

In This Issue

Medicare’s Fall Open Enrollment Now Underway!	2
LIFE Program is Expanding	5
Legislation Introduced to Expand MAWD	6
New Rules for Delivering Medicaid-Funded Mental Health Services to Kids	7
Short Window To Enroll In ACA Health Insurance Marketplace: It Ends Dec. 15th	11
Pennsylvania Releases HealthChoices Physical Health RFA	13

PA Medicaid Adopting a Uniform Preferred Drug List

Pennsylvania’s Medicaid program will have a single statewide Preferred Drug List (PDL) effective January 1, 2020. The statewide PDL was developed by the DHS Pharmacy and Therapeutics (P&T) Committee and published via an [MA Bulletin](#) on October 10, 2019. Officials with the Department of Human Services (DHS) report that requiring the Medicaid managed care plans to use a single medication formulary will result in substantial cost savings for the Medicaid program and improve consistency for providers and recipients. Each individual Medicaid managed care plan currently maintains its own list of preferred or non-preferred medications (formulary), and its own corresponding prior authorization guidelines. Under the statewide PDL, all Medicaid managed care plans responsible for providing medicines to their members—i.e., HealthChoices plans Community HealthChoices plans—and MA Fee-for-Service (FFS) will use the same list of preferred medications and the same prior authorization guidelines.

The DHS Pharmacy Director reported at a public meeting in late October that 149,741 consumers would be impacted by the transition, meaning they would need to change medications or get prior authorization to continue taking their current medication. Of those, about 39,000 would have more than one medication impacted. Both FFS MA and the Medicaid managed care plans are scheduled to mail letters to impacted consumers by November 1, sixty (60) days prior to the effective date.

Medicaid consumers who get a letter about the new PDL should talk to their doctors about the preferred medication listed on that

Subscribe...

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

letter. They will need prior authorization to have their current medication covered once the new PDL goes into effect in January. The Medicaid managed care plans are required to decide prior authorization requests within 24 hours.

Any Medicaid consumer who has a script denied at the pharmacy because the medication they have been taking now requires prior authorization can request a 15-day emergency supply. Emergency supplies are reimbursed by the managed care plan but provided at the discretion of the pharmacist.

More information on the Medicaid program PDL and the P&T Committee can be found [here](#). Consumers who are denied a medication can contact the PHLP Helpline at 1-800-274-3258.

Medicare's Fall Open Enrollment Now Underway!

Medicare's Annual Open Enrollment Period started October 15th and will run through December 7th. During this period, all Medicare beneficiaries can change their health or drug plan coverage. Changes made during this period start January 1, 2020. APPRISE staff and volunteers can help people across Pennsylvania review their 2020 Medicare coverage options. Medicare beneficiaries who need help reviewing their plan options for next year are encouraged to call APPRISE at 1-800-783-7067.

Details About 2020 Medicare Plan Offerings

Stand-Alone Prescription Drug Plans: There are 31 stand-alone prescription drug plans available across Pennsylvania for enrollment in 2020. Premiums for these plans range from \$13.20 to \$168.40 per month. There are still ten plans to choose from that are "zero-premium" for individuals who qualify for the full Extra Help (click [here](#) for the 2020 list). However, there are a few changes to this list between this year and next – the Aetna Medicare Rx Saver plan will no longer be offered in 2020, and there are two new zero-premium plan choices in 2020 – Clear Spring Health Value Rx and Well-care Medicare Rx Saver.

Medicare Advantage Plans: Residents in every county in Pennsylvania continue to have many Medicare Advantage plans to choose from. Bucks County has the most Medicare Advantage plans (62) and Pike County has the fewest (20). These numbers do not include Medicare Special Needs Plans that limit their enrollment to certain groups of Medicare beneficiaries: dual eligibles, people in nursing homes, and people with certain chronic conditions.

Most, but not all, of the Medicare Advantage plans available include drug coverage. Individuals considering a Medicare Advantage plan for 2020 should check the plan's costs, benefits, provider network and pharmacy network, list of covered drugs, and any extra benefits offered, such as dental or vision care.

