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State Budget Update

On June 30th, the day the state's fiscal year ended, the Pennsylvania legislature passed a bipartisan spending plan for Fiscal Year 2017-18. On July 10th, Governor Tom Wolf let the state budget-spending bill become law without his signature. At $32 billion, the general fund budget passed by the General Assembly (House Bill 218) is an increase of $54.3 million over last year's budget and supplemental appropriations. While the legislature and the Wolf Administration reached agreement on a spending package, the revenue portion, and how Pennsylvania is going to meet its nearly $2 billion budget deficit, is still under discussion.

The effect of the FY 2017-18 budget on the state's Medicaid program is still unclear. The spending plan appears to largely "flat-fund" Medicaid, however it does provide additional funding to expand enrollment into community-based waiver programs for individuals with intellectual disabilities.

Although the budget bill does include language giving the state budget secretary authority to combine departmental appropriations in the next fiscal year, it appears unlikely that the merger of the Departments of Aging, Drug and Alcohol Programs, Health, and Human Services as proposed by the Governor will move forward this fiscal year. As of the time this newsletter is published, there has not been any legislation introduced to authorize the merger which is necessary to implement it.

The General Assembly has begun moving "code" bills – legislation needed to implement various portions of the overall state budget. One of these codes, the Human Services Code (formerly the Public Welfare Code), which governs Medicaid eligibility and benefits, is

the subject of several last minute but significant changes. The most concerning changes for PHLP's clients included in Pennsylvania House Bill 59 are:

- Requiring Pennsylvania's Department of Human Services (DHS) to seek a waiver from the federal government for "reasonable employment and job search requirements for those physically or mentally able, as well as appropriate limits on nonessential benefits, such as nonemergency transportation".

  PHLP has opposed work requirements, which increase red tape for families and the state. Most Medicaid recipients are already working: fifty-eight percent of Medicaid expansion recipients are working and nearly three in four are in working households. Work requirements create additional layers of bureaucracy that will create paper-chases and processing errors.

- Requiring DHS to lock Medicaid consumers into a managed care plan for a 12-month period, unless the individual qualifies for an exemption.

  PHLP also opposes "lock-ins". Since HealthChoices (managed care) was created in 1997, consumers have been able to change plans whenever they need to without having to go through a formal process of proving they have a good reason to change plans. Moreover, the 12-month lock-in could also apply to the new Community HealthChoices (CHC) program and harm seniors and people with disabilities. Consumers (in either HealthChoices or CHC) may find themselves in a situation where their current plan's network is inadequate because they don't have the right type of specialist, enough primary care providers, or a neighborhood pharmacy. Or, they could have a crucial provider leave their plan's network. Federal law requires states that use a lock-in to have an exception process so that consumers can change their plans if they show just cause—for example, medical reasons. Establishing these new lock-in and exception processes means that Pennsylvania will have to set up a costly, time-consuming system that drains administrative resources.

- Requiring DHS to seek premium payments for children who currently qualify for Medicaid due to a medical diagnosis without regard to their family's income (more commonly known as PH-95 families). This will change the review to be based on the family income, and premiums would be charged when a family's income exceeds 1,000 percent of the federal poverty limit (or, $246,000/year for a family of four). The premiums would be based on a sliding scale in accordance with Children's Health Insurance Program.

These changes to the Human Services Code were fast tracked and made without discussion or debate in public hearings. Many legislators saw the bill language for the first time in the hours before a vote was held.

The House passed HB 59 on July 11th by a vote of 102-91. All Democrats who were present voted no. They were joined by 15 Republicans. The legislation will now move to the Senate, but it is not yet known whether or when the Senate will hold a vote on HB 59.

Governor Wolf has expressed concerns and opposes the Medicaid changes in HB 59. However, it is unclear at this time if he will sign it into law if it is ultimately approved by the Senate. If passed, the changes would take effect immediately. Readers and other individuals who are interested in voicing their opinions about the changes are encouraged to contact their Pennsylvania Senators.

