PENNSYLVANIA Health Law PROJECT

SENIOR HEALTH NEWS

A publication of the Pennsylvania Health Law Project

Helpline: 800-274-3258 • www.phlp.org
Volume 15, Issue 1 • February 2013

Proposed State Budget's Impact on Older Adults

Governor Corbett presented his proposed FY 2013-2014 budget to the General Assembly on February 5th. House and Senate Appropriations Committee hearings are now underway during which the head of every state agency appears before the Committees and answers questions. Over upcoming months, both the House and Senate will develop their own appropriation bills that detail their spending plans. Then, the Governor and legislative leaders will negotiate on one bill that will pass both chambers. The final budget needs to be passed by July 1st.

The big news regarding the budget proposal for DPW is that the Governor announced the administration does not plan to expand Medicaid eligibility as allowed by the Affordable Care Act at this time. However, the language in his written materials seemed to leave the door open to the possibility of the state expanding Medicaid eligibility in the future. Hospitals and advocacy groups are urging Governor Corbett to change his position. It has been estimated that over 600,000 uninsured Pennsylvanians would benefit from this expansion. Please note that Medicaid expansion under the Affordable Care Act does not apply to those age 65 and older, or to those enrolled in Medicare. However, younger seniors could certainly benefit from Medicaid expansion.

Overall, the General Fund budget as proposed is $28.4 billion-a 2.4 percent increase from the previous year. This is the first budget in which the Governor proposes increasing, rather than cutting, spending. Much of the increase is due to mandatory expenses (i.e., slight reduction in the federal share of funding for Medicaid, increases in Medicaid enrollment). Much of the spending in the proposed budget depends on policy changes that are not guaranteed such as the administration's efforts to privatize the lottery and the

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(Continued from Page 1) state stores. Highlights of the proposed budget affecting older adults include:

- Expanding Home and Community-Based Services to serve more people and reduce waiting lists.
  - ◊ $50 million in lottery funds to:
    - ♦ serve an additional 1,550 older adults through the Aging Waiver
    - ♦ serve 5,400 additional people in the Options program (currently there is a waiting list of over 5,000 individuals for these services statewide)
    - ♦ support Area Agencies on Aging (AAAs)
    - ♦ modernize senior centers
    - ♦ support individuals with disabilities who are turning 60 and moving into the aging programs

    **It is important to note that, in the Governor's budget proposal, this $50 million dollars is dependent on the privatization of the lottery. If the lottery is not privatized, it is uncertain whether this additional funding would still be available.

  - ◊ Increased funding to expand home and community-based services for individuals with disabilities and reduce waiting lists that currently exist for some of these programs—this funding would allow almost 1,200 more individuals with intellectual disabilities to be served with a special focus on those with aging parents.
- Additional $9 million to increase the number of older adults served through the LIFE program
- 2 percent increase in Nursing Home payment rates

We continue to analyze the budget proposal and will have more information in upcoming newsletters as developments occur. Individuals interested in other information about the proposed budget should consider subscribing to our Health Law PA News.

State Budget 2013-2014: 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.

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For Southeast PA, go to www.uwsepa.org and select donor choice number 10277.
For the Capital Region, go to www.uwcr.org and pledge a donation to PHLP.
For the Pittsburgh Region, go to www.unitedwaypittsburgh.org and select agency code number 11089521.

2013 Poverty Levels Announced

The 2013 Federal Poverty Level (FPL) guidelines were published in the Federal Register on January 24, 2013 and are higher than last year's poverty levels. 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 programmatic deductions and disregards are applied.

Category	Description	2013 Monthly Income Limit	2013 Resource Limit
Healthy Horizons (QMB Plus)	Full Medicaid coverage for individuals age 65 and older and persons with permanent disabilities	$958 single $1,293 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	$958 single $1,293 married	$7,080 single $10,620 married
Specified Low-Income Medicare Beneficiary (SLMB)	Helps Medicare beneficiaries pay the Part B premium	$1,149 single $1,551 married	$7,080 single $10,620 married
Qualified Individual (QI-1)	Helps Medicare beneficiaries pay the Part B premium	$1,293 single $1,745 married	$7,080 single $10,620 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	$2,394 single $3,232 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	$2,130 (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 $1,293 single $1,745 married Partial Subsidy $1,436 single $1,939 married	Full Subsidy $7,080 single $10,620 married Partial Subsidy $11,800 single $23,580 married

HealthChoices New East Zone Starts March 1st

Twenty-two counties in North Central and Northeastern PA will make up the HealthChoices New East Zone that goes live on March 1st. As of that date, DPW will have completed the statewide expansion of HealthChoices (mandatory managed care for most Medicaid consumers) that it started a year ago. The counties affected are: Bradford, Carbon, Centre, Clinton, Columbia, Juniata, Lackawanna, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne and Wyoming.

Medicaid consumers residing in these 22 counties were given a deadline of February 7th (which DPW later extended to February 14th) to make a choice and enroll into one of three Medicaid managed care plans available in the Zone-namely, Geisinger Health Plan, Coventry Cares and Amerihealth Northeast. Anyone who did not enroll by that date was randomly auto-assigned to one of the three plans. All enrollments are effective March 1st.