Special Needs Plans for Dual Eligibles (D-SNPs): These plans only enroll Medicare beneficiaries who also have Medicaid (dual eligibles). However, it is important to remember that the D-SNP only provides the member with their **Medicare** coverage and the person still has Medicaid as their second, separate insurance coverage. In 2020, all counties in Pennsylvania will have at least two D-SNPs available. United will only offer one D-SNP next year—i.e., the UnitedHealthcare Dual Complete ONE plan will not be available in 2020. All other current D-SNPs will continue to operate in 2020 and many are expanding to new counties where they have not been previously available. The Advantra Cares plan in 2019 will be called Aetna Medicare Advantra Cares next year. Click [here](#) for the listing of D-SNPs by county for 2020.

Medicare Plan Finder – Update

Since our last newsletter, the old Medicare Plan Finder has been discontinued and all Medicare beneficiaries, advocates, and APPRISE counselors must use the new Medicare Plan Finder. To personalize a search that can be saved, Medicare beneficiaries will have to create an account at www.mymedicare.gov. No email address is required to create an account. Advocates working with Medicare beneficiaries have reported challenges entering the correct quantities of prescription drugs, getting accurate and complete estimates of annual out-of-pocket costs for plan comparison purposes, difficulty determining Extra Help status or seeing details about Extra Help costs, and general technical glitches with the system.

Dual Eligibles and People with Extra Help Who Want to Change Plans Must Do This by December 7th!

This year, dual eligibles (people who have both Medicare and Medicaid) and others with Extra Help were limited to changing their Medicare health or drug plan once per quarter instead of monthly. Now that we are in the final quarter of the year, these individuals can no longer change their plan for this year.

People can pick a new plan to start January 1, 2020; however, they must choose the new plan before December 7, 2019. In past years, dual eligibles and others with Extra Help had until the end of the year to choose a plan for coverage starting January 1st.

Next year, people with Extra Help can change their plan once per quarter between January 1st and September 30th. The request to change plans becomes effective the next calendar month. For example, if a dual eligible beneficiary with Original Medicare made an election to change their Part D plan in April, the change would go into effect May 1st, and they would not be able to make another plan change until the next quarter (July-September). During the last quarter of the calendar year (October-December), dual eligibles and those with Extra Help can use the annual open enrollment

period from October 15th-December 7th to make changes to their coverage, with the new plan starting January 1st.

Cautions about Medicare Marketing

During the Medicare Open Enrollment Period, people on Medicare are bombarded with advertisements about Medicare plans through mailings and television, newspaper, and billboard advertisements. This can be especially confusing for people with both Medicare and Medicaid who are moving to Community HealthChoices on January 1, 2020 and are getting mailings and information about this change, too.

This year, the federal government relaxed some of the rules that apply to Medicare plans when marketing plans to Medicare beneficiaries. Specifically, plans and agents/brokers are now allowed to hold marketing/sales events right after an educational event. Educational events provide more general information about Medicare plan options, but marketing events allow plan representatives, agents, and brokers to steer people to certain plans and provide enrollment forms and salespeople's contact information. This change means there is no longer a required "cooling off period" between these types of events to give people a chance to think about whether they want to get more information about particular plans or even check to make sure a certain plan will meet their needs before sales attempts start.

What People Should Consider Before Changing their Medicare Health or Drug Plan:

- Plan names are similar, and it can be hard for people to tell the difference between Medicare plans and Medicaid HealthChoices or Community HealthChoices plans – read mailings carefully!
- People going into Community HealthChoices (CHC) do not have to change their Medicare coverage. They can have Medicare coverage through Original Medicare and a stand-alone Prescription Drug plan or they can have a Medicare Advantage plan that covers health services and prescription drugs. Each CHC plan has an aligned Medicare Special Needs Plan, but it is **not** required that someone enroll in the aligned Medicare plan!
- Before signing up for a Medicare Advantage Plan, people should check with any healthcare providers they want to keep seeing to make sure the provider takes the Medicare plan. They should also check about whether there are any special rules they have to follow to get care, such as referrals or prior authorization requirements.
- Before signing up for a Medicare Advantage plan or a Medicare Prescription Drug plan, people should check with the plan to make sure all of their prescriptions are covered on the plan's formulary.
- APPRISE is an unbiased source of information about Medicare plan options. People needing assistance with comparing Medicare plan options are encouraged to call APPRISE at 1-800-783-

7067.