We will provide further updates about Pennsylvania's FY 2017-18 budget and its impact on the Medicaid program in our next newsletter.

Legal Challenges Stop DHS From Moving Forward With HealthChoices Physical Health Plan Changes

Three insurance companies (Aetna, AmeriHealth Caritas, and United Healthcare) recently took legal action to challenge the Department of Human Services' (DHS) procurement process for HealthChoices ***physical health*** plans across Pennsylvania. Aetna and United asked the Commonwealth Court for emergency relief and that all activities related to the newly chosen HealthChoices physical health plans be halted. Hearings were scheduled for June 29, 2017; however, prior to the hearing date, DHS agreed to a stay (stop) and will not take any action to move forward with the selected physical health plans until the legal proceedings are completed and the Court makes a final determination on these cases.

As we reported in our March newsletter, these Southwest plan changes were to begin in January 2018. Given the stay agreed to by the Department, these plan changes are unlikely to start as scheduled, at least in the Southwest. Please note that this article relates only to the **HealthChoices** plans and **not** to Community HealthChoices (see page 6 for updates about CHC implementation).

Attention Cambria County Medicaid Recipients

Medicaid recipients in Cambria County have a new **behavioral health** managed care plan. Starting July 1, 2017, Magellan Behavioral Health is the HealthChoices behavioral health plan chosen by the county, replacing Value Behavioral Health.

Medicaid recipients impacted by this change should have received a welcome letter and a Member Handbook from Magellan by the end of June. Anyone in Cambria County who has **not** received this information should call Magellan Member Services to request it at 1-800-424-0485. Information is also available on Magellan's website.

> **Please note**: The vast majority of people on Medicaid receive their behavioral health coverage through a HealthChoices plan, but there are some exceptions. The following groups of people now get their behavioral health coverage through the ACCESS card and are **not** currently impacted by this change:
>
> ◊ Older adults enrolled in the Aging Waiver;
> ◊ Individuals on Medicaid in nursing homes; and,
> ◊ Those enrolled in the Health Insurance Premium Payment (HIPP) Program

Magellan reports that they have contracted with "the majority of the existing Cambria County HealthChoices provider network". However, members should contact any mental health or substance abuse services providers they use for treatment to be sure they now have a contract with Magellan. Providers who want to be in Magellan's network but who are not yet enrolled can contact the plan.

Those with questions or who have problems accessing the care they need through Magellan Behavioral Health can contact PHLP's Helpline at 1-800-274-3258.

New Quality Initiatives Highlighted in Medicaid Managed Care Contracts

Patient Centered Medical Homes and Value Based Purchasing are two new quality initiatives included in the Department of Human Services' (DHS) contract with its Medicaid managed care companies for calendar year 2017. Of the over 2.8 million residents now enrolled in Pennsylvania's Medicaid program, nearly 2.3 million receive their physical health coverage through HealthChoices, PA's mandatory managed care delivery system.

Patient Centered Medical Homes

As of this year, the Medicaid managed care plans responsible for the delivery of physical health coverage are now required to provide enhanced payments to high-volume provider practices that become Patient Centered Medical Homes (PCMH). A PCMH is a team-based primary care model noteworthy for a high degree of patient engagement and a commitment to measuring patient satisfaction. Doctors and other providers in a PCMH offer increased access (such as expanded hours) and actively coordinate the patient's physical and behavioral health/drug & alcohol care treatment. As required by the DHS managed care contract, PCMHs will also deploy care management teams comprised of nurses, social workers, peer specialists, and community health workers to actively engage patients, develop care plans, and connect patients with community resources for help with problems such as food insecurity or housing instability.

For 2017, DHS will require the managed care plans to serve at least 10% of their overall members, and at least 20% of their most expensive members (those in the top 5th percentile by medical cost), in a PCMH practice. In 2018, these thresholds will increase to at least 20% of a plan's overall membership and 33% of its most expensive members. Managed care plans are also required to collect and report key quality metrics from the PCMH practices.

