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Changes to OLTL Waivers Affecting Consumers Across the State

The Department of Public Welfare (DPW) published new rules and regulations in May affecting waiver programs administered by the Office of Long-Term Living (OLTL). OLTL administers the Aging Waiver, Attendant Care Waiver, CommCare Waiver, Independence Waiver, and OBRA Waiver as well as the Act 150 program. The rules primarily address provider qualifications and payment provisions.

Aging Waiver and Service Coordination

One of the most significant changes included in these rules affects Aging Waiver recipients and the move from care management services to service coordination. Area Agencies on Aging (AAAs) must now provide **service coordination** rather than care management to Aging Waiver recipients. Although the main tasks of service coordinators are the same tasks as those provided by care managers (i.e., developing the service plan, assisting consumers in accessing services), there are some notable changes:

- Under the new rules service coordination agencies can only bill a certain number of units (15 min units as opposed to previous hourly, weekly or monthly units for care management) per year for each Aging Waiver recipient. If an individual waiver recipient requires more service coordination, then a request must be made by the AAA to OLTL for approval of any additional units.
- The new rules require only that service coordinators make one phone call to or have one face-to-face visit with their consumers in a calendar quarter and require only two face-to-face visits per calendar year. Typically, care managers had much more frequent contact with waiver recipients and could make unlimited contacts with a waiver recipient throughout the month. Given the limits on service coordination billing units, as well as decreased emphasis on the number of personal contacts with individual waiver recipients, consumers will likely

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(Continued from Page 1) hear from and see less of their Aging Waiver service coordinator than they did in the past.

- OLTL has specifically stated that service coordination cannot include nurse review of the service plan or home visits by a nurse unless there is a documented need for a nurse to be involved in the case in the individual's service plan. Prior to this change, AAAs typically had RNs review each service plan and make home visits to all Aging Waiver recipients.

The new rules also allow Aging Waiver recipients the choice of receiving their service coordination services through a provider other than their local AAA.

Community Choice Ended as of 7/1

Another big change affecting consumers seeking services through Waiver programs is the end of Community Choice. Community Choice existed in certain counties across the state and allowed Waiver applications to be expedited when an individual was at imminent risk for placement in a nursing home or other type of facility. Community Choice also allowed Waiver services to start within 24-72 hours to prevent that person from being institutionalized and enabling them to remain in their community - the preference of most individuals seeking long-term care services.

At this point, Community Choice no longer exists in any county in Pennsylvania. This means that before any consumer can begin to receive services through a Waiver program, their Waiver application must first be approved by the County Assistance Office (which can take 30 days) and the OLTL followed by the development of a service plan which must be approved by OLTL. As a result, new Waiver recipients are now waiting several weeks, if not months, before any services can begin.

Ending Community Choice also means that in cases where an individual is trying to transition from a nursing home or hospital back to their home, the service plan cannot even be developed until they are in the community. Once the plan is developed, it must be sent to OLTL for review and approval. As a result, consumers can no longer put services in place before they return home. This often creates problems for consumers and their family members who must then figure out how to provide informal services to their loved one or privately pay for services when they first arrive home and until the Waiver service plan is approved and services start.

Consumer advocates and others who work with the elderly and those with disabilities are concerned that these delays in getting Waiver services approved and started will result in more people going to a nursing home if they need immediate services, or people being unable to leave nursing homes and receive care in the community. Unlike Waivers, someone can receive long term care services in a nursing home immediately upon admission and the nursing home can apply to get reimbursed for their services back to the date of admission if the individual qualifies for Medicaid.

DPW selects Financial Management Services (FMS) vendor for Two Regions

Waiver participants across Pennsylvania who choose to use the consumer-directed model for their services (where they choose, hire, train and fire their attendants) get Financial Management Services (FMS) to help with the administrative tasks of hiring and paying their own work- *(Continued on Page 3)*

(Continued from Page 2) ers (i.e., writing pay checks, paying required taxes).

At the August meeting of the Long-Term Care Subcommittee, OLTL announced the selection of Public Partnerships, LLC as the sole FMS provider for the state's Western and Eastern Regions. OLTL has not yet selected a FMS provider for the Central region. Per the information provided during the meeting, OLTL plans to have individuals living in the Western or Eastern region who are new waiver recipients, or who are new to the consumer –directed model, start to use Public Partnerships, LLC on October 1st. Current waiver consumers in these regions will move to the new FMS provider as of December 1st. OLTL is working with Public Partnerships, LLC on the roll out plan so that consumers have a smooth transition to the new FMS provider.