People can contact APPRISE (see above) or Medicare (1-800-633-4227) if they have questions about whether certain activities are allowed under Medicare's marketing rules. Unfortunately, PHLP has received calls from people who ended up getting enrolled in a Medicare plan they did not want or that does not meet their needs. If this happens, people may be able to change their plan if Medicare agrees that a plan or insurance agent violated Medicare's rules or provided misleading information to get someone to join a plan.

LIFE Program is Expanding

The PA Department of Aging [recently announced](#) that the Living Independence for the Elderly (LIFE) program will be expanding to 14 new counties over the next 18 months. Under the expansion, new LIFE programs will be established in Bradford, Cameron, Carbon, Centre, Clearfield, Elk, Fulton, Jefferson, Monroe, Potter, Sullivan, Susquehanna, Tioga and Wayne counties.

The LIFE program, which is known nationally as the Program of All-Inclusive Care for the Elderly (PACE), is a long-term care program that provides integrated physical health as well as community-based supports for seniors 55 and older who require a nursing facility level of care. Participants must live in an area served by a LIFE program, must be able to be safely served in the community, and must also meet financial eligibility requirements. The program allows seniors to live more independently by providing personal care and other services in their own homes and communities, rather than in nursing homes.

The LIFE Program was implemented in Pennsylvania in 1998 and currently serves nearly 7,500 seniors across 39 counties. The expansion of the LIFE Program will provide an additional option for long-term care to seniors in 14 predominantly rural counties.

Carbon, Monroe, Susquehanna, Wayne and Centre counties will be served by LIFE Geisinger, which currently serves nine other counties. LIFE Northwestern Pennsylvania, which already covers 7 other counties, will serve Clearfield, Jefferson, Elk, and Cameron counties. Bradford, Potter, Sullivan, Tioga, and Fulton counties will be covered by Community Life.

Legislation Introduced to Expand MAWD

Earlier this month, Pennsylvania state Senator Robert Mensch introduced legislation ([SB890 of 2019](#)) to create a new category of the Medical Assistance for Workers Program, called “Workers with Job Success” (WJS). This new category will help people with disabilities who are working reach their full potential and move up in their careers by allowing them to stay on MAWD after their income exceeds the current limit. Representative Klunk also has a [co-sponsorship memo](#) for companion legislation in the House and is expected to introduce legislation soon.

Currently, MAWD coverage is only available to individuals with disabilities if they earn less than \$61,000 annually. Under Workers with Job Success, workers making above \$61,000 who have been on MAWD for at least a year will be able to keep MAWD. These individuals will pay a higher premium for the coverage-the premium will be 7.5 percent or 10 percent of their countable income depending on how much income they have. For people making \$61,000 or less, the premium would remain at 5 percent. As a reminder, the premium is based on the percentage of someone's countable income, not their gross income.

When deciding to return to work or work more, an important consideration for people with disabilities is how the income from work will impact their continued eligibility for Medicaid health coverage, especially Medicaid-funded home and community-based services. Individuals often limit how much they work and may turn down raises or promotions to keep their earnings under the limit needed to keep their Medicaid.

Employer health coverage does not include home and community-based services, such as nursing care or Personal Assistance Services. People with disabilities rely on these important services to be able to work and live independently. Under current Medicaid rules, the Medical Assistance for Workers with Disabilities (MAWD) program offers a way for individuals getting home and community-based services to continue to financially qualify for Medicaid when they are working.

According to Senator Mensch’s sponsorship memo, only 35 percent of Pennsylvanians with disabilities work, and only 21 percent work full time. Pursuing these changes in Pennsylvania would encourage more people with disabilities to seek employment and allow these individuals to work to their full potential without fearing they will lose important benefits. Eleven other states have already made similar changes to support working people with disabilities.