Value Based Purchasing

A Medicaid reform intended to shift payments toward value and outcomes over volume, the Value Based Purchasing initiative also began with the 2017 managed care contracts. Through this initiative, the state Medicaid program is requiring the plans to use an increasing percentage of the capitation payments they receive from the state and apply those monies towards value-based purchasing strategies intended to shift financial risk onto physicians, hospitals, and other healthcare providers. Reimbursing providers a set fee for the service provided is currently the predominant payment arrangement used by the managed care plans. Value-based purchasing strategies include patient-centered medical homes (discussed above), shared saving arrangements, episodes of care payments, bundled payments, and contracting with Accountable Care Organizations.

For calendar year 2017, the plans are required to spend at least 7.5% of the medical portion of the capitation payments they receive on value-based purchasing strategies. This requirement increases to 15% in 2018 and 30% in 2019.

Enrollment reports and the Medicaid managed care contract (titled the "HealthChoices Agreement") can be found on the DHS website here. State officials report that the 2017 contract will be posted soon.

Community HealthChoices Implementation Moving Forward

With less than six months to go before Community HealthChoices (CHC) starts in Southwestern PA and less than a year to go before it is scheduled to start in Southeastern Pennsylvania, many activities are underway to prepare consumers and providers for the changes that CHC will bring. Read on for updates about these activities, primarily geared toward happenings in Southwestern PA.

CHC Background

Community HealthChoices (CHC) is the new managed long term services and supports initiative that will require those in the CHC target population to join a managed care plan and get their Medicaid physical health coverage **and** their long term care through that plan. The target population includes:

- **Most dual eligibles** (those on Medicare and Medicaid)-note that dual eligibles who receive services, ***or*** who are on a waiting list for services, from the Office of Developmental Programs will **not** be enrolled in CHC
- **Those enrolled in one of the OLTL Waiver programs** (Aging, Attendant Care, COMMCARE, Independence and OBRA—*see more about the OBRA Waiver below*)
- **Those receiving Medicaid long term care in a nursing home**

The Southwest will be the first zone to implement CHC on January 1, 2018. After that, the Southeast Zone has a target implementation date of July 1, 2018 and then the remaining 48 counties making up Zone 3 will start CHC January 1, 2019.

Zone 1 Updates-Southwestern PA

The PA Department of Human Services is moving "full steam ahead" on the implementation of Community HealthChoices in the 14 county Southwest zone scheduled to start on January 1, 2018.

Consumer Outreach and Education

The Office of Long Term Living (OLTL) will be mailing out an informational flyer in early August to approximately 100,000 people in the Southwest region who will be in the CHC target population. This flyer will give basic information about CHC and a phone number where people can call if they have questions. The flyer also tells consumers that they will soon be receiving information from Aging Well about upcoming informational sessions that will be held in their area.

Aging Well is an entity with whom the state is contracting to do outreach and education to the CHC population. Aging Well will be conducting 20 in-person sessions across the Southwest zone in Sep-

tember. The target audience for these sessions will be consumers who are on Medicare and Medicaid but who are getting no long term services and supports. OLTL plans to list these sessions on the Community HealthChoices website when they are scheduled.

In addition, Aging Well will be responsible for educating service coordinators who serve the OLTL Waiver population as well as nursing home staff in the Southwest region. The service coordinators and nursing home staff will then be tasked with educating and assisting their consumers/residents (and their family members) on Community HealthChoices and the enrollment process.

In late August or early September, pre-transition mailings will be mailed to the CHC Southwest population giving them more information about Community HealthChoices, how they will be affected, and the CHC plan enrollment process. In addition, those in the Southwest zone who are enrolled in a LIFE (Living Independence for the Elderly) Program will get a separate mailing telling them they can choose to stay in LIFE or they can move to CHC. As a reminder, LIFE programs will continue to exist as an alternative to CHC for those who qualify going forward. Anyone who chooses to enroll into LIFE will not be required to go into Community HealthChoices.