Current waiver recipients using the consumer-directed model have been having problems with FMS services in past months. A number of providers stopped providing FMS services on July 1st and as a result 1700 waiver recipients had to move to a new FMS provider. Since the change, there have been problems with caregivers/attendants not being paid and receiving incorrect payments. OLTL is aware of the problems and working to correct them so that affected caregivers can receive correct and timely paychecks. Attendants working under the consumer-directed model are encouraged to review their paystubs to ensure their pay amounts are correct and that their withheld local taxes are going to the correct municipality or county and at the correct rate. Any discrepancies should be reported to the FMS agency immediately.

Medicare Announces 2013 Part D Costs

Medicare recently announced the standard cost-sharing for 2013 Medicare Part D Plans. Any Part D plan that offers **standard** benefits uses this cost-sharing for its members. Part D plans that instead offer **alternative or enhanced** benefits must assure their coverage is actuarially equivalent to the standard benefits.

The average monthly Part D premium in 2013 is expected to be $30. In addition to the premium, beneficiaries who do not qualify for a subsidy will pay the following for a 2013 standard Part D Plan:

- An annual deductible of **$325** (up from $320 in 2012)
- During the initial coverage period, a 25% co-pay for each prescription until the consumer's total drug costs reach **$2,970** (up from $2,930 in 2012)
- During the coverage gap (also referred to as the "doughnut hole"), a percentage of the costs of drugs (in 2013, 47.5% of the cost of brand name drugs and 79% for generic drugs plus a small dispensing fee) until the consumer's total out-of-pocket expenses reach **$4,750*** (this figure was $4,700 for 2012) and
- During the catastrophic coverage period, a co-pay of **$2.65** for generics and **$6.60** for name-brand drugs, or a 5% co-pay, *whichever is greater* (the current co-pays are $2.60 and $6.50)

More information about the costs of Medicare Part D coverage in 2013 can be found by contacting 1-800-MEDICARE (1-800-633-4227).

**Not all of the costs consumers pay during the donut hole count toward total out of pocket expenses.*

LIS Costs in 2013

The Low-Income Subsidy (LIS) program (also called *Extra Help with Medicare Prescription Drug Plan Costs*) helps qualified consumers with the costs of Medicare Part D. **All** dual eligibles (people that have both Medicare and Medicaid-even if Medicaid is only paying the person's Medicare Part B premium) automatically qualify for a full subsidy. Other beneficiaries can qualify for a full or partial subsidy if they submit an application and meet income and resource guidelines. The current guidelines* to qualify for the LIS are:

- Income less than 150% FPL ($1,396/mo for a single person; $1,891/mo for a married couple)
- Resources below $11,570 for a single person; $23,120 for a married couple.

**These are the limits someone must meet after all disregards are taken.*

In 2013, the LIS benchmark premium for PA is $36.57. This is the maximum amount LIS will pay toward a premium for someone with a full subsidy who is in a standard Part D plan.

People who qualify for the **full subsidy** in 2013 will pay only these small co-pays for their Part D medications (depending on their income):

- $1.15 generics/$3.50 brand name; or
- $2.65 generics/$6.60 brand name; or
- $0 if someone is a full dual eligible (has Medicare and full Medicaid coverage) and is receiving long term care services in a nursing home or through a Home and Community-Based Services Waiver program.

Individuals who qualify for a **partial subsidy** in 2013 will pay the following:

- An annual deductible reduced to $66;
- A 15% co-pay for their drugs once the deductible is met until they spend $4,750 out-of-pocket;
- Co-pays of $2.65/generics and $6.60/brand name drugs for the rest of the year.

Please note there is no coverage gap or "doughnut hole" for people who receive any level of subsidy.

Please support PHLP by making a donation through the United Way of Southeastern PA.

Go to www.uwsepa.org and select donor choice number 10277.

It's Time for LIS Redeterminations!

Each summer and fall, the Centers for Medicare and Medicaid Services (CMS) and the Social Security Administration (SSA) redetermine eligibility for the Medicare Part D Low-Income Subsidy (LIS) for the following year. Redeterminations are now underway for 2013.