All affected consumers should have been sent a membership card from their managed care plan which they must use to obtain all their physical healthcare and their medications beginning in March. Generally, under HealthChoices, Medicaid consumers must receive all their healthcare and services from healthcare providers who are in their plan's network. However, for those who are pregnant, those receiving prior authorized services, or those in a course of treatment with a provider, there are continuity of care rules in place. These require the managed care plan to continue to provide the services and honor existing treatment relationships for some period of time after the consumer joins the plan.

Presenting to the Consumer Subcommittee of the Medical Assistance Advisory Committee, DPW officials reported that 44 percent of Medicaid consumers in the New East Zone made a choice and enrolled into one of the plans. Of those, 69 percent chose Geisinger Health Plan, 17 percent chose Amerihealth Northeast and 14 percent chose Coventry Cares. The remaining 56 percent of consumers who did not make a choice will be equally shared among the three plans through a random assignment process. Anyone wanting to switch the managed care plan they chose, or were assigned to, can do so at any time by contacting PA Enrollment Services at 1-800-440-3989 or by going to www.enrollnow.net.

Certain Medicaid consumers in the New East Zone **will not** be affected by the HealthChoices expansion because they are exempt from managed care and continue to receive their Medicaid coverage through the ACCESS card. They include:

- **Full Dual Eligibles-** Medicare beneficiaries who also have full Medicaid through their ACCESS card
- **Aging (PDA) Waiver participants**
- **LIFE program participants**
- **HIPP participants-** Medicaid consumers who are also enrolled in employer-sponsored health insurance for which Medicaid is paying the premium

Anyone experiencing difficulties accessing healthcare coverage and services in the New East Zone is encouraged to call PHLP's Helpline at 1-800-274-3258 or to email us at staff@phlp.org.

Reminder: Full Dual Eligibles Receiving Waiver Services Should Have No Part D Co-Pays

Since the beginning of 2012, individuals on Medicare who also qualify to receive Home and Community-Based Services (HCBS) through **any** of Pennsylvania's Waiver programs should have $0 co-pays under Medicare Part D. This means that all dual eligibles receiving services through any of the following programs qualify for this $0 co-pay for all medications covered by their Part D plan:

- Aging (PDA) Waiver
- LIFE Program
- Attendant Care Waiver
- Independence Waiver
- COMMCARE Waiver
- OBRA Waiver
- Person/Family Directed Support (PFDS) Waiver
- Consolidated Waiver
- AIDS Waiver
- Adult Autism Waiver

The waiver consumer's Part D plan should receive information from Medicare that the individual qualifies for this $0 co-pay under the low-income subsidy. The Department of Public Welfare regularly sends data files to Medicare to identify all dual eligibles and these data files are what also identifies the individual as receiving HCBS. Medicare then updates their system to reflect the subsidy and the correct cost-sharing level and then notifies the various Part D plans about their members subsidy status and particular cost-sharing that should be charged (either $0, $1.15/$3.30, or $2.65/$6.60).

Please note that the $0 co-pay only applies to medications covered under the individual's Part D plan. If someone gets a medication that their Part D plan does not cover (because it is not on the plan formulary or needs Prior Authorization), the individual could be charged for that medication unless their doctor requests a formulary exception or submits a Prior Authorization Request. Also, Medicaid still covers a few medications that are excluded from the Part D benefit (certain over-the-counter medications and barbiturates when not used to treat cancer, epilepsy and chronic mental health conditions). If a dual eligible gets a medication at the pharmacy that is being covered by Medicaid (i.e., their ACCESS card), the individual may have to pay a small co-pay for those medications ($1 for generics or $3 for brand names).

PHLP still occasionally hears from Dual eligible Waiver recipients who are not receiving their Part D meds for the $0 co-pay. If someone needs assistance with this issue, please contact our Helpline at 1-800-274-3258.

Payment Problems Continue for Waiver Recipients and Caregivers under New Vendor

Individuals receiving services through the Aging, Attendant Care, COMMCARE, Independence, and OBRA Waivers and their caregivers continue to struggle with payment problems even after a new vendor, Public Partnerships, Ltd (PPL) took over responsibilities late last year. Consumers in these waiver programs who choose to hire their own workers under the consumer model receive Financial Management Services (FMS) for the administrative tasks associated with the consumer model. The FMS provider is responsible for writing paychecks, paying required taxes, and handling paperwork related to workers compensation and other employment-related issues.

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As discussed in previous newsletters, the Office of Long-Term Living (OLTL) decided to contract with only one company, PPL, to provide FMS services across the state. PPL started as the FMS provider for new Waiver recipients, and for Waiver recipients who were new to the consumer model as of October 1st. Ongoing Waiver recipients in the programs listed above who had previously been receiving FMS services were transitioned to PPL in mid-December so that PPL could start issuing paychecks as of January 1st.

