prescribed medications. Your goal is to end up in the health plan that covers all of your child's doctors and medications!

Contacting PA Enrollment Services is a good way to figure out what to do in this situation. You can tell PA Enrollment Services the names of your child's doctors, and they can tell you which plan has them all. You can call PA Enrollment services at 1-800-440-3989.

Continuity of Care Rules

Many families worry that there will be a break in their child's services requiring prior authorization (e.g. shift nursing or home health aide services) if they decide to switch the child's health plan, or if the child is switched from Managed Care to Fee-for-Service MA. Fortunately, Continuity of Care rules exist so that families can avoid breaks in prior authorized services when this type of switch occurs. These rules apply when your child is switching from Fee-for-Service to an MCO, from MCO to Fee-for-Service, or from one MCO to another MCO.

There are different continuity of care rules for adults than for children. The rules for adults are at the end of this section. It is important to know the difference between the rules for adults and the rules for children, in case the MCO mistakenly tries to use the adult rules for your child.

If your child has a prior authorization for services from Fee-for-Service and switches into an MCO:

The MCO must continue to provide the same level of service at the same number of hours, until the end of the authorization period approved by Fee-for-Service.

You should talk with your home health agency about submitting a new authorization request to the MCO before the end of the Fee-for-Service authorization period. Once the MCO gets the request to continue the service, the MCO will decide whether the service is still medically necessary, just like it would at the end of any other authorization period. This makes sure that services are not ended or reduced while the MCO decides.

If your child has a prior authorization from an MCO and switches to a different MCO:

The MCO must continue to provide the same level of service at the same number of hours, until the end of the authorization period approved by the previous MCO.

You should talk with your home health agency about submitting a new authorization request to the new MCO before the end of the current authorization period. Once the MCO gets the request to continue the service, the MCO will decide whether the service is still

medically necessary, just like it would at the end of any other authorization period. This makes sure that services are not ended or reduced while the MCO decides.

If your child has a prior authorization from an MCO and switches to Fee-for-Service:

Fee-for-Service must continue to provide the same level of service at the same number of hours, until the end of the authorization period issued by the previous MCO. Your child's home health agency must submit a re-authorization request to continue the prior authorized service to DPW thirty (30) days before the end of the previously approved period.

Continuity of Care Rules for Adults

As discussed above, the Continuity of Care rules are different for adults on MA. If an adult aged 21 or over is transferring from Fee-for-Service to MCO or from one MCO to another while they are receiving services under a previous authorization, the new MCO must continue to provide the same level and hours of service for 60 days from the date of the transfer or until they do their own review to decide if the service is medically necessary.

This 60 day rule is only for adults, not children. If your child's MCO is trying to apply the 60 day rule to your child, contact PHLP for assistance.

What Can I Do If My Child's MA MCO Denies a Prescribed Service?

If your child's MA MCO denies a service that your child's doctor prescribed, you have more appeal options under managed care than you have in MA Fee-for-Service. This is a brief overview of appeal rights for children in managed care plans. For more information on service denials and appeals, see the PHLP Publication on Appealing Medical Assistance Service Denials.

What is a "Denial"?

A denial occurs any time your child's MCO fails to approve a prescribed service or authorizes something different from what was prescribed. **You have a right to appeal any denial, whether it is complete or "partial"**.

Some examples of denials:

- **Complete denial**: the denial letter will state that the service is "denied completely" because it is not medically necessary.

- **Authorization of a different service:** for instance, your child's doctor prescribed Skilled Nursing, but MA authorizes a Home Health Aide instead.

- **Partial denial:** for instance, your child's doctor prescribed 10 hours per day of skilled nursing, but MA authorizes only 5 hours per day instead.

How and When to Appeal

If you get a denial, you should appeal immediately. Children enrolled in an MCO have two appeal options when a denial occurs: the internal grievance process and the DPW Fair Hearing Process. You can pursue both the grievance and the DPW Fair Hearing simultaneously, or you can choose one or the other. For advice on which appeal option is best in your child's case you can contact PHLP for advice and assistance.

How long you have to appeal depends on whether or not the service being denied is one that your child is currently receiving:

- If your child is currently receiving the service (it is an **ongoing service**) you have 45 days to appeal the decision. **However, you must appeal the denial within 10 days of the date of the decision if you want your child to continue getting the service during the appeal process.**

- If the service requested is **not** one that your child is currently receiving (it is a new or first-time request), you must appeal the denial within **45 days**.

Your Right To Continued Services During the Appeal Process

If the MCO is trying to stop, reduce, or in any way change services your child is currently receiving, appealing the denial **within 10 days** of the date of the MCO decision allows your child to keep getting the service at the existing level during the appeal process. This means **it's very important to appeal right away if you get a denial or reduction of existing services.**

Conclusion and Contact Information

The Pennsylvania Health Law Project (PHLP) provides free legal services and assistance to individuals and families throughout Pennsylvania who are having trouble accessing publicly-funded health insurance coverage or services.

More information about Medical Assistance and Managed Care can be found on our website at www.phlp.org. If you need further information about Medical Assistance or Managed Care, or you need advice or help with appealing a service denial from your child's MA MCO, please call us on our toll-free Helpline at 1-800-274-3258. Our Helpline is open Mondays, Wednesdays, and Fridays from 8am-8pm.