Dual Eligibles and Re-deeming Eligibility

Any Medicare beneficiary who gets help from Medicaid (whether full benefits or just help with their Part B premium) automatically qualifies for the full low-income subsidy. The Department of Public Welfare (DPW) in PA sends monthly data files to CMS to identify dual eligibles. CMS then updates the information in their system to reflect the full LIS and informs the individuals' Part D plans about their subsidy status. Once someone qualifies for the LIS as a dual eligible, they continue to get this help for the remainder of the calendar year. Each year, CMS re-deems individuals for the next calendar year based on the July data files sent by DPW. Therefore, Medicare beneficiaries who are also receiving Medicaid benefits in July should be automatically approved for the LIS for all of 2013.

Individuals who lost Medicaid coverage prior to July and have not re-qualified will be sent a notice (on grey paper) from CMS in mid-September telling them that they will lose their automatic LIS on December 31, 2012 because they are no longer a dual eligible. The notices will include an application for LIS. If someone receives this notice, they should complete the application and send it to SSA to determine whether they continue to qualify for the LIS in 2013. They may still qualify based on income and resources; they just no longer qualify automatically for the LIS as a dual eligible.

People who qualify for Medicaid and become dual eligible between now and the end of the year will be approved for the LIS for the remainder of 2012 and all of 2013 as well. They will get a purple notice from CMS.

Orange notices will be sent in early October to individuals who continue to automatically qualify for the LIS in 2013, but whose co-pays will change next year.

Redetermining Eligibility by SSA

Individuals who do not automatically qualify for the LIS must submit an application to SSA, meet income and resource guidelines, and be approved for this help. Thereafter, each year SSA chooses a group of individuals among those they previously approved for the LIS to go through a redetermination. Those selected for redetermination receive a form (SSA Form 1026B) in mid-September. Anyone who receives this redetermination form must complete and return it within 30 days even if nothing in their situation changed. Anyone who does not return the form to SSA could end up losing their LIS at the end of the year.

SSA will review the redetermination forms submitted and send notice to individuals if there is a change in their subsidy status for 2013. Beneficiaries not chosen for redetermination by SSA will continue to get their current subsidy in 2013.

HealthChoices New West Starts October 1st

Most Medical Assistance (MA) recipients living in Northwestern PA will be enrolled in a managed care plan for coverage starting October 1st. As of that date, MA consumers living in Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango and Warren become part of the newly created **New West HealthChoices Zone.** ACCESS Plus ends in these counties on September 30th. As reported in previous newsletters, this is part of the statewide expansion of HealthChoices (mandatory managed care for most Medicaid consumers) that is occurring in phases.

Individuals who have been getting their MA coverage through ACCESS Plus needed to join a plan by September 6th; individuals who missed this deadline will be auto-enrolled into one of the four plan options available in the New West zone: **Amerihealth Mercy, Coventry Cares, Gateway Health Plan** and **UPMC for You.**

Those currently enrolled in a Voluntary Plan with either Gateway Health Plan or UPMC for You had the option to stay in the plan they are in (in which case they will move into HealthChoices in the same plan effective October 1st) **or** switch to a new plan (by enrolling no later than September 6th) that will go into effect October 1st. **Those currently enrolled in a Voluntary Plan with United Healthcare Community Plan will *not* be able to stay in this plan because it is no longer doing business in the Zone as of the end of September**. Therefore, all those in United Healthcare needed to enroll in one of the four available plans by September 6th or be auto-assigned to a plan.

As a reminder, Medical Assistance recipients with Medicare (dual eligibles) do **not** join HealthChoices and therefore do not have to pick a health plan. These dual eligibles and those listed below remain in the fee-for-service delivery system and will continue to use the ACCESS card for their Medicaid coverage. Other groups of people exempt from HealthChoices include:

- **Aging (PDA) Waiver** participants,
- **LIFE Program** participants,
- **Nursing Home Residents** (who have been in the nursing home longer than 30 days),
- **HIPP Participants** (Medicaid consumers who are also enrolled in employer-sponsored health insurance for which Medicaid is paying the premium), and
- Women eligible for Medical Assistance under the **Breast and Cervical Cancer Prevention and Treatment (BCCPT) Program.**

MA recipients who missed the September 6th deadline can still contact PA Enrollment Services (1-800-440-3989) to join a plan; however, the effective date of this plan may be after October 1st. In this case, they would be enrolled in the plan they were assigned to for a short time and then be changed to the plan of their choice. Individuals can also call PA Enrollment Services to find out what plan they were assigned to for coverage starting October 1st. Finally, consumers in the New West zone can change plans at any time. Individuals wishing to change plans can contact PA Enrollment Services to join a new plan and will be told the date their new coverage will become effective.