Senator Mensch is currently seeking co-sponsors for this legislation. Interested readers can learn more and track the progress of the efforts described above at United Way of Southwestern Pennsylvania's [#IWantToWork](#) Campaign. The proposed bill has been referred to the Senate Health and Human Services Committee. We'll update readers about any progress in future newsletters.

New Rules for Delivering Medicaid-Funded Mental Health Services to Kids

There are significant changes to rules governing the delivery mental health services to children and adolescents. The Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) has established new regulations for Intensive Behavioral Health Services (IBHS) that replace Behavioral Health Rehabilitation Services (BHRS) for the delivery of child and adolescent services in the home, school, and community. The new regulations (Title 55, Chapters 1155 and 5240) become effective on January 17, 2020 (90 days after they were promulgated on October 19, 2019).

IBHS support children, youth, and young adults with mental, emotional, and behavioral health needs. IBHS include a wide array of services that can meet the needs of these individuals in their homes, schools, and communities. There are three categories: 1) Individual services which for one child; 2) Applied Behavior Analysis (ABA), which is a specific behavioral approach; and 3) Group services, which are most often provided to multiple children at a specific place.

The changes include increased requirements for staff training, supervision, and credentialing. These new regulations were built from needs identified, during a years-long process, by community stakeholders (including school district principals, provider agencies, and consumers) during targeted focused groups for improved access and quality of care for children, youth, and young adults.

The new IBHS Regulations can be accessed [here](#). The state has created a DHS/Health Choices IBHS web page repository for information regarding IBHS and the ongoing implementation. This website has IBHS Regulations, the IBHS Preamble, upcoming regional training information and registration, as well as important IBHS forms.

What's Happened with Applied Behavioral Analysis?

One of the changes that has drawn the greatest attention is that Applied Behavioral Analysis (ABA) is covered as a distinct service. Previously it was covered under generic Behavior Health Rehabilitation Services (also known as wraparound). There had been no regulations governing the coverage, just a series of PA state bulletins. From 2016, the state Office of Mental Health Services and a group of stakeholders, including PHLP, worked on regulations that would codify coverage of ABA as a distinct service. Providers can begin providing and billing for services as set out below; they will be required to comply with the new regulations starting January 17, 2020. Below are some of the key provisions affecting families seeking ABA services under Medical Assistance.

How to Obtain ABA Under Medical Assistance

1. Written order (prescription)

- It is written by physician, licensed psychologist, certified registered nurse practitioner, or physician assistant supervised by a physician.
- It is for any behavioral health disorder diagnoses in the DSM or ICD, not just autism spectrum disorders.
- It is written within 12 months prior to initiation of services.
- Face-to-face interaction with prescriber is not necessary.
- The written order includes:
 - ◇ clinical information supporting need for ABA
 - ◇ maximum hours of each service per month (*Note: this is not necessarily the number of hours that will be requested. The assessment and individual treatment plan will specify the exact number of hours being requested in each setting- not to exceed the number specified in the written order*)
 - ◇ settings where ABA is to be provided
 - ◇ level of goal achievement at which point services can be reduced (titrated)

2. Assessment (formerly the “psych eval”)

- This no longer needs to be done by psychiatrist or psychologist. It must be done by an individual qualified to provide behavioral analytic or behavior consultation services (see below for required qualifications).
- The assessment must be face-to-face with child/youth and parent, legal guardian, or caregiver “as appropriate.” It must be completed within 30 days of initiation of ABA services but before completing the treatment plan so services can begin before assessment is completed.
- It provides specifics for treatment delivery, including the number of hours of each service needed at each location.
- The signature of the family is not required on the assessment.
- If progress towards goals in treatment plan have not been made within 90 days, another assessment is needed in order to revise treatment plan.