Provider Outreach and Education

In preparation for the start of Community HealthChoices in the Southwest, OLTL is hosting Southwest Provider Summits in late July in three locations in Southwestern PA (Cranberry, Pittsburgh, and Altoona). They had to add a second session in Cranberry due to high registration. Registration is now closed for these sessions, but OLTL will make Summit materials available on its CHC website.

In late June, OLTL also sent out a communication to OLTL service coordination entities, Home and Community-Based Waiver providers, LIFE providers and Nursing Home Transition coordination agencies informing them of a Home and Community-Based Services Loan Program. Under this program, loans of between $50,000-$200,000 are available to qualified providers for projects that will help the state meet its goal of expanding long term services and supports in the community.

Other information and resources for providers regarding CHC can be found on the "For Providers" page of the Community HealthChoices website.

OBRA Waiver Redeterminations

In planning for the transition of those in OLTL Waivers to Community HealthChoices, the state is reassessing the level of care needed by those in the OBRA Waiver. The OBRA Waiver is the only OLTL waiver that does not require the consumer to be "nursing facility clinically eligible". Instead, people can be in OBRA if their level of care is "Intermediate Care Facility-Other Related Condition" (ICF-ORC).

If the assessment process results in the person being determined nursing facility clinically eligible, she will be put into the CHC Southwest target population and be required to go into CHC on January 1st. However, if the person is assessed to have an ICF-ORC level of care, she will remain in the OBRA Waiver. Once CHC is implemented in a region, the OBRA Waiver is the only OLTL Waiver that will continue to exist for those age 18 to 21 and for those with an ICF-ORC level of care.

Zone 2 Update-Southeastern PA

On June 28th, the Southeast Region held its first Community HealthChoices information sessions hosted by the First Hospital Foundation. OLTL officials provided various stakeholders with information about key activities that will be taking place prior to the July 2018 start date for Southeastern Pennsylvania.

Individuals who are interested in receiving updates about CHC implementation in any of the three zones are encouraged to sign up for the OLTL-COMMUNITY-HEALTHCHOICES ListServ here and participate in the Third Thursday Webinars conducted by the Office of Long Term Living. The next webinar is scheduled for **July 20th** at **1:30 pm**.

PHLP will continue to update readers about CHC developments through our newsletter.

REMINDER: September 30th Deadline to Act for People Who Delayed Enrolling in Medicare Because of Marketplace Coverage

Individuals who had Marketplace coverage and delayed enrollment into Medicare have until **September 30th** to ask the government for relief from Medicare late enrollment penalties and/or the Part B enrollment rules that would normally apply. More information can be found in our March newsletter.

Medicare Lifts Enrollment Sanctions on Cigna

On June 16th, the federal agency that administers the Medicare program announced it was lifting enrollment sanctions placed on Cigna Medicare Advantage plans and Cigna Medicare prescription drug plans. The sanctions began in January 2016 after the federal government identified numerous areas where Cigna was not following federal rules resulting in problems that posed a serious threat to the health and safety of Medicare beneficiaries enrolled in Cigna's plans. Cigna was prohibited from marketing their Medicare plans and enrolling new members for the last year and a half while under sanctions.