Please contact our Helpline at 1-800-274-3258 if you have any problems accessing services after October 1st or if you have questions about HealthChoices.

What Happens When I Become a Dual Eligible?

(Part 2 in a Series)

Each month through our Helpline, PHLP talks to individuals (or to their family members, advocates or providers) who are "new" dual eligibles. New dual eligibles can be people who have been on Medicaid and then also become eligible for Medicare, or people who have been on Medicare who then also qualify for Medicaid. Individuals can be ***full dual eligibles*** *(people that have Medicare and get full coverage through Medicaid categories such as Healthy Horizons/QMB Plus, MAWD, or Waivers) or* ***partial dual eligibles*** *(people who have Medicare and then obtain only limited coverage through Medicaid such as having Medicaid pay for their Part B premium).*

This series reviews what happens when someone becomes a dual eligible and what, if any, actions they need to take. Our April 2012 Senior Health News (available at www.phlp.org) discussed individuals receiving full Medicaid coverage who ***then*** *become eligible for Medicare. This newsletter will discuss individuals on Medicare who later become eligible for full Medicaid. An upcoming newsletter will discuss partial dual eligibles - those who have only limited benefits from Medicaid (like the Medicare Savings Program where Medicaid pays someone's Part B premium—also called "buy-in").*

Individuals who have Medicare coverage and then become eligible for full Medicaid

Individuals become entitled to Medicare when they turn 65, after they've received Social Security Disability Insurance (SSDI) cash benefits for 24 months, or if they have End-Stage Renal Disease. Older adults and people with disabilities on Medicare can also qualify for Medicaid if they have limited income and resources. The most common categories of Medicaid for individuals with Medicare are: Healthy Horizons, Medical Assistance for Workers with Disabilities, or those who need long-term care services through a home and community-based services Waiver program or in a nursing home. In addition to providing full health care coverage, individuals in these categories may also qualify for the state to pay their Part B premium (depending on their income and resources).

Medicare beneficiaries who apply and are found to qualify for full Medicaid benefits receive a notice from the County Assistance Office saying they're approved for Medicaid benefits. They also receive an ACCESS card (yellow if they only qualify for MA benefits; greenish-blue if they also qualify for food stamps) that acts as secondary insurance to their Medicare.

- ***Medicare beneficiaries who qualify for full benefits through Medicaid now have coverage for their Medicare deductibles and coinsurance plus coverage for benefits Medicare doesn't offer.***

  Action Needed: When they are making their medical appointments, dual eligibles need to let their providers know that they now have Medicaid coverage through their ACCESS card in addition to their Medicare and other insurance. They should always show their ACCESS card along with their Medicare and other health insurance cards when getting **any** health care services. The ACCESS card should cover Medicare deductibles and coinsurance; individuals should only receive bills from their medical providers for very small amounts.

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Any dual eligible who has been paying for a Medicare Advantage Plan or a Medigap policy may want to consider dropping that coverage because they now have comprehensive secondary insurance through Medicaid/ACCESS. Before making this decision, however, these consumers should check with their doctors and other health care providers to make sure that the provider will continue to treat them with only Medicare and the ACCESS card.

⇒ One option these individuals have is to enroll in a Medicare Special Needs Plan (SNP) for dual eligibles (not available in every county in PA) or to join a zero-premium stand-alone Medicare drug plan. Before joining a SNP, individuals should check that their providers are in the plan's network since the SNP becomes their Medicare coverage.

⇒ Individuals who choose to drop their Medigap policy may want to ask to have their policy suspended because they now qualify for Medicaid. Suspending Medigap policies allows individuals to get the coverage back if for some reason they lose Medicaid within 24 months. Individuals should talk to Medicare (1-800-633-4227) or APPRISE (1-800-783-7067) to learn more about this.

