SENIOR HEALTH NEWS

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2012-2013 Budget Proposal Announced

Governor Corbett announced his 2012-2013 Proposed Budget February 7th. The Department of Public Welfare (DPW) held a budget briefing later that same day.

The proposed budget for DPW aims to maintain the safety net for the most vulnerable while encouraging independence and self-sufficiency. Budget proposals for the Medicaid program include expansion of HealthChoices (mandatory managed care), audit enhancements to make sure Medicaid is paying claims properly, reviewing high cost cases to better coordinate care, and reducing rates to certain providers such as nursing homes and hospitals. The proposed budget also includes changes to the eligibility criteria for certain General Assistance categories of Medicaid and changes to how the Medical Assistance for Workers with Disabilities (MAWD) premium is calculated. Our March Health Law PA News will detail the DPW budget and its impact on Medicaid and the other public health programs.

The PA Senate Appropriations Committee held a DPW budget hearing February 28th. The PA House Appropriations Committee will hold its DPW Budget Hearing March 7th at 9:30 am in Room 140 of the Main Capitol. These hearings are open to the public.

Secretary Brian Duke testified at the Department of Aging Senate Appropriations Budget Hearing on February 21st. He stated that the PACE/PACENET programs will continue to serve older adults with limited incomes and that there are no plans to reduce the number of enrollees despite reduced funding for the program in the proposed budget. Also, the Aging Department supports the growth of Home and Community-Based Services and recognizes the challenge in allocating funding across the continuum of care, especially in rebalancing efforts. PA currently spends 58% of long-term care funds on institutional care (i.e., nursing homes) and 42% on home and community-based services.

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MATP Co-Pays To Start May 1st

The Department of Public Welfare (DPW) plans to impose a $2 co-pay on Medical Assistance Transportation Program (MATP) riders for each one-way paratransit trip ($4 for a round trip) beginning May 1, 2012. DPW recently issued proposed regulations about these co-pays (see below). They also released a Draft Operations Memo and Consumer Notice regarding the MATP co-pays and sought comment from stakeholders including the Consumer Subcommittee of the Medical Assistance Advisory Committee, county MATP programs, and other interested parties.

According to DPW's draft policy, the following individuals will be **excluded** from the co-pay requirement:

- Consumers under the age of 18
- Pregnant women (this exclusion will last through their 60 day post-partum period)
- Women on Medical Assistance through the Breast & Cervical Cancer Prevention and Treatment Program (BCCPTP)
- Consumers who live in personal care homes that do not provide transportation to their residents
- Consumers in hospice care

All other MATP consumers who use paratransit or taxi services will be subject to the $2 co-pay per one-way trip. Those escorting a consumer to their medical appointments are not subject to the co-pay.

The county MATP programs will send out a written notice to all current MATP paratransit riders in advance of the co-pay policy going into effect. **The draft policy specifies that the county may not deny transportation to a consumer who is unable to pay the co-pay.** However, the policy goes on to say that the consumer is still responsible for the co-pay and that the county can attempt to collect outstanding co-pays from consumers.

DPW Issues Proposed Regulations for Quick Comment under Act 22

Earlier this month, DPW published its regulatory agenda in the PA Bulletin identifying several regulations that will go through expedited rulemaking under Act 22 of 2011. This means that the Department will not go through the formal regulatory process and that the proposed changes will happen quickly. DPW posted the proposed regulations available for public comment on its website. **Comments are due March 9th**.

Proposed regulations include changes to Medicaid co-pays (including the MATP co-pays previously discussed) as well as provider qualifications and rates for home and community-based services. The proposed regulations and information about where to submit comments can be found here: http://www.dpw.state.pa.us/publications/budgetinformation/act22-expeditedregulatorychangestothedpw/index.htm

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LIS & MSP Resource Limits Increase in 2012

The 2012 resource limits to qualify for the Part D Low-Income Subsidy (LIS) and the Medicare Savings Programs (MSP) have been announced and are higher than the previous limits.

Part D Low-Income Subsidy (LIS)

The Part D LIS helps with Medicare Part D prescription costs by eliminating the donut hole, reducing co-pays, and helping with the annual deductible and monthly premium costs.

LIS asset limits in 2012 will be:

- **Full Subsidy: $6,940 for a single person and $10,410 for a married couple**
  (in 2011, the limits were $6,680/single person and $10,020/married couple)
- **Partial Subsidy: $11,570 for a single person and $23,120 for a married couple**
  (in 2011, the limits were $11,140 for a single person and 22,260 for a married couple)

Please note that the asset limits shown above are *after* all deductions and disregards are taken (including the $1,500 per person disregard the Social Security Administration gives to LIS applicants who plan to use their assets for funeral or burial expenses).

Individuals can apply for the LIS through the Social Security Administration (online at www.ssa.gov/prescriptionhelp or call 1-800-772-1213 for a paper application).

Medicare Savings Programs (MSPs)

The MSPs provide payment of the Medicare Part B premium and may help with Medicare Parts A and B cost-sharing (deductibles and coinsurance) for certain qualified individuals. Federal law requires MSP resource limits to match the resource limits for the full Low-Income Subsidy. **Therefore, in 2012, the MSP asset limits will be $6,940 for a single person and $10,410 for a married couple.** The limits in 2011 were $6,680 (single) and $10,020 (married couple). Again, these amounts are after all deductions and disregards are taken.

Individuals apply for MSP through the PA Department of Public Welfare. There is a paper application specifically for the Medicare Savings Program (PA 600M) which can be downloaded at www.dpw.state.pa.us or by calling 1-877-395-8930. People can also apply via www.compass.state.pa.us, but there they must complete the entire Medicaid application.

Please contact PHLP's Helpline at 1-800-274-3258 with questions about qualifying for either the LIS or MSP.