Now that the sanctions have been lifted, Medicare beneficiaries can again enroll in Cigna's Medicare plans. The federal government will continue to closely monitor Cigna to determine if any further actions are necessary. The following Cigna plans are available in Pennsylvania in 2017:

Stand-alone Prescription Drug Plans (available across Pennsylvania):
• Cigna-HealthSpring Rx Secure (a zero-premium plan for people with the full Extra Help) • Cigna-HealthSpring Rx Secure-Extra

Medicare Advantage Plans (available in certain counties in South Central and Eastern Pennsylvania):	
Plans Available to Most Medicare Beneficiaries:	**Special Needs Plans (available to certain Medicare beneficiaries noted below):**
• Cigna-HealthSpring Advantage • Cigna-HealthSpring Preferred • Cigna-HealthSpring Preferred Plus • Cigna-HealthSpring Preventive Care	• Cigna-HealthSpring TotalCare (*for people with both Medicare and Medicaid*) • Cigna-HealthSpring Achieve (*for people with diabetes*) • Cigna-HealthSpring Traditions (*for people who live in an institution or require nursing care at home)*

Medicare beneficiaries who have questions or who are interested in changing their Medicare coverage are encouraged to call APPRISE for help – 1-800-783-7067.

The U.S. Senate's Better Care Reconciliation Act – A Summary of Its Impact on Medicaid

On June 22nd, Republican leaders in the U.S. Senate released the Better Care Reconciliation Act of 2017 (BCRA), their bill to repeal and replace the Affordable Care Act. This bill, like its U.S. House-passed counterpart, the American Health Care Act (AHCA), makes drastic changes to the Medicaid program. The Senate bill was created by a small group of Senators, including Pennsylvania Senator Pat Toomey, and crafted in a way that allows the bill to head straight to the Senate floor for debate. There, the Republican leadership intends to use a process called "reconciliation," which allows the chamber to pass a bill with 51 votes. The Senate bill would fail if just three of the 52 Republican Senators vote no, since all Democrats oppose it. Republican leaders had hoped to hold a vote on the bill prior to the July 4th recess but cancelled the vote when it became clear they didn't have enough support to pass the bill.

On July 13th, a revised version of the Senate bill was released that includes some changes from the original bill with the hope of gaining enough Republican support to pass it. Unfortunately, the revised bill leaves the Medicaid cuts and changes in place. In addition to the significant Medicaid changes, the Senate bill allows states to drop coverage for essential health benefits required by the Affordable Care Act including maternity care, emergency services, and mental health treatment. It also reduces the income limits for people to qualify for tax credits to help them purchase insurance, and raises deductibles and premiums for marketplace plans purchased by older Americans. It eliminates the penalty for people who do not have coverage and phases out the cost-sharing help people with limited incomes can get now to pay the deductibles and coinsurance for Marketplace plans. The Congressional Budget Office is expected to review and score the revised bill on July 17th or 18th. It is possible that a vote on the Senate bill could happen very soon after the CBO report is released.

Of major concern to PHLP and our clients, the Senate bill fundamentally changes how the federal government funds the Medicaid program and ends the federal government's commitment to share all Medicaid costs with states. The Senate bill replaces that federal commitment with a **per capita cap** that would limit—and significantly reduce—federal Medicaid spending. The cap would apply to virtually all Medicaid spending- including the care provided to low-income children, pregnant women, adults with disabilities, and older adults. The Senate Bill differs from the House bill in that is changes how the per capita cap is calculated and exempts children with disabilities from the cap.

The cuts to Medicaid under the Senate Bill are even greater than under the House Bill- particularly over the next decade. Even though spending for children with disabilities would not be counted toward the per capita cap and the costs for covering this population would not be used in setting the cap, these children could still be impacted by changes their state will be forced to make to its Medicaid program as a result of drastically reduced federal funding. Consumer advocates worry these changes could include limits on eligibility, benefits, and provider payments that will affect consum-

ers access to care

In addition to the mandatory per-capita-cap funding formula for most populations covered by Medicaid, the Senate bill allows states the option to request a block grant to cover certain populations including pregnant women, parents, and now, the expansion population. The block grant option gives states flexibility on benefits covered and allows states to charge premiums and deductibles for those populations covered.