In addition to helping with Medicare cost-sharing, Medicaid covers certain services not covered by Medicare. This includes dental care and eye exams. Full dual eligibles can get these services through their ACCESS card. Medicaid also covers long-term care services for qualified individuals; Medicare doesn't cover ongoing long-term care.

- ***New Dual Eligibles will automatically qualify for the full LIS to help with their Medicare Prescription Drug Plan (Part D) costs.***

  Action Needed: Individuals don't need to take any action to get the full LIS. Once someone qualifies for full MA benefits, they automatically qualify for the full LIS to help with their Medicare Part D costs. The state regularly sends data to Medicare to identify full dual eligibles; Medicare then updates their systems to show the LIS and notifies the individuals' Part D plan. The full subsidy limits someone's Part D costs to $0 (if she receives Medicaid covered long-term care services in a nursing home or through a waiver program) or $1.10/$2.60 for generic drugs and $3.30/$6.50 for brand name drugs, depending on their income.

- ***Full dual eligibles have to get their drug coverage through Medicare Part D, but Medicaid provides limited drug coverage through the ACCESS card.***

  Action Needed: Medicare beneficiaries who are new to full Medicaid can join a Part D plan if they do not currently have one, or they can change their Part D plan. As a dual eligible, individuals qualify for an ongoing Special Enrollment Period and can therefore enroll in a Part D plan or change Part D plans any time during the year. Because individuals qualify for the full LIS, they are not subject to any late enrollment penalty that might apply.

  Dual eligibles who do not yet have active Medicare Part D coverage (and who are not in a Medicare Advantage medical only plan) can use LI NET to get their medications until their Part D enrollment becomes active (the first of the month after enrolling). If any new dual does not take action to join a Part D plan, Medicare will randomly assign them to *(Continued on Page 9)*

(Continued from Page 8) a zero-premium prescription drug plan. If that plan doesn't meet someone's needs, he can change to a different plan.

Full duals can use their ACCESS card at the pharmacy to get certain medications excluded from Part D coverage. This currently includes benzodiazepines (i.e., Ativan, Klonopin), barbiturates (i.e., Phenobarbital), and certain over the counter medications.

- ***Individuals who had been getting prescription coverage through PACE or PACENET will no longer qualify for that coverage.***

  Action Needed: New full duals who have been getting their medications through PACE or PACENET should join a Medicare Part D plan if they do not already have one. This is especially true if someone is in a Medicare Advantage medical only plan and using PACE/NET as their drug coverage because Medicare will not enroll them in a separate drug plan nor can they use the back-up LI NET plan to get their medications. These individuals need to switch to a Medicare Advantage plan that includes Part D coverage (could be a Special Needs Plan for duals), or join a stand-alone drug plan in which case they'd switch back to Original Medicare. Individuals can contact the PHLP Helpline for advice about their plan options or for help selecting a Part D plan, or they can contact APPRISE or Medicare.

- ***Individuals may receive a HealthChoices Packet instructing them to enroll in a Medicaid managed care plan.***

  Action Needed: Individuals should pick a Medicaid plan that allows them to see their doctors (it will still be secondary coverage to their Medicare); however, they will soon be taken out of the plan and go back to using their ACCESS card. DPW's computer system typically requires Medicare beneficiaries new to MA to initially enroll in a Medicaid managed care plan. Though these duals must join a plan, they will only be in the plan for a short 1-2 month period until the state's systems are fully updated to show that they have active Part D coverage.

A future newsletter will discuss partial dual eligibles.

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Medicare Annual Open Enrollment Starts October 15th!

The time of year when all Medicare beneficiaries can make changes to their drug coverage and/or their Medicare Advantage plan coverage starts October 15th. This period, known as Open Enrollment, runs until December 7th. Any changes made by a beneficiary during this period become effective January 1, 2013. Information about plan options for 2013 should be available from Medicare in mid to late September. Medicare drug plans and Medicare Advantage plans must send their current members information by the end of September about how the plan benefits will change in 2013. Plans can start marketing for 2013 on October 1st and Medicare's website (www.medicare.gov) will be updated with the 2013 plan information in early October. Everyone on Medicare should review their current plan to see if it will continue to meet their needs in 2013. Individuals who need help during the Open Enrollment Period can contact APPRISE (PA's State Health Insurance Program) at 1-800-783-7067.

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