3. Individual Treatment Plan (ITP)

- Must be based on the assessment and developed within 45 days of initiation of ABA services
- It is completed by an individual who is qualified to provide behavioral analytic or behavior consultation services (see below for required qualifications)- typically someone who works for the

ABA service provider from whom services are being sought.

- Individual Treatment Plan includes:
 - ◇ Service type, settings and number of hours of each service and in each setting
 - ◇ Specific measurable goals & timelines for completion
 - ◇ Whether and how parent, legal guardian or caregiver training, support and participation is needed to achieve the identified goals (*Note: the regulations do not require that a parent or other caregiver be present while ABA is being provided- that is determined by the Individual Treatment Plan*)
 - It is signed by the youth or their parent/legal guardian.
 - The Interagency Service Planning Team is meeting no longer necessary.
4. The Written Order, Assessment, and Individual Treatment Plan are submitted to the child's Behavioral Health Managed Care Organization (BH MCO) for review. The BH MCO decides whether to approve the services requested in the treatment plan. If approved, the provider can bill for services. If denied, the family can appeal the decision.

ABA Services Covered

ABA is comprised of a variety of models that use observation, data collection, and analysis of that data to develop techniques to produce socially significant improvement in behavior and improve skills or functioning. The regulations do not recognize any specific types or models of ABA. It is left up to the ABA professionals and family to determine, by way of the individual treatment plan, which model is most appropriate for the child. Instead, the regulations specify the qualifications and roles of various professionals who can provide ABA under Medical Assistance.

- ◆ Behavior analytic services consist of:
 - ◇ clinical direction of services, development and revision of individual treatment plan, oversight of the treatment plan, and consultation with the treatment team
 - ◇ also doing functional analysis
- Staff qualification is a Board-Certified Behavior Analyst (BCBA) who is also a:
 - ◇ licensed behavior specialist;
 - ◇ licensed psychologist;
 - ◇ licensed professional counselor, marriage and family therapist, clinical social worker, social worker; or
 - ◇ certified registered nurse practitioner
- ◆ Behavior consultation- ABA

- Services are the same as behavior analytic services except they do not include doing functional analysis.
- Staff qualification is not a BCBA, but must include one of the licenses above plus one of the following qualifications:
 - ◊ A Board-Certified Assistant Behavior Analyst (BCaBA);
 - ◊ One year full time provision of ABA + 12 college credits in ABA; or
 - ◊ One year full time provision of ABA under the supervision of a BCBA + 40 hours of ABA training approved by DHS or the Behavior Analyst Certification Board
- ◆ Assistant Behavior Consultation
 - Services consist of assisting an individual who provides behavior analytic services or behavior consultation—ABA services and providing face-to-face behavioral interventions.
 - Staff qualifications:
 - ◊ Must meet the licensure requirements for behavior specialist except they don't yet have 1000 hours of in-person clinical experience; or
 - ◊ Certified as a Board-Certified Assistant Behavior Analyst (BCaBA), with a bachelor's degree in psychology, social work, counseling, education or a related field; or
 - ◊ Must have a minimum of six months of experience in providing ABA services, a bachelor's degree in psychology, social work, counseling, education or a related field, and a minimum of 12 credits in ABA from a college or university
- ◆ BHT-ABA (Behavioral Health Technician)
 - These services consist of implementing the individual treatment plan. They take the place of the TSS.
 - Staff qualifications, effective July 1, 2020:
 - ◊ Certified as a Board-Certified Assistant Behavior Analyst (BCaBA); or
 - ◊ Certified as a Registered Behavior Technician (RBT); or
 - ◊ Certified as a Board-certified autism technician (BCAT); or
 - ◊ High school diploma/GED + have completed a 40-hour training covering the RBT Task List as evidenced by a certification that includes the name of the trainer, who is certified as a BCBA or BCaBA; or
 - ◊ Minimum of two years of experience in providing ABA services and a minimum of 40 hours of training related to ABA approved by the Department or provided by a continuing education provider-approved by the Behavior Analyst Certification Board
 - ◊ A college degree is not required

Short Window To Enroll In ACA Health Insurance Marketplace: It Ends Dec. 15th

Open enrollment season for the Affordable Care Act marketplace, www.healthcare.gov, began Friday, Nov. 1 and runs through Sunday (yes, Sunday), Dec. 15. People who currently have a marketplace plan will be automatically re-enrolled in the same plan or one offered by the same insurer that is similar for 2020.