Since the transition to PPL began, thousands of caregivers have experienced delays in receiving their paychecks, leaving individual waiver consumers at risk for losing their workers who they rely on for their daily care and placing great burden on caregivers who are struggling to pay their bills. Adding to the frustration of these individuals is the fact that they were unable to reach PPL by phone to report problems or find out the status of their pay. These problems have been occurring across the state and across the various OLTL Waiver programs.

OLTL is aware of the problems and they have been working with PPL to get these problems resolved. Both OLTL and PPL blame many of the problems with the delayed payments on problematic data received from previous FMS providers. At a meeting of the Long-Term Care Subcommittee of the Medical Assistance Advisory Committee earlier this month, the Office of Long-Term Living reported that 94 percent of timesheets submitted have been paid and noted that if someone has not been paid, there is likely a problem with the timesheet submitted to PPL. OLTL also noted that PPL should provide assistance with filling out their forms if needed.

Important Information for Consumers using PPL

- The packet does not need to be completed to submit timesheets; however, PPL timesheets must be used (available at www.publicpartnerships.com). Consumers who don't already have a PPL time-sheet with their attendant's name on it can download a blank copy from PPL's website, fill it out completely, and use that.
- Only one time sheet should be faxed at a time. If a consumer hires more than one worker, wait until the first timesheet goes through before faxing the next. Consumers are advised **not** to fax a cover sheet- just the time sheet. In addition, timesheets may **not** be faxed before the due date, even if the worker will not be working any more days during that pay period.
- Consumers with access to the internet can get a user name and password to track the processing of their workers' timesheets online.
- Consumers who are trying to hire a new attendant are currently experiencing a delay of about a month before they are put on payroll by PPL.

Waiver consumers who experience problems with their caregivers being paid by PPL can contact PHLP's Helpline at 1-800-274-3258.

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Would you like to get these newsletters by e-mail?

Then contact staff@phlp.org and let us know!

PA Fair Care Stops Taking Applications on March 3rd

PA Fair Care, Pennsylvania's health insurance plan for people with pre-existing conditions, stops taking applications as of March 3rd. The Centers for Medicare and Medicaid Services recently imposed this deadline to suspend enrollments to ensure funding is available throughout 2013 to continue to cover the individuals enrolled in the programs and others like it across the country. As of January 2013, 6,779 people were enrolled in PA Fair Care.

PA Fair Care was created by the Department of Insurance as a temporary insurance program for people with pre-existing conditions who were not able to purchase coverage on their own because of their conditions. The Affordable Care Act (ACA) created the Pre-Existing Condition Insurance Plan (PA Fair Care is a state-based pre-existing condition insurance plan) and offered funding for both the federally-run program and the state-based programs to offer temporary coverage to individuals until 2014. As of January 1, 2014, the Affordable Care Act makes affordable coverage available to adults regardless of their health status or pre-existing conditions through health insurance marketplaces (also called "exchanges").

Starting in October 2013, Pennsylvania residents can begin to use the exchange to enroll in health care coverage that will start January 1, 2014. Governor Corbett has decided that Pennsylvania will not operate its own health insurance exchange and instead will use an exchange operated by the federal government. The exchange will offer individuals and their families a choice of health plans resembling what workers at major companies already receive. Through the exchange, the federal government will also help many households pay their premiums by giving them a federal tax credit. Much work remains to be done and many decisions need to be made by federal **and** Pennsylvania officials. Individuals interested in information about the exchange and how things will work in Pennsylvania are encouraged to join the e-mail list to receive our Health Law PA News (see page 2).

Individuals can find more information about PA Fair Care and about how to apply at its website: www.pafaircare.com.

Keystone Mercy Health Plan Enrollments Suspended

Beginning April 2nd, DPW is suspending new enrollments into Keystone Mercy Health Plan (KMHP) for the remainder of the 2013 calendar year. Although dual eligibles are not in Medicaid managed care, this suspension could affect some younger seniors who are not yet eligible for Medicare, who live in Southeastern PA, and who are currently in a Medicaid managed care plan.

KMHP initiated the request to suspend enrollments and DPW stated it approved the suspension in order to balance membership distribution in the Southeast HealthChoices Zone. Though it is one of five man-

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(Continued from Page 7) aged care plans available in the Southeast Zone, KMHP currently covers 55 percent of the Southeast HealthChoices population. This is the second time KMHP requested, and DPW approved, a suspension of enrollments into the plan-the first being in 2010. Consumers and advocates have expressed concern to DPW over its intervention, yet again, in KMHP enrollments and in the resulting reduction of plan choices for consumers in the HealthChoices Southeast zone.

The enrollment suspension will **not** affect existing KMHP members. People who had KMHP and who then lose Medicaid eligibility will be enrolled back into KMHP as long as their break in coverage is less than six months. KMHP members who **change** plans will not be able to change back to KMHP until the suspension is lifted.

MA consumers in the Southeast Zone enrolling into a managed care plan for the first time, as well as anyone wanting to switch from their current plan to KMHP, must enroll no later than **March 14th** in order for the change to go into effect before the April 2nd enrollment "freeze."

If you have any questions about your health plan choices, contact PA Enrollment Services at 1-800-440-3989. You can also contact PHLP's Helpline if you need additional assistance or have questions about plan choices.

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