State Budget 2012-2013: Stay Informed

PHLP's Health Law News will be providing important information about the state budget and its impact on health care in the coming months.

If you don't already subscribe to the Health Law News, email staff@phlp.org or call the Helpline to join the Health Law News mailing list.

2012 Federal Poverty Levels Announced

The 2012 Federal Poverty Level (FPL) guidelines were published January 26, 2012 and are higher than previous income limits. Public benefit programs (such as Medicaid) use these guidelines to determine who qualifies for coverage. Below is a brief overview of financial eligibility for programs that affect older adults and that use FPLs in determining eligibility. Please note that these figures are what someone must meet **after** all deductions and disregards are applied.

Category	Description	2012 Monthly Income Limit	2012 Resource Limit
Healthy Horizons (QMB Plus)	**Full Medicaid** coverage for individuals age 65 and older and persons with permanent disabilities	**$931** single **$1,261** married	**$2,000** single **$3,000** married
Qualified Medicare Beneficiary (QMB)	Helps Medicare beneficiaries with Part A and B cost-sharing as well as the Part B premium	**$931** single **$1,261** married	**$6,940** single **$10,410** married
Specified Low-Income Medicare Beneficiary (SLMB)	Helps Medicare beneficiaries pay the Part B premium	**$1,117** single **$1,513** married	**$6,940** single **$10,410** married
Qualified Individual (QI-1)	Helps Medicare beneficiaries pay the Part B premium	**$1,257** single **$1,703** married	**$6,940** single **$10,410** married
Medical Assistance for Workers with Disabilities (MAWD)	**Full Medicaid** coverage for individuals through age 64 who have a disability and who are able to do some work	**$2,328** single **$3,153** married	**$10,000** for single and married individuals
Home and Community-Based Services (HCBS) **Waivers**	Individuals age 60 and older and younger people who have certain disabilities and who meet level of care requirements can get **support services** to remain living as independently as possible and get **full Medicaid** coverage	**$2,094** (only applicant's income is counted)	**$8,000** (if married, the resources of both spouses are considered and spousal impoverishment rules apply)
Medicare Part D Low-Income Subsidy/Extra Help	Helps Medicare beneficiaries with their Part D (prescription drug) costs. Individuals who do not qualify for Medicaid must meet the income and resource limits shown here	Full Subsidy **$1,257** single **$1,703** married Partial Subsidy **$1,396** single **$1,891** married	Full Subsidy **$6,940** single **$10,410** married Partial Subsidy **$11,570** single **$23,120** married

DPW To Change Consumer-Directed Support Services

A number of Pennsylvania's Home and Community Based Services (HCBS) Waiver programs that serve people with disabilities and older adults allow consumers to receive certain services such as Personal Assistance Services or Respite using the Consumer Model (also known as the Participant Directed Model). Individuals who choose this model can hire and fire their own support staff. The state pays an organization to provide Financial Management Services (FMS) to the waiver participant which includes issuing paychecks to staff, paying the required taxes, and completing unemployment and workers compensation paperwork.

The waivers that offer this service include Aging, Attendant Care, CommCare, Consolidated, Independence, OBRA and Person Family Directed Supports (PFDS). PA currently has 37 organizations that perform this FMS function for 22,000 people in various parts of the state.

On January 5th, DPW announced it intends to only contract with up to three organizations — one for each of three geographic regions of the state — to perform the FMS function. Organizations can apply to perform FMS for one, two or all three regions so, depending on DPW's decision, there could be just one agency chosen to serve the entire state. Applications are due March 30th.

DPW maintains that reducing the number of Financial Management Service organizations from 37 to 3 or less, will reduce costs and increase efficiencies. Consumer advocates are concerned because waiver recipients will lose their ability to choose their Financial Management Service organization as there will be only one FMS organization per region. Additionally, several organizations that currently provide Financial Management Services are consumer-run organizations, such as the Centers for Independent Living. Losing that funding will not only affect the consumers that use those organizations, but will likely result in layoffs of people employed by those organizations, many of whom are people with disabilities.

PHLP will keep readers posted about this matter in future newsletters.

PA Developing 2012-2016 State Plan on Aging

The PA Department of Aging and the Office of Long Term Living have started the process of updating the State Plan on Aging that guides the provision of services to older adults in Pennsylvania. This Plan must be updated every four years.

Stakeholder input will be sought and gathered through focus groups, town meetings, and public hearings. The plan will be submitted to Governor Corbett for approval and then sent to the federal Department of Health & Human Services' Administration on Aging by the end of June 2012.

See www.aging.state.pa.us for more information on the state plan.

Update about Part D Co-Pays for Dual Eligible Waiver Recipients

Medicare's systems have now been updated to show dual eligible Home and Community-Based Services (HCBS) Waiver recipients as having $0 co-pay for Part D covered medications. As discussed in previous newsletters, Medicare beneficiaries who also receive HCBS Waiver services are not to have co-pays under Medicare Part D as of January 1st .

There was a delay in implementing this change due to problems with the data transfer between the Department of Public Welfare and Medicare that identifies which dual eligibles qualify for the zero co-pays. Now that those problems appear to be resolved, Medicare should be notifying the various Part D plans about which of their members qualify for zero cost-sharing. Part D plans then must update their systems to reflect this zero co-pay in order for HCBS waiver recipients to be charged no co-pay at the pharmacy.

Dual eligible waiver recipients who are still being charged a co-pay at the pharmacy for their Part D covered medications should contact their Part D plan to see if the Plan's systems are updated to reflect the zero co-pay. In addition, Part D plans are responsible for updating their systems back to January 1st and refunding those who paid co-pays but who qualified for zero cost-sharing back to that date.

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