The price of marketplace plans has stabilized in the last few years. The statewide average increase for 2020 is four (4) percent for individual market plans, much less than stretches of drastic increases when the program first launched in 2014. However, fewer people are buying ACA plans across the nation and across Pennsylvania, because of the elimination of the financial penalty for people who don't purchase insurance, and cuts in funding that kept copays and deductibles affordable and that promoted marketplace plans. The number of ACA enrollees dropped from about 389,000 Pennsylvanians in 2018 to 366,000 in 2019.

It's a good idea to review your coverage, even if you like your plan, because the prescription medications and doctors covered may have changed, or there may be new plan options that are a better fit.

Here's What You Need To Know For Open Enrollment:

Where do I buy comprehensive health insurance?

Consumers should be careful of where they shop for health insurance. Some companies and agents are offering plans they say are ACA-compliant, however many consumers, after expensive medical bills, find out later they are not. For example, short-term limited duration insurance plans do not offer the same comprehensive coverage as ACA-compliant plans.

If you are buying insurance as an individual—and especially if you qualify for income-based tax credits—the safest and most reliable place to shop is the federal health exchange, www.healthcare.gov. The website lists only plans that meet the ACA's requirements for comprehensive health insurance.

Private exchange websites may also be able to help you enroll in a marketplace plan, but these websites can also sell health plans with incomplete coverage and are not required to show you all the marketplace plans available in your area.

Information on the various ACA-compliant plans available in Pennsylvania and where to seek enrollment assistance are available [here](#), operated by the PA Department of Insurance. Consumers may also visit [Consumers' Checkbook](#) to view Pennsylvania plan options, estimate monthly premiums and total annual out-of-pocket costs for each plan, and learn how to buy a plan. Checkbook also includes information on ACA-compliant plans sold outside of the exchange, which may be a good option for consumers who know they do not qualify for financial assistance.

Consumers buying an off-exchange plan directly from a company should make sure they are on an

official website for one of Pennsylvania's seven insurers offering individual health insurance: Capital Blue Cross, Pennsylvania Health & Wellness, Geisinger, Highmark, Independence Blue Cross, Oscar Health and UPMC Health Plan.

Consumers shopping at www.healthcare.gov can also determine if they qualify for Medicaid and the Children's Health Insurance Program (CHIP). If they or their beneficiaries qualify, they will be automatically redirected to the Department of Human Services' COMPASS website to complete their application.

What is comprehensive health insurance?

Plans that meet all the ACA's rules for basic coverage requirements, such as preventive care, maternity and mental health services, and prescription medications, are considered comprehensive. Such health plans cannot deny coverage for pre-existing conditions, and there is a limit to the amount members can be required to pay out of pocket.

Other types of insurance, including short-term limited duration plans and association health plans, are significantly cheaper because they are not required to cover basic services and can refuse to pay for care they determine is related to a pre-existing condition. It's important to be aware of these other types of plans because they are often marketed to resemble full health insurance on websites that look a lot like the federal and state marketplaces.

What types of plans are available?

ACA marketplace plans are organized by metal level: bronze, silver, gold and platinum. Bronze plans have the lowest monthly premium and the highest deductibles. Gold and platinum plans have the most expensive premiums, with lower out-of-pocket costs. Silver plans fall in the middle and are a popular option for marketplace shoppers. The number of insurers and plan options for each metal level will vary depending on where you live.

Choosing the best plan

Premium (the amount you pay on a monthly basis to maintain coverage) is the number one thing consumers consider when shopping for health insurance, analysts say. But it's far from the only factor that affects how much you will spend on health care in a year. The deductible (the amount you must spend out of pocket before the plan pays a greater share) and the out-of-pocket maximum (the maximum amount you can be asked to pay in a year) are also important. Consider whether your doctors are in-network and whether the medications you take are covered to avoid surprise costs later.