The Senate bill allows states to continue covering people under the Medicaid expansion rules (adults age 19-64 who do not have Medicare and have income less than 138% FPL based on their household size); however, it phases out and eventually eliminates the enhanced federal funding for this population. The bill also eliminates the essential health benefit requirements for people who qualify under this category. Even though the states could reduce the benefits provided to this population, it remains unclear whether states will continue covering these individuals given the drastic cuts in federal funding. As a reminder, over 700,000 Pennsylvanians have gained coverage since Medicaid Expansion started here in 2015.

The Senate bill includes other Medicaid reforms such as: allowing states to impose work requirements for beneficiaries who are not disabled, elderly or pregnant as a condition of eligibility; eliminating retroactive eligibility; ending presumptive eligibility; allowing for more frequent redeterminations of eligibility; and revising the federal regulatory process. Many of these changes could cause people to lose coverage and increase States' administrative costs.

The revised bill released on July 13th includes the additional following changes to the Medicaid provisions that were in the original bill:

- States will be allowed to apply for a Waiver to continue home and community-based services for older adults and people with disabilities.
- In situations where a state declares a public health emergency, Medicaid spending in the affected emergency area will not be counted toward the per capita caps or block grant allocations during the emergency period.
- Changes to how the Disproportionate Share Hospital benefit that states receive is calculated.

The revised bill also provides an additional $45 billion in funding to states for substance abuse treatment and recovery to help states fight the opioid epidemic. This is an increase from the $2 billion included in the initial version of the Senate bill; however, experts note that the increased amount will likely not be enough to meet states' needs, especially given the bill's drastic reduction in federal Medicaid funding.

Scoring from the Congressional Budget Office

As noted previously, the CBO will review and analyze the impact of the most recent changes made to the Senate bill. These results are expected early the week of July 17th.

On June 26th, the Congressional Budget Office (CBO) released its report on the impact of the initial Senate Bill. If the initial bill were to become law, CBO projects that 22 million people would lose health insurance by 2026—and millions more would see increased out-of-pocket costs. CBO estimates that 15 million people would lose Medicaid coverage by 2026 as a result of the phase-out of the Medicaid expansion funding and the reduction in federal Medicaid dollars states would receive. CBO projects federal spending on state Medicaid programs would be reduced by $772 billion over the next 10 years.

On June 29th, the CBO released additional information about the longer term effects of Medicaid spending under the Senate Bill if its Medicaid changes were to become law. In this analysis, the CBO acknowledged the biggest impact on spending under the Senate Bill would be for Medicaid- noting the funding changes to Medicaid would result in a 26 percent reduction in federal Medicaid spending in the next decade and a 35 percent decrease in federal Medicaid spending by 2036- compared to federal Medicaid spending under current law.

With less federal funding, CBO projects that states would have to either allocate more of their own resources to Medicaid-for example, by raising state taxes- or else cut costs. Cutting costs could include reducing Medicaid payments to hospitals and nursing homes, dropping optional services, restricting eligibility, or finding other ways to make service delivery more efficient. The effects would be felt by older people in nursing homes, children, people with disabilities, pregnant women, and women with young children.

What's Next?

At the time of this publication, it appears that Senate Leadership hopes to act quickly and hold a vote on the revised bill-possibly as early as July 18th. Readers and other individuals who are interested in voicing their opinions about the Senate bill are encouraged to contact Pennsylvania's U.S. Senators-Pat Toomey and Bob Casey.

We'll keep readers updated about any future developments.

A Note to Our Readers...

PHLP's next newsletter will be published in September 2017.

We will share important news through targeted email alerts as needed between newsletter publications.

Enjoy the rest of your summer!

Our Mission

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

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

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

Support Our Work

Please support PHLP by making a donation on our website at phlp.org. You can also donate through the United Way.

For Southeast PA, go to uwsepa.org and select donor choice number 10277.

For the Capital Region, go to uwcr.org and pledge a donation to PHLP.

For the Pittsburgh Region, go to unitedwaypittsburgh.org and select agency code number 11089521.

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