Who is eligible for tax credits and how do I get one?

Financial assistance is available for Pennsylvanians who shop on the marketplace at healthcare.gov. Depending on the income of their household, many consumers qualify for subsidies to reduce their monthly premiums and some also qualify for assistance that lowers their out-of-pocket costs like co-pays and deductibles. About 80% of Pennsylvanians enrolled through the marketplace receive finan-

cial assistance.

Tax credits are available to offset the cost of insurance premiums for people within 400% of the federal poverty level—that’s an annual income of slightly less than \$50,000 for an individual. The amount of the credit depends on your income. People who are eligible for a premium tax credit can get extra financial assistance if they choose a silver-level plan.

Where can I get help?

Navigator programs paid for by state and federal funds provide free, in-person support to help you select a plan. If you want an appointment, don’t procrastinate — funding for navigator programs has been cut dramatically over the past few years, which means fewer enrollment specialists are available.

Many independent health insurance brokers are certified to sell ACA marketplace plans. Brokers are paid commissions from insurance companies when they sell a health plan and may sell both comprehensive health insurance and plans that do not offer full benefits.

Use [healthcare.gov](https://www.healthcare.gov) to find a navigator or independent broker licensed to sell health plans that meet ACA marketplace rules.

Use the Pennsylvania Insurance Department’s broker search tool to verify that your agent is licensed and in good standing, and to see which insurers he or she has relationships with. New Jersey Department of Banking and Insurance has a similar tool. Brokers who have relationships with many common insurers will have more plan options to show you and may have less financial incentive to sell you a specific plan.

Pennsylvania Releases HealthChoices Physical Health RFA

The Pennsylvania Department of Human Services released a request for applications (RFA) on October 15, 2019, seeking Medicaid managed care organizations (MCOs) for its [Physical HealthChoices Program](#), Pennsylvania’s mandatory managed care programs for Medical Assistance (Medicaid) recipients. Currently, seven different Physical Health MCOs are responsible for ensuring that 2.26 million Pennsylvanians (including 1.2 million children) receive medical care and access to physical health services (including medicine) whether the services are delivered on an inpatient or outpatient basis.

Seven Physical HealthChoices MCOs plans (Aetna, AmeriHealth Caritas (Vista), Gateway, Geisinger, Health Partners Plans, UnitedHealthcare, UPMC) operate in five different HealthChoices zones covering all 67 counties: Southeast, Southwest, Lehigh/Capital, Northwest,

and Northeast. The contracts for the newly issued RFA are worth nearly \$13 billion.

Previous Procurements

This is Pennsylvania's third RFA attempt for Physical HealthChoices. The Commonwealth tried to implement new contracts in 2016 as well as in 2017, but those attempts were negated after state courts found the bidding and contract processes violated the procurement law. As result, the Physical HealthChoices program has been operating under extensions of contracts originally awarded in 2012.

The most recent awards in early 2017 were for the following HealthChoices zones:

- **Southeast Zone:** Gateway Health, Health Partners Plans, PA Health and Wellness (Centene), UPMC for You, Keystone First Health Plan (Vista)
- **Southwest Region:** Gateway Health, PA Health and Wellness (Centene), UPMC for You, AmeriHealth Caritas Health Plan (Vista)
- **Lehigh/Capital Region:** Gateway Health, Geisinger Health Plan, Health Partners Plans, PA Health and Wellness (Centene)
- **Northeast Region:** Gateway Health, Geisinger Health Plan, UPMC for You
- **Northwest Region:** Gateway Health, UPMC for You, AmeriHealth Caritas Health Plan (Vista)

Aetna and UnitedHealthcare were not awarded contracts for any region, but after protests the state canceled the process. The same MCOs and new entrants are expected to compete for the next round.

New Dates

Applications from interested MCOs are due December 17, 2019, and contracts are expected to begin January 2021, running for five years, with an option to extend for an additional period of three years. We'll update readers about any progress in future newsletters.